Bundle Finance and Performance OPEN 21 July 2025

Agenda attachments

ITEM 00 FPC Agenda - 21 July 2025 - Open

0 09:30 - OPENING ITEMS

1 Chair's welcome, apologies, and confirmation of quorum

2 Declarations of Interest

ITEM 02 Board Member Register of Interests as at 13 July 2025

3 Minutes of last meeting

ITEM 03 2025-05-20 Draft OPEN F and P Minutes

4 Action log and matters arising

ITEM 04 Action Log

ITEM 04.1 FPC AAA Open 20 May 2025

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Operations Quarterly Report

ITEM 05 Operations Quarterly Report for Committees 25-26 Q1 FINAL

6 10:00 - Financial Position for Month 2, 25/26

6.1 Financial Position for Month 3, 25/26

ITEM 06 Finance Report Month 2 25-26 Final

ITEM 06.1 Month 02 2025-26 - Welsh Ambulance Services NHS Trust - Monitoring Return - final

7 10:10 - Financial Sustainability Programme Update

ITEM 07 Financial Sustainability Programme Position Paper - Finance and Performance Committee 21 July 2025

8 10:20 - 25/26 Commissioning

ITEM 08 2526 Commissioning Update SBAR FPC 20250721

ITEM 08.1 Commissioning Intentions

9 10:35 - Integrated Medium Term Plan (IMTP) Progress Report

9.1 Long Term Plans Organogram

ITEM 09 Executive Summary - IMTP Delivery & Assurance Q1 2526

ITEM 09.1 - Strategy Landscape Jul 2025 and Organogram

ITEM 09.1a Appendix A - 2506 - CMT Programme Highlight Report

ITEM 09.1b Appendix B - IMTP Delivery & Assurance Report Q1 Jun 25

10 10:50 - Monthly Integrated Quality Performance Report

ITEM 10 MIQPR SBAR FPC May June 2025

ITEM 10.1 MIQPR FPC May June 2025

10.1 11:00 - COMFORT BREAK

11 11:15 - Quality and Performance Management Framework (QPMF) Benefits Map

ITEM 11 Q&PMF 2025-28 SBAR LBM F&PJul25 hb20250703(1)

ITEM 11.1 Q&PMF Logic Models v4

12 11:30 - Emergency Preparedness, Resilience and Response (EPRR) Annual Reports

12.1 Annual HART KPI Report - Circulated by e mail

12.2 Welsh Government Annual Emergency Planning Report

12.3 Business Continuity Annual Report

12.4 Resource Escalation Action Plan

ITEM 12 SBAR EPRR Annual reports to FP Committee JB FINAL

ITEM 12.2 EPRR Annual Report 2024-2025 Final

ITEM 12.3 WAST Business Continuity Annual Report 2024-25 FINAL

ITEM 12.4 WAST REAP v6 Final

13 12:00 - Digital Reporting

13.1 Metrics

13.2 Deep dive on new and emerging projects (listed under digital transformation and CMT)

13.3 Audit Wales Digital Deep Dive Self Assessment against the digital provision - Verbal Update

ITEM 13 Digital Reporting July 2025 - Cover Paper

ITEM 13.1 Digital Reporting July 2025 - Metrics

ITEM 13.2 Digital Deep Dive - July 2025 FPC

14 12:20 - Information Governance Report
ITEM 14 Information Governance Reporting July 2025

15 12:30 - Risk Management and Board Assurance Framework Report
ITEM 15 Executive Summary Risk Management Report FPC 220725

16 12:40 - Internal Audit Report - Capital Systems
ITEM 16 Internal Audit Report Feedback from ARAC - Capital Systems
ITEM 16.1 WAS-SSU-2425-19 Capital Systems_Final Internal Audit Report

17 12:45 - Internal Audit Report - Contract Management
ITEM 17 Internal Audit Report Feedback from ARAC - Contract Management
ITEM 17.1 Contract Management Final Advisory Report
ITEM 17.2 Contract Management Internal Audit

18 12:50 - Internal Audit Report - Emergency Communication Nurse System (ECNS) Implementation
ITEM 18 Internal Audit Report Feedback from ARAC - ECNS
ITEM 18.1 WAS-2425-12 ECNS Final Internal Audit Report_for Trust issue

19 12:55 - Internal Audit Report - Forecasting & Modelling
ITEM 19 Internal Audit Report Feedback from ARAC - Forecasting and modelling
ITEM 19.1 WAS-2425-06 Forecasting & Modelling_Final Internal Audit Report

20 13:00 - Updates to NHS Wales No Purchase Order No Pay Policy
ITEM 20 F&PC SBAR - No Po No Pay
ITEM 20.1 No PO No Pay policy

21 13:05 - Urgent and Emergency Care - Arrangements for Managing Demand
ITEM 21 UEC Arrangements for Managing Demand - WAST

21.1 CONSENT ITEMS

22 Committee Cycle of Business and Priorities Update
ITEM 22 FPC Priorities and Cycle Monitoring Report - July 2025
ITEM 22.1 Monitoring report
ITEM 22.2 Cycle notes

22.1 13:10 - CLOSING ITEMS

23 Reflections and Summary of Decisions/Actions

24 Any Other Business

25 Date & Time of the Next Meeting: 16 September 2025

Length of Meeting:	03:45	Agenda Status:	[OPEN] FINANCE AND PERFORMANCE COMMITTEE - 21 JULY 2025						Deadline: 10/07/25
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: 20 May 2025	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair	n/a
		4.1	20 May 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 - Q1	Paper	Discussion	Standing	Ops	Lee Brooks	Toni-Marie Norman
10:00	00:10	6	Financial Position for Month 2, 25/26 Financial Position for Month 3, 25/26	Paper Presentation	Assurance	CoB	FinCor	Chris Turley	Ed Roberts
10:10	00:10	7	Financial Sustainability Programme Update	Paper	Assurance	CoB	People	Carl Kneeshaw	Alex Crawford, Gareth Taylor
10:20	00:15	8	25/26 Commissioning	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett
10:35	00:15	9	Integrated Medium Term Plan (IMTP) Progress Report 9.1 Long Term Plans Organogram	Paper	Assurance	CoB	SPP	Rachel Marsh	Alex Crawford, Hugh Bennett
10:50	00:10	10	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Georgia Tizzard, Melanie
11:00	00:15		COMFORT BREAK						
11:15	00:15	11	Quality and Performance Management Framework (QPMF) Logic Benefits Map	Paper	Assurance	Forward Planner	SPP	Rachel Marsh	Hugh Bennett
11:30	00:30	12	Emergency Preparedness, Resilience and Response (EPRR) Annual Reports 12.1 Annual HART KPI Report - Circulated by e mail 12.2 Welsh Government Annual Emergency Planning Report 12.3 Business Continuity Annual Report 12.4 Resource Escalation Action Plan	Paper	Assurance	CoB	Ops	Lee Brooks	Judith Bryce
12:00	00:20	13	Digital Reporting 13.1 Metrics 13.2 Deep dive on new and emerging projects (listed under digital transformation and CMT) 13.3 Audit Wales Digital Deep Dive Self Assessment against the digital provision - Verbal Update	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
12:20	00:10	14	Information Governance Report	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
12:30	00:10	15	Risk Management and Board Assurance Framework Report	Paper	Assurance	CoB	Gov	Julie Boalch	n/a
12:40	00:05	16	Internal Audit Report - Capital Systems	Paper	Assurance	CoB	FinCor	Chris Turley [Osian Lloyd]	Steve Owen, CorGov
12:45	00:05	17	Internal Audit Report - Contract Management	Paper	Assurance	CoB	FinCor	Chris Turley [Osian Lloyd]	Steve Owen, CorGov
12:50	00:05	18	Internal Audit Report - Emergency Communication Nurse System (ECNS) Implementation	Paper	Assurance	CoB	Ops	Lee Brooks [Osian Lloyd]	Steve Owen, CorGov
12:55	00:05	19	Internal Audit Report - Forecasting & Modelling	Paper	Assurance	CoB	SPP	Rachel Marsh [Osian Lloyd]	Steve Owen, CorGov
13:00	00:05	20	Updates to NHS Wales No Purchase Order No Pay Policy	Paper	Approval	Ad Hoc	FinCor	Chris Turley	Ed Roberts
13:05	00:05	21	Urgent and Emergency Care - Arrangements for Managing Demand	Paper	Assurance	Ad Hoc	Quality	Liam Williams	
			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.						
13:10	00:00	22	Committee Cycle of Business and Priorities Update 2025-26	Paper	Information	CoB	Cor Gov	Trish Mills	Alex Payne
			CLOSING ITEMS						
		23	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a
13:10	00:05	24	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a

		25	Date & Time of the Next Meeting: 16 September 2025	Verbal	Information	Standing	n/a	Chair		n/a
13:15	**03:45**		**CLOSE**							

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Chair and Non-Executive Director
Julie Boalch	Assistant Director of Corporate Governance and Risk
Carl Kneeshaw	Director of People
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		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		
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
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		
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019	31 May 2025	
		Emeritus Professor - Swansea University	Non-Financial Professional	31 May 2025		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	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		
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		

MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 20 MAY 2025 IN THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Hugh Bennett	Assistant Director, Commissioning and Performance
Lee Brooks	Executive Director of Operations
Jason Collins	Head of Financial Management
Colin Dennis	Chair of the Trust Board (Left during 43/25)
Wendy Herbert	Assistant Director of Quality and Nursing
Carl Kneeshaw	Director of People
Osian Lloyd	Head of Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager (Left after Item 35/25)
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources

APOLOGIES:

Rachel Marsh	Executive Director of Strategy, Planning and Performance
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

OBSERVERS:

Skye Banks	Compliance Administrator

30/25 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 18 March 2025 were considered by the committee and confirmed as a correct record.

Matters Arising: Hugh Bennett referred to the section of the Minutes in which it had been noted there had been a significant drop in 111 patient survey data as raised by the committee given satisfaction levels have dropped from 88% to 49%. It was agreed that Hugh Bennett would investigate further and provide details at the next meeting. Hugh advised that it does not distinguish between the part of the 111 service the Trust runs, and the part managed by Health Boards. Therefore, it was difficult to draw conclusions from these results. He suggested focusing on patient experience in the clinical model transformation (CMT) programme during their informal CMT board meetings. This approach was agreed by the committee.

Action Log: Action number 17/25: IMTP Delivery/Assurance – Progress Update 2024/27. *In response to the discussion and concerns regarding the impact of the pace of changes over the last year to staff it was agreed to refer to the People and Culture Committee (PCC) to seek assurance on the ways in which morale, wellbeing and support are a focus in the change management programmes in place to support delivery of the IMTP and provide an update back to the FPC.* An update has been given to PCC on 15 May by Carl Kneeshaw as follows - We are actively working to embed the principles of effective change management throughout WAST. We recognise that meaningful and sustainable change can only happen when people are brought on the journey and feel supported throughout; wellbeing is a central thread in this work, and we are aligning our efforts with our Health and Wellbeing Plan and the emphasis on listening through mechanisms such as Speaking Up Safely. We're also working to ensure that leaders and managers are equipped with the skills and confidence they need to support their teams effectively, including in relation to change, having meaningful, regular 1-1s and crucial conversations, supported through Our WAST Way leadership development framework and the Managers' Essentials programme. Change management capability was intentionally woven throughout Our WAST Way, reinforcing that these are core leadership skills as opposed to additional / separate skills. To help embed these principles more widely, we've established a Change Community made up of colleagues from across the organisation, all of whom have completed accredited change management training. This network was helping to embed change principles at every level, effectively supporting change and building momentum "from within". In larger programmes such as the CMT programme, we've introduced dedicated Change Leads within each workstream to maintain focus on the people aspects of change (including wellbeing and engagement), offer practical tools and support and bring a structured change lens to delivery. This work is closely aligned with our wider organisational efforts, including our response to the staff survey and our commitment to the three themes of the Our WAST Way leadership and management development framework (Care, Connect, Value Everyone). Any further updates will be provided post PCC meeting. This action was proposed and agreed for closure.

Action number 18/25. IMTP Delivery/Assurance – Progress Update 2024/27. *It was recognised that in respect of NHS 111 call back times, P2 and P3 performance has dropped away, and Hugh Bennett explained it may be due to the amount of deflection that was coming through from the remote clinical screenings which may be a factor. He agreed to investigate this matter further and update the committee on his findings.* The method of calculating P1 to P3 has

changed (linked to new system) with the triage now starting only when the patient answers the call back. Prior to the new CAD clock stop was the time we tried to contact the patient. Action agreed for closure.

The Committee highlight report dated 18 March 2025 was received.

The Committee RESOLVED TO:

(1) Approve the minutes of the Finance and Performance Committee held on 18 March 2025.
(2) Consider the Action log and noted the update as described above.
(3) Receive the Committee highlight report dated 18 March 2025.

31/25 OPERATIONS UPDATE

Lee Brooks highlighted key points from the Operations Report.

1. Special Operations Response Team (SORT) Recruitment: Progress continued with the recruitment of SORT operatives and discussions with the Welsh Government (WG) about capital spending for vehicles.
2. The training for drone operations has been completed successfully, with all staff passing the training, and now awaiting the first use of drones in an operational context.
3. Manchester Arena Inquiry: Four scrutiny sessions have concluded, and the Trust was awaiting Commissioners' output. Four recommendations have slipped but were expected to be completed soon.
4. Hospital Handover Delays: The Minister's task and finish group was underway.
5. Non- Emergency Patient Transfer System (NEPTS) Roster Review: There was positive engagement with Trade Unions, and the Trust was working on further modelling.
6. Capacity Management Plan Cancellations: In March there were 900 eligible patients journeys cancelled due to capacity constraints. Discussions with Commissioners were ongoing, and an options appraisal was being prepared.
7. Two-Way Short Message Service (SMS) Development: A note of thanks was recorded for the Digital Directorate for technical advancements, aiming to reduce cancellation rates and improve patient experience.
8. 111 Roster Review: There was ongoing work to determine capacity needs and best rostering practices.
9. Quality and Support Days: Continued value has been seen in these days; a supplementary report was provided for more information.

A query arose on Short Notice Cancellations Analysis - Lee Brooks provided details on the previous analysis on short notice cancellations during the meeting adding that the detailed briefing document would be uploaded to the FPC reading room in iBabs following this meeting.

Jonny Sammut updated the committee on the development of drone usage which added credibility to efforts in exploring beyond visual line of sight capabilities for delivering medical supplies such as defibrillators or trauma packs. To achieve this, collaboration with the UK Government was essential for regulatory changes. Furthermore, the operational drone enhanced credibility as an ambulance service by improving situational awareness for both safety and patient care.

Bethan Evans raised several comments: Quality and Support Days: was pleased to see these days happening, emphasising their importance for staff support. National Volunteer Manager: Bethan was encouraged about the National Volunteer Manager's invitation to speak at the Ambulance Leadership Forum and the potential for additional funding. Overdue Investigations: Bethan provided assurance that the issue of overdue investigations, which breached WG Tier 1 targets, was discussed in detail at the Quality, Patient and Experience Committee (QuEST) meeting.

The Committee RESOLVED TO note the update.

32/25 FINANCIAL POSITION FOR MONTH TWELVE 2024/25 AND MONTH ONE 2025/26

MONTH TWELVE 2024/25

Jason Collins presented the Committee with the financial position of the Trust as at month twelve, 2024/25. The Trust was reporting a small revenue surplus £70K for month 12 and year end, subject to audit. In line with the financial plans that supported the Integrated Medium Term Plan (IMTP), gross savings of £6.838m have been achieved in month 12 against a target of £6.421m. The financial risks for 2024/25 have been managed effectively, with one financial risk escalated to WG in relation to the re-banding of the EMT 2/3 posts.

Peter Curran, Chair of the Audit, Risk and Assurance Committee (ARAC) raised the following points: The achievement of the savings target, noting that 60% of the savings were recurrent, which was an improvement over the budgeted 56%. He commended the management of capital allocation, emphasising the difficulty of managing cash flow and ensuring capital was spent within the year. Peter praised the finance team for submitting the draft accounts by 02 May, noting the efficiency in completing the accounts within a month.

The Chair commended all those involved for their hard work notwithstanding the challenges.

The Committee RESOLVED TO:

(1) Note and gain assurance in relation to the Month 12 (and therefore draft 2024/25 year end) revenue and capital financial position and performance of the Trust as at 31st March 2025.
(2) Note the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust.
(3) Note the Month 12 Welsh Government monitoring returns submission included within *Appendices 1 – 2* (as required by WG).

MONTH ONE 2025/26

Jason Collins gave a presentation on the month one 2025/26 position with a cumulative year to date position reporting a small underspend of £4k with the savings plan overachieving by £50k of which an element of this was recurrent. Significant risks were highlighted early in the year relating to funding streams and the savings target which has increased to £8.5m for 2025/26. The Capital plan for 2025/26 was planned at c£32.2m of which c£26.2m was related to All Wales Capital programme schemes and the residual balance of c£6m for discretionary programmes.

Chris Turley mentioned that the Trust was forecasting to achieve a break-even position for the year. Chris highlighted several risks, including the need for additional savings and stressed the need to remain cautious, as there were growing pressures and unavoidable costs that would impact the financial position throughout the year.

Lee Brooks inquired about the status of additional savings required by the Joint Commissioning Committee (JCC), noting that a return had been provided to Commissioners weeks ago. Jason Collins confirmed they have not received any feedback from the JCC regarding the additional savings, which was why it was currently assessed as a low risk.

Jonny Sammut highlighted the challenges posed by inflationary pressures on technology pricing.

The Committee RESOLVED TO note the month one 2025/26 financial position.

33/25 INTEGRATED MEDIUM TERM PLAN (IMTP) DELIVERY/ASSURANCE – END OF YEAR REPORT

Hugh Bennett provided details on the following points:

1. Clinical Model Transformation (CMT) Programme: The overall programme was rated yellow due to documentation and workload pressures. However, all five clinical frontline work streams were rated green.
2. Directorate Led IMTP Deliverables: Most were on target (green) or complete (blue), with three rated yellow (cautionary).
3. Ministerial Priorities: The report included the status against ministerial priorities, with some areas needing improvement, such as the 111 abandonment rate and discharge and transfer journeys.
4. Commitments to Our People: Actions were being taken to address shift overruns, digital experience, and flexible working.
5. Forward Assurance for 2025-2026: Focus areas included prevention, timely access to care, mental health, community capacity, and Women's Health.
6. Shift overruns: a task and finish group has been set up collaboratively with Trade Union partners, with workshops in Q4 focussed on what further actions were within the Trust's gift to address overruns.

Bethan Evans raised a question regarding the recruitment of a Head of Commercial. Carl Kneeshaw added that the recent initial recruitment for Head of Commercial was unsuccessful. The job description was being revised to better align with market expectations, with plans to use internal networks and LinkedIn.

Jayne Beeslee questioned whether a highlight report from the CMT Board could be presented to the committee.

It was agreed that a highlight report from the CMT Programme Board would be beneficial for the committee to provide better oversight, instead of including it in the paper which covered a broad range of topics and making it easier to understand its impact on strategic objectives. Hugh Bennett agreed to explore this to use existing information to meet the request without creating additional reports.

Furthermore, the Committee acknowledged that the Cabinet Secretary's priorities were already monitored within existing work streams and rather than duplicate work it was proposed that a Red, Amber, Green (RAG) rating system, against these priorities, would be incorporated into the next update to help focus the committee's attention on specific areas. Hugh Bennett agreed to take this action forward.

The Committee RESOLVED TO:

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

34/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

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

1. Data quality issues were being addressed, with more capacity being put behind this effort.
2. Handover lost hours remained high, with ongoing efforts to address this issue.
3. Clinical screening and Advance Paramedic Practitioner (APP) recruitment were progressing well.
4. 111 call handling was stabilising but not yet meeting the target abandonment rate.
5. Non-emergency patient transport was stable, but there were underlying capacity issues.
6. Sickness absence was at 7.35%, slightly above the target of 6%.
7. The consult and close metric has a new definition agreed with the Commissioner, showing a significant uplift.

8. Patient cancellations and conveyance to Emergency Departments (ED) were down, indicating positive trends.

Peter Curran raised a point regarding the average jobs per shift metric, which was currently classified as amber. Given the significant impact on patient harm, Hugh Bennett agreed to review the methodology used to classify the metrics and either amend it to red or provide an explanation for the current classification at the next meeting.

Bethan Evans commented on the distressing impact of system-wide pressures on staff and patients. She highlighted the frustration felt by staff due to spending the majority of their shifts on very few calls.

Jayne Beeslee inquired about the measures and actions required for Health Boards to achieve the newly established 45-minute target. She requested clarification on the Trust's efforts towards meeting this target and sought information on how Non-Executive Board Members could support the engagement initiatives.

Lee Brooks commented that achieving the 45-minute target would require collaboration with Health Boards, specifically the availability of space and beds. He mentioned that the WG task and finish group was charged with looking at the 45-minute target and the four-hour emergency department target.

RESOLVED: The Committee RESOLVED TO:

(1) Consider and note the March 2025/ April 2025 Integrated Quality & Performance Report and actions being taken.
(2) Note that the report provided sufficient assurance
(3) Note the response to the Board development feedback and the iterative work on the indicators.

35/25 INFORMATION GOVERNANCE REPORTING

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

1. Data Protection Impact Assessments (DPIA) Non-Compliance: There was a significant backlog in DPIAs. Efforts were being made to address this by establishing an Information Asset Owners group and retraining them to take accountability for DPIAs.
2. IG Training: The Trust failed to meet the 85% target for Information Governance (IG) training, achieving 78.98%. Despite this, it was the highest rate seen in the Trust. Efforts to improve include integrating training into LMS365, targeted sessions, and reminders to line management about mandatory training requirements.
3. Freedom of Information (FOI) Compliance: Compliance rates for FOI requests were good in January (84%) but dropped significantly in February (27%) due to higher priority work. Efforts to improve included reviewing the platform used to manage FOI

requests and increasing scrutiny through the Information Governance Steering Group (IGSG).

4. Phishing Campaign: Results of the Phishing campaign were mentioned as a lowlight and would be discussed in further detail in the closed session.

In terms of FOIs Trish Mills commented that the Team was working to define "complex" requests and apply exemptions where appropriate. She emphasised the need for a comprehensive review of the FOI process to improve compliance and manage complex requests more effectively.

Bethan Evans expressed concern about the low compliance rate for FOI requests in February and pointed out a discrepancy in the numbers reported for FOI requests, noting that the total should be 26 instead of 25. Trish Mills acknowledged the discrepancy and agreed to double-check the numbers.

Following a query on IG training compliance, Carl Kneeshaw emphasised the importance of ensuring staff complete their IG training, linking it to agenda for change terms and professional body requirements. He suggested that operational managers need to give staff sufficient time for training.

In terms of the DPIA non-compliance issue Trish Mills suggested it might be appropriate for it to be added to the alert section of the committee AAA report, indicating its importance and the need for focused attention.

The Committee RESOLVED TO note the contents of the report.

36/25 DIGITAL REPORTING

Jonny Sammut updated the committee on the following points:

1. The team was working with a supplier on an enhanced Interactive Voice Response (IVR) system for 111 and NEPTS. The new IVR will be able to take basic demographic details from the patient, such as name and date of birth, which will save each call taker approximately 15 seconds.
2. Recruitment into the new digital posts following additional investment during 2024/25 was progressing well.
3. A Copilot artificial intelligence (AI) pilot was running for approximately 150 participants. An engagement session has been conducted called "promptathons" to help users improve their prompting with AI. Linked to this, an AI policy was being developed in response to the increasing prevalence of AI and the need for a structured approach.
4. The Trust was planning to relax the restrictions on the copy and paste function across devices in a safe and controlled manner commencing with the ePCR tool which will be particularly helpful for neurodiverse users.
5. The Microsoft Hello project, which involved introducing facial recognition software on laptops, was progressing.

6. Early infrastructure and architecture work has commenced for the Computer Aided Dispatch (CAD) replacement, which was a significant upcoming project.

The Committee RESOLVED TO note the contents of the report and the trends in metrics presented.

37/25 ENVIRONMENT, DECARBONISATION AND SUSTAINABILITY UPDATE - MAY 2025

Chris Turley presented the report which highlighted the significant progress in the decarbonisation and environmental sustainability efforts but noted there were still challenges, including financial constraints and reliance on national infrastructure.
He mentioned the need to refresh the Board approved environment strategy, which expires in 2025.

The Committee RESOLVED TO note the update.

38/25 INTERNAL AUDIT REPORT: ENERGY MANAGEMENT

Chris Turley conveyed satisfaction with the results of the internal audit report, which delivered substantial assurance. He pointed out that there were three medium-rated recommendations, and the management's responses to these recommendations were incorporated into the report. Chris mentioned that the audit encompassed aspects of national energy contracts, which were outside the Trust's direct control. He underscored the Trust's ISO accreditation in this domain, which has been upheld for several years, thereby contributing to demonstrating sound governance and assurance.

The Committee RESOLVED TO note the report.

39/25 REPORT ON COMMISSIONING

Jayne Beeslee advised that the report was received very late, and the item was not considered.

Hugh Bennett apologised for the lateness of the paper, and it was agreed the paper would be circulated by e mail and presented as an updated report at the next meeting.

The Committee RESOLVED TO note that the paper was to be circulated to attendees following the meeting and be added to the forward planner for presentation at the next meeting.

40/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

Julie Boalch provided an overview of the Risk Management Report, highlighting to members that the detail in the report was that presented to the March Trust Board, and provided assurance that the risks have all been reviewed during this period and were due to be considered by the Executive Leadership Team (ELT) tomorrow.

Julie mentioned that the highest scoring risks in the Trust would form part of a deep dive process to be undertaken by the Assistant Directors' Leadership Team and Executive Leadership Team. This process aimed to examine the controls and mitigating actions, particularly focusing on how these risks were scored.

Trish Mills noted that all risks were reviewed quarterly with no score changes. The highest rated risks were prioritised in the agenda setting meetings.

There was a specific discussion on the Decarbonisation Risk (Risk 542 - Failure to deliver the Welsh Government's NHS decarbonisation strategy action plan) Julie Boalch agreed to take an action that at the next meeting, as part of the risk update to include a detailed review of the controls and mitigations in place for this multifaceted risk.

The Committee RESOLVED TO note the contents of the report.

41/25 AUDIT TRACKER -Q4

Trish Mills presented the Q4 audit tracker, noting no escalations for internal or external audits. She reported a strong 95% closure rate of audit recommendations, including those previously escalated. The Committee had agreed to focus each report on the data quality internal audit following November board escalations. While some management action dates have shifted, the changes related to the new clinical model and recent digital team recruitment. Trish Mills added that the audit trackers were not included in the pack of papers and were now available in the iBabs reading room.

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.

42/25 POLICIES FOR APPROVAL

Information Risk Policy

Jonny Sammut mentioned that the information risk policy has undergone review by various stakeholders, including IG specialists within his team, to ensure all relevant regulations were linked throughout the policy. The policy has also been reviewed by the leadership team and was presented for approval.

The Committee approved the Information Risk Policy.

The Committee RESOLVED TO approve the Information Risk Policy.

43/25 FEEDBACK FROM EFFECTIVENESS REVIEW, COMMITTEE CYCLE OF BUSINESS MONITORING REPORT AND 2025/26 PRIORITIES

Trish Mills highlighted the need to ratify the Chair's action for the approval of the annual report and the terms of reference, which were required before the meeting.

Trish Mills provided an update on the first Audit, Risk and Assurance Committee (ARAC) meeting, noting that it reviewed the annual report and terms of reference from all board committees. The common themes and changes would be compiled and presented to the board. The ARAC aimed to explore committee quorums, meeting frequencies, and potential reductions. A subgroup, including Non-Executive directors, the ARAC chair, Chris Turley, and Trish Mills, would oversee this work.

Committee Priorities

Trish Mills suggested that priorities should focus on areas within the committee's remit rather than additionality. She mentioned specific focus areas such as the benefits of the quality and performance management framework, value-based healthcare, and the performance of new Clinical Model Transformation (CMT) codes.

Peter Curran commented that all committees have proven effective adding there was a potential issue of paper duplication and excessive length, as highlighted in the update. He added it was important to adopt a lighter approach next year, as well as undertake a fundamental review of committee structures. The committees should incorporate performance within their remit, considering the various technical and clinical areas they addressed. Furthermore, it was essential to examine the interaction between the performance committee and other committees focusing on specific areas such as digital information governance and commercialisation.

Lee Brooks underscored the significance of long-term financial planning and the ongoing attention to the Manchester Arena Inquiry's developments.

Chris Turley acknowledged the discussion about shifting the committee's focus towards more forward-looking scrutiny. He agreed with the idea but emphasised the need to balance this without creating additional work outside of business as usual. He suggested that the change should involve presenting and evidencing assurance or scrutiny in a slightly different way rather than adding new tasks.

Jonny Sammut drew attention to Artificial Intelligence (AI), its ethics, and managing it to ensure proper adherence. There was also a need to balance getting the basics right with focusing on future advancements in digital elements.

Jayne Beeslee stressed the importance of focusing on financial sustainability highlighting the need to look beyond the current year and consider the financial challenges and opportunities in the coming years, advocating for a forward-looking approach that considered future financial challenges and integrated with other priority areas. Jayne added that when considering performance, there should be a focus on the CMT and its significant impact.

Regarding performance metrics, the committee should prioritise addressing the Cabinet Secretary's priorities and the 45 minute challenge. Furthermore, resilience remained a critical focus, alongside strategic planning which encompassed not only cyber security but also information security, ensuring continuous development.

Trish Mills mentioned that the committee will receive metrics on what good looks like for its remit and this would help in understanding and measuring performance and strategy effectively. Priorities should guide the committee's agenda without creating extra work. The focus should be on ensuring existing reports and discussions aligned with these priorities.

Chris Turley acknowledged the concerns about capacity constraints, highlighting the need to consider the Trust's ability to take on additional priorities. He noted the importance of avoiding commitments that might exceed current capacity suggesting that the Committee should prioritise existing tasks and ensure efficient delivery rather than adding new ones.

The Committee agreed that the priorities for 2025/26 were as follows; a focus on financial sustainability, CMT performance, and resilience including information security and progress on any MAI recommendations.

The Committee RESOLVED TO:

(1) Ratify the decisions made by Chair's Action effective 24 April 2025 in relation to the outputs of the annual committee effectiveness review.
(2) Note the output of the Mentimeter survey held on the 18 February 2025.
(3) Note the proposed changes to operating arrangements for 2024/25 and the outcome of the meeting of the ARAC on 01 May.
(4) Discuss and agreed its priorities for the 2025/26.
(5) Note the cycle of business monitoring report for quarter one of 2025/26.

44/25 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

Members noted the effective chairing, clear papers, and well managed discussion on priorities. There was positive feedback regarding the use of the iBabs reading room, which facilitated focus on more concise reports during the meeting. Additionally, several actions were identified throughout the meeting, and these would be documented in the action log.

Meeting concluded at 12: 45

Date of Next Meeting: 22 July 2025

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

Action	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
33/25	20 May 2025	Integrated Medium Term Plan delivery/Assurance - End of Year report	It was agreed that a highlight report from the Clinical Model Transformation (CMT) programme would be beneficial for the Committee to provide better oversight, instead of including it in the paper which covered a broad range of topics and making it easier to understand its impact on strategic objectives. Hugh Bennett agreed to explore this to use existing information to meet the request without creating additional reports.	Hugh Bennett	21 July 2025	Update 21 July 2025 The CMT programme highlight report is included with the papers	Complete
33/25a	20 May 2025	Integrated Medium Term Plan delivery/Assurance - End of Year report	The committee acknowledged that the Cabinet Secretary's priorities were already monitored within existing work streams and rather than duplicate work it was proposed that a RAG rating system, against these priorities, would be incorporated in to the next update to make it easier to identify areas needing attention and help focus the committee's attention on specific areas.	Hugh Bennett Alex Crawford	21 July 2025	Update 21 July 2025 This information is incorporated within the report	Complete
34/25	20 May 2025	Monthly Integrated Quality Performance Report	Peter Curran raised a point regarding the average jobs per shift metric, which was currently classified as amber. Given its significant impact on patient harm, Hugh Bennett agreed to review the methodology used to classify the metrics and either amend it to red or provide an explanation for the current classification at the next meeting.	Hugh Bennett	21 July 2025	Update 21 July 2025 Verbal Update	Open
39/25	20 May 2025	Report on Commissioning	The report was not considered during the meeting given it was received after publication. It was agreed that the report would be circulated to the committee following the meeting and included at the next meeting for endorsement.	Steve Owen	20 May 2025	20/05/25: The report was circulated by e mail to committee members and included on the Forward Planner for the next meeting.	Complete
40/25	20 May 2025	Risk Management and Board Assurance Framework	It was agreed to undertake a deep dive on the Decarbonisation Risk (Risk 542) in readiness for the next meeting which will include a detailed review of the controls and mitigations.	Chris Turley	21 July 2025	Update 21 July 2025 Discussed at the FPC ASM on 3 June, it was agreed this action would be discussed offline at a meeting involving, Jayne Beeslee, Peter Curran, Chri Turley and Julie Boalch.	Complete

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	29 May 2025
Committee Meeting Date	20 May 2025
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No alerts arose from this meeting for particular escalation to the board.

2. Whilst not an alert for escalation, the **Energy Management Internal Audit** was presented which received substantial assurance and included three medium rated recommendations. The Trust maintains an ISO accreditation in this area, which likely contributed to the positive audit outcome. The report highlighted that energy management involves a national contract for energy, meaning the Trust does not contract directly with energy suppliers which adds a layer of complexity to implementing some recommendations.

ADVISE

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

3. The **Information Risk Policy** was approved.

4. The **Operations Update for Q4 2024/25** was received, with the following of note for the board:

   - The training for drone operations has been completed successfully, with all staff passing the training, and now awaiting the first use of drones in an operational context for which we remain alert. The drones are expected to enhance situational awareness, improve patient safety, and provide operational benefits. Initial feedback from staff trained is positive.
   - SORT (Special Operations Response Team) growth is progressing with ongoing recruitment and discussions with WG about capital for vehicle purchases being carried over from 24/25 to 25/26.
   - With respect to the Manchester Arena Inquiry (MAI), four scrutiny sessions with Commissioners have been concluded, with positive feedback from the WAST team. We now await the Commissioners' output, and we are informed to expect that around August. Four recommendations have slipped from last year but are expected to be completed in a couple of

months and will be monitored through incorporation in our risk management approach.

- Eligible patient journey cancellations due to capacity constraints reached 900 in March. Discussions and an options appraisal are ongoing to address this issue however increasing complexity requiring more stretcher transport and changing service design increasing average travel distances are contributory factors.
- A new two-way SMS system has been developed to reduce short notice cancellations and improve patient experience by confirming transport needs in advance.
- Quality and support days continue to be implemented to provide additional support to staff, with positive feedback noting this will feature as a staff story at a future People and Culture Committee meeting.
- The pressures regarding investigations were noted, including this received consideration at the Quality Committee meeting.

5. A **report on commissioning** was originally scheduled for presentation at this meeting. However, as the paper was submitted later than planned, it will now be circulated to members and brought to the July meeting to ensure it receives appropriate consideration.

6. Members **reflected** that the meeting was chaired well, that papers were clear, and that whilst the discussion on priorities was difficult, it was navigated well. Positive feedback was expressed on the use of the Ibabs reading room which allowed focus on more concise reports during the meeting. It is seen as a useful tool to streamline the meeting process and reduce the volume of detailed documents in the main agenda.

ASSURE

(Detail here assurance items the Committee receives)

The following items will also be presented to board at their 29 May meeting however members may benefit from the following points of discussion from the committee:

7. With respect to the **financial position for month 12 2024/25**, the Trust is reporting a small revenue surplus £70K for month 12 and year end, subject to audit. In line with the financial plans that support the IMTP, gross savings of £6.838m have been achieved in month 12 against a target of £6.421m. The financial risks for 2024/25 have been managed effectively, with one financial risk escalated to Welsh Government in relation to the re-banding of the EMT 2/3 posts. Discussions continue with commissioners on this issue.

8. A stable **month 1 2025/26** position was reported with a cumulative year to date position reporting a small underspend of £4k with the savings plan overachieving by £50k of which an element of this is recurrent. Significant risks are highlighted early in the year relating to funding streams and the savings target which has increased to £8.5m for 2025/26. Capital plan for 2025/26 is planned at c£32.2m of which c£26.2m is related to All Wales Capital programme schemes and the residual balance of c£6m for discretionary programmes. There is likely to be an increasing pressure on spend and unavoidable costs throughout the year with an emphasis on profiling, spend against budget and savings delivery. Members noted the challenges relating to digital savings targets given inflationary rates in technology pricing.

9. The board will receive the **Monthly Integrated Quality and Performance Report** (MIQPR) for March/April 2025 at its May meeting and the output and plan of action following the board development session on the MIQPR in April, however of note:

    - The average jobs per shift is shown at 2.64 (amber rating). Members questioned if this should be red due to its impact on staff morale, productivity, and patient care. The low figure is mainly due to persistent handover delays - 21,183 lost hours in April. A separate productivity report is being considered to explore this further
    - Members asked if more board-level involvement with Health Boards is needed with respect to their plans to address handover delays. A Ministerial Taskforce, including Jason Killens for WAST, is addressing the 45-minute handover and 4-hour ED targets. Formal engagement awaits the recommendations of the taskforce though testing informally appetite at one health board to operationalise an approach is underway. Updates will be included in the patient harm report and of note were the ongoing efforts to ease burdens and improve flow into emergency departments through the Clinical Model Transformation (CMT) program.

10. The board will receive the **Integrated Medium Term Plan (IMTP) Delivery and Assurance Report (end of year report)** at its May meeting, however of note:

    - The recent initial recruitment for Head of Commercial was unsuccessful. The job description is being revised to better align with market expectations, with plans to use internal networks and LinkedIn. The role is key to driving efficiencies and commercial opportunities.
    - The CMT programme is rated amber due to documentation and workload pressures. The Chair and the Executive Director of Strategy, Planning and Performance will discuss whether reporting on the programme could make use of a more focused highlight report for more focused oversight and alignment with strategic goals.

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

11. 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:

    - The team is working with a supplier on an enhanced Interactive Voice Response (IVR) system for 111 and NEPTS. The new IVR will be able to take basic demographic details from the patient, such as name and date of birth, which will save each call taker approximately 15 seconds. This timesaving, when rolled up across the volume of calls in Wales, is significant.
    - Recruitment into the new digital posts following additional investment during 2024/25 is progressing well.
    - A Copilot artificial intelligence (AI) pilot is running for approximately 150 participants. An engagement session has been conducted called "promptathons" to help users improve their prompting with AI. The feedback has been positive. Linked to this, an AI policy is being developed in response to the increasing prevalence of AI and the need for a structured approach.
    - The Trust is planning to relax the restrictions on the copy and paste function across devices in a safe and controlled manner commencing with the ePCR tool which will be particularly helpful for neurodiverse users.

- The Microsoft Hello project, which involves introducing facial recognition software on laptops, is progressing.
- Early infrastructure and architecture work has commenced for the Computer Aided Dispatch (CAD) replacement, which is a significant upcoming project.

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

    - Despite recent improvements in reducing the backlog of Data Protection Impact Assessments two recent instances of non-compliance occurred where processes launched without IG and cyber assurance. The IG team is actively working with process owners to mitigate risks and reinforce the need for assurance prior to go-live to prevent recurrence.
    - Freedom of information compliance rates dropped from 84% in January to 27% in February due to fluctuating request volume and complexity. The team is working to define "complex" requests and apply exemptions where appropriate.
    - The Trust met all actions in its 2024/25 IG Toolkit Improvement Plan and submitted on 31/03/25, achieving or exceeding 'Minimum Expectations' in all areas except 'Training & Awareness'. IG training compliance stands at 78.98%, below the 85% target for the IG toolkit, though it's the highest rate achieved in WAST. Improvement efforts include LMS365 integration, targeted sessions, manager reminders, and digital access for staff on the move.

13. Members received the **Environment, Decarbonisation and Sustainability update** including reporting against the Trust's Decarbonisation Action Plan highlighting that while significant progress has been made there are still challenges related to funding, technological advances and national infrastructure particularly national support for rapid charging for vehicles. The Environment Strategy will be refreshed being realistic, pragmatic, and ambitious in setting future goals, considering external factors and commercial challenge. See further below regarding the decarbonisation risk next steps.

14. The **Q4 audit tracker** was produced with no escalations reported for either internal or external audit management actions. There was excellent closure of audit recommendations in quarter of 95%, including those escalated last quarter that had been on their third revised date. The committee agreed last year to focus each report on the data quality internal audit following escalations to the board in November and whilst dates on some management actions have moved, the committee were assured that these related to focus on the new clinical model and recent recruitment into the digital team.

15. The outputs of the **Committee's annual effectiveness review for 2024/25** were discussed and the terms of reference and annual report that were approved by Chair's Action were ratified. The committee's priorities for 2025/26 are a focus on financial sustainability, CMT performance, and resilience including information security and progress on any MAI recommendations. The committee's terms of reference has a focus on the strategic forward look which will be supported by developing reporting on 'what good looks like' metrics for the long term strategic objectives.

16. In **closed session** members received the update on the cyber KPIs, cyber audit actions and the cyber risk. There were no escalations to the board with respect to those items. The closed session also

considered the outline business case for the Emergency Services Network which was endorsed for approval by the board. They also discussed and endorsed the 2025/26 capital plan for approval by the board. 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.

RISKS

The committee received the **Risk and Board Assurance Framework report** noting that whilst this data was presented to the Trust Board in March 2025, the activity during this period is due to be considered by the Executive Leadership Team on 21 May 2025. All risks have undergone their quarterly review, with no changes in scores. It was emphasised that the highest rated risks are considered when setting the agenda ensuring that these are integrated into the papers and discussions throughout the meeting.

Risk 542 Decarbonisation noting that this is a complex and multifaceted risk and challenging to mitigate given its nature and external dependencies; however, there is an aspiration to reduce this from a score of 16 to 8. It was agreed that a deep dive will be undertaken in conjunction with a review of the risks that sit underneath it at the programme board level. A detailed update will be presented at the next meeting. This will include a detailed review of controls, mitigations impacting the risk score.

COMMITTEE AGENDA FOR MEETING		
Financial position month 12 2024/2 Financial position month 1 2025/26	IMTP Delivery/Assurance update End of year report	MIQPR Annual review of metrics
Information governance report and update on IG toolkit	Digital reporting	Environment, decarbonisation and sustainability update
Internal audit on energy management	Report on commissioning	Risk management and BAF
Audit tracker	Information risk policy	Feedback from effectiveness review

COMMITTEE ATTENDANCE						
Name	**20 May 2025**	**22 Jul 2025**	**16 Sep 2025**	**18 Nov 2025**	**20 Jan 2026**	**17 Mar 2026**
Jayne Beeslee (Chair)						
Bethan Evans						
Peter Curran						
Chris Turley						
Rachel Marsh	Hugh Bennett					
Lee Brooks						
Liam Williams	Wendy Herbert					
Carl Kneeshaw						
Jonny Sammut						
Trish Mills						
Hugh Parry						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

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

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2025-26 Q1 (April – June 2025)

National Operations & Support

IMTP

Launch of Assemble

The Volunteer Service has launched a brand-new Volunteer Management System which improves our access to volunteer demography, volunteer availability and acts as a single source of communication to volunteer groups across the Trust. Training was developed and delivered by a Volunteer Support Officer. Feedback from volunteers was excellent including comments such as “This is probably the biggest advance since Penthrox” and "You truly deserve credit for this piece of work."

Volunteer Steering Group Refresh

The Volunteer Steering Group membership has been refreshed with a newly elected Chair taking position in April 25. A volunteer representative is also now included in the attendance of the WAST Charity Committee.

Volunteer Structure

The Volunteer Steering Group has now commenced a review of the Volunteer Structure which will address gaps in capacity within the volunteer service by upskilling volunteers and implementing a consistent structure across volunteer teams, localities and territories which will improve volunteer experience.

Volunteer Responder Pathway

Applications opened for CWR to CFR transition courses which relates to our new volunteer pathway. 30 applications have been received with 28 CWRs progressing onto CFR transition courses from July.

General Update

Business Continuity (BC) Software

Implementation of BC software continues with data being provided to the supplier to pressure test the system. Additional information is being sought from various departments and support is required to get this information in a timely manner. Support via the Operations Senior Operations Team (SOT) is being sourced to facilitate this. Rollout to wider departments and directorates is scheduled for August with full implementation to complete Sept-Oct 25.

Resourcing, EMS Coordination and Quality

General Update

Estates

The refurbishment of Llangunnor estates has been completed. After consultation with colleagues working from the site, Ty Tywi was selected as the name for the newly renovated site.

Operational teams relocated from Bryn Tirion to Ty Elwy, finishing with EMSC on 8 May 2025. WAST became the first Trust to implement the life X control room solution in new facilities. The Ty Elwy Coordination and Communications Centre was officially opened by High Sheriff Julie Gillbanks on 12 June 2025, with Lee Brooks and Andy Swinburn attending.

MAIT

Multi Agency Incident Transfer (MAIT) allows incidents to be electronically shared between WAST, police, and fire services, negating the need for telephone contact. It went live on Monday, 16 June 2025 with Gwent Police and South Wales Police. Other emergency services will join in phases.

Training

CMT (Clinical Model Transformation) training was undertaken and successfully rolled out prior to the July 1st launch of the new Ambulance Performance Framework. Relevant SOPs have been updated, and training feedback will help shape the CMT FAQs.

Yorkshire Ambulance Services

We continue to support Yorkshire Ambulance Service (YAS) by answering a proportion of their 999 call activity whilst they complete their training on their replacement triage software (NHS pathways replacing MPDS). This support is likely to continue until early October 2025. There are discussions ongoing to establish whether the level of support can be reduced slightly during the busier summer months when annual leave uptake will be higher. WAST has agreed income because of this support and regularly monitors for any significant performance consequences.

Kings Ambulance Service Medal (KAM)

Laura Charles, Operations Manager at Vantage Point House, has been awarded the 2025 King's Ambulance Medal for her dedication and commitment to the Ambulance Service.

Operations Quality

The Operations Quality OCP planning is ongoing, with the intention to move broader call audit functions (CPSS and ECNS), and complaints/coroners' investigations across from Integrated Care into Operations Quality. The first phase of this is the recruitment of 10 CPSS Quality Auditors, which has been approved, and the recruitment process is well underway and are now live on TRAC.

Challenges

EMSC Sickness

We will continue efforts to address sickness and support staff. There has been a slight improvement in our current position since the last quarter's update, following workshops conducted by the EMSC leadership team, trade union partners, and people services.

Operations Quality

Operations Quality continues to experience challenges in completing and returning investigations for concerns and coroners. There are now 117 outstanding concerns investigations of which 94 have breached the Welsh Govt. Tier 1 target. However, there are now 27 outstanding coroner's statements down from 55 at the end of Q4.

Challenges persist in obtaining key information for investigations involving clinician input (Clinical Support Desk). Teams are collaborating to expedite requests and prioritise coroner's statements as needed by Legal Services, having returned three Schedule 5 statements to HMC by the requested date.

IMTP

EMSC Reconfiguration and Restructure

We held an EMSC restructure review with Trade Union partners and colleagues, and feedback will be incorporated into ongoing operations. The evaluation included the single allocator model, and teams will pursue identified quick wins. Largely positive feedback, recognising the development opportunities and career progression now available within EMSC. Some themes identified within the feedback highlighted was that roles were now clearly defined, issues were heard and actioned, good collaboration with Trade Union Partners and felt that the consultation process was robust and transparent. One of the main concerns from the feedback was the changes to the zones/border realignment which will be further reviewed.

Resourcing

Move from Geographical to Functional Model:

This process aims to standardise operations, with a dedicated resourcing team assigned to each of the four main business areas. As part of the phased rollout, Ambulance Care Coordination and Central and West resourcing for Ambulance Care Assistants have joined the North Resourcing team. Ongoing improvements and feedback will inform future planning. We are on track to implement the full model by the end of Quarter 3.

111 to GRS:

Currently, the 111 teams use ShiftTrack as a rostering system but plan to transition to GRS. To minimise staff disruption, a project team has set up a test environment and will collaborate further with Total Mobile for testing. Two groups are being established: one to complete pre-production rostering in GRS and self-roster, and another to review post-production processes like meal break management and intraday activity.

eTimesheet & GRS to Cloud:

The project board and working groups are established, with good progress on eTimesheets and GRS cloud migration. July's partnership meetings will discuss some matters relating to terms and conditions and reaching agreement on those for the electronic timesheet.

Emergency Medical Service

Challenges

Continued System Pressures

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. . 21,181 hours were lost in April, 19,670 in May and 15,276 in June. The impacts of these pressures are regularly discussed at Committee and Trust Board.

Community Wait Times

While handover delays have seen a degree of improvement compared to January 2025 at 27,212 hours and June 15,276, this has not fully translated into improved Red performance. However, while it is recognised that there have been some improvements in Red response, from January 2025 48.3% to 50.7% end of June, overall, the Red performance fell short of 65%. We have however experienced an improving trend in our Amber median and Amber 95th percentile wait times (Amber median reporting 149 minutes in January 2025, and 93 minutes in June 2025 – according to EMS Operations Power BI report).

IMTP

APP Roster Review

Work is now progressing with the full roster review of all APP rotas. The roster review will take account of all aspects of APP work including all rotational and commissioned workstreams as well as the APP operational contribution. The rotational models currently undertaken by WAST APPs include Primary Care (including GPOOH) and APP Navigator models.

Team Based Working

An initial workshop has been arranged to discuss the approach to pilot Team Based Working into EMS. Initially this will be undertaken as a pilot process likely in an urban and rural setting to fully understand the implications and change adaptions required to accommodate. Timelines and locations will be discussed and agreed at the workshop, planned in for 28th July 2025 in Cardiff.

General Update

EV Solo Response Vehicle (SRV) Introduction

EMS will soon see the role out of the 24/25 SRV, which includes the Ford Transit Hybrid (PHEV) along with the Maxus (BEV). The Maxus battery powered electric vehicle will be the first vehicle commissioned by Welsh Government that will be fully electric.

To support the role out and subsequent evaluation of these vehicles, supportive infrastructure has been put in place; this includes a number of 50kw chargers at locations across Wales.

A training package is also in development to support staff in the use of the EV, alongside an accompanying SOP to support the 4-month evaluation determining the future use of electric vehicles across Emergency Operations.

End of Shift Overruns

Trade Union Partners (TUP) and leadership teams have worked to understand the current issues through three overrun workshops focusing on the following:

- Workshop 1: Analysis of the current position, blue sky thinking, welcoming all ideas
- Workshop 2: Exploring feasible solutions and realistic options
- Workshop 3: Developing an agreed plan for implementation

Next step is to complete a paper mapping out future options with recommendations to support meaningful change to improve end of shift overruns and support staff welfare. Dialogue with trade unions is ongoing.

Finance - Overtime

Following the reasonable assurance outcome from our internal audit, the following measures have been applied:

To ensure maximum uptake whilst maintaining equity of services we have proposed the following:

- Overtime hours to be allocated in the same manner as previous years once budget has been set. Therefore, each health board area will have an allocation dependant on vacancies at the beginning of FY.
- During the monthly review, any underspends in the previous month will be offered to those areas with a strong likelihood of uptake to maximise potential

for expenditure. These additional hours will be subject to the same criteria/UHP levels.

- At the end of every quarter, a review of all overtime activity to be undertaken to assess utilisation. Any areas consistently under-utilising their allocation will have a review and potential change to hours available. Surplus hours will then be re-allocated to other areas to ensure maximum uptake.

Hospital Trials

Royal Glamorgan Hospital (RGH)

A suite of tactics have been employed across the Emergency Department to focus on reduced notification to handover (N2H). Continuous dialogue between WAST and RGH is ongoing with regular evaluation of performance. N2H for the 3 weeks preceding this report averages between 23-40mins which demonstrates a significant reduction already seen from previous averages of 90 minutes.

Morriston Hospital

Conducting a 6-week PDSA across the whole system to support reduction in handover times. Average handover since inception (2nd June) is 61 mins which also demonstrates a significant reduction from previous average of 160 minutes.

EAP Training

EAP training continues to progress well. The following table provides an overview of the 'live' position of staff who have completed their training:

Total number of EMT 2 staff who have applied for the EAP course	494	
Total EMT2 staff trained to date		
Matrix	48	
Pentwyn	46	
Ty Elwy	46	
Total	140	28%
Total number of EMT3 staff trained to EAP	37	

In addition, there are a total of 40 staff currently on courses, and a further 174 staff due to complete the course prior to the end of the year. This means that 354 or 72% of EMT2 staff will have become EAPs by the end of the year. Whilst we are supporting the release of staff to attend the EAP training programmes, unfortunately there is an impact on UHP during these times. Attempts to mitigate this are to spread out the release of staff across service

areas to reduce the effect of UHP, when staff must be released in areas that are already low in UHP due to other abstractions, the release for EAP training does compound the position. The forthcoming winter UHP position is a slight concern, and we will continue to mitigate the effect of reduced UHP by ensuring staff are released in targeted areas rather than overburdening any individual area. The ongoing work with the Financial Savings Plans and overtime allocation will also look to mitigate the effects of release of staff for EAP training.

Ambulance Care

Challenges

Call Taking

Call taking continues to be a challenge with a continual turnover of staff. Work is ongoing through a digital perspective to consider alternative ways of reducing activity, such as voice recognition and improved texting services and digital access.

Courtersy call back is now live and patients no longer have to wait actively on the phone line but instead can choose to have WAST re-call them when their place in the queue presents itself.

IMTP

Digital Innovation

Quarter 1 saw a major upgrade to the Cleric CAD system, which allows the service to build on the work completed to date to further develop patient commuinication options.

In July, patients will begin to receive texts when our crew is on route to pick them up, which will allow them to get ready in advance, reducing wait times as well as providing another opportunity for the patient to tell us that they no longer need the transport and minimise unnecessary journeys. Further text engagement will also follow through quarter 2, including additional texts when journeys are cancelled and through the booking process.

Roster Review

The NEPTS roster review saw a significant amount of feedback received regarding the review process and particularly the impact that the proposed outcomes would have on the staff across the service. This feedback was shared via the working party meetings either direct from colleagues or through Trade Union Partners.

Following the completion of the 2nd working party, a commitment was made by the service management team to review the feedback and consider the most appropriate way forward.

Upon completion of this exercise, it was agreed that rather than continue with the existing plan and timelines, a request would be made to the data modelling partners to consider alternative proposals that provide different options such as longer shift lengths and a reduced amount of Saturday working which was identified as some of the pressures. Until this work is completed no additional working parties are held, and we will continue to work in partnership as we progress this workstream.

General Update

Purple Review and UCS allocation

On the1st July 2025, WAST went live with its new approach to high-priority incident responses. The current red category was replaced by three new classifications: Purple Arrest, Red Emergency, and RCS0.

As part of this transition, Urgent Care Service (UCS) began responding to Purple calls. They will act as first and co-response resource, like Community First Responders, to deliver Basic Life Support. Emergency Medical Services (EMS) will continue to be dispatched. We have established a notification protocol so that UCS management are alert to UCS attending a Purple Arrest incident so staff support can be provided.

Integrated Care

Challenges

Call Handling Performance

Call taking performance has improved month on month. In March, 11.18% of calls were abandoned in 60 seconds, performance was 10.15% in June 2025 (down from 10.51% in May25). The team have a performance recovery plan, to achieve below 10% abandonment, which has proved challenging. This is in part due to absence, increased demand on weekends, and some periods of increased abstractions (training etc). The team have considered and implemented numerous operational tactics, which has continued to maintain improvement. The team are awaiting the rostering practice review including capacity modelling to test if we have sufficient resource to meet performance.

General Update

Launch of New Emergency Ambulance Performance Framework

The team have been actively working with colleagues from across the Trust to "go live" and implement organisational changes on the 01st of July 2025. The team have reviewed over 50 Standard Operating Procedures (SOP'S) and made changes to around 15, in preparedness for "go live". This has required considerable efforts in ensuring appropriate governance to support the changes. New processes have been developed, to ensure patients have access to a Rapid Assessment Queue, and briefings have been provided to all teams within Integrated Care.

Care Planning Workshop

The Integrated Care Team held a Care Planning Workshop in Cwmbran in May 25. This workshop discussed feedback from frontline clinicians and focused on developing a set of priorities for care planning as part of the RICS programme of work. An SBAR is currently being developed and will be shared through the RICS Project Board, to consider the next steps for care planning.

Simply Do Ideas Platform

The Quality Improvement Team have worked with the Integrated Care Team, to become the first users to use their new improvement idea engagement platform. This platform will eventually replace the WIIN platform, which has been in operation for some years. The platform has been operational for a few weeks and is focused on generating ideas for improving call taking performance. All Call Handler Coordinators have been invited to use the platform, with over 16 ideas being submitted to date.

Process Group RICS

A new group (subgroup of the RICS Project Borad) has been formed to lead the process elements of the RICS Clinical Model for Transformation. Chaired by the Head of Service for Integrated Care the group will focus on; Care Planning; Integration of SOPs, remote scheduling, Implementation of new call flow and categorisation model.

Consult and Close

Consult and Close activity has remained high within Integrated Care (20.15% in March and May 2025). This equated to 6,766 incidents in March, to 6829 in May 2025.

Pan Operations

Staff Survey – Quality and Support Day

Following the findings from the NHS Wales Staff Survey 2024, the Operations Directorate agreed, through discussions in EMG (EMS Management Group) and SOT (Senior Operations Team) meetings, that a forthcoming Quality and Support Day will concentrate on the Staff Survey. All service areas agreed a collaborative approach to the Q&S Day with the following focus:

- To comprehend the experiences of staff who took part in the survey and to pinpoint the obstacles encountered by those who did not complete it.

- To collect feedback on the 2024 staff survey results and to ascertain what actions and next steps staff feel would be most beneficial.

Data is currently being collected and discussed within the service areas, with a view to develop action plans for improvements.

AGENDA ITEM No	**6**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

Financial Performance as at Month 2 – 2025/26

MEETING	Finance & Performance Committee
DATE	21st July 2025
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Interim Assistant Director of Finance) Steph Taylor (Assistant Head of Capital Planning)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

This paper presents to the Committee the latest Financial Performance Report of the 2025/26 financial year, the reported position as at Month 2 (May 2025).

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.

KEY ISSUES/IMPLICATIONS

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

- The Trust is reporting a small revenue surplus (£5k) for month 2 2025/26;
- In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust is currently forecasting to breakeven for the 2025/26 financial year;
- Capital expenditure plans are being finalised with plans to fully achieve in year;
- In line with the financial plans that support the IMTP, gross savings of £1.406m have been achieved in month 2 against a target of £1.327m;
- Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.8% for the number, and 99.3% of the value of non NHS invoices paid within 30 days

REPORT APPROVAL ROUTE
• FP&C – 21st July 2025

REPORT APPENDICES
Appendices 1 – 2 *– Monitoring return submitted to Welsh Government for month 2 – as required by WG* ***Appendix 3*** *– Savings performance – Ibabs reading room*

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

FINANCE & PERFORMANCE COMMITTEE

FINANCIAL PERFORMANCE AS AT MONTH 2 2025/26

INTRODUCTION

1. This report provides the Committee with a summary of the revenue financial performance of the Trust as at 31st May 2025 (Month 2 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 – 31st May 2025) are that:

   - The cumulative revenue financial position reported is a small **underspend against budget of £0.005m**, 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 **£1.406m** have been achieved against a target of **£1.327m**;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 98.8% for the number, and 99.3% of the value** of non-NHS invoices paid within 30 days.

3. Whilst continuing to be broadly balanced at the outset of the financial year, which is clearly encouraging, it is key to also note the following assumptions that have been made in reporting this current and forecast position:

   - The ability to deliver a minimum of c£8.500m in savings and efficiencies in year. This equates to c2.7% of the Trusts discretionary income;

   - 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 includes any costs, capital or revenue, emerging from the recommendations of the Manchester Arena Inquiry.

- Despite an element of additional funding provided, some cost elements are still hard to predict through the 2025/26 financial year (and beyond) and may remain volatile;

- 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.

- Income assumptions in opening financial plan are fully funded via commissioners and Welsh Government (i.e. pay awards / Employers National Insurance increases)

4. As we know, no plan, forecast or reported delivery at this stage of the financial year is risk free. The risks included in the Welsh Government Monitoring Return at Month 2 are set in line with the submitted IMTP and summarised later in this report. Accepting that it is early in the new financial year, as we go through the next few months these will continue to be scrutinised and amended accordingly, with mitigations and management plans in place.

REVENUE FINANCIAL PERFORMANCE – MONTH 2 2025/26

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

Revenue Financial Position for the period 1st April - 31st May				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-312,556	-50,959	-51,138	-179
Expenditure				
Pay	234,504	38,789	38,603	-187
Non-pay	62,550	9,585	9,939	354
Total pay & non-pay expenditure	297,053	48,375	48,542	167
Depreciation & Impairments / interest payable & receivable	15,502	2,584	2,591	7
Total	**0**	**0**	**-5**	**-5**

Income

6. Reported Income against the initial budget set to Month 2 shows an overachievement of **£0.179m**.

Pay Costs

7. Overall, the total pay variance at Month 2 is an underspend of **£0.187m**.

Non-pay Costs

8. The overall non-pay position at Month 2 is an overspend of **£0.354m**. In addition, for reporting purposes Depreciation, Impairment and interest is excluded from the above figure, overspend of **£0.007m,** hence the total underspend to budget of **£0.005m**.

Savings

9. 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.

10. Month 2 in month performance was, plan of £0.664m and £0.688m achieved, therefore an overachievement of £0.024m (recurrent underachievement of £0.070m and non recurrent overachievement of £0.094m), 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	475	405	-70	948	890	-58	6,225	6,108	-117
Non Recurrent Schemes / Themes	2,275	190	284	94	379	515	136	2,275	2,392	117
Overall Total	**8,500**	**664**	**688**	**24**	**1,327**	**1,406**	**78**	**8,500**	**8,500**	**0**

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

11. ***Appendix 3*** provides the overall detail for Month 2 by theme. This is now further split over recurring and non-recurring schemes.

Financial Performance by Directorate

12. Whilst there is a small surplus reported at Month 2, there are some small variances between Directorates, as shown in the table below, when compared to the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature, given we are so early in the financial year, but they will be continued to be closely monitored.

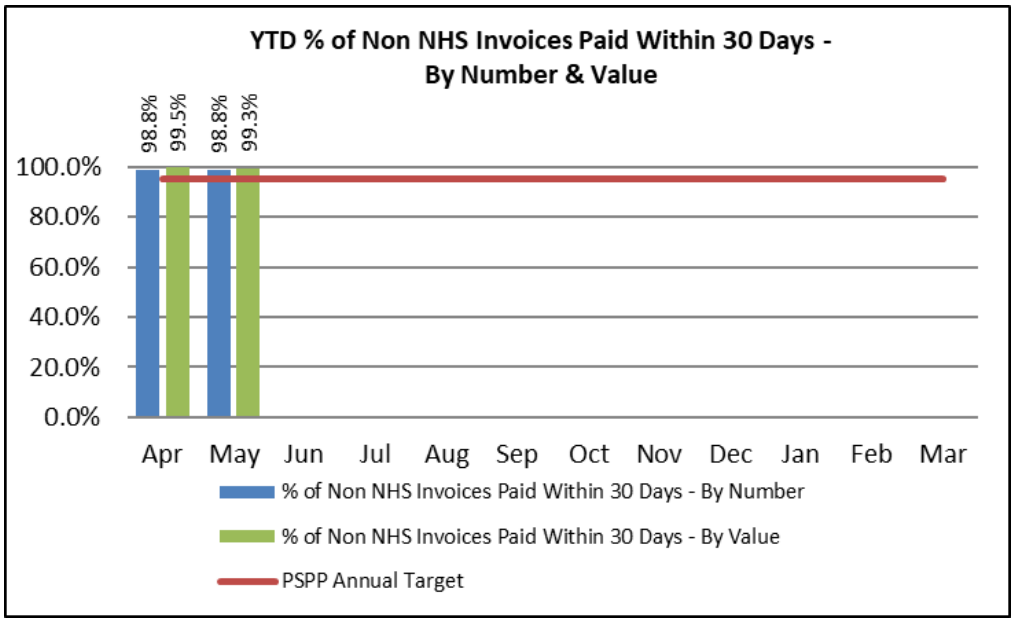
Financial position by Directorate @ 31st May	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	216,408	36,072	35,892	-180	-0.5%
Chief Executive Directorate	2,132	388	388	0	0.0%
Board Secretary	671	103	103	-0	0.0%
Partnerships & Engagement Directorate	563	84	83	-0	-0.1%
Finance and Corporate Resources Directorate	36,432	6,147	6,131	-16	-0.3%
Planning and Performance Directorate	3,005	438	430	-8	-1.9%
Quality, Safety and Patient Experience Directorate	7,070	1,154	1,135	-19	-1.6%
Digital Directorate	16,542	2,214	2,146	-68	-3.1%
People and Culture	6,286	1,033	1,074	41	4.0%
Medical & Clinical Services Directorate	5,853	896	910	13	1.5%
Trust Reserves	1,217	70	301	232	333.5%
Trust Income (mainly JCC)	-296,178	-48,598	-48,598	-0	0.0%
Overall Trust Position	**0**	**0**	**-5**	**-5**	

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

- Most directorates broadly in line with budget plan for Month 2 with the exception of Trust reserves where this includes a carry-over of spend for Ambulance Care provision agreed with JCC.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

14. Public Sector Payment Policy (PSPP) compliance to Month 2 was **98.8%** against the **95%** WG target set for non-NHS invoices by number and **99.3%** by value.



2025-26 INITIAL CAPITAL PROGRAMME

15. As we are in the early stages of the financial year the discretionary capital programme and resulting budgets are only now being finalised.

16. At Month 2, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2025/26 is **£32.216m**. This includes **£26.268m** of All Wales Approved schemes and **£5.948m** for Discretionary schemes.

RISKS AND ASSUMPTIONS

17. Understandably this early in the financial year, the risks reported are still being fully assessed, however at present it is considered that there are no medium or high likelihood risks, but as we move through the next few months we will continue to review the risks to ensure that the level of likelihood is assessed along with the financial value. Alongside ensuring that Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.

18. At the outset of this financial year there are a number of risks that need to be documented within this initial reported financial position, which aligns to that fully described within the financial plan submitted as part of the IMTP. The main ones are described below, along where possible with an indicative value currently placed on these risks, as required by WG as well as the current assessed level of risk. Inevitably at the start of any financial year many of these values are very indicative.

19. A low risk has been included around the JCC additional saving request, whilst nothing further has been raised in relation to this risk, it remains but with a zero value.

20. Given the increased requirement again in our savings target that has been required this financial year; to cover increasing cost pressures the Trust has included a risk around the identified savings. This has been reassessed in month and reduced from £3.000m to **£1.000m** (low risk). Despite these schemes all being green there is always a level of risk associated with the delivery of these schemes and given the weighting of some of these schemes into the latter part of the financial year the Trust feels that it is prudent given how early we are in the financial year to include a small low risk at this stage, as always this will be closely monitored as we move through the coming months.

21. 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.

22. A low-level risk was included re PIBS (Permanent Injury Benefit Scheme) of **£1.000m**, following confirmation from WG that matched funding for this highly volatile area will be provided by WG on an annual basis, it has been removed from the risk table.

23. A new risk has been included for month 2 following discussions with WG, relating to the risk around the additional Employer National Insurance contributions not

being fully funded via WG, as per the discussions at the initial funding meeting in December 2024 and subsequently at DDoFs and DoFs meetings; this was always assumed to be 100% funded via WG. As such our income and pay values were assumed to net off for this element. Given this has now been flagged as a potential issue but not quantified a risk this risk has now been included, and once more information is available, this amount will be quantified. The delivery of our balanced plan is predicated on this being fully funded in year and therefore any in year shortfall in this would now likely lead to a deficit.

24. Also included is an unquantified risk, this is still being worked through internally and relates 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. This is highlighted at this stage as being a low risk, and from a purely financial perspective it is, as costs have not been committed for this and are arguably not unavoidable – should these not be funded, costs for these cannot be incurred. However, the wider impact of such decisions may be argued as being of a higher than low risk, non-financially.

25. As noted above, whilst there are therefore no current individually assessed high or medium financial risks as we enter the financial year, however when this is then considered alongside continuing significant service pressure and the likely balancing of this risk against patient safety, quality and experience, it is clear that, as expressed within the IMTP, this will likely be another challenging financial year, despite the reported good financial performance in M02.

26. 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.

RECOMMENDED that the Committee:

a) **Notes** and gains **assurance** in relation to the Month 2 revenue financial position and performance of the Trust as at 31st May 2025;

b) **Notes** the delivery of the 2025/26 savings plan, and the context of this within the overall financial position of the Trust;

c) **Notes** the capital programme for 2025/26, and

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

Appendix 1

Attached

Appendix 2

iBabs reading room

Appendix 3

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 2

	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	8	8	0	50	50	0
Balance Sheet Flexibility	200	0	0	0	0	0	0	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	0	-100
Disposals	250	0	0	0	0	0	0	250	250	0
End of Shift Overrun	100	9	8	-1	18	16	-2	100	98	-2
Fuel	230	20	20	0	39	62	23	230	253	23
Interest Receivable	516	43	25	-18	86	78	-8	516	487	-29
Non Pay Local Schemes - Corporate	914	64	45	-18	127	93	-35	914	914	0
Non Pay Local Schemes - Operations	650	51	47	-5	102	93	-9	650	641	-9
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	283	256	-28	568	540	-28	3,140	3,140	0
Pay Vacancy Management - Corporate	2,275	190	284	94	379	515	136	2,275	2,392	117
Pay Vacancy Management - Corporate 25-26	75	0	0	0	0	0	0	75	75	0
Totals	**8,500**	**664**	**688**	**24**	**1,327**	**1,406**	**78**	**8,500**	**8,500**	**0**

Savings Performance by Theme 25-26 - Recurrent

Reporting Month 2

	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	8	8	0	50	50	0
Balance Sheet Flexibility	200	9	8	-1	18	16	-2	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	0	-100
Disposals	250	0	0	0	0	0	0	250	250	0
End of Shift Overrun	100	0	0	0	0	0	0	100	98	-2
Fuel	230	20	20	0	39	62	23	230	253	23
Interest Receivable	516	43	25	-18	86	78	-8	516	487	-29
Non Pay Local Schemes - Corporate	914	64	45	-18	127	93	-35	914	914	0
Non Pay Local Schemes - Operations	650	51	47	-5	102	93	-9	650	641	-9
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	283	256	-28	568	540	-28	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	0	0	0	0	0	0	75	75	0
Totals	**6,225**	**475**	**405**	**-70**	**948**	**890**	**-58**	**6,225**	**6,108**	**-117**

Savings Performance by Theme 25-26 - Non Recurrent

Reporting Month 2

	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	284	94	379	515	136	2,275	2,392	117
Pay Vacancy Management - Corporate 25-26	0	0	0	0	0	0	0	0	0	0
Totals	**2,275**	**190**	**284**	**94**	**379**	**515**	**136**	**2,275**	**2,392**	**117**

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

12th June 2025

Your ref:

Dear Andrea,

Re: MAY 2025 (MONTH 02 2025/26) MONITORING RETURN

Please find attached the Monitoring Returns for the Welsh Ambulance Services University NHS Trust for May 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 02 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 Employers National Insurance contribution increase for 2025/26 funding, this wasn't included in the Month 2 payment from JCC, however discussions are ongoing and it is assumed this will pass through to the Trust.

The resulting reported performance at Month 2 as per Table B, is a small underspend against budget / surplus of **£0.005m**

The reported total pay variance against plan as at Month 2 is an underspend of **£0.187m**, set against the budgets.

The non-pay position at Month 2 is a reported overspend of **£0.361m**.

Income at Month 2 shows an overachievement of **£0.179m**.

2. Movement (Table A)

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

In line with the Month 12 report the Trust has amended it's brought forward position to £2.278m this is now reflected within Table A **(Action Point 1.2)** the Trust has also adjusted it's profile from month 2 onwards as per the discussion between yourself and Edward Roberts **(Action Point 1.1)**

As also discussed, the "Profit on Sale of Assets" difference is reflected in the Saving target, the £0.445m within Table A reflects the annual profit target from sale of vehicles and equipment, with the additional £0.250m reflected in the saving target. **(Action Point 1.3)**

3. Underlying Position (Table A1)

Table A1 has been adjusted to agree with Table A **(Action Point 1.4)**

4. Risk (Table A2)

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

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

A low risk has been included around 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 m01 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 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**. (Action Point 1.5)**

Following the comment in the reply letter the Trust has reassess the risk around non delivery of savings and reduced this down from £3m to £1m despite these schemes all being green there is always a level of risk associated with the delivery of these schemes and given the weighting of some of these schemes into the latter part of the financial year the Trust feels that it is prudent given how early we are in the financial year to include the small low risk at this stage, as always this will be closely monitored as we move through the coming months.

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.

A new risk has been included for month 2 following your letter and subsequent discussions with Edward Roberts, this relates to the risk around the additional Employer National Insurance contributions being fully funded directly via WG as per the discussions at the initial funding meeting in December 2024 and also subsequently at DDoFs and DoFs meetings; this was always assumed to be 100% funded via WG. As such our income and pay values were assumed to net off for this element. Given this has now been flagged as a potential issue but not quantified a

risk has been included within Table A2, and once more information is available, this amount may be able to be quantified. However, to again be clear, the delivery of our balanced plan is predicated on this being fully funded in year (along with as I understand it the rest of the NHS in Wales) and therefore any in year shortfall in this would now likely lead to a deficit.

A low-level risk was previously included re PIBS (Permanent Injury Benefit Scheme) £1m. Matched funding for this highly volatile area is provided by WG on an annual basis, arranged between Jillian Gill and Jackie Salmon, following your confirmation that this funding will be matched funded going forward this risk has now been removed **(Action Point 1.6)**

Included within the table is an unquantified risk, this is still being worked through internally,and relate 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 noted within the returns, this is highlighted at this stage as being a low risk, and from a purely financial perspective it is, as costs have not been committed for this and are arguably not unavoidable – should these not be funded, costs for these cannot be incurred. However, the wider impact of such decisions may be argued as being of a higher than low risk, non-financially.

As noted above, whilst there are therefore no current individually assessed high or medium financial risks as we enter the financial year, however when this is then considered alongside continuing significant service pressure and the likely balancing of this risk against patient safety, quality and experience, it is clear that, as expressed withing the IMTP, this will likely be another challenging financial year, despite the initially reported good financial performance in M02, based on the assumptions made in reporting this.

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

Also in the opportunity table, is the possible VAT rebate for the Microsoft licences following the guidance around this, subject to additional advice.

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,

Table B2 now aligns with the totals from the IMTP, with adjustments made in month 2 to 12 **(Action Point 1.7)**

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

Agency costs for Month 2 totalled £0.081m. 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.

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

For Month 2 the Trust is reporting planned savings (including Income generation) of £1.327m and actual savings of £1.406m.

As can be seen from Table C3, the Trust overachieved its savings target in month 2 but it still forecasting to achieve the total savings target for the year.

In relation to **(Action Point 1.9)** as discussed between yourself and Edward Roberts, we can confirm that whilst we will always try to reduce our non-recurrent savings, it is extremely difficult to reduce this non recurrent saving and make it recurrent, as it relates to delaying the recruitment process of corporate vacancies, these are short term savings, and the only way to make them recurrent is to reduce our corporate staffing, as per the discussion given the additional the services the Trust has and is currently undertaken often with no financial support for these support services to do so would add additional pressure to support and corporate departments.

With regards to the “Disposals” this is accounted for under non-pay saving, again as per your discussions with Edward Roberts, this is shown in this manner in part due to the national NHS Wales procurement savings which are reported via shared services, along with Profit and loss on sales being shown with the non-pay element of table B. **(Action Point 1.10)**

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

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

The Trust is now able to include estimated income assumptions within table E1, please note the JCC income figure quoted assumes the funding for the 24-25 pay award. The figures included are high level estimates based on the latest calculations around Employer National Insurance contributions funding and the 25-26 pay award funding. **(Action Point 1.8)**

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

At Month 2 there was 3 invoices over 11 weeks, there are no issues with these invoices and expect them all to be paid in month 3.

We can confirm that the outstanding invoice with C&V was paid during the month **(Action Point 1.11)**

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	13	13	13	13	13	13	13	13	13	13	158
Other Non NHS Income	329	268	244	244	244	244	244	244	244	244	244	244	3,037
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	0	435	300	300	300	300	300	300	300	300	300	300	3,435
Risk Pool Refund	1,519	0	1,020	0	0	0	0	0	0	0	0	0	2,539
Total	1,864	715	1,577	557	557	557	557	557	557	557	557	557	9,169

12. Public Sector Payment Compliance (Table H)

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

13. Capital (Tables I, J and K)

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

Given it is only Month 2, 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 2 Financial Monitoring Return will be presented to the Finance and Performance Committee on 22 July 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 Chris Turley, Executive Director of Finance & Corporate Resources and Jason Killens, Chief Executive.

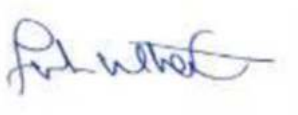
15. Other Issues

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

Chris Turley
Executive Director of Finance & Corporate Resources



Jason Killens
Chief Executive

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

AGENDA ITEM No	**7**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**0**

Financial Sustainability Programme Position Paper

MEETING	Finance and Performance Committee
DATE	21 July 2025
EXECUTIVE	Carl Kneeshaw, Director of People Chris Turley, Executive Director of Finance & Corporate Resource Rachel Marsh, Executive Director of Strategy, Planning and Performance
AUTHOR	Richard Baxter, Project Manager Gareth Taylor, Senior Project Manager
CONTACT	Email: richard.baxter@wales.nhs.uk gareth.taylor3@wales.nhs.uk

EXECUTIVE SUMMARY

- The Trust continues to face a significant financial challenge, with a planned savings target of £8.5 million for 2025/26. The revised Financial Sustainability Programme (FSP) Delivery Framework aims to address this through a stronger focus on recurrent savings (73% of the target). Early performance is encouraging, with a slight overachievement against the year-to-date plan. However, the forecast indicates a reliance on non-recurrent savings, highlighting the need for sustained momentum in delivering long-term efficiencies and cash releasing savings. As part of our commitment to robust governance and financial stewardship, we have ensured that the Financial Sustainability Programme reporting process is aligned with the Checklist for NHS Board Members regarding cost-saving arrangements, as outlined by Audit Wales. This alignment reinforces our ambitions to deliver sustainable efficiency savings and income generation by embedding key principles that support the identification, delivery, and monitoring of sustainable and recurrent cost savings.

- **The Administration and Support Review**, initiated in 2023, has made progress with 9 of 24 recommendations completed. However, capacity constraints, staff turnover, and competing priorities have delayed full implementation. A new lead has been appointed to re-energise the programme, with a renewed focus on aligning with the broader FSP Service Review and ensuring delivery of outstanding actions.

- **The FSP Service Review** The service review was a holistic review across the whole organisation, represents one of the most comprehensive organisational assessments in

recent WAST history. It engaged over 50 service areas and produced 16 Mini Business Cases and a detailed Efficiencies Workbook. Key findings include both strengths (e.g. workforce commitment) and challenges (e.g. structural inefficiencies, digital immaturity). The Executive Leadership Team (ELT) has endorsed some of the recommendations of the review and approved a tiered implementation model.

- **Recruitment for the Head of Commercial Development** has progressed, with an offer extended following interviews in June 2025. Once in post, this role will be pivotal in advancing commercial initiatives aligned with the FSP.

- **Project resource** will be recruited to ensure the capacity required to maintain momentum of the FSP over the next two years.

- **Skill Mix -** In response to rising service demands and financial pressures, a Task and Finish Group was formed with Trade Union partners to review Emergency Ambulance crew composition. The group developed evidence-based recommendations for a clinically safe, operationally effective, and financially sustainable skills mix model. An options paper outlining these findings has been submitted to the Executive Leadership Team for consideration.

- **Ideas Forum** - A new governance structure is being introduced to integrate financial sustainability with innovation. The Financial Sustainability Opportunities Group will now have formal representation on the newly established Innovation Project Board, ensuring coordinated prioritisation of improvement initiatives across the organisation.

- **Architecture Mapping** - A digital architecture mapping initiative is underway to catalogue all digital systems and projects. This will support cost savings, reduce duplication, and improve digital governance. The mapping will also inform a future control panel to assess new digital investments based on strategic fit and cost-effectiveness.

- **SupplyX Implementation** - The rollout of the SupplyX Inventory Management System across five Make Ready Depots has been completed, delivering measurable improvements in stock visibility, cost control, and operational efficiency. The system has achieved 95% catalogue coverage and is now being extended to larger sites. Early analysis indicates significant cost savings and improved business continuity.

REPORT APPROVAL ROUTE
Finance and Performance Committee - 21 July 2025

REPORT CHECKLIST	
Confirm that the issues below have been considered and addressed	**Confirm that the issues below have been considered and addressed**

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

Situation

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

Background

2.1 Since the last progress report, engagement remains ongoing regarding the re-development of the Financial Sustainability Programme Structure.

2.2 The Financial Sustainability Programme Delivery Framework for 2025/26 proposed a three-group approach encompassing Review Implementation, Opportunities, and Commercial Development, alongside a financial planning group. These would report into the FSP Governance Group.

2.3 While the re-development is still under way and engagement with the Executive Leadership Team takes place, work has continued in the following areas,

- Administrative Review Action Plan;
- Engagement regarding implementation of the Service Review recommendations;
- Commercial Development recruitment;
- Identifying opportunities for re-developing existing skill mixes;
- Engagement with both Quality and Digital regarding their approaches to improvement submission (WiiN, SImplyDo, and Digital Innovations Lab) to develop an aligned approach; and
- Working with colleagues to identify existing opportunities, such as Architecture Mapping in Digital, and Supply X implementation in Quality.

1. Financial Position

3.1 The organisation is currently facing a challenging financial position, primarily due to the increased cost of National Insurance contributions. It had been anticipated that this additional cost would be offset through funding allocations from the Welsh

Government. However, this expectation was not met, as the final allocation did not include provision for these increased costs."

3.2 Following Board approval of its IMTP, the Trust is expected to deliver an £8.5m savings plan (approximately) and will require greater momentum in identifying and delivering recurrent efficiency opportunities.

3.3 Of this £8.5m total, £6.225m (73%) is recurrent and £2.275m (27%) non recurrent. The 2024/25 savings target total of £6.421m had a split of c57% recurrent and c43% non-recurrent so greater proportion included as recurrent is the ambition to make savings more sustainable.

3.4 As of Month 2, performance against a plan of £0.664m was an overachievement of £0.024m. Cumulative YTD performance was plan of £1.327m with £1.406m achieved so a YTD over achievement of £0.078m.

3.5 15.6% of the annual plan has been phased in YTD as at Month 2 which is slightly less than flatline (16.7%) so shows savings plans are phased greater in future months. 16.5% of the 25/26 overall plan value of £8.5m has been achieved YTD.

3.6 Forecast year end projections remain at an overall breakeven position based on current assumptions.

3.7 We are on track to appoint the new Head of Commercial by winter, following a successful recruitment process and offer made in June 2025. In parallel, we are working towards establishing a formal programme delivery structure by year-end, which will enhance our governance framework and provide stronger oversight and support for strategic initiatives.

3.8 It is important to note that we will never eliminate the non-recurrent savings but will look to further reduce reliance and its value in future financial plans.

Assessment

2. Administrative 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 Subsequent updates have been informed by changes in personnel across the Trust, helping to identify gaps and outstanding actions required to deliver the recommendations. Leadership of the review has recently transitioned to the Assistant Director of Planning and Transformation.

Current Status

- 9 recommendations have been completed.
- 3 recommendations are on target.
- 6 recommendations require further attention.
- 5 recommendations have not yet been started.

4.3 A cross-reference with the Finance Sustainability Programme Service Review has been undertaken. In parallel, the Assistant Director Leadership Team (ADLT) has re-evaluated the current status of workstreams and identified the actions needed to progress outstanding milestones within the Administration Review work programme.

4.4 Capacity constraints have emerged, particularly due to competing priorities such as CMT activity. As a result, ADLT has adjusted some delivery timelines.

4.5 The additional workload from this plan has also been considered as a risk to delivery, due to impact on capacity across existing improvement workstreams.

4.6 Staff turnover has also affected continuity. Some workstream leads have left the Trust, and while certain actions are marked as complete, follow-up work and linked activities remain. New leads are currently being identified.

4.7 Consideration must also be given to the outputs from the Service Review which are expected to increase the workload for Assistant Directors and their teams. This will require careful prioritisation alongside this action plan, CMT commitments, IMTP delivery, and core business-as-usual responsibilities.

4.8 During the next reporting period, the new review lead will engage with the Administrative and Clerical Community to clarify outstanding actions and expectations.

4.9 ADLT will continue to drive forward the implementation of the plan, focusing on unresolved actions with direction from ELT to close down actions where possible in this financial year.

4.10 The review lead will coordinate this action plan with the Service Review recommendations and the forthcoming action plan, pending final report approval.

3. 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). The service review was a holistic review across the whole organisation.

5.2 Over an 18-month period, the Review engaged with over 50 service areas, analysed more than 330 improvement proposals put forward by those service areas, and produced a comprehensive diagnostic—the 'State of Play Report' (October 2024)—

alongside 16 Mini Business Cases and a detailed Efficiencies Workbook. This has been one of the most extensive organisational assessments in recent WAST history, aligning with the Trust's strategic objectives as set out in the IMTP and Vision 2030.

5.3 The Review surfaced both significant strengths and critical areas for improvement. Strengths included a committed workforce, strong mission alignment, and examples of best practice. Challenges identified included structural inefficiencies, functional duplication, inconsistent governance, and digital immaturity. It is important to note that the review draws on evidence from 2023/24, and the organisation has since made progress in areas such as digital maturity and statutory functions through increased capacity and organisational change.

5.4 The recommendations are structured around a tiered implementation model:

- Just Do It,
- Local Implementation,
- Programme-Level Delivery,
- Further Review,

5.5 These tiers are to be supported by a central Implementation Tracker and governance through the FSP Governance Group and Strategic Transformation Board (STB), Key implications include a shift to integrated service delivery and corporate support, improved workforce clarity and governance, enhanced digital and data capabilities, and a structured, transparent approach to implementation and benefits realisation.

5.6 A final report was presented to the ELT on 11 June 2025. The ELT approved the report and endorsed the implementation of recommendations at the various tiers. It was however acknowledged that not all recommendations can be implemented simultaneously, and prioritisation will be required through normal directorate and IMTP planning processes. The ELT also approved the tiered implementation model and associated governance structure, including reporting through FSP to STB with appropriate escalation processes in place and decision making through ELT as required.

5.7 The establishment of 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 supported, with the caveat that not all actions can be implemented at once.

5.8 Next steps include endorsement of the communications and engagement plan to maintain momentum and transparency, recruitment of the Senior Project Manager, finalisation and rollout of the Implementation Tracker, launch of the first quarterly

implementation review cycle, and directorate-level planning to align local delivery with programme-level priorities.

5.9 Two key projects progressing as a result of the review are:

i. the transfer of Make Ready Depots from Operations to Fleet, creating synergy and efficiencies between fleet maintenance and make ready; and

ii. the right sizing of capacity across the patient experience, community involvement and engagement functions of the organisation, whereby some resources will transfer by way of an OCP to Clinical and Partnerships & Engagement from QSPE.

5.10 The FSP Service Review has provided a robust foundation for understanding WAST's structure, strengths, challenges, and opportunities. While some major initiatives are already underway, the real value lies in the detailed efficiency ideas captured in the State of Play Report and Efficiencies Workbook. With ELT's endorsement, WAST is now positioned to move confidently from insight to action—building a more efficient, integrated, and sustainable organisation that better serves patients, staff, and partners.

4. Commercial Development

6.1 Interviews for the Commercial Development post have concluded as of the 19th June 2025.

6.2 An offer has been made subject to relevant references checks, and we expect progress following a brief onboarding process.

5. Skills Mix

7.1 In response to evolving service demands and increasing financial pressures—particularly those associated with the unfunded uplift linked to the Band 5 Emergency Ambulance Practitioner (EAP) role a Task and Finish Group was established in collaboration with our Trade Union (TU) partners.

7.2 The group was commissioned to evaluate and recommend a clinically safe, operationally effective, and financially sustainable skills mix model for Emergency Ambulance crews. This work was undertaken with a shared commitment to maintaining high standards of patient care while addressing the implications of rising staffing costs.

7.3 Following a comprehensive review, an options paper has been submitted to the Executive Leadership Team. This paper outlines the group's findings and presents a set of evidence-based recommendations for a revised skills mix model that aligns with both current service requirements and long-term sustainability goals.

6. Ideas Forum

8.1 As part of the revised FSP Delivery Framework, a new governance structure was proposed for implementation in 2025/26. This structure aims to strengthen alignment between financial sustainability efforts and innovation across the organisation.

8.2 Ongoing work has focused on enhancing the role of the Financial Sustainability Opportunities Group, particularly in how it identifies and supports efficiency opportunities.

8.3 To improve collaboration and integration, it has been agreed that this group will have formal representation on a newly established Innovation Project Board, which will be overseen by the Quality Directorate.

8.4 The Innovation Project Board will serve as a central forum to review and prioritise opportunities—both those emerging from the Financial Sustainability portal and other innovation channels—ensuring a coordinated and transparent approach.

8.5 This collaborative model will help maximise value, reduce duplication, and ensure that all initiatives are aligned with organisational priorities and quality standards.

7. Architecture Mapping

9.1 Within the Digital Directorate, work has commenced on scoping a comprehensive digital architecture map that captures all the digital projects and systems currently in use across the organisation. This initiative presents a significant opportunity to align with the FSP's objectives by:

- Avoiding unnecessary procurement by identifying existing tools that can meet current and future needs;
- Maximising the value of existing investments by fully utilising underused capabilities within current digital products;
- Rationalising the digital estate by identifying and addressing duplication in systems, processes, and functionality.

9.2 The immediate focus is on building the architecture map. This will provide a centralised view of all digital assets within the organisation, enabling better visibility and governance. It will also help identify product owners and leads, ensuring accountability and clearer lines of responsibility.

9.3 Key benefits of this work include:

- Cost savings and spend avoidance, particularly in licensing and support costs;
- Reduction in duplicated projects that serve similar purposes;
- Improved process efficiency through better alignment and integration of digital tools;

- Enhanced decision-making by understanding the full capabilities of existing products;
- Support for breaking down silos, encouraging collaboration and shared understanding across teams.

9.4 Additionally, the mapping exercise will capture funding sources, distinguishing between capital and revenue-funded initiatives.

9.5 Following the scoping phase, the aim is to establish a control panel or assessment framework. This will help evaluate new digital product requests based on cost, existing capabilities, and alignment with organisational needs.

8. Supply X

10.1 In June 2021, the Welsh Government approved funding for the national "Scan for Safety" initiative, designed to enhance patient safety through improved data accuracy and traceability.

10.2 Following a contract agreement with Omnicell in September 2021, the Supply X Inventory Management System was selected for rollout across NHS Wales, beginning with five Make Ready Depots (MRDs). A dedicated working group within WAST was established to oversee the implementation.

10.3 SupplyX integrates with Oracle to automate stock control, optimise inventory levels, and reduce manual ordering based on pre-defined thresholds.

10.4 All five MRD sites across Wales are now live with SupplyX, and full stock takes have been completed at each site.

10.5 A key project group has been established with stakeholders from WAST and NWSSP.

10.6 The system has been successfully configured for ambulance-specific use, achieving 95% catalogue coverage.

10.7 Key Benefits - the implementation of SupplyX has delivered significant improvements in operational efficiency, cost control, and stock management. Key outcomes include:

- Enhanced visibility of stock holdings, locations, and expenditures across MRDs;
- Data-driven stock level management, reducing reliance on informal knowledge;
- Improved business continuity, with reduced risk from staff turnover;
- Streamlined ordering processes and reduced waste;
- Strong team engagement and departmental commitment;
- Accurate data and stock audits supporting informed decision-making;
- Ongoing communication and collaboration across stakeholders.

10.8 We aim to be able to provide a tangible financial impact across the next reporting period subject to data availability.

10.9 The rollout of SupplyX will continue across several larger sites in the coming months, further extending the benefits of the system across NHS Wales.

Recommendation: The Finance and Performance Committee are asked to NOTE the content of the paper.

AGENDA ITEM No	8
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

25/26 COMMISSIONING

MEETING	Finance & Performance Committee
DATE	21st July 2025
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this report is to provide Committee with a short overview of the 2025/26 commissioning arrangements.

The Trust's 111 patient pathway, 999 patient pathway and Non-Emergency Patient Transport Service (NEPTS) patient pathway are all commissioned by the Joint Commissioning Committee (JCC) and are subject to specific commissioning frameworks.

The JCC came into being on 01 April 2024 and its commissioning arrangements are still developing. With the demand pressures on NHS Wales and the general financial pressure in NHS Wales, managing the commissioning interface remains a key stakeholder relationship for the Trust.

RECOMMENDATION

Committee is asked to: -

- **Note** the continuing development of the new commissioning arrangements within the JCC.
- **Consider** whether the Trust's arrangements for managing this interface are appropriate.

REPORT APPROVAL ROUTE

Date	Meeting
02nd July 2025	**Executive Director Strategy, Planning & Performance**
21st July 2025	**Finance & Performance Committee**

REPORT APPENDICES
Appendix 1 – 25/26 Commissioning Intentions

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

SITUATION

1. The Trust's three main patient pathways (111, 999 and NEPTS) are commissioned services. As part of the commissioning arrangements the Trust works to "commissioning intentions" from the Joint Commissioning Committee (JCC), supported by a "resource envelope" and is held to account through a variety of governance mechanisms.

2. The JCC came into being on the 01 April 2024 bringing together three organisations, the National Collaborative Commissioning Unit (NCCU), Welsh Health Specialist Commissioning Committee (WHSCC) and mental health services commissioning. The JCC is still in a period of transition and development.

3. The commissioning interface is a key stakeholder relationship for the Trust.

BACKGROUND

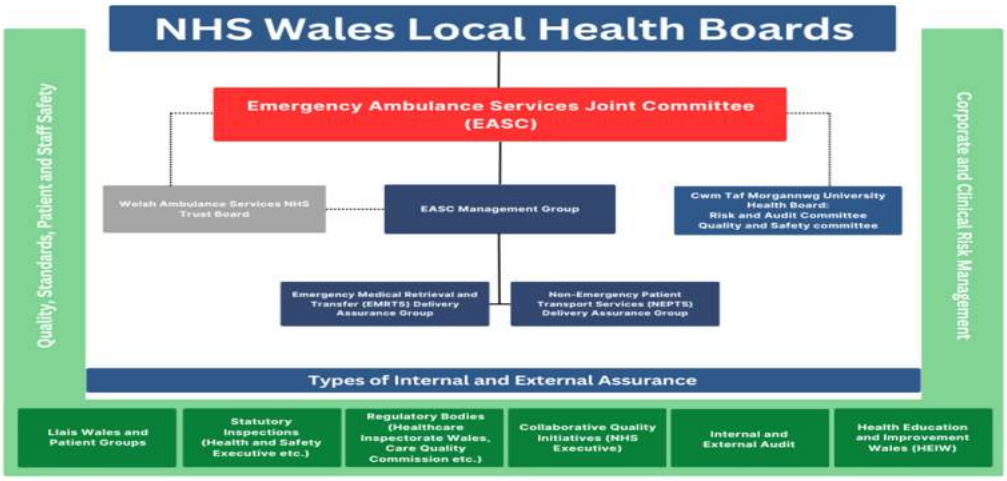
4. From the 01 Apr-24 the Trust has been commissioned for 111, 999 and NEPTS by the JCC. This arrangement is very new, but 999 services have been commissioned since 2015, NEPTS since 2018 and 111 since 2023. The NCCU was previously responsible for commissioning 999 and NEPTS with 111 being previously commissioned by the 111 Commissioning Board.

5. In 2024/25 the Trust's arrangements for managing the 111-commissioning interface were subject to an advisory audit. The Strategy, Planning & Performance Directorate has delivered all the management actions arising from that audit that are within its gift to do so (some are dependent on the JCC).

ASSESSMENT

<u>Formal Governance</u>

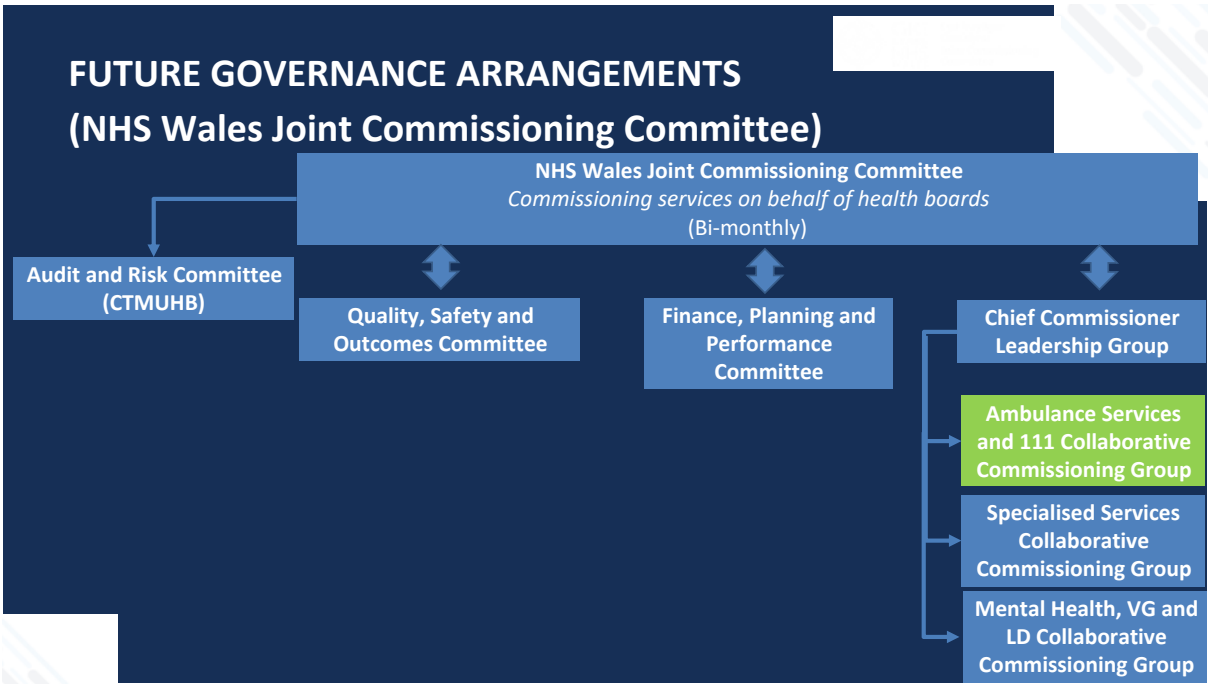
6. The Trust's previous commissioning governance arrangements for 999 and NEPTS were as follows:-



Note: 111 was separately commissioned from May 2023.

7. Underneath these pan-Wales arrangements were specific commissioning meetings with each health board, but there is a general acknowledgement that these meeting were of variable value. In addition there was a monthly Chief Ambulance Services Commissioner (CASC) Assurance meeting.

8. The proposed new governance arrangements are:-



9. The arrangements are still in development, for example, NEPTS Delivery & Assurance Group (DAG) is still meeting, but may be subsumed into the Ambulance Services and 111 Collaborative Commissioning Group, although the latest thinking is that this meeting is working and should be retained. Equally, discusssions are on-going regarding whether specific health boad commissioning meetings will be reinstated or whether these will be regional. A new JCC Provider Assurance meeting is antcipated from Q2, replacing the CASC Assurance meeting.

10. It should be noted that there are separate governance accountability arrangements with Welsh Government, in particular, the bi-monthly Integrated Quality, Planning & Delivery (IQPD) meeting and six monthly Joint Executive Team (JET) meetings. JCC representatives do currently attend the IQPD meeting and the Trust's slides for both are shared with the JCC.

<u>Informal Governance</u>

11. Whilst it is recognised that formal governance arrangements between the Trust and the JCC need further development, the informal governance arrangements are more established. The Trust's CEO and Executive Director Strategy, Planning &

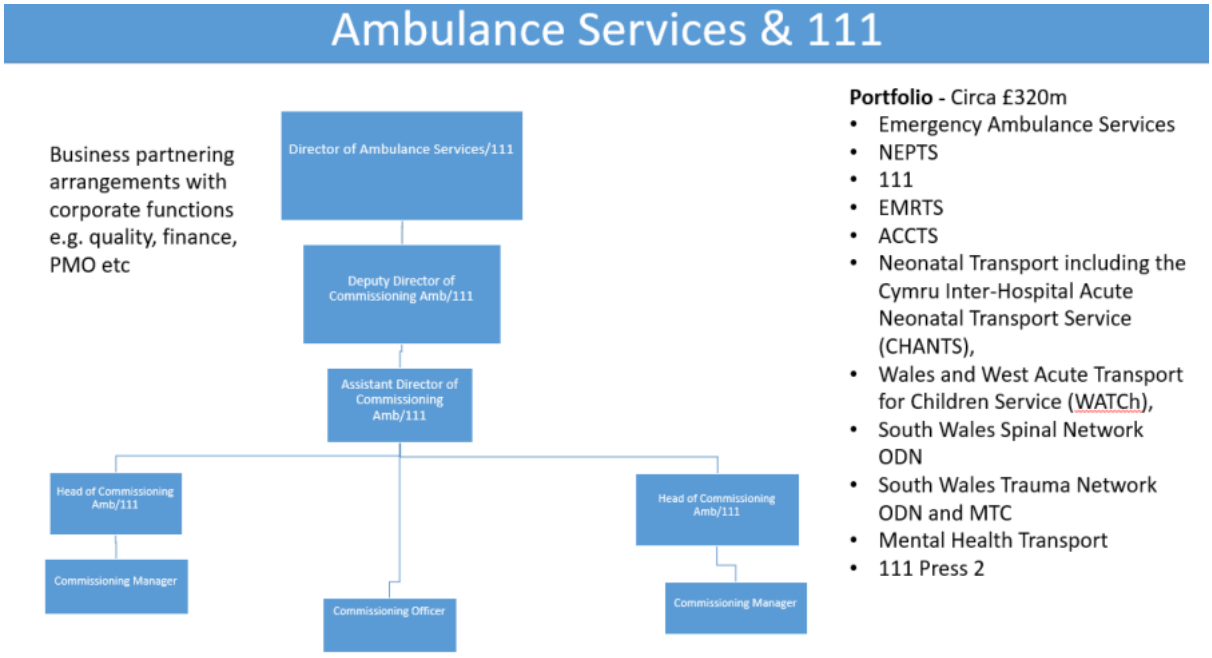
Performance meet every week with the Director of Commissioning for Ambulance Services & 111. The Assistant Director Commissioning & Performance has the day to day responsibility for managing the commissioning interface.

JCC Posts

12. Previously EASC employed the CASC. Stephen Harrhy was the CASC from 2015 to 2025 when he retired. In the new JCC structures the title has changed to Director of Commissioning for Ambulance Services & 111 and Ross Whitehead has been appointed into this role. Ross is a paramedic and has NHSWales operational experience of EMS and the Clinical Support Desk.

13. The JCC's Chief Commissioner, is Hugh George, previously the Deputy Chief Executive of Public Health Wales. Hugh is the third JCC Chief Commissioner in just over one year, but hopefully there will now be a period of continuity.

14. The Director of Commissioning for Ambulance Services & 111 is recruiting into the following structure:-



15. The portfolio is wider than just commissioning with the Trust, but the new structure may have implications for the Trust, for example, increased scrutiny.

Commissioning Intentions

16. The Trust receives draft commissoning intentions each autumn. These are then discussed internally, including at Executive Leadership Team (ELT), and a formal response is sent (if required) by the Trust to the Director of Commissioning for Ambulance Services & 111 . There is normally then a process of dialogue and

negotiation before the intentions are finalised in Q4. ELT consider the 2025/26 commissioning intentions supportive of the Trust's strategic ambitions. They are attached at Appendix 1.

17. Expected areas of commissioning focus in 2025/26 include:-

    a. The overall Clinical Model Transformation (CMT) Programme, which is consistent with the 999 commissionig framework ambition to "shift demand left, where it is clinically safe and appropriate to do so " i.e. hear & treat and see & treat, avoiding emergency department conveyance;

    b. A national ambulance patient handover improvement programme, with the Director of Commissioning for Ambulance Services & 111 on the related taskforce along with executive level representation from the Trust;

    c. Specifically within the overall programme the new ARREST and EMERG category went live on 01 July 2025, with the Director of Commissioning for Ambulance Services & 111 being a key arbiter in signing off the proposed definitions and monitoring & assurance arrangements. This involvement is expected to continue into the next phase of the clinical response model's development;

    d. The CMT programme collaborative and independent evaluation with the Director of Commissioning for Ambulance Services & 111 being the joint Senior Responsible Owner (SRO) along with the Trust's Executive Director of Quality & Nursing;

    e. Further clinical outcomes measures for the EMERG category and wider outcome measures, for example, survival rates (out of hospital cardiac arrest registry) and data linking with health boards, so the Trust can prove that early interventions (hear & treat, see & treat) are benefiting the wider system;

    f. Productivity: with the the general pressure on NHS Wales budgets the Trust is coming under more pressure to be more efficient/effective and find internal savings, for example, no funding has been made available from the JCC to support the B5 Emergency Ambulance Practictioner role;

    g. 111: developing the digital front end, including increasing public awareness of the offer and a greater ability to self-serve through a modernised digital front end; and undertaking a review of roster practices to improve call abandonment performance variation and produce workable roster patterns;

h. NEPTS capacity, in particular, undertaking a complex and difficult re-roster to deliver more patient journeys, the use of digital technology to reduce patient cancellations, in particular, two way texting and integration between health board booking systems and Cleric; and

i. Manchester Arena Inquiry: the JCC have set a specific objective for this year around responding to the MAI and to the comprehensive report that was submitted to them from the Trust in August 2024.

18. In year the Trust completes quarterly updates against the commissioning intentions, which are then signed off by Executives at either ELT or Strategic Transformation Board (STB) and reported onwards to the Ambulance Services and 111 Commissioning Group.

<u>IMTP 2025-28 & Financial Plan</u>

19. During late Q3 and early Q4 Strategy, Planning & Performance establishes specific IMTP planning meetings with commissioners.

20. The commissioning intentions are built into the IMTP main document:-

3.5 What do our commissioners say?

The current commissioning of WAST's ambulance services now falls within the remit of the **NHS Wales Joint Commissioning Committee (NWJCC)** which was operational from 1 April 2024. The NWJCC's IMTP is published at the same time as the WAST IMTP and commissioning of our services is set out in the Ambulance and NHS 111 Commissioning portfolio which consists of five commissioned services: NHS 111; Emergency Ambulance Services (EAS); Non-Emergency Patient Transport (NEPTS); Emergency Medical Retrial and Transfer Service (EMRTS) and the Adult Critical Care Transfer Service (ACCTS).

The previous commissioning intentions for EMS, NEPTS, and EMRTS for 2024-2025 have been reviewed and updated for 2025-2026. The new commissioning intentions now also include NHS 111 Wales and the Adult Critical Care Transfer Service (hosted by Swansea Bay University Health Board). These intentions align with the NWJCC strategic priorities and the NHS Wales planning framework, addressing ambulance and 111 commissioning risks through an assessment against the health and care quality standards.

The key priorities set out within the commissioning intentions for NHS 111, 999 and NEPTS are:

NHS 111

- Maximise clinical outcomes and patient safety by aligning NHS 111 and 999 infrastructure where clinically appropriate.
- Implement technology enhancements such as a digital front end to improve operations.
- Enhance productivity through alignment with 999 infrastructure and focus on industry benchmarks for efficiency.
- Collaborate with partners via the JCC to develop system-wide solutions for maximizing NHS 111 commissioned capacity.

EMS

- Evaluate and enact the evolving clinical model to improve clinical outcomes and patient safety.
- Align 999 and NHS 111 infrastructure where clinically appropriate to maximise outcomes.
- Implement technology enhancements to improve operations.
- Enhance productivity through the evolving clinical model and focus on industry benchmarks.
- Collaborate with partners to improve resource utilisation and system flow.
- Prepare for major incidents in line with the Civil Contingencies Act and collaborate on preparedness and response developments.

NEPTS

- Utilise technology to streamline booking and coordination processes for improved efficiency and responsiveness.
- Align NEPTS and Urgent Care services where clinically appropriate to improve system outcomes and patient experience.
- Collaborate with partners to optimise transfer and discharge resources.
- Work with health boards and system partners to develop and redesign services in response to changing requirements.

21. The Trust's response to the commissioning intentions is effectively Trust Board approved as part of the approval process for the IMTP. The commissioners explicitly approve the commissioning intentions at their relevant committees.

22. WAST's annual funding, including inflation uplifts is worked up and agreed between the Trust and JCC as part of the IMTP and financial plan development. Contract value monitoring is undertaken on the three commissioning service components of EMS, NEPTS and 111 and cash payments are made monthly on the 1st working day of each month. Monthly meetings are held between WAST & JCC finance teams to ensure full reconciliation of payments against contract values and also to discuss any contract variations that will impact on contract values. There is a probability that during this financial year additional cost returns may be requested from JCC, but this is not currently active.

23. As previously reported to Trust Board (Mar-25, IMTP/Financial Plan) the Trust received a general uplift for inflationary and other cost pressures for 2025/26 of 1.77% and a requirement to make a 2% cost avoidance / containment and savings plan. The JCC requested that the Trust consider how additional cost releasing savings might be made, and whilst this requirement was not built into the Trust IMTP, it is likely that the JCC will return to the discussion over the course of this financial year, given their own financial situation.

Assessment

24. The Trust has a strong track record of delivery and is in routine monitoring with Welsh Government i.e. the lowest level; however, there is no room for complacency. The on-going issues around patient safety, staff well-being, general system pressures and the level of available funding mean that the Trust is anticipating an increased level of scrutiny by the JCC, particularly, as its new structures become more established in the second half of 2025/26.

RECOMMENDATIONS

Committee is asked to: -

- **Note** the continuing development of the new commissioning arrangements within the JCC.
- **Consider** whether the Trust's arrangements for managing this interface are appropriate.

Commissioning Intentions NHS 111

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	NHS 111
Operating Model	**The provider and its Commissioners will maximise the opportunities offered within the commissioning framework.**
	Commissioning Statement: The 5 step Pathway provides a framework for health systems to collaborate to optimise the care patients receive at each step. A high performing health system will enable services and practitioners at each step to resolve a patient episode of care without the need to progress further along the pathway, for example increased remote clinical assessment and screening. Maximising the potential of this opportunity will require system wide collaboration that transcends traditional organisational and professional boundaries.
Provider Priorities	• Maximise opportunities to improve clinical outcomes and patient safety through the alignment of NHS 111 and 999 infrastructure, where it is clinically safe and appropriate do so.
	• Explore opportunities and implement technology to enhance the operating e.g. digital front end.
Capacity	**The provider and its Commissioners will secure and optimise sufficient service capacity to respond to system demand.**
	Commissioning Statement: The NHS Wales Joint Commissioning Committee holds statutory responsibility for the planning and securing of sufficient ambulance and NHS 111 services for the population of Wales. Discharging this responsibility requires close collaboration between commissioners and the providers, to ensure that all available resources are used effectively to deliver high standards of performance and quality, reduce harm and support effective system flow.
Provider Priorities	• Continue to optimise the use of existing resources to meet demand e.g. rostering practices, and explore the impact of the digital front end to consider future demand, quality and patient safety through a collaborative and independent strategic demand and capacity review.
	• Through the delivery of the strategic workforce plan, maintain sufficient and appropriate workforce levels to respond to demand.

Commissioning Intentions NHS 111

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	NHS 111
Productivity	**The provider and its Commissioners will maximise productivity from available resources and demonstrate continuous improvement.**
	Commissioning Statement: Ensuring appropriate levels of productivity from the resources available is a key component of delivering an effective ambulance service. There are a number of external and internal drivers leading to suboptimal productivity. Addressing these areas has the potential to deliver significant improvements in performance standards, improving clinical outcomes for patients, reducing harm and improving flow within the emergency and urgent care system.
Provider Priorities	• Enhance the productivity of NHS 111 service through the alignment of NHS 111 and 999 infrastructure and continue to focus on recognised industry benchmarks for productivity.
	• Via the JCC, work with partners to identify and develop system wide solutions to maximise the productivity of NHS 111 commissioned capacity.
Value	**The provider and its Commissioners will develop a Value-Based approach to service commissioning and delivery, which enables an equitable, sustainable and transparent use of resources to achieve better outcomes for patients.**
	Commissioning Statement: Value is created when we achieve the best possible healthcare outcomes for the Welsh population with the most efficient and effective use of available resources. We also recognise that value can be depleted and therefore the development of a Value-Based strategy will need to identify ways to effectively manage and mitigate the risks of value depletion in addition to identifying opportunities for value creation
Provider Priorities	• Aligned to the principles of Value Based Healthcare, work with the JCC and partners to develop a costing and benefit methodology for NHS 111.
	• Develop data linking with the wider health care system, which enables a more robust assessment of the value of provider initiatives.

Commissioning Intentions NHS 111

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	NHS 111
Harm and Outcomes	**The provider and its Commissioners will collaborate to reduce and prevent harm and improve quality of service and outcomes for patients.**
	Commissioning Statement: The provider operates in complex and challenging environments. The delivery of a quality healthcare service requires effective, safe and people-centred care. To realize the benefits of quality health care, services must be timely, equitable, integrated and efficient. A mature health system proactively seeks opportunities to reduce and prevent harm. Continuous improvement based on learning from errors and adverse events must be a cornerstone of a healthcare service provision.
Provider Priorities	• The provider will provide quarterly assurance reports to the JCC on their compliance with the Duty of Quality and Candour.
	• The provider will ensure the appropriate and timely sharing of data with the JCC and relevant partners, to monitor and assess the impact on service performance, clinical outcomes and patients safety.
Wider Health System	**The provider and its Commissioners will collaboratively develop and deliver services that allow the provider to contribute to the wider health system through the modernisation of service delivery.**
	Commissioning Statement: The Welsh Ambulance Service and EMRTS have a unique role of providing urgent, emergency and critical care services to the population of Wales. The Welsh Ambulance Service and EMRTS are able to provide a range of urgent, emergency and critical care services through remote and mobile response functions, utilising a range of highly trained staff. Therefore, the Welsh Ambulance Service and EMRTS are key partner in the development and delivery of services, to modernise the wider urgent, emergency and critical care system.
Provider Priorities	• Working in collaboration with the JCC, health boards and urgent and emergency care partners, the provider will take an evidence based approach to the development of services and pathways to ensure patients can access the right service first time.
	• The provider will participate and collaborate in the national development of the NHS 111 service.

Commissioning Intentions EMS

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	Emergency Ambulance Services
Operating Model	**The provider and its Commissioners will maximise the opportunities offered within the commissioning framework.**
	Commissioning Statement: The 5 step Pathway provides a framework for health systems to collaborate to optimise the care patients receive at each step. A high performing health system will enable services and practitioners at each step to resolve a patient episode of care without the need to progress further along the pathway, for example increased remote clinical assessment and screening. Maximising the potential of this opportunity will require system wide collaboration that transcends traditional organisational and professional boundaries.
Provider Priorities	• Enactment and evaluation of the evolving clinical model, designed to deliver improved clinical outcomes and patient safety at each step of the pathway.
	• Maximise opportunities to improve clinical outcomes and patient safety through the alignment of 999 and NHS 111 infrastructure, where it is clinically safe and appropriate do so.
Capacity	**The provider and its Commissioners will secure and optimise sufficient service capacity to respond to system demand.**
	Commissioning Statement: The NHS Wales Joint Commissioning Committee holds statutory responsibility for the planning and securing of sufficient ambulance and NHS 111 services for the population of Wales. Discharging this responsibility requires close collaboration between commissioners and the providers, to ensure that all available resources are used effectively to deliver high standards of performance and quality, reduce harm and support effective system flow.
Provider Priorities	• Optimisation of remote clinical triage and medical dispatch resources across the 5 step pathway to deliver improved clinical outcomes and patient safety.
	• Through the delivery of the strategic workforce plan, maintain sufficient and appropriate workforce levels to respond to demand at each step of the pathway.

Commissioning Intentions EMS

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	Emergency Ambulance Services
Productivity	**The provider and its Commissioners will maximise productivity from available resources and demonstrate continuous improvement.**
	Commissioning Statement: Ensuring appropriate levels of productivity from the resources available is a key component of delivering an effective ambulance service. There are a number of external and internal drivers leading to suboptimal productivity. Addressing these areas has the potential to deliver significant improvements in performance standards, improving clinical outcomes for patients, reducing harm and improving flow within the emergency and urgent care system.
Provider Priorities	• Enhance the productivity of emergency ambulance services through the implementation of the evolving clinical model and continue to focus on recognised industry benchmarks for productivity.
	• Via the JCC, work with partners to identify and develop system wide solutions that contribute to the improved utilisation of resource.
Value	**The provider and its Commissioners will develop a Value-Based approach to service commissioning and delivery, which enables an equitable, sustainable and transparent use of resources to achieve better outcomes for patients.**
	Commissioning Statement: Value is created when we achieve the best possible healthcare outcomes for the Welsh population with the most efficient and effective use of available resources. We also recognise that value can be depleted and therefore the development of a Value-Based strategy will need to identify ways to effectively manage and mitigate the risks of value depletion in addition to identifying opportunities for value creation
Provider Priorities	• Aligned to the principles of Value Based Healthcare, work with the JCC and partners to develop a costing and benefit methodology for emergency ambulance services.
	• Develop data linking with the wider health care system, which enables a more robust assessment of the value of provider initiatives.

Commissioning Intentions EMS

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	Emergency Ambulance Services
Harm and Outcomes	**The provider and its Commissioners will collaborate to reduce and prevent harm and improve quality of service and outcomes for patients.**
	Commissioning Statement: The provider operates in complex and challenging environments. The delivery of a quality healthcare service requires effective, safe and people-centred care. To realize the benefits of quality health care, services must be timely, equitable, integrated and efficient. A mature health system proactively seeks opportunities to reduce and prevent harm. Continuous improvement based on learning from errors and adverse events must be a cornerstone of a healthcare service provision.
Provider Priorities	• The provider will provide quarterly assurance reports to the JCC on their compliance with the Duty of Quality and Candour.
	• Aligned to the evolving clinical model and revised ambulance performance measures, the provider will ensure the appropriate and timely sharing of data with the JCC and relevant partners, to monitor and assess the impact on clinical outcomes and patients safety.
Wider Health System	**The provider and its Commissioners will collaboratively develop and deliver services that allow the provider to contribute to the wider health system through the modernisation of service delivery.**
	Commissioning Statement: The Welsh Ambulance Service and EMRTS have a unique role of providing urgent, emergency and critical care services to the population of Wales. The Welsh Ambulance Service and EMRTS are able to provide a range of urgent, emergency and critical care services through remote and mobile response functions, utilising a range of highly trained staff. Therefore, the Welsh Ambulance Service and EMRTS are key partner in the development and delivery of services, to modernise the wider urgent, emergency and critical care system.
Provider Priorities	• Working in collaboration with the JCC, health boards and urgent and emergency care partners, the provider will contribute to delivery of improved system flow through optimisation of all available transfer resources.
	• 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.

Commissioning Intentions NEPTS

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	Non-Emergency Patient Transport Services
Operating Model	**The provider and its Commissioners will maximise the opportunities offered within the commissioning framework.**
	Commissioning Statement: The 5 step Pathway provides a framework for health systems to collaborate to optimise the care patients receive at each step. A high performing health system will enable services and practitioners at each step to resolve a patient episode of care without the need to progress further along the pathway, for example increased remote clinical assessment and screening. Maximising the potential of this opportunity will require system wide collaboration that transcends traditional organisational and professional boundaries.
Provider Priorities	• Utilise technology and introduce alternative methods to streamline journey booking and coordination processes to improve efficiency and responsiveness.
	• Maximise opportunities to improve system outcomes and patient experience through the alignment of NEPTS and Urgent Care Services, where it is clinically safe and appropriate do so.
Capacity	**The provider and its Commissioners will secure and optimise sufficient service capacity to respond to system demand.**
	Commissioning Statement: The NHS Wales Joint Commissioning Committee holds statutory responsibility for the planning and securing of sufficient ambulance and NHS 111 services for the population of Wales. Discharging this responsibility requires close collaboration between commissioners and the providers, to ensure that all available resources are used effectively to deliver high standards of performance and quality, reduce harm and support effective system flow.
Provider Priorities	• Continue to review NEPTS resource capacity to respond to outpatient, oncology, renal, discharge and transfer demand, aligned to health boards strategical and operational requirements.
	• Through the delivery of the strategic workforce plan, maintain sufficient and appropriate workforce levels to respond to demand at each step of the pathway.

Commissioning Intentions

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	Non-Emergency Patient Transport Services
Productivity	**The provider and its Commissioners will maximise productivity from available resources and demonstrate continuous improvement.**
	Commissioning Statement: Ensuring appropriate levels of productivity from the resources available is a key component of delivering an effective ambulance service. There are a number of external and internal drivers leading to suboptimal productivity. Addressing these areas has the potential to deliver significant improvements in performance standards, improving clinical outcomes for patients, reducing harm and improving flow within the emergency and urgent care system.
Provider Priorities	• Working with the JCC and partners, the provider will aim to maximise NEPTS resource availability by implementing systems to reduce the number of cancelled journeys.
	• Via the JCC, the provider will work with partners to identify and develop system wide solutions that contribute to the reduction in handbacks for discharge and transfer journeys.
Value	**The provider and its Commissioners will develop a Value-Based approach to service commissioning and delivery, which enables an equitable, sustainable and transparent use of resources to achieve better outcomes for patients.**
	Commissioning Statement: Value is created when we achieve the best possible healthcare outcomes for the Welsh population with the most efficient and effective use of available resources. We also recognise that value can be depleted and therefore the development of a Value-Based strategy will need to identify ways to effectively manage and mitigate the risks of value depletion in addition to identifying opportunities for value creation
Provider Priorities	• Aligned to the principles of Value Based Healthcare, work with the JCC and partners to develop a costing and benefit methodology for non-emergency patient transport services.

Commissioning Intentions

NWJCC Ambulance and NHS 111 Commissioning Intentions	
Commissioning Intentions	Non-Emergency Patient Transport Services
Harm and Outcomes	**The provider and its Commissioners will collaborate to reduce and prevent harm and improve quality of service and outcomes for patients.**
	Commissioning Statement: The provider operates in complex and challenging environments. The delivery of a quality healthcare service requires effective, safe and people-centred care. To realize the benefits of quality health care, services must be timely, equitable, integrated and efficient. A mature health system proactively seeks opportunities to reduce and prevent harm. Continuous improvement based on learning from errors and adverse events must be a cornerstone of a healthcare service provision.
Provider Priorities	• The provider will provide quarterly assurance reports to the JCC on their compliance with the Duty of Quality and Candour.
	• Aligned to the ambitions of the JCC's NEPTS Future Vision and the recommendations of the NHS Wales Health and Social Care Committee, the provider will ensure the appropriate and timely sharing of data with the JCC and relevant partners, to monitor and assess the impact of operational and system changes on performance outcomes and patients experience.
Wider Health System	**The provider and its Commissioners will collaboratively develop and deliver services that allow the provider to contribute to the wider health system through the modernisation of service delivery.**
	Commissioning Statement: The Welsh Ambulance Service and EMRTS have a unique role of providing urgent, emergency and critical care services to the population of Wales. The Welsh Ambulance Service and EMRTS are able to provide a range of urgent, emergency and critical care services through remote and mobile response functions, utilising a range of highly trained staff. Therefore, the Welsh Ambulance Service and EMRTS are key partner in the development and delivery of services, to modernise the wider urgent, emergency and critical care system.
Provider Priorities	• Working in collaboration with the JCC and planned care partners, the provider will contribute to the delivery of improved system flow through the optimisation of all available transfer and discharge resources.
	• Via the JCC, the provider will work with health boards and system partners at a strategic and operational level in the development and redesign of services, to ensure that NEPT services are able to respond to the changes in service requirements.

AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

Integrated Medium Term Plan (IMTP) Delivery/Assurance 2025-26 End of Q1 Position

MEETING	Finance & Performance Committee
DATE	21 July 2025
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Planning & Transformation Heather Holden, Head of Transformation Deborah Kingsbury, Senior Planning & Performance Business Partner
CONTACT	alexander.crawford2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide the Committee with an end of Q1 position for IMTP delivery and assurance for the 2025/26 year of the 2025-28 IMTP.

This paper provides a position for the Clinical Model Transformation (CMT) programme, Directorate-led IMTP portfolio, and Cabinet Secretary's Priorities for NHS Wales set out in the 2025-26 NHS Wales Planning Framework.

This paper does not contain an assessment against the 'what good looks like' outcomes statements as it is a Q1 position and it is proposed that these are presented every 6 months allowing time for incremental changes delivered through the IMTP to realise their benefits. However, performance continues to be monitored at the tactical level through the Monthly Integrated Quality and Performance Report (MIQPR).

This report will set out in detail how the Clinical Model Transformation programme continues to deliver significant evolution of our clinical response model, now in line with the new Ambulance Performance Framework announced in March, and how the wider IMTP is has being delivered through a directorate led approach.

RECOMMENDED:

That the Committee

1. **Agrees** to the proposed approach to reporting on strategic outcomes and benefits;
2. **Notes** the CMT programme end of Q1 position;
3. **Notes** the Directorate-led IMTP end of Q1 position;

4. **Notes** the Q1 position for the Cabinet Secretary's priorities set out in the 2025-26 planning framework;
5. **Advises** of any further assurance needed for the Board.

KEY ISSUES/IMPLICATIONS

The WAST IMTP for 2025-28 was approved by Trust Board on 27 March 2025 and submitted to Welsh Government on 31 March 2025. Welsh Government approved the IMTP on 30 June 2025, at the time of writing this report we are awaiting accountability conditions.

Clinical Model Transformation (CMT) Programme Key Issues/Implications:
The end of Q1 position has been summarised within the main SBAR and the complete assurance report included as Appendix A.

The CMT programme continues to evolve with a strong emphasis on connectivity and transparency. In line with our commitment to digitised programme management, **all core delivery plans have now transitioned from MS Excel to MS Project/Planner**. This transition has **improved plan visibility and cross-sighting and has supported a better understanding of resource allocation across the programme**. This transition will also enable interdependencies to be formally mapped and tracked, an area of focus for the team over the next reporting period.

Progress on Quality Impact Assessments (QIAs) remains a priority. To date, **QIAs have been approved for three of the five core workstreams**, with the remaining two scheduled for Clinical Quality Governance Group (CQGG) review in July. The **programme-level Equality Impact Assessment (EQIA) has received approval** from both the CMT Board and the Strategic Transformation Board (STB), reflecting our commitment to equitable and inclusive transformation. A review of the Programme Definition Document (PDD) and the CMT Board's Terms of Reference is also scheduled to ensure these remain aligned with programme evolution.

A **dedicated session with Executive Sponsors and Senior Responsible Owners has been arranged to finalise Logic-Benefits Maps (LBMs) for each workstream**. These documents will underpin the benefits realisation approach and inform the development of workstream-level dashboards by the IDS team, enabling routine monitoring of benefit delivery across the programme. This will also lead to the formalisation of the programme's Benefits Realisation Plan.

The CMT Board received an update on actions taken across the programme to improve outcomes and experience. In January, colleagues were invited to share their experiences and to help shape how we continue to improve – highlighting areas including communication and engagement, connectedness, structure, and leadership. Feedback has **informed targeted changes aimed at improving both outcomes and the day-to-day experience for those involved in delivery** including:

- Clearer, more consistent communications
- Better use of Siren to keep everyone informed
- New digital tools like MS Project and Miro to boost coordination across workstreams

- Stronger leadership visibility and collaboration, with a refreshed Transformation Delivery Network (TDN) on the way, designed to bring people together from across corporate and operational teams

Looking forward, **we will be exploring the professional culture underpinning the programme by defining clearer roles for programme leaders** and starting honest conversations about the support needed to build skills and confidence in these essential roles.

Finally, **a proposal will be submitted to the Executive Finance Group (EFG) for modest additional investment in the Transformation Support Office (TSO)**. This investment will facilitate adjustments to the current structure – expanding the skill mix and introducing senior project management capacity – **to align with the complexity and scale of the programme**.

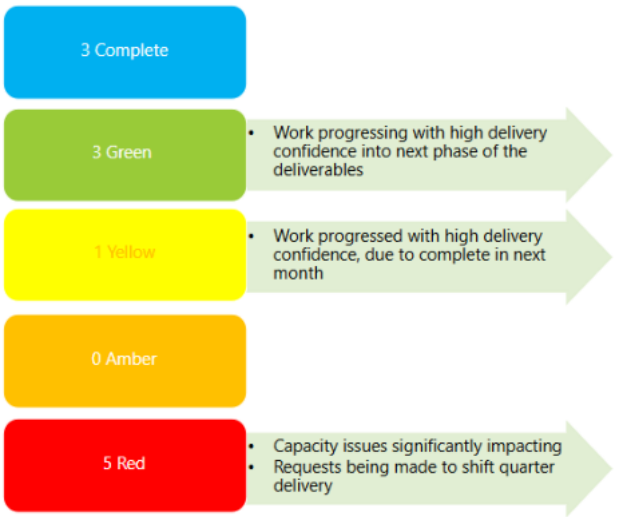
The programme remains **YELLOW** (cautionary) due to ongoing challenges related to documentation and workload pressures arising from the pace of change.

Directorate-led IMTP Portfolio Key Issues/Implications:
The assurance report in Appendix B sets out the end of Q1 position for the directorate led portfolio of IMTP deliverables.

During Quarter 1 the Planning Team has **developed a digitised system for Directorate Plans**, working with Directorate leads to transition to a live platform through MS365. This provides a dynamic single source of information that is more streamlined, user friendly and through greater visibility will support greater interdependency planning across the organisation. **Developments will continue** to enhance the system further, building reports and further automations into Quarter 2.

This is all facilitated through a newly developed **Sharepoint site for integrated planning** that includes the **Directorate plans, planning guidance, support and a single point of reference**; work will continue throughout Quarter 2 to build this resource further.

The current update in this paper is the end of quarter 1 position. **12 deliverables were committed to for delivery within the IMTP by the end of quarter 1. The diagram below provides an overall position on progress.**



STB considered progress and the **5 deliverables noted** as **RED** status, discussing the issues. All 5 of the deliverables **requested a shift in delivery quarter to later in the year** due to capacity issues, one external capacity impacting necessitating a review of timelines. **All were agreed at STB as reasonable with STB requesting further updates at the next meeting** for any further support required.

In addition to the quarter 1 update STB requested a focus on our **Strategic Objective 2 (Enabling our people to be the best they can be).** There are **10 key underpinning plans** that span the entire year, a comprehensive update was provided at STB, **with overall good progress with high confidence that delivery remains on track.**

A specific focus on three key issues based on feedback received through engagement with staff and volunteers, surveys and TU relationships was also requested. These were also discussed at STB with recognition of progress and deliverability. These are:

- **Shift overruns**
- **Digital Experience**
- **1:1 Conversations (delivered through our WAST way)**

The deliverables to progress these commitments to our people are not due in Q1 but the progress and ongoing work being undertaken is set out in the table below.

Objective	IMTP Deliverable	Q1 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	Outputs of the work of the **Shift Overrun** task and finish group delivered by **Q2**	**Green**		An SBAR has been submitted to Formal SOT To highlight the work in partnership that has been completed and recommendations made (2) for Formal SOT membership to review and discuss and approve if appropriate.
Ensuring the skills and capability needed to achieve our purpose	**Our WAST Way** leadership behaviours framework and an aligned development framework, developed and launched in 2025/26 (this incorporates **1:1 conversations**)	**Green**		• As per earlier slide on our WAST Way
SO3: Being at the forefront of innovation & technology				
Pillar 1 Everyday Essentials	**Simplified sign on** will be developed and implemented by the end of Q4 giving users a better **digital experience**	**Green**	**Moderate**	The discovery piece is near conclusion and a "show and tell" of the work undertaken to date took place on 5th June 2025 with digital, estates and workforce all in attendance. Indicative costings are to follow to enable a decision to be made on next steps and plan delivery of any smart station initiatives.
Pillar 4 Security, Safety & Cyber	**Smart station** initiative will be rolled out by Q4	**Green**	**Moderate**	Current initial delays to development due to dependency on work by DHCW

Forward assurance plan in 2025/26

Both CMT and ISPD have made significant progress with digitised mechanisms to support programme and directorate-led IMTP delivery using the Microsoft suite of applications available to the Trust. This may result in a change in the format of reporting. However, the general approach will remain as in 2024/25 with updates against the CMT programme, directorate-led updates and against ministerial templates.

Ministerial priorities

Appendix C sets out how we are progressing against the ministerial priorities set out in the last NHS Planning Framework. Good progress is being made, in line with commitments in the IMTP, with **no RED** status deliverables.

Outcomes measures

It is proposed that 'what good looks like' outcomes monitoring be presented on a six-monthly basis. The last update was given in May 2025 as an end of 2024/25 financial year position. It is therefore proposed that the next update will be in the September interim Q2 update to the Committee and the Board. In the meantime, the MIQPR provides the tactical oversight of performance impacted by our various plans.

The IMTP is a key plan underpinning the delivery of the long term strategy 'Delivering Excellence'. However, there are further enabling plans which also support the strategy. The Committee requested an organogram showing the relationship between these plans, the IMTP and the strategy. This is overseen by the Quality and Performance Management Steering Group and can be seen in Appendix 9.1.

REPORT APPROVAL ROUTE
Strategic Transformation Board (STB) 30 June 2025

REPORT APPENDICES
Appendix 9.1 Strategy Landscape July 2025 and Organogram **Appendix A – 2506 - CMT Programme Highlight Report** Appendix A (separate attachment) **Appendix B – IMTP Delivery Assurance Report** Appendix B (separate attachment) **Appendix C- Assurance against the Cabinet Secretary's priorities 2024/25**

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

Appendix C

Assurance against the Cabinet Secretary's priorities 2024/25

BACKGROUND

WAST submitted four templates covering plans against four of the Cabinet Secretary's priorities for NHS Wales. These covered:

- **Timely Access to Care**
- **Prevention**
- **Community Capacity**
- **Mental Health**

We did not submit a template in relation to Women's Health as the delivery expectations in the NHS Wales Planning Framework were very much around health board run Women's Health Hubs. However, we provide progress to Welsh Government through IQPD and JET meetings on our plan for maternity and neonatal support to our clinical teams, having permanently appointed our lead midwife this year.

ASSESSMENT

The following table sets out the key areas for WAST against the priorities, and the milestones to be achieved by the end of Q1. The table sets on what was committed to for the year against each priority (Area for WAST column), Q1 specific milestones, RAG status of each deliverable and summary progress. From Q2 the report will include progress against trajectories set out in the templates.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	RAG (Delivery)	Progress
Timely Access to Care	**Ambulance Target Review & Call Categorisation** Respond to the outcome of the Welsh Government-led Task & Finish group to determine the appropriateness of the current Red 8-minute target.	• Ambulance Target Review complete with a formal mandate from Welsh Government • MIS configuration of Arrest category • Dual reporting for Ambulance Target Review go-live (subject to confirmed recommendation)		• Completed and gone live 01 July 25.
	Rapid Clinical Screening Transition to a clinically prioritised emergency response model with early clinical input to improve the accuracy of prioritisation, providing more timely response to the most critically unwell patients	• Implement RCS0 call category		• Completed
	RICS Strengthen and expand the use of the Call Prioritisation Streaming System (CPSS) enabling call handlers to provide safe, effective advice and referrals to a broader range of calls Design and implement processes and policies to deliver an effective integrated care clinical team including revisions to SOPs, alignment of terms and conditions, strengthened quality and safety governance arrangements, and implementation of a Home and Remote Working Model to enhance service delivery and support seamless collaboration	• Complete evaluation of Winter Desk • Implement a sustainable solution to the Winter Desk Test of Change • Strengthen Quality and Safety Governance arrangements • Define processes for single Integrated Care Clinical team and replace 52 SOPs • Align terms and conditions for clinical teams		• Review of winter desk completed with proposals for establishment of a permanent desk presented. • A quality and safety dashboard has been developed • SOPs in development – in year sign off via SOT – staggered due to volume • Consultation on the 20th May - verbal feedback on progress to be provided
	Transfer & Discharge Service Model Engage with commissioners to develop a Transfer & Discharge service model appropriate to Health Board & strategic service development needs - including opportunities to implement a Transfer Clinical Hub (subject to external funding)	• Agree the internal vision for Transfer & Discharge aligned with the national direction of travel • Work with six goals team to integrate NEPTS processes into system wide discharge planning •		• Internal vision being progressed, further discussions with Commissioners to ensure alignment with national direction of travel
	Non-Emergency Patient Transport Service (NEPTS) Continued development of the service to ensure the right capacity is in place to meet demand to support planned care and cancer services.	• Data and insights to improve co-ordination and decision making with health boards throughout 25/26.		• Ongoing collaborative work with Health Boards

Cabinet Secretary Priority	Area for WAST	Milestones Q1	RAG (Delivery)	Progress
Population Health and Prevention	**NHS 111 Wales website**: the website will provide information and advice to support people to access the right part of the health system or self care, preventing escalation of care unnecessarily. **NHS111.Wales Improvement** Deploy a Virtual Assistant integrated with Robotics AI to empower patients with the tools and information needed to manage their health needs more autonomously, enhancing accessibility and supporting self-care. **Online Symptom Checker (OSC)** Identify and implement an effective Online Symptom Checker tool to enhance patient access to timely, accurate advice	• Deliver and evaluate the initial proof of concept for the Virtual Assistant (navigation of the A-Z Directory (funded).		• *Green* Outline Business Case submission provided to Welsh Government. • *Green* Soft Launch go live of the Virtual Assistant achieved early July 2025. • Online symptom checker -Trust Board approved direct award, enabling us to move forward on the single tender action process. Funding dependency.
	Falls services: Objectives are to lift patients at the earliest opportunity to prevent deterioration and avoid hospital conveyance where safe and appropriate to do so. Where hospital conveyance is required the aim is to convey in a timely manner to prevent further deterioration. By the end of FY25/26: Optimise the current Falls Level One Service in line with Health Board specifications and remit, National Falls Framework, and WAST Falls Response to provide an effective and safe Falls Service across Wales. We will also develop the subsequent transformational amendments to Falls incident management and deployment (including RICS, RCS, Care Planning, and UCR Hubs) to ensure patient safety. By the end of FY27/28: Deploy and optimise a Falls Level Two Service in collaboration with Health Boards, and in line with the National Falls Framework and Trust Level Two	• L1 - Identify data availability regarding National Falls Framework Metrics (conveyance, response, community, resource, and HB data) • L2 - Continue assessing developing Level One service to begin drafting Level Two specification		• Data analysis undertaken, additional work ongoing to develop data further once capacity available within in digital. • Ongoing work collaboratively on falls model

Cabinet Secretary Priority	Area for WAST	Milestones Q1	RAG (Delivery)	Progress
	Specification including subsequent transformational amendments to Falls incident management and deployment (including RICS, RCS, Care Planning, and UCR Hubs) to ensure patient safety.			
Building Community Capacity	**APP Navigators** By the end of FY26/27: Deliver an APP Navigator in every Health Board, fully integrated into Health Board MDT hubs to enhance collaboration, optimise resource allocation, and ensure a consistent, equitable service offer across all seven Health Boards. To deliver this, a roster review will also be conducted to support efficient deployment and service consistency.	• Engagement with HBs to identify opportunities to co-locate APP Navigators in MDT hubs		• APP Navigators embedded in all health boards, ongoing collaborative work.
	Care Planning Explore opportunities to schedule care through the planned deployment of internal responders including Community Welfare Responders, Falls, Mental Health, and Advanced Paramedic Practitioners etc, including expanding volunteer and community response resource i.e. Community Welfare Responders (CWRs) as required.	• Implement Care Planning capability • Expand volunteer and community resource numbers including CWRs		• Workshop undertaken, evaluation & long-term planning process scheduled to commence. • Further exploration into sustainable remote monitoring solutions will be undertaken to support future service delivery models
	End of Life Care By the end of FY27/28: In collaboration with Health Board Specialist Palliative Care Teams, integrate Palliative Care Paramedics (PCPs) into the Advanced Practice portfolio and deploy a PCP in every Health Board, fully operationalising PCPs within our commissioned service offer to deliver an equitable, patient-centred, and specialised palliative care service	• Secure funding pathway with Marie Curie (3-5 year funding) and establish shared vision, and baseline metrics for performance monitoring and evaluation • Secure palliative care training pathway with Swansea and Cardiff SPCT • First cohort of Trainee Advanced Paramedic Practitioners (TAPPs) to complete palliative care training pathway (Swansea and Cardiff)		• Phase 1 and 2 of Marie Curie funding bid complete. • Ongoing work with Swansea University regards palliative care training and APP recruitment
	CTAS (formerly PTAS) By the end of FY26/27: Deliver a Clinical Triage Assessment Service (CTAS) in every Health Board to facilitate direct patient access to remote specialist clinical care (e.g. physiotherapists). Collaborate with Health Boards to implement an integrated model that enhances patient access and delivers a consistent, equitable service across all seven Health Boards.	• Development of MoUs with Health Boards • System integration / interoperability to enable the dynamic transfer of patients • Development if inclusion/exclusion criteria and ability to identify suitable patients		• Ongoing collaboration with Health Boards seeking sign off for governance documentation to enable CTAS further.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	RAG (Delivery)	Progress
Mental Health Access	As part of our remote integrated care offer we will explore opportunities to schedule care through the planned deployment of internal responders including Mental Health By the end of FY26/27: we aim to evaluate and optimise the Mental Health Response Vehicle (MHRV) blended model and expand across Wales as part of a wider developing mental health service offer.	• Implement care planning capability • Quality measures confirmed • Performance metrics, and service offer defined - MHRV Logic Model approved		• Care planning as noted above under care planning section • Logic model and draft evaluation near completion to inform further development of the service model.

- **Notes** the end of year position for the Cabinet Secretary's priorities set out in the 2025-28 planning framework.

Welsh Ambulance Services University NHS Trust

Strategies & plans

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

Strategies & plans
Version 1.0
Released: July 2025

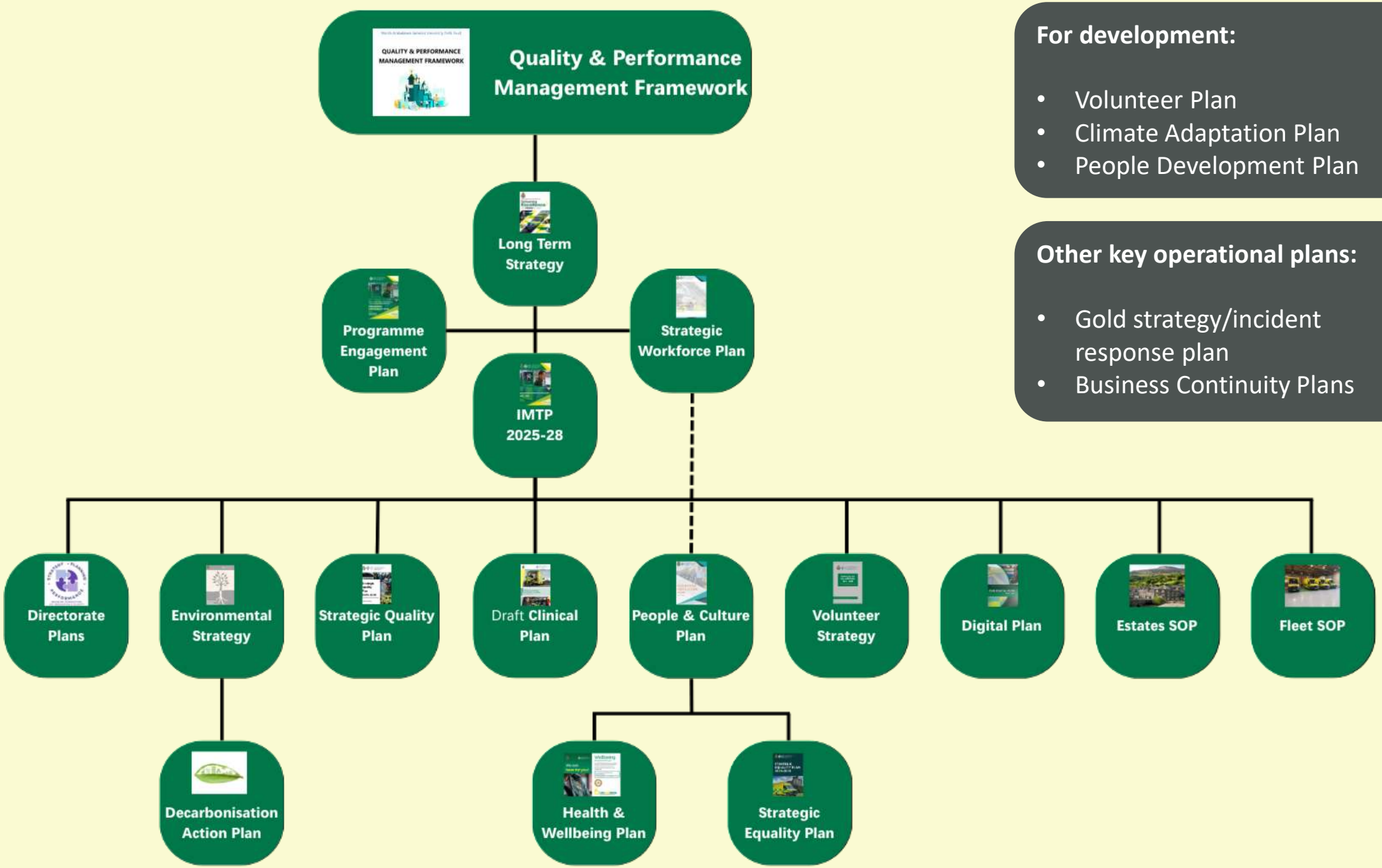
by Alex Crawford
Alexander.crawford2@wales.nhs.uk

Our Organisational Purpose

Our Long-Term Strategy

Our Strategic Objectives

Strategies and plans - organogram



For development:

- Volunteer Plan
- Climate Adaptation Plan
- People Development Plan

Other key operational plans:

- Gold strategy/incident response plan
- Business Continuity Plans

Welsh Ambulance Services University NHS Trust

Clinical Model Transformation (CMT) Programme Highlight Report

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

Clinical Model Transformation (CMT) Programme Highlight Report
Released: 19th June 2025

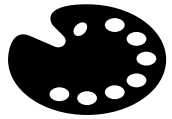
Transformation Support Office

Content

Use hyperlinked headers to navigate to each section

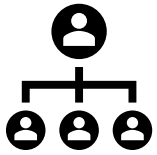
Programme Management Update

Programme Management Highlights



Developing our programme vision:

- Final revisions being made to our **Clinical Services Model Information Pack** with circulation expected before the next CMT Board (July).
- **Programme Improvement plan developed and in delivery** to strengthen our programme approach; presented to CMT Board (June).



Establishing the CMT Programme Delivery & Assurance Arrangements:

- **Benefits realisation:** Executive session arranged for mid-July) to review and refine workstream LBMs and v1 scorecards.
- **Digitising our assurance approach:** Continued development of the **Programme Portal** and development of SOPs for Project Managers. **FY25/26 Workstream Plans** developed in MS Project for all workstreams and are available centrally.

Developing formal programme documentation and audit readiness:

- **Workstream QIAs developed and timeline for CAG/CQGG submission confirmed**; see next slide.
- CMT **programme 'health check' complete** (structured review of documentation and controls across all projects and workstreams).

- ❑ **Patient personas in development**; delayed due to the requirement to refresh to ensure alignment with the new Ambulance Performance Framework – in progress.
- ❑ **Evolving our Transformation Delivery Network (TDN);** delayed due to Strategy Team vacancy (due in post mid-July) – acceleration expected.

- ❑ **Benefits realisation:** Final workstream-level scorecards will be presented to CMT Board for approval for IDS team development. Aim to present to CMT Board (July).
- ❑ **Digitising our assurance approach:** Development of a **Power BI dashboard to automate some elements of reporting,** with risk and issue management identified as the first use case for development and testing – in progress, supported by the IDS team.

- ❑ **Impact assessments:** Revisions to QIAs and submission to CQGG.
- ❑ **Audit readiness:** Prioritised improvement plan will be developed and incorporated into the programme plan.
- ❑ **Programme Definition Document** to be reviewed and updated, and Benefits Realisation Plan to be developed following the outputs of the benefits realisation meeting with Executive Sponsors (14/07).

QIA Update

April	May	June	July

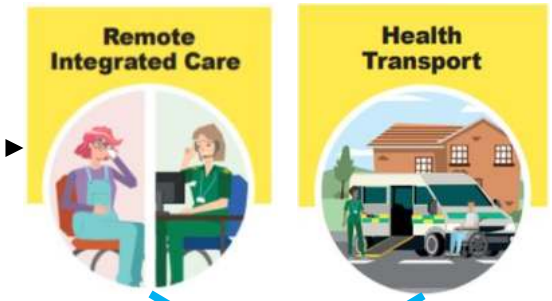
Clinical Quality Governance Group Approval Group

APPROVED (14/04)

APPROVED (12/05)

Minor revisions required prior to CQGG submission

SCHEDULED (15/07)



Clinical Advisory Group Review Group

REVIEWED (23/05)

REVIEW SCHEDULED (27/06)

The Emergency Response QIA was approved in October 2024, however, the QIA has been refreshed and updated following the Welsh Government's review of the national Red 8-minute target and the introduction of 'Purple', 'Red', and 'RCS0' categories. V9 of the QIA was subsequently approved by CQGG on the 12th May.

CMT Programme Update – Enabling Groups

Report Date:	Overall Programme RAG	Previous RAG	For Noting:	Executive Sponsor:	Rachel Marsh
Jun-25	Yellow	Yellow	Not Applicable.	Programme Manager:	Heather Holden

ENABLING GROUP UPDATES

Group	RAG Status	RAG Trend	Summary Position
Quality & Performance Metrics	**Greem**	↑	The **final definitions for Purple, Red, and RCS0 categories are with Welsh Government for approval**; no issues are anticipated following joint sign-off by the Director of Commissioning. **Preparations for go-live reporting from 1st July remain on track**, with the Monitoring & Assurance Plan reviewed and priority reports identified in collaboration with the Executive Director of Operations. Work is ongoing to ensure data system readiness, including timing and access arrangements. The Board was updated that **the CMT evaluation procurement process is nearing completion, with the shortlist reduced to two suppliers and final due diligence to be completed by the 1st July**. representation from IDS has been requested, and Leanne Smith will join the evaluation steering group. **Development of the workstream and overall CMT scorecards is nearing completion**, with a final executive sponsor workshop planned for 14th July. N.B. **The Board discussed the classification of "misses" under the new Arrest (Purple) category**, with consensus emerging that rather than reverting to an **8-minute benchmark, this measure should instead serve as an indicator of resource availability**, aligning more closely with outcome-focused principles of the revised Ambulance Performance Framework. The Board also discussed the **terminology "hit/miss" with a clear steer from the Board that this should be avoided and framed as "out of range".**
Change Management	**Yellow**	↔	The workstream continues to support engagement and readiness across the programme. **While no escalations were raised, there is a growing need to enhance proactive communication**, particularly around digital changes such as the Virtual Assistant *(comms now planned),* to manage expectations and reduce anxiety. SRO reflections emphasised the value of pausing, learning, and resetting where needed. Emotional responses and variable readiness highlight the importance of tailored, audience-specific engagement. The **addition of new SROs from Digital Front End and RICS to the Change Management Group has already added value through cross-programme collaboration**. Key risks include change saturation, communication overload, and disengagement in areas not directly impacted. **Targeted, manager-led communications and bottom-up approaches are being progressed**, alongside the **development of engagement tools (i.e. 'talking heads' videos)** to support shared understanding.
Partnerships & Engagement	**Green**	↔	The workstream continues to progress key engagement activities with no escalations or new risks identified. **Clinical stakeholder engagement has advanced, with sessions delivered to groups including the Welsh Cardiovascular Society and Llais Service Delivery Group**. Preparations are underway for a presence at the Mastering Diversity Conference in September. **Communications plans and collateral to support the Ambulance Performance Framework changes from 1st July have been approved**. Responsibility for **internal programme communications is being formally transferred from the Change Management to the P&E workstream to improve alignment and operational efficiency;** revised Terms of Reference were approved by the CMT Boatd (16th June). Positive feedback has been received from Llais colleagues, with no concerns raised on the communications approach.

Welsh Ambulance Services University NHS Trust

Clinical Model Transformation (CMT) Programme Workstream Updates

A summarised Workstream Highlight Report has previously been provided to STB for assurance, however as the focus of the June meeting is on IMTP Delivery Assurance, the complete Workstream Highlight Reports will be presented for completeness.

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

Clinical Model Transformation (CMT) Programme
Workstream Updates
Released: 19th June 2025

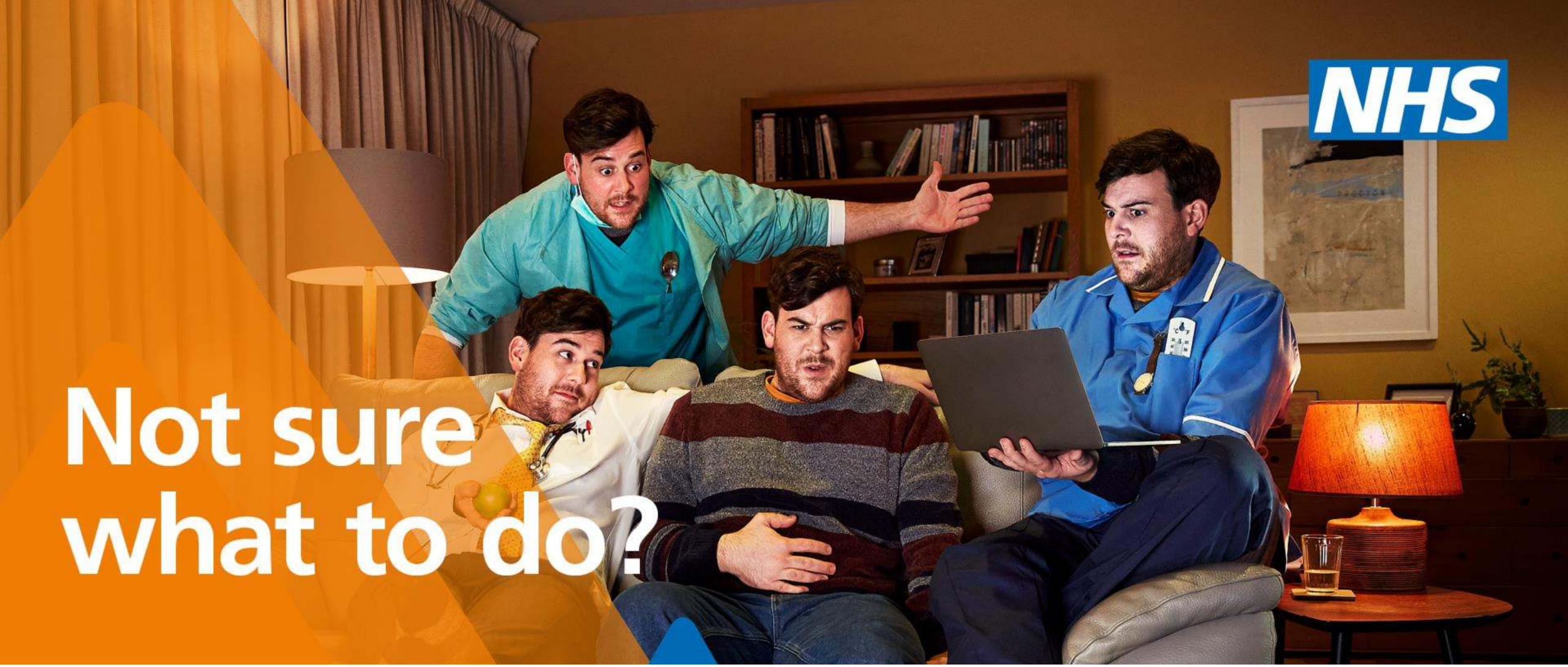
Heather Holden, Programme Manager

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

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



Digital Front-End Workstream

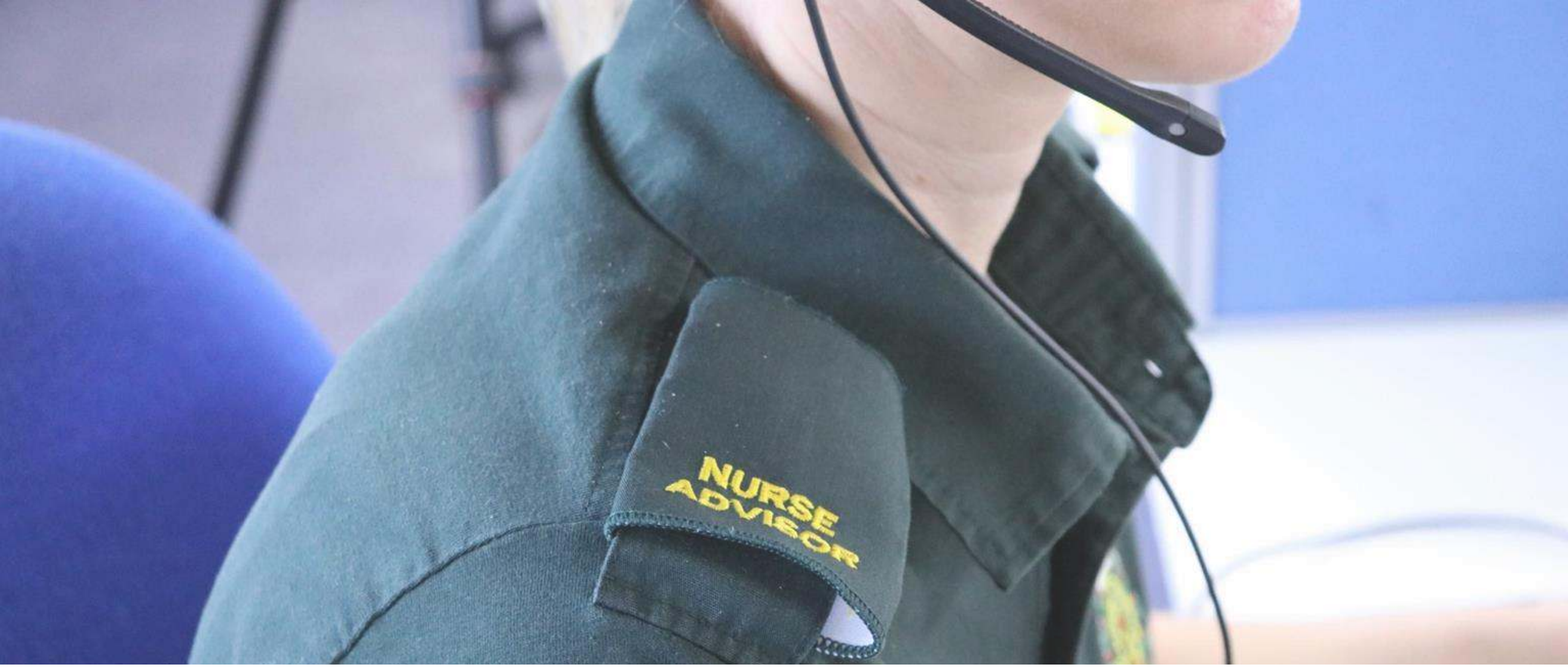
Executive Sponsor: Jonny Sammut

Senior Responsible Owner: Jonathan Turnbull-Ross

Digital Front-End Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Jonny Sammut
Jun-25	Amber	Yellow	Delay to the deployment to the Virtual Assistant due to ongoing amendments to the website privacy policy, DPA and some contract changes.	SRO:	Ceri Griffiths
Project Management Update:	Digital Front-End is currently being managed as a stand-alone project reporting directly into the CMT Board. A Business Case is in development for funding to support the longer-vision for the Digital Front-End service.				

Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View
Virtual Assistant Implementation	Red	↓	• Security Assessment and DPIA approved by the Project Group. • Preparations for deployment of Virtual Assistant on NHS 111 Wales website being made by WAST and Supplier. **Expected go-live postponed to mid-Jun due to delay meeting Information Governance requirements**.	• Virtual Assistant to be deployed on live NHS 111 Wales website (mid-Jun, postponed from Apr-end). • Over 60 suggestions received from CEO Roadshow to name the Virtual Assistant. Survey for 'Bot' name to be shared via Siren during soft launch.
Symptom Checker Funding Decision	Red	↓	• Delayed approval of the use of the discretionary funding and the route to market by Trust Board means that it is unlikely we will be **able to deliver the web-based version of Call Prioritisation Streaming Service (CPSS)** and deliver revised symptom checkers before the end of the financial year as per our IMTP commitment for 2025/2026. • Quotes requested **for external independent commercial advice** on CPSS Intellectual Property; expectation that this will cost up to £15,000.	• Unable to progress without Trust Board direction; legal advice being sought on Intellectual Property concerns.
Business Case Development	Yellow	↓	• Awaiting Welsh Government feedback – Meeting took place between WAST and WG in early April on how we progress the Digital Front End opportunities. High-level summary of Business Case shared with WG for initial feedback and to propose a way forwards (including potential investment).	• **Feedback outstanding from WG to fully develop the Business Case (currently in draft).** The governance route for approval has been mapped, and timelines will be finalised following receipt of the proposed way forward from WG. **Yellow (cautionary status) as continued lack of direction from WG could present a barrier to our ability to deliver meaningful change within the financial year.**
Project Management	Green	↔	• **Project plan has been digitised** and shared with Project Group members to ensure alignment and visibility.	



Remote Integrated Care Service Workstream

Executive Sponsor: Liam Williams

Senior Responsible Owner: Pete Brown

Remote Integrated Care Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	SRO:	Pete Brown
Jun-25	Yellow	Green	The overall RAG status is trending downward towards Yellow **(cautionary status)**, driven by interdependencies with concurrent projects and reliance on external providers such as MIS. Additionally, there is a strategic need to assess and evaluate key functional areas, including Care Planning, to mitigate emerging risks and maintain project alignment.	Project Manager:	Rebecca Whitmore

Scope:	Phase 2 of Remote Integrated Care Service developments which fall under the Clinical Model Transformation (CMT) Programme Board.

Task / Milestone	Status	RAG Trend	Current Position	Forward View
Project Management	Green	↔	• Project documentation produced in draft. • QIA endorsed at CAG with minor amendments (30/05).	• Approvals of associated documentation.
Care Planning Function	Amber	↓	• Following the recent Care Planning workshop, it was determined that further operational development is necessary to refine and shape the function prior to undertaking a formal evaluation. • A verbal update following the workshop was given to the Board outlining the need for a strategic paper outlining roles, functionality, and how we establish success.	• A comprehensive evaluation and long-term strategic planning process for the Care Planning function is scheduled to commence. • Further exploration into sustainable remote monitoring solutions will be undertaken to support future service delivery models.
New Call Flows & Categories	Green	↔	• Planning activities and development of supporting documentation for the introduction of RCS0—aligned with ARREST and EMERG—are actively underway. Notable progress is being achieved across technical implementation, standard operating procedures (SOPs), and communications.	• Testing and exploration are underway to assess communication and training requirements, including an evaluation of potential resourcing needs for the Rapid Assessment Queue to ensure operational readiness and effectiveness.
Strengthening, Application, and Evaluation of CPSS	Yellow	↓	• Proposals regarding the funding and resourcing model have been submitted for consideration to sustain and enhance the current Winter Desk function. • Further exploration into potential expansion is ongoing; however, the feasibility and timelines will be influenced by available funding and MIS system capabilities.	• Ongoing expansion of the current Winter Desk function is in progress. Concurrently, exploration into additional expansion opportunities is underway to assess broader applicability and impact. Further planning into the resourcing and improvement of the Winter Desk.
Alignment of CSD and 111	Green	↔	• Significant progress continues in establishing the necessary structures for RICs, with strong engagement from OCPs and overall progress remaining on track. • No issues have been identified regarding the alignment of Terms & Conditions, which is supporting effective collaboration across teams.	• Detailed plan and process to be shared outlining the development and reviewing of existing SOPs

RICS Enabling Deliverables

Report Date:	Remote Integrated Care **Enabling Deliverables**	For Noting:
Jun-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	Update
Integrated Care Structures	• Consultation with the Senior Management Team has concluded, with job descriptions developed, evaluated, and shared with affected staff. • Co-design sessions are currently underway with the SCA/DOM First Line Management teams to shape roles for Remote Integrated Care. • Job descriptions for the Audit & Education Team will shortly be shared to commence the OCP. • Rostering Review • IC Terms and Conditions alignment.

Evaluations of Tests of Change	• In-depth evaluations have been presented at the RICS Board, with recommendations for continuation and improvement for the following initiatives:
	  • 111 Call Handlers Managing Green 3 Calls
	  • 111 Clinician-Led Ambulance Response
	  • Luscii Remote Monitoring Tool
	• The evaluations received agreement to continue these initiatives with enhancements, along with a commitment to ongoing review and continuous improvement.

Integrated Care Support Desk	• Building on recommendations from the Winter Desk Evaluation, a proposal to establish a permanent **Integrated Care Support Desk**—expanding on the original remit—was presented. This will optimise resources and capacity within Integrated Care. • The SBAR outlining this new function was approved by SLT (27/05) and the RICS Board (28/05), with support from TU colleagues. • A Quality Impact Assessment (QIA) is scheduled for endorsement at the next CAG meeting.
Digital Capabilities	• An SBAR recommending the adoption of a **single, consolidated LowCode list** for Integrated Care Clinicians has been approved. • A **CAD options appraisal** is in development and will be presented at the RICS Board on 25/06. • Implementation of **video functionality** across Integrated Care is scheduled in the coming weeks. • Work is progressing toward all Integrated Care teams operating on a **unified telephony system**.

SCW Outputs	• Following the evaluation of the Remote Integrated Care project, SCW has delivered several key outputs, including:
	  • A **RICS Review** with proposed recommendations
	  • A **Quality and Safety Dashboard**
	  • A **Case Study Evaluation** of key tests of change
	• A review of these recommendations, along with a formal response, is currently being drafted.

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
Jun-25	Yellow	Yellow	• **Data limitations are affecting the ability to gather comprehensive baseline data for Falls & Frailty PDSAs.** • 3rd MHP recruitment approved and started, **RISK** regrading Dashboard development delays. • **Phase 1 and 2 of Marie Curie funding bid complete. Further APP recruitment planned with the aim to increase the establishment to 130.7 FTE. APP AQM testing completed in preparation for go live.**	SRO:	Sonia Thompson

Project/Working Group	RAG Status	RAG Trend	Summary Position
UCR Scheduling	Green	↔	• Paper in draft to be **to be brought to Workstream Board in July (ahead of next CMT Board), detailing options to implement scheduling before Winter.**
UCR Model	Complete	↔	• UCR Service Specification approved, CMT feedback incorporated re-circulated. Closure Report being drafted for UCR Workstream approval and feedback.
Falls & Frailty Response Model	Yellow	↓	• **Unable to submit request to add Falls Referral Field Guide ePCR until it is determined whether Emergence Ambulance Practitioner are permitted/not permitted to make referrals as non-registrants.** • Data analysis undertaken to assess the efficiency of Level 1 Falls Responders, focusing on response times, triage, and centralised management. Since Clinical Navigation removed predefined L1 responses, only 25% of calls are routed to RICs, with the rest returning for response. **It remains unclear who manages RICs calls (CSD, Care Planning, or both), how long they stay in RICs, and when they are returned (unable to get this data).** • Agreed Falls Responders will adopt the existing CFR ePCR format, supported by a SOP for guidance on completing clinical documentation. Falls Responders will transition from Entonox to Penthrox (already covered in St John's in-house training) as Entonox not included as a medication in CFR ePCR. This change will also enable the capture of pain scores within the clinical indicator bundle. • **Request submitted for additional data to be included on the Falls Dashboard. IDS has agreed in principle but unable to confirm a start date, which is currently limiting our ability to meet Health Board data requests.**
Tasking Optimisation	Green	↔	• First draft of MHRV Evaluation nearing completion and due for review in late June/early July. Data limitations being worked through with IDS team. • **Request for third MHP now approved**, recruitment process has begun. • APP AQM and RCDM documents going through approval routes (CPAS 11/06, Workstream Board 04/06). Attached for noting under 'Information Items'. • Ongoing discussions regarding APPNAV Power BI report; APP reporting requirements to be included in the overall CMT reporting request.
Advanced Practice Delivery Group	Yellow	↓	• Recruitment adverts published for both Trainee and qualified APPs across Betsi Cadwaladr, Powys, and Hywel Dda Health Boards. Successful appointments will increase the overall workforce establishment to 130.7 FTE. • **Misalignment between recruitment processes and workforce planning may impact upcoming recruitment activity (e.g. stakeholder engagement/securing university place and clinical placements) and presents a strategic and reputational risk. To be considered whether this risk needs to raised at a corporate level. Propose that a minimum staffing figure is agreed to allow planning to proceed with recruitment activities while awaiting final recruitment numbers.** • Approval will also be sought to transition from APP AQM to UCR AQM. A phased, health board–by–health board transition plan for completion by the end of Oct. • Interest has been received to progress palliative care offering in Hywel Dda and Aneurin Bevan; however, timelines may be impacted by Swansea University not offering courses in March and is subject to uplift in APP establishment. • **Ongoing challenge in securing timely internal and Health Board sign-off for governance documentation is delaying the introduction of key services such as APPNav and CTAS. Delays pose a significant risk to progressing UCR Workstream. Recommend escalation to the UCR Workstream Board and Trish Mills (Director of Corporate Governance/Board Secretary) for strategic resolution.** • Luke Watkins (Clinical Development Lead) has offered support with requesting additional reporting requirements for APP transformation workstream. Longer-term planned work with regards to reporting APP activity while working on EAs has been deferred to Q3.

Emergency Response Service Workstream

Executive Sponsor: Lee Brooks

Senior Responsible Owner: Greg Lloyd

Emergency Response Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Lee Brooks
Jun-25	Green	Yellow	**Training CAD to be updated with new DCR codes by 05/06.**	SRO:	Greg Lloyd
Scope:	This initiative streamlines the clinical triage process for the most critical emergency calls (Arrest, Emergency and RCS0), enabling faster escalation, improved patient outcomes, and enhanced operational efficiency across frontline services.				

Task / Milestone	RAG Status	RAG Trend	Current Position	Next Steps
Rapid Clinical Screening: Metrics and Reporting	Amber	↓	• **AQM reporting remains outstanding** (currently an IDS team priority) presenting a barrier to effective evaluation of Rapid Clinical Screening (RCS).	• Implement AQM reporting once work completed by IDS
Call Flow Prioritisation: CAD Developments	Green	↔	• The **training CAD was successfully updated** with new call categories on 22/05. • DCR Group approved vital changes for implementation, with **code updates scheduled for 05/06.**	• AQM review to be completed in readiness for new changes. • IDS Team to commence Reporting Metrics required for go-live in July.
Call Flow Prioritisation: Data Definitions and Monitoring and Assurance Arrangements	Green	↔	• Data Definitions and Monitoring and Assurance Arrangements documents reviewed for support / approval at Project Group (22/04), CMT Metrics Group (23/04), CMT Board (06/05) and CQGG (12/05). • Documents received by Joint Commissioning Committee for review and submitted to Welsh Government (30/05).	• Expected approval to proceed with Call Flow Prioritisation Project from Welsh Government
Call Flow Prioritisation: Operational and Training Arrangements	Green	↔	• **Emergency Ambulance Performance Framework Explainer** received final approval, ensuring a unified understanding across stakeholders. • Training SWAY document for Integrated Care including staff category explanations in progress for delivery in June.	• Self-directed training to be published on Siren • Associated **policies and procedures** for EMSC and Integrated Care are being updated and will soon be signed off. • Comprehensive **Go-Live Implementation Plan** is in development to ensure a coordinated rollout.
Emergency Response: Project Management Documentation	Green	↔	• **Project plan has been digitised** and shared with Emergency Response Workstream members to ensure alignment and visibility. • QIA v9 approved by CQGG (12/05).	

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
Jun-25	Green	Green	Not Applicable.	SRO:	Mark Harris

Project/Working Group	In Scope	RAG Status	RAG Trend	Summary Position
Access to Planned Transport	Develop a pathway process from RICs	Green	N/A	• Process mapping and systems flow to be completed • Data analysis for taxi suitable patients to be completed • Products required to implement identified and resource secured to focus on development • Dates and Timelines will be agreed in collaboration with RICS Workstream
	Identify additional routes of call origin	Green	N/A	• Opportunities for inclusion within Health Transport to be identified.
Transfer & Discharge	Continued engagement on options with health boards (commissioning response/ strategic service dev)	Yellow	↓	• Engagement continues with Health Boards. Contact made with JCC to arrange meeting to discuss.
	Agree outline service model for further engagement with HB (commissioning response/ strategic service dev)	Yellow	↓	• Session to be planned to agree the internal vision for T&D and a subsequent service definition. Date to be confirmed (diary hold sent for 24/06).
	Develop Transfer & Discharge service model	Not Started	N/A	• Will follow on from actions above.
	Develop case for 24/7 Major Trauma Desk	Not Started	N/A	• Data to support both options to be acquired and reviewed. Network keen to resubmit business case collaboratively when resource allows.

Welsh Ambulance Services University NHS Trust

IMTP Delivery Highlight Report Q1 (Outside Scope of CMT)

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

IMTP Delivery Highlight Report
Released: June 2025

Planning & Performance Business Partners

Summary Position

Q1 Deliverables:
Total 12 deliverables specifically committed to delivery within the IMTP by end of Q1

- 3 Complete
- 3 Green
  - Work progressing with high delivery confidence into next phase of the deliverables
- 1 Yellow
  - Work progressed with high delivery confidence, due to complete in next month
- 0 Amber
- 5 Red
  - Capacity issues significantly impacting
  - Requests being made to shift quarter delivery

Focus on SO2: Enabling our people to be the best
Updates provided for; updates provided against 10 key plans as full year deliverables plus specific update on commitments to our people by request.

- 7 Green
  - Significant progress with high delivery confidence
- 3 Yellow
  - Progress with high delivery confidence
- 1 Amber
  - Delays but high confidence remains
- 0 Red

- Continued work with Directorates, developing the digitalisation and dashboards, enabling a forward look on delivery confidence going forward.

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

IMTP Objective	IMTP Deliverable	Q1 RAG Status	Delivery Confidence	Progress Summary
A modern, easily accessible, user-friendly and integrated digital offer	WAST internal Directory of Services (DOS) - the case for improvements completed by end of Q1	**Red**	**Low**	Change in plan quarter to Q4 A review is currently underway of the various milestones related to Directory of Services within the IMTP. This is required due to various staff changes internally and externally, the latter being Welsh government personnel changes and continuity related to external DOS. A decision needs to be made whether to combine this with the wider Digital Front End business case proposal (which is also subject to Welsh Government steer) or agree the implementation and ownership of a standalone business case. This will be discussed at Digital Leadership Group, discussed at Digital Front End Project board with a recommendation on how to proceed coming to a future STB for approval [mid august].
Rapid call answering initial triage & onward referral	CCC in Ty Elwy fully operational - ICT Impact by Q1	**Green**	**High**	WAST Staff working out of new St Asaph site is complete. The relocation of services from Llanfairfechan server room to St Asaph is likely to take at least another 12 – 16 weeks due to the volume and complexity of work.
	111 Website (refresh) Business Case - submission	**Complete**	**N/A**	A proposal has been submitted. awaiting steer from Welsh Government regarding funding and next steps before we take through any internal and external governance.

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 staff to ensure that their ESR Welsh language competencies are up to date.	**Yellow**	**High**	• Working with Workforce Systems Team to finalise guidance for staff to complete and update their Welsh language skills on ESR. • Completion expected by end of July.

SO4: Developing our services in collaboration

IMTP Objective	IMTP Action/ Deliverable	Q1 RAG Status	Delivery Confidence	Progress Summary
Meet the requirements of the Wellbeing of Future Generations Act	A programme of internal & external communication of our Wellbeing Objectives enacted in Q1	**Green**	**High**	Working with Corporate Governance to incorporate into key documents, being refined for sign off Guidance required to support and ensure proposals do deliver on the objectives. Required to develop steps we will takes that are different to meet the core guidance commence in September – reconvene task and finish group.
Well place 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**	CMT Model comms process. – Reported through CMT Q2-Q3 (go live July 1st)

SO5: Being Quality driven & clinically led

Defining our focus and delivering on population health and health inequalities	Draft Population Health Plan, approved.	**Red**	**Low**	• QuESt received assurance on the development of a Draft Population Health Plan and health inequalities maturity matrix. The draft plan supports delivery of the Trust's strategic objectives and compliance with the Health & Care Quality Standards 2023.
	Updated health inequalities maturity matrix for reducing impact	**Red**	**Low**	• To secure support from within the directorate to start moving the Population Health Plan forward. Request for change in Quarter from Q1 to Q3 due to lack of capacity.
A culture of quality improvement with robust quality management systems	WAST Quality Plan	**Complete**	**N/A**	• Plan endorsed by QuESt on 09 May with a request for the associated draft implementation plan to be enhanced to ensure achievable timescales for delivery and appropriate prioritisation to support the delivery of the plan. The plan was subsequently approved by Trust Board on 29 May 25
High Quality Health and Safety systems	Develop WAST Health and Safety Strategic Plan to ensure compliance with existing and emerging legislation	**Red**	**Low**	• Change in Quarter from Q1 to Q3 due to lack of capacity. Actions carried out to date; Manual handling improvements & list of recommendations. Q3 delivery as driving it via NARSF and taking it there in September 2025.
Excellent Clinical Leadership	Secure the Lead Midwife post by end of Q1	**Complete**	**N/A**	• Post secured July 1st 2025 and in place to take forward the work.
Systems that meet the requirements of the Duty of Quality and Duty of Candour Align with Digital Pillar	Develop Data Engineering and modelling around HARM Developed in Q1	**RED**	**Low**	• RED for Q1 delivery due to requirements unknown (by both Digital and PTR). Flagged by H.O. PTR as unknown also with Digital Director – scope and requirements unknown. Change in Quarter from Q1 to Q4 to allow for this to be understood.

SO2: Enabling our people to be the best they can be

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
Ensuring the right Capacity needed to achieve our purpose	Embedding Health & Wellbeing Plan	**Yellow**	**High**	• Delivery of the objectives outlined within the Health & Wellbeing programme remains on track. Notable progress has been made in both promotion and prevention initiatives. Highlights include strong attendance at our REACT sessions and the successful launch of Health Diagnostic Testing. • Development of SOPs is progressing, to help achieve SEQOHS accreditation, albeit at a slower pace than anticipated due to reduced team capacity. However, recruitment efforts are underway to address this and support timely delivery moving forward.
	Enhancing Organisational Retention	**Green**	**High**	• Continued development of the digital corporate onboarding and induction programme remains on track for completion in Q2. Planning is in place for pilot implementation and testing in Q3 to ensure a smooth and effective rollout. • Coaching and Mentoring Guides have been completed and are now being embedded as core resource and linked to Our WAST Way. Next phase will focus on promoting uptake and embedding the guides across the organisation, with ongoing evaluation to ensure continued relevance and impact.
	Delivery of Strategic Workforce Plan	**Amber**	**High**	• **Data / Analytics:** The Power BI Workforce Dashboard is currently in development. However, the Generic Workforce Monitoring Report is not yet automated due to data correlation issues between ESR and the Data Warehouse. As a result, dashboard production remains labour-intensive. Work is ongoing to resolve these integration challenges and streamline reporting processes. • **Workforce Plans:** Ongoing efforts are underway to engage directorates in the development of directorate-level workforce plans.
	Delivery the outputs of the NHS Workforce Solutions Transformation Programme	**Green**	**High**	• Work progressing to deliver key projects as part of ESR Optimisation in readiness to transfer data into a new products. • Business case for additional resource in development. Anticipated risk if no funding available to recruit a dedicated Project Manager for the NHS Workforce Solutions Transformation Programme. This poses a significant risk to the programme's delivery, as the absence of a Project Manager will impact the team's capacity to effectively plan, coordinate, and execute key transformation activities.

SO2: Enabling our people to be the best they can be

IMTP Objective	IMTP Deliverable	Q1 RAG Status	Delivery Confidence	Progress Summary
Ensuring the skills and Capability needed to achieve our purpose	Embed Our WAST Way Leadership Framework	**Green**	**High**	• Our WAST Way officially launched on 28 May 25. Series of introductory sessions scheduled from June through August, with strong early engagement, over 100 staff attended the first three sessions, reflecting positive momentum from early adopters. • Essential Conversations sessions have been successfully incorporated into the recent Leadership Symposium. A broader rollout to all managers is planned for the next quarter to further embed these principles across leadership levels.
	Develop Managers Capabilities to lead and manage Change	**Green**	**High**	• Change Management Toolkit launched for managers to access on the 15 May 25. Products being discussed at Change Management Community Forum to seek feedback and make improvements, ensuring skills associated with Change Management are threaded into our WAST Way.
	Development of WAST People Development Plan	**Green**	**High**	• Progress continues the development of the PDP, with milestones achieved in the policy formulation and strategic document. Key stakeholders have been identified and engaged in the development of these documents.
Establishing our Culture as the way we achieve our purpose	Enhanced approach to amplifying voices	**Green**	**High**	• Progress remains on track with the NHS Staff Survey results. Directorate leads identified and directorate level data released. Directorate leads to produce a set of agreed actions. HIVE Pulse Survey went live 02/06/25. Discussions underway to refresh the hierarchy structure for the 2025 Staff Survey and identify how we promote uptake.
	Oversee the implementation of the Strategic Equality Plan Objectives	**Yellow**	**High**	• Good progress made against the legislative requirements and Statutory Action Plans. • Continuing to roll out a range of development initiatives, including Our WAST Way: Essential Conversation, which places a strong emphasis on inclusion and equity. We recognise that staff are currently facing challenges in attending specific EDI training sessions. There is a range of training opportunities available and the ongoing need to maintain high-quality service delivery. To address this, we will be working closely with SOT to plan and schedule training in a way that supports both operational demands and staff development. We aim to maximise engagement and participation across all our learning and development programmes. • Completed a Digital Team Inclusive Recruitment Initiative to fill 19 vacancies, following two targeted workshops held to support BAME applicants, 1270 applications were received with 1005 (79%) from BAME candidates. All 19 roles were filled, with 5 offers (26%) made to BAME applicants.
	Promote and enable Sexual Safety across the Trust	**Green**	**High**	• Themed Sexual Safety workshops have been designed and delivered to the TUPs with feedback incorporated and these will be rolled out across the organisation during the next 2 quarters. • Continuing to provide high level people & culture metrics in relation to speaking up and safety in the workplace

Update on Commitments to our people

Objective	IMTP Deliverable	Q1 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	Outputs of the work of the **Shift Overrun** task and finish group delivered by **Q2**	**Green**		An SBAR has been submitted to Formal SOT To highlight the work in partnership that has been completed and recommendations made (2) for Formal SOT membership to review and discuss and approve if appropriate.
Ensuring the skills and capability needed to achieve our purpose	**Our WAST Way** leadership behaviours framework and an aligned development framework, developed and launched in 2025/26 (this incorporates **1:1 conversations**)	**Green**		• As per earlier slide on our WAST Way
SO3: Being at the forefront of innovation & technology				
Pillar 1 Everyday Essentials	**Simplified sign on** will be developed and implemented by the end of Q4 giving users a better **digital experience**	**Green**	**Moderate**	The discovery piece is near conclusion and a "show and tell" of the work undertaken to date took place on 5th June 2025 with digital, estates and workforce all in attendance. Indicative costings are to follow to enable a decision to be made on next steps and plan delivery of any smart station initiatives.
Pillar 4 Security, Safety & Cyber	**Smart station** initiative will be rolled out by Q4	**Green**	**Moderate**	Current initial delays to development due to dependency on work by DHCW

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

AGENDA ITEM No	10
OPEN	OPEN
No of ANNEXES ATTACHED	2

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – May 2025 / June 2025

MEETING	Finance and Performance Committee (FPC)
DATE	21st July 2025
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Georgia Tizzard – Commissioning and Performance Officer Melanie O'Connor - Senior Performance Analyst Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Georgia.Tizzard@wales.nhs.uk Melanie.O'Connor@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

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

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

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

4. The response times for red 8-minute performance was 50.7% in June 2025, with performance marginally decreasing compared to May 2025. The Amber 1 median was 1 hour 29 minutes, which was also a slight improvement on the 1 hour 51 minute 12-month average. The Trust knows these extended times (the ideal is 18 minutes) lead to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining high levels of EA production (93% in May, slightly below the

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

5. The Trust lost 15,278 hours to handover in June 2025 (30-days), one of the lowest levels for 4 years. However, this level of lost capacity is difficult to compensate for, despite all of the actions being taken by the Trust.

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

7. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in June 2025, with performance decreasing slightly to 10% from 10.5% in May 2025. There is currently a review of 111 rostering practice – initial report expected in June.

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

9. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 6.81% in May 2025. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions remain minimally above the 30% benchmark figure in June 2025 at 32.63%.

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

RECOMMENDATION

FPC is asked to: -

Consider the May 2025 / June 2025 Integrated Quality & Performance Report and actions being taken and determine whether:

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

REPORT APPROVAL ROUTE
11.07.2025 Executive Director of Strategy, Planning & Performance

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard Appendix 2 – Outcome of Board development discussion

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

SITUATION

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

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

Slide Title	Slide Number
111 Call Answering/Abandoned Performance Indicators	3
111 Clinical Assessment Start Time Performance Indicators	4
999 Call Performance Indicators	5
Red Performance Indicators	6
Amber Performance Indicators	7
Patient Experience – Influencing Ambulance Care Indicators	8
Capacity - Ambulance Abstractions and Production Indicators	18
Shift Overruns	22
Ambulance Care Indicators	24
Finance Indicators	25
EMS Utilisation	26
Average Job/Shift Times	27
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators	28
Consult & Close Indicators	29
Conveyance to ED Indicators	30

BACKGROUND

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

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

4. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. 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 in 2025/26, aligned to the new performance framework announced by the Cabinet Secretary. No specific other 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 likes' 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 4 domains. Appendix 2 to this report sets out the key areas of discussion.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

6. **999** call answering times reduced in June 2025 with the 95th percentile decreasing to 26 seconds, compared to 22 seconds in May 2025. The 65th percentile and median performance remain consistently good; and data quality checks have been undertaken. Work will be undertaken early in Q1 on a demand and capacity analysis of 999 call demand.

7. **111 call answering performance has minimally improved over recent weeks,** with the call abandonment performance for June 2025 being 10%, still failing to achieve the 5% target. Recruitment has been undertaken to ensure that staff in post reflect the establishment position, and this has seen performance improve, but high abstraction levels are having an effect. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2024/25 compared to last year (-4%).

8. 111 demand in June 2025 was 9.39% lower than during June 2024. The Trust procured a third party in January 2025 to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.

9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 96.4%. Response times for lower priority calls declined, recording 87.5% and 52% for P2CT and P3CT respectively. This is consistent with previous years but needs to be monitored closely over the coming months.

10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for June 2025 was 50.74%, remaining below the 65% target, and increasing slightly compared to May 2025. The Trust is reaching more red patients in 8-minutes, but the denominator (demand) has also grown. The Amber 1 median in June was 1 hour and 29 minutes and the Amber 1 95th percentile was 5 hours 18 minutes. The Clinical Safety Plan and CHARUs will protect red demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on avoidable patient harm. New performance arrangements were announced by the Cabinet Secretary on 11 March 2025 which will come into effect on the 1st of July 2025 and will see the introduction of new purple arrest and red emergency categories alongside an increased emphasis on improving patient outcomes.

11. Traditionally the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. The Trust's main focus is to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme, elements of which have been implemented. Areas of focus for 2025/26 include: -

    - Data quality issues have been identified with APPs and these are currently being addressed.
    - 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. (MH pilot live);
    - New Purple Arrest and Red Emergency categories (announced on 11 March 2025) which went live 01 July 2025.

12. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 15,278 hours were lost during June 2025. Cardiff & Vale's handover lost hours continues to remain comparably much lower, due to an organisational focus within the health board. There was also a dramatic improvement with both Swansea Bay and Cwm Taf Morgannwg in June 2025. While some small improvements have been seen in other health boards, Betsi Cadwaladr health board remains significantly high but just below its two-year average figure, with 6,064 hours being lost within the health board during June 2025. WG have 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 WG pan-Wales target of no handovers of more than one hour, equates to 7,500 lost hours.

13. **Ambulance Care (Patient Experience)**: Oncology performance in June 2025 was 76.3%, achieving the 70% target. Renal performance remained above target, achieving 72.57%. Advanced discharge & transfer journey performance however increased marginally to 80% but remains below its 95% target. Same day discharge & transfer journey performance achieved target with 95%. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive Health Transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is currently re-rostering NEPTS transport (now started) which will better align available capacity with changing demand patterns (on target). This is proving complex and difficult but will be delivered.

14. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported eight NRI's to the NHS Executive in June 2025, more than May 2025 (3) and 18 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In June 2025 complaint response times improved to 88%, compared to the 72% recorded in May 2025, exceeding the 75% target for the first time, however cases remaining complex.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 89.8% in June 2025, minimally decreasing and remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system, and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate also decreased to 19.3% in June 2025 compared to 22.6% in Mey 2025.

16. The Trust can report on call to door times for Stroke and STEMI patients. For June 2025, these highlight call to hospital door times of two hours and 24 minutes for stroke patients and two hours and twenty-six minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, because of the pressures and issues outlined in this report.

17. In June 2025, 5,953 patients **cancelled** their ambulance (this figure excludes patients who refused treatment). This is a significant reduction on previous levels. This reduction is likely to be the impact of switching on RCS through the winter. The Trust believes that 50% (of the pre-RCS switch on figure) of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Anecdotal evidence from health boards suggests that as the Trust has switched on RCS and as the level of patient cancellations has dropped, so has the demand presenting elsewhere in the system. Caution is required at this stage though as a longer run of data is required in order to properly evaluate the changes made.

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

Our People (workforce resourcing, experience, and safety)

18. **Hours Produced**: The Trust produced 115,205 Ambulance Response unit hours during June 2025 and delivered an emergency ambulance unit hours production (UHP) of 91%, remaining below the 95% target.

19. **Response Abstractions:** EMS abstraction levels increased minimally to 32.63% in June 2025, remaining minimally above the 30% benchmark figure. Response sickness abstractions stood at 6.48% (benchmark 5.99%).

20. **Trust sickness absence:** the Trust's overall sickness percentage was 6.81% in May 2025, an improvement on the 7.13% recorded in April 2025. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 6.81% is marginally above the 2023/24 IMTP ambition of 6%.

21. **Staff training and PADRs:** PADR rates did not achieve the 85% target in June 2025 and increased slightly to 81.81%. Compliance for Statutory and Mandatory training also increased slightly to 88.05% but continues to achieve the 85% target.

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

Finance & Value

23. **Financial Balance**: the reported outturn performance at Month 2 is a surplus of £0.005m and the Trust is forecasting achievement of both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

24. The consult & close rate was 19.1% in June 2025, a slight decrease from the previous month continuing to achieve the IMTP ambition (and Welsh Government target) of 17%. The Trust has a recovery plan in place, with further work continuing during 2024/25 including investing an additional 23 FTEs into the Clinical Support Desk and developing updated clinical model at pace.

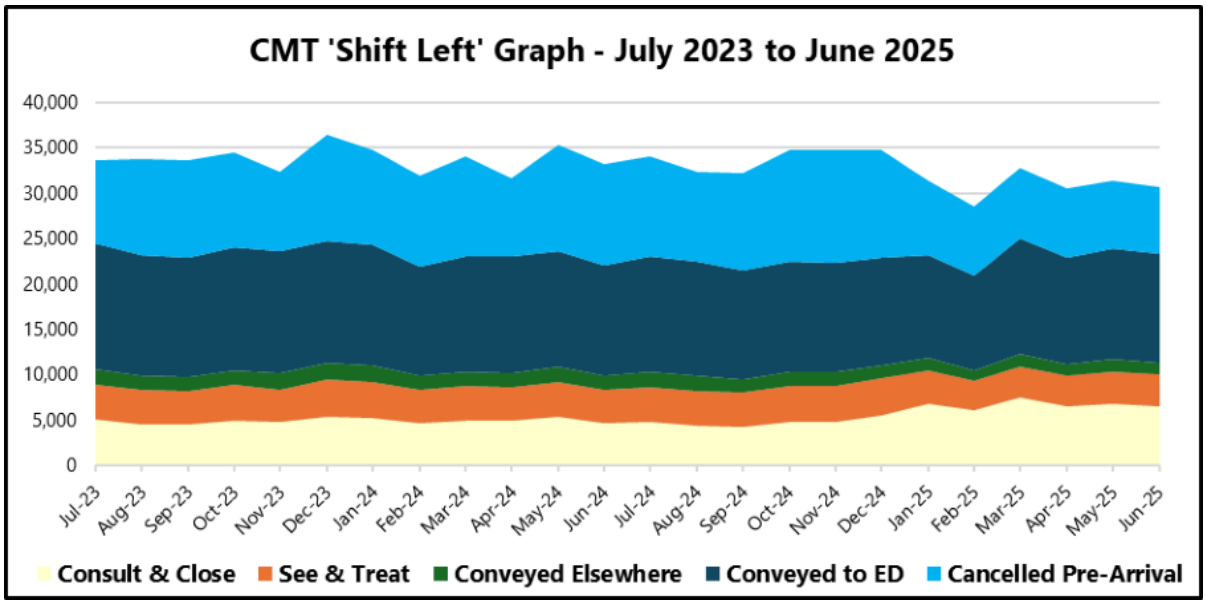
25. Same Day Emergency Care (SDEC) centres continue only see a low level of ambulance activity and handover levels remain extreme, which make the work on the updated clinical model, before next winter, a tactical imperative.

Summary

26. The indicators used at this high-level highlight that 111 has been resilient during the winter months, more so than in in previous years. However, performance variation during 2025 and the level of performance for 111 remains a hot topic with the JCC and WG.

    For the 999-emergency pathway, the Trust produced good metrics on what it can control e.g. production, abstractions etc. and managed to turn on new elements of its clinical model transformation programme, which appears to be having a positive effect. Hospital handover lost hours have also declined to the lowest levels seen since September 2021. These improving levels give further strategic imperative to continuing with the clinical model transformation and work by WG on focusing health boards on further reducing handover lost hours.
    NEPTS performance was stable, with the NEPTS transport re-roster started, but proving complex and difficult.

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



RECOMMENDATIONS

FPC is asked to: -

i. **Consider** the May 2025/June 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.

Appendix 2

The following indicators and points have been identified through the Board Development session on the MIQR.

Board Development MIQPR Session

Board considerations	Response
Acknowledgement of limited capacity either in SP&P or Digital Services at present to develop MIQPR or associated reports. It would be helpful to consider what reporting could look like into the future, potentially using AI as a tool.	2025/26 IMTP investment into the Insight & Data Services function's analytical capability, which will come online later in the year. Executive Director Strategy, Planning & Performance currently reviewing capacity within Commissioning & Performance Team AI does offer potential and will form part of the on-going review of capacity in both Insight & Data Services and Commissioning & Performance. Consideration will be given to increasing capacity e.g. through use of PhD / Masters students or through use of charitable funds.
There was a discussion about whether there needed to be a focus on a smaller number of top-level metrics that align with strategic objectives.	A smaller set of metrics which demonstrate progress towards the Trust's strategic direction (what good looks like) are currently being finalised and visualised which will aid discussions at Board level (first draft included in the IMTP).
The importance of data literacy was highlighted to ensure results can be interpreted effectively and scrutinize adequately.	Data literacy/training has been identified as an action in the Quality & Performance Management Framework work programme. The proposed action is training for all B7 managers and above through to Board, with the training having two parts a) generic, b) tailored to particular role in the Trust. This is currently programmed as a year 2 IMTP action i.e. 26/27, with planning for it in 25/26.
Data linkage across different health services and the legal challenges in Wales were noted as areas that need improvement for better population health outcomes.	Data linking is a key enabler for the Clinical Model Transformation programme, supporting improved patient outcomes and helping the Trust prove the benefit of remote clinical interventions and community interventions e.g. see & treat. The Trust is currently testing data linking for cardiac arrest data via the National UK Registry. The Trust is also

	currently testing data with the NHS Executive. Once the data flow is finalised and accurate this approach can be replicated.
There were concerns about the immense volume of data items presented in the MIQPR, with potential for making sense of this through more analysis. There was a recognition that this linked to the point above around capacity. There was interest in understanding more on productivity and variation.	The Trust is a complex organisation with data/analytics being a key enabler of quality and performance. The MIQPR is high level relative to the amount of data being used by the Trust, however, it is acknowledged that it contains a lot of information. The scorecard at the front does provide a one-page summary. Deep Dives could be a mechanism that each committee could consider whereby one-off analysis could be undertaken on particular topics. An area of interest potentially may be productivity, as this is also an area of interest for Commissioners. This will be discussed with each committee. Another
The importance of quality assurance in data collection and reporting was discussed, with ongoing efforts to address data quality issues from various sources.	There is a recognition that more is needed in this area. This will be considered as part of the Data Strategy that is being developed. The additional investment into IDS will also allow for further work to be completed to improve data quality and to address outstanding

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

May 2025 / June 2025

Annex 1 – Top Indicator Dashboard

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

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2025/26	May-25	Jun-25	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	10.5%	10.0%	8.9%	R
111 Clinical Triage Call Back Time (P1)	90%	97.4%	96.4%	97.6%	G
999 Call Answer Times 95th Percentile	00:06	00:22	00:26	00:23	R
999 Red Response within 8 minutes	65%	50.0%	50.7%	49.2%	R
999 Amber 1 Median	00:18	01:29	01:29	01:35	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	74.7%	76.3%	73.5%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	76.1%	80.0%	79.7%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	22.6%	19.3%	19.9%	A
Stroke Patients with Appropriate Care	95%	89.9%	89.8%	83.7%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:23	02:24	02:25	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	69.1%	69.1%	56.5%	R
National Reportable Incidents reports (NRI)		3	8	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	6,015	5,953	8,601	G
Concerns Response within 30 Days	75%	72%	88%	57%	G
Enactment of the Duty of Candour Total		10	10	5	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	93%	91%	89%	A

Top Monthly Indicators	Target 2025/26	May-25	Jun-25	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	6.81%	N/A	7.76%	R
Mental Health Absence Rates	Reduction Trend	2.34%	N/A	2.33%	R
Staff Turnover Rate	Reduction Trend	8.18%	8.44%	8.30%	G
Statutory & Mandatory Training	>85%	87.56%	88.05%	79.16%	G
PADR/Medical Appraisal	>85%	81.35%	81.81%	74.05%	A
Number of Shift Overruns	Reduction Trend	3,745	3,441	3,723	G
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	2.82%	2.53%	1.9%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	N/A	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	28.1%	26.6%	28%	G
Average Jobs per Shift (All Vehicles)		2.64	2.33	2.35	A
NEPTS on the Day Cancellations	Reduction Trend	13.4%	14.7%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	20.2%	19.1%	15.3%	G
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	10.10%	N/A	11.2%	R
Number of Handover Lost Hours	7,500	19,670	15,278	21,619	R
NHS111					
NHS111 Dental Calls	Increasing Trend	8,827	8,749	7,894	G
Consult & Close Volumes by NHS111	Increasing Trend	2,372	2,238	1,310	G

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

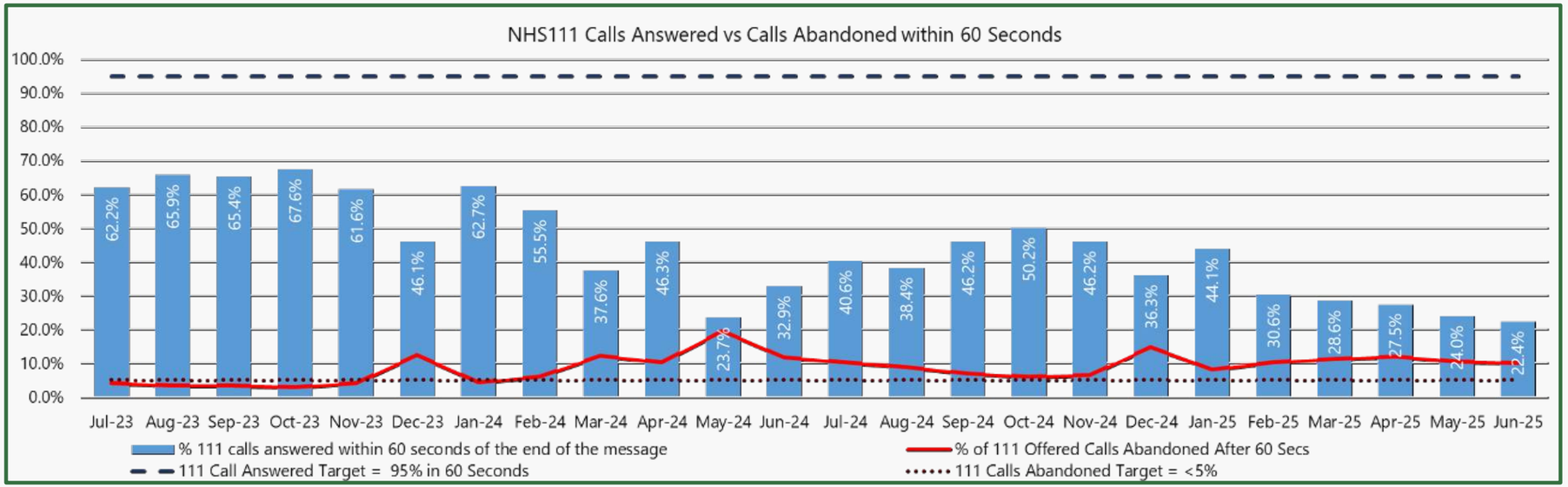
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

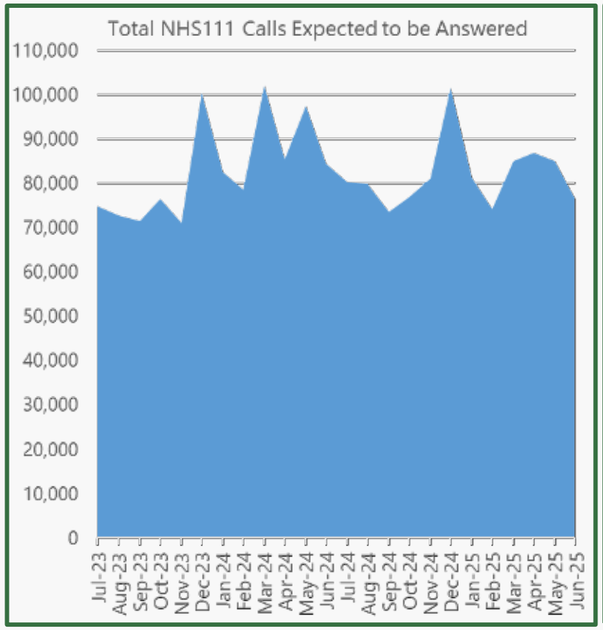
(Responsible Officer: Lee Brooks)

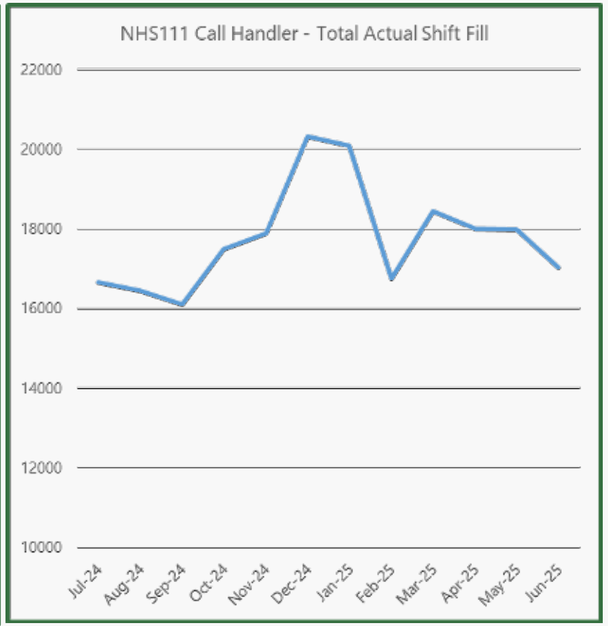
Abandonment Rate R

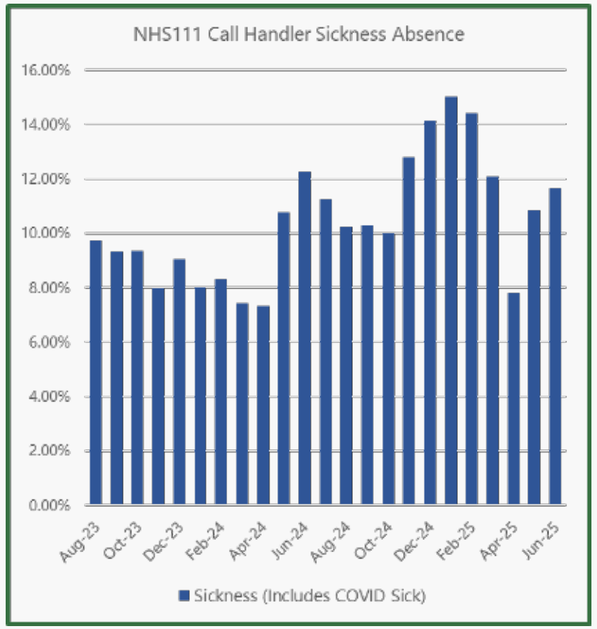
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate improved slightly to 10% in June 2025 from 10.5% in May 2025. However, the percentage of 111 calls answered within 60 seconds declined from 24% in May 2025 to 22.4% in June 2025 and continues to remain significantly below the 95% target.

Following a decline in performance during the middle of 2024, due mainly to the introduction of the new 111CAS system, performance did improve in October and November 2024. However, performance levels have continued to decline with the call answer rate within 60 seconds of 22.4% in June 2025, being the lowest seen in the past two years. This is at a time when UHP capacity for call handlers has continued to reduce compared with recent months and abstraction levels have increased, particularly in relation to Annual Leave and Secondments.

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 focus on realising the benefits of the new 111CAS;
A 111-re-roster pre-work review (underway) that takes account of the increased demand the Trust is seeing; what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.

The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.
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 might expect to see an improvement in performance in the summer, traditionally a period with lower demand and sickness. 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.

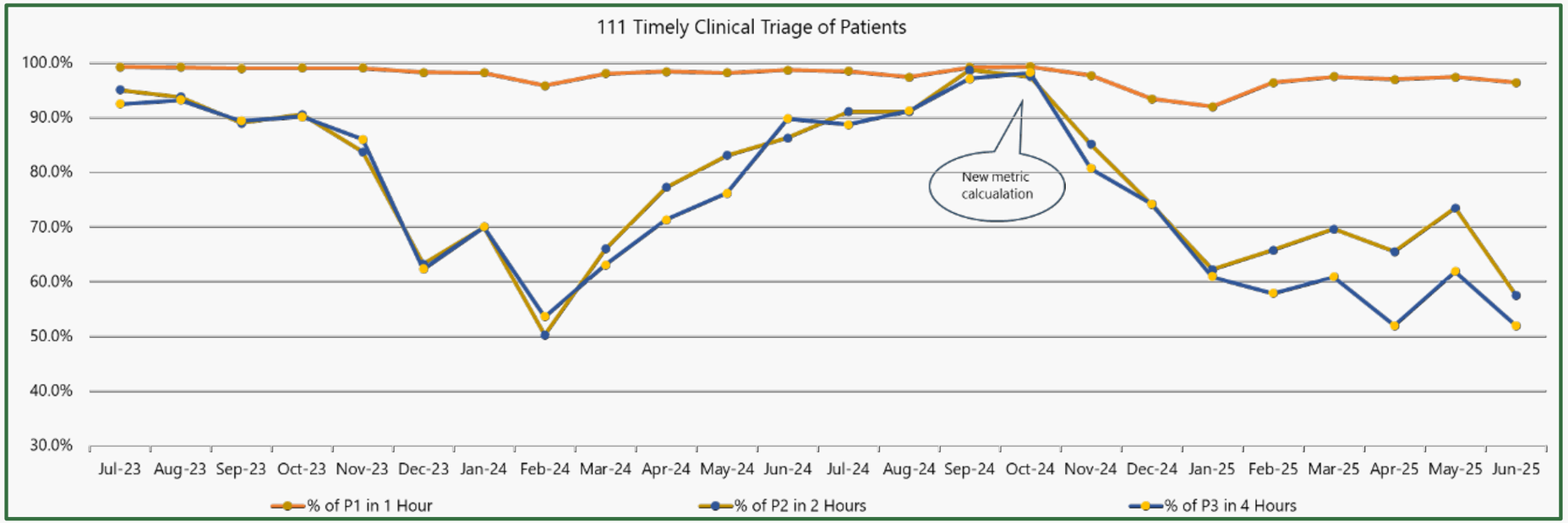
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

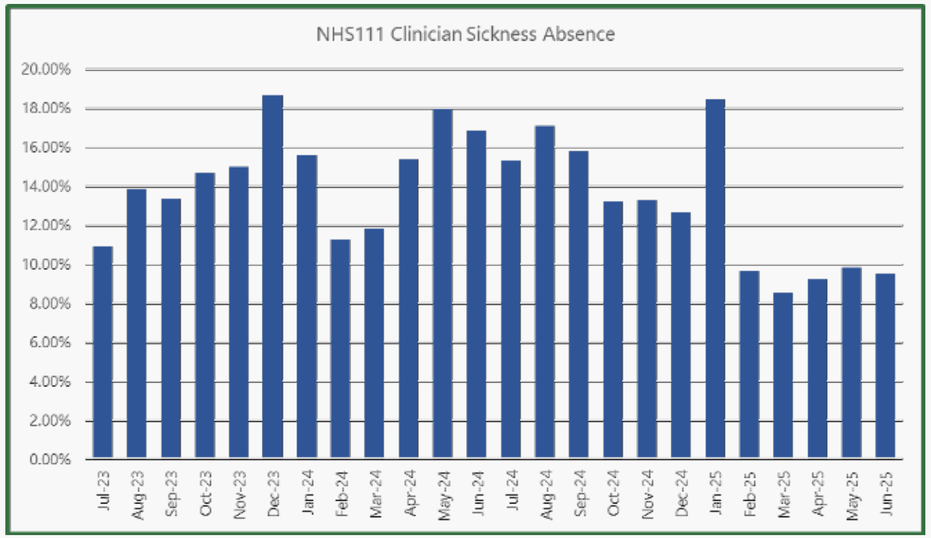
(Responsible Officer: Lee Brooks)

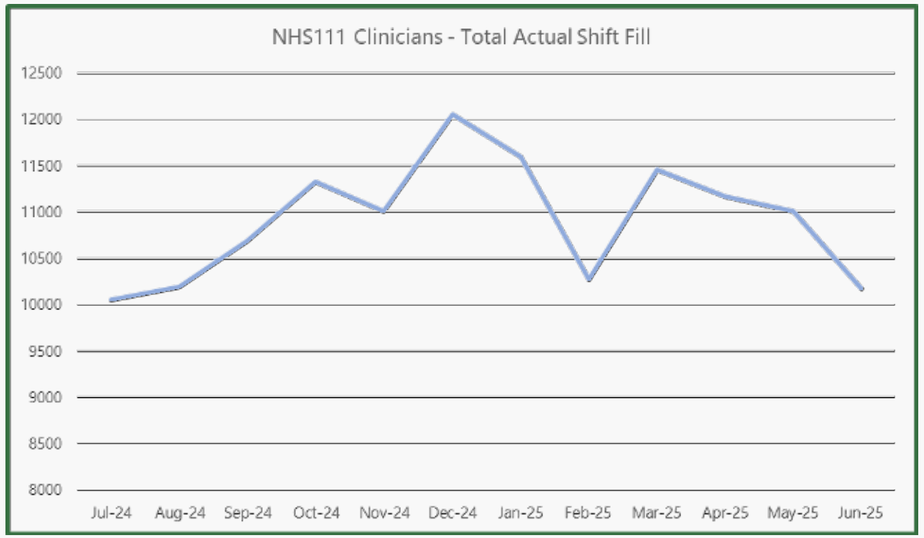
P1CT G

FPC

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







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 96.4% in June 2025.

Ring back times for lower category calls decreased during June 2025, with P2CT calls increasing to 57.5% and P3CT to 52%.

Numbers of clinician hours produced decreased again during June 2025, reducing from 11,004 hours in May 2025 to 10,173 hours in June 2025, albeit over one less day in the month. However, this was a 2.6% increase on the hours produced during June 2024. Clinician sickness absence decreased slightly during June 2025 at 9.50%.

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, this will be reversed in August,

Expected Performance Trajectory

It is likely that there will be a performance improvement through the summer 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

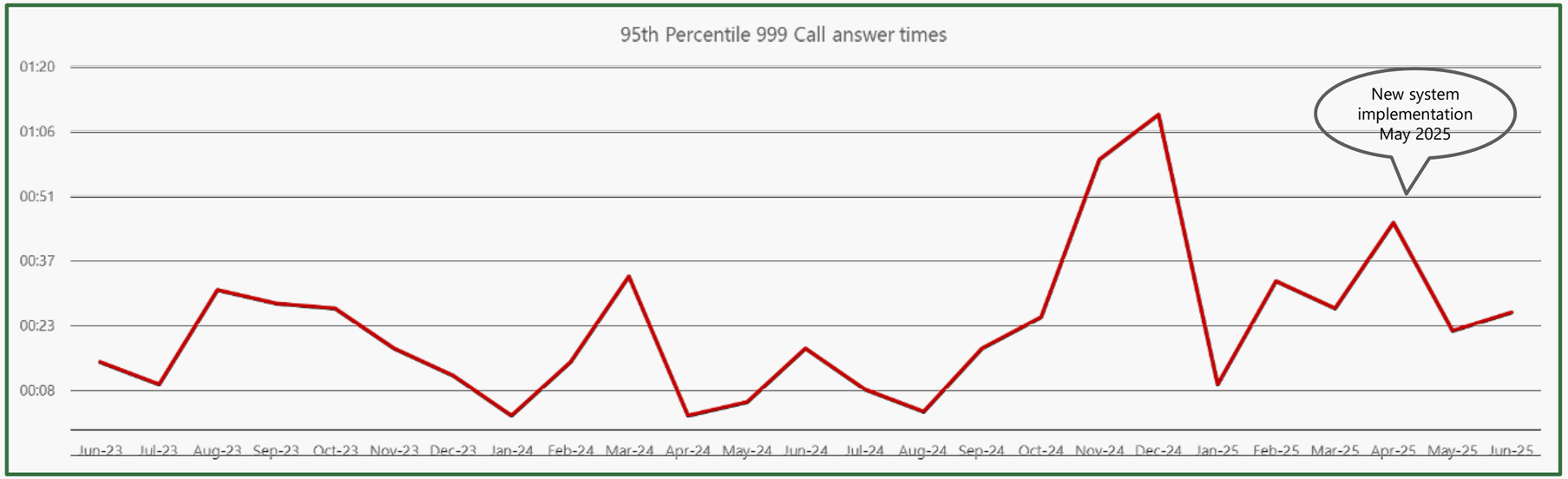
(Responsible Officer: Lee Brooks)

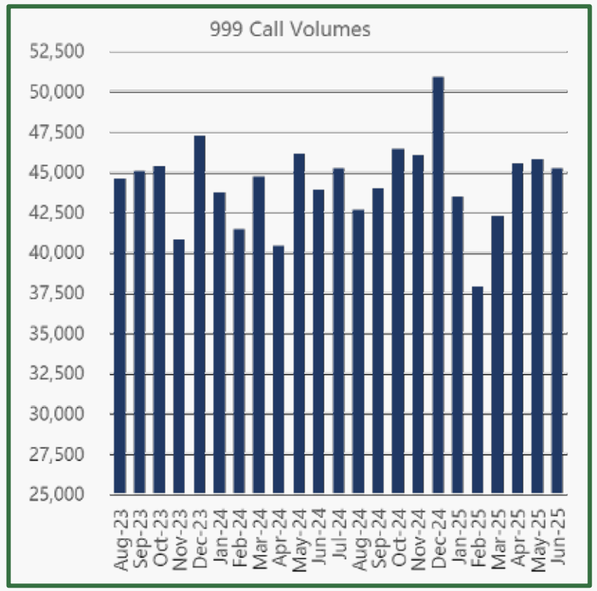
R

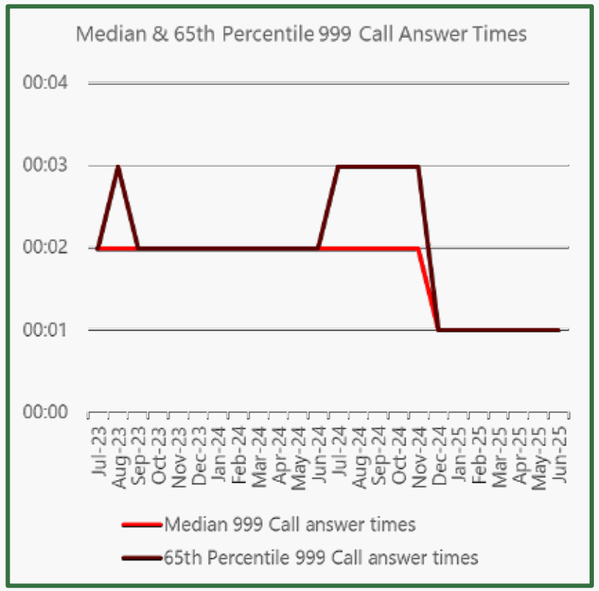
FPC

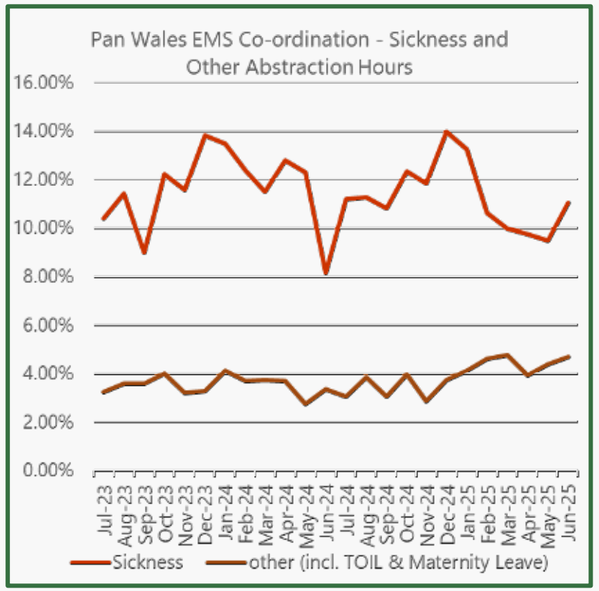
CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance increased to 26 seconds in June 2025 and remaining 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 slight decrease in demand during June 2025 to 45,286 calls from 45,814 in May 2025.

Sickness levels saw an increase, from 9.48% in May 2025 to 11.05% in June 2025.

Remedial Plans and Actions

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

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
Red Performance Indicators
Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

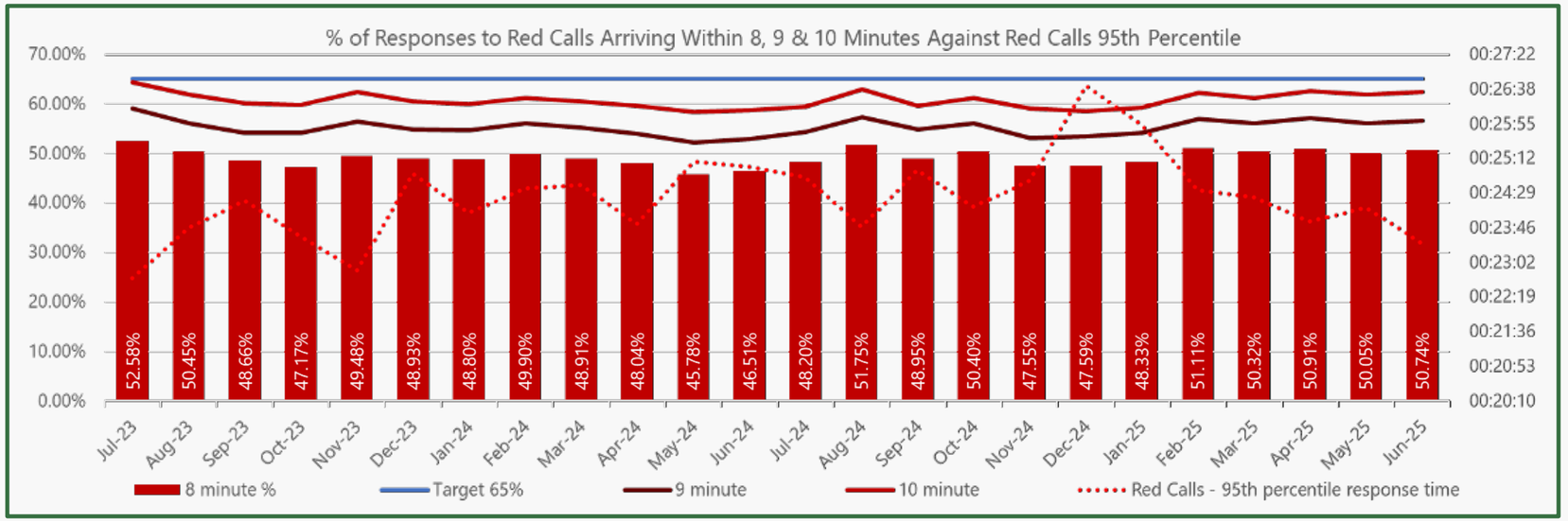
8 Min

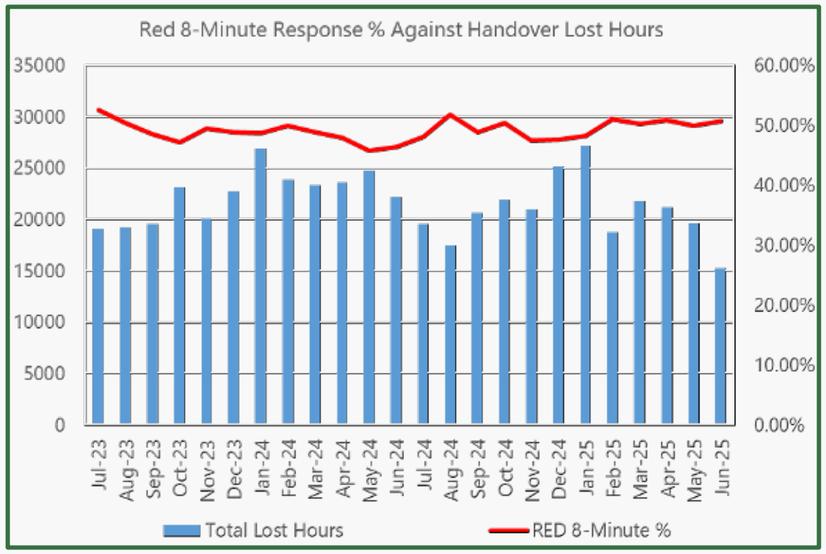
R

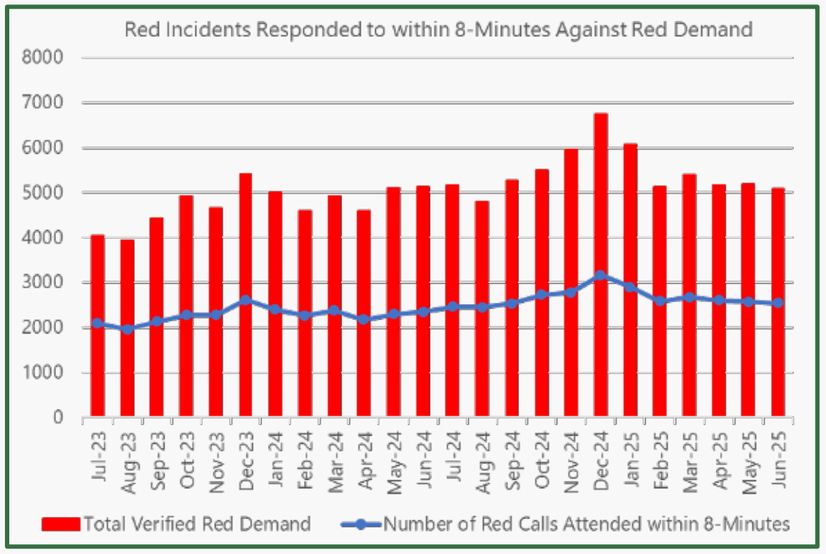
QUEST

FPC

CI







Analysis

Red 8-minute performance improved slightly in June 2025 to 50.74% from 50.05% in May 2025 but remains below the 65% target.

Red 10-minute performance for June 2025 was 62.4%, which is marginally above the 2-year average (60.8%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in June 2025 being 26.8% higher than that seen in June 2023. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for June 2025 of 2,547, being 18.2% higher than the figure for June 2023, i.e. the Trust is reaching more red calls in 8-minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and **hospital handover lost hours**, which shows that as handover rates decrease, so red performance improves. There were 15,278 lost hours during June 2025, which is the lowest figure recorded since September 2021.

Remedial Plans and Actions

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

- To maintain commissioned establishment in post levels overall: the Trust remains close to achieving its 95% UHP benchmark in June with 93.8% UHP (all resources);
- Full roll out of the Cymru High Acuity Response Unit (CHARU): the Trust achieved its highest ever CHARU UHP in January;
- The deployment of rapid clinical screening, as outlined in our IMTP (the Trust achieved this); and

Expected Performance Trajectory

On the 11th March 2025 the Cabinet Secretary for Health & Social Care announced that the current Red category will be replaced with a new arrest and emergency category which went live on 1st July 2025. This will see the focus moving to measures of the chain of survival and patient outcomes i.e. saving lives, rather than a hit/miss time targets.

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

(Responsible Officer: Lee Brooks)

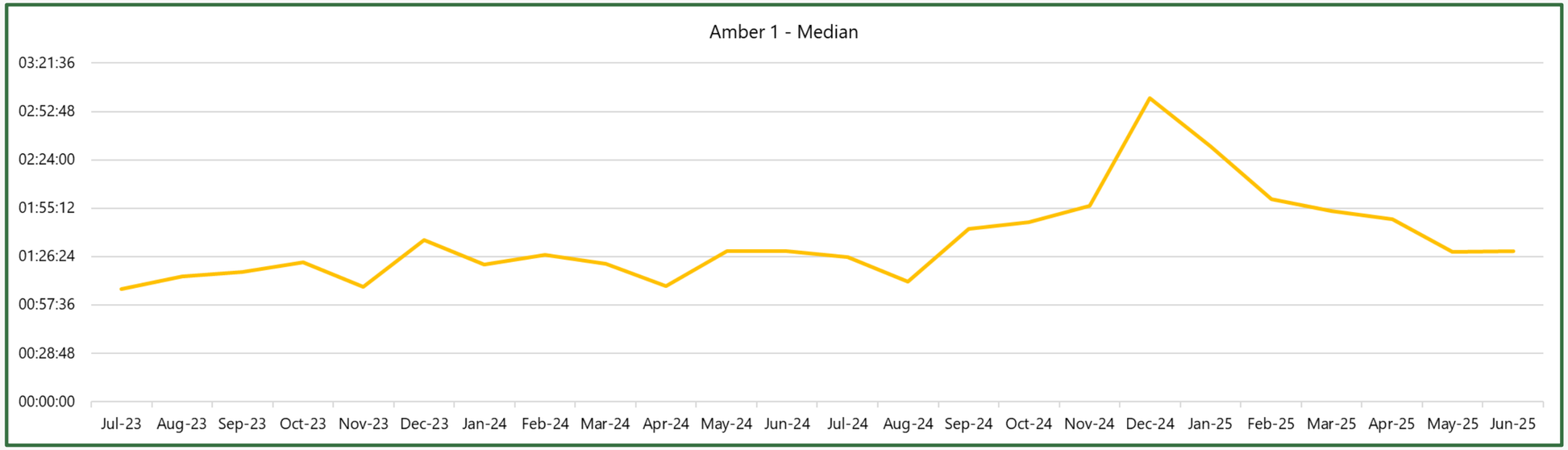
R

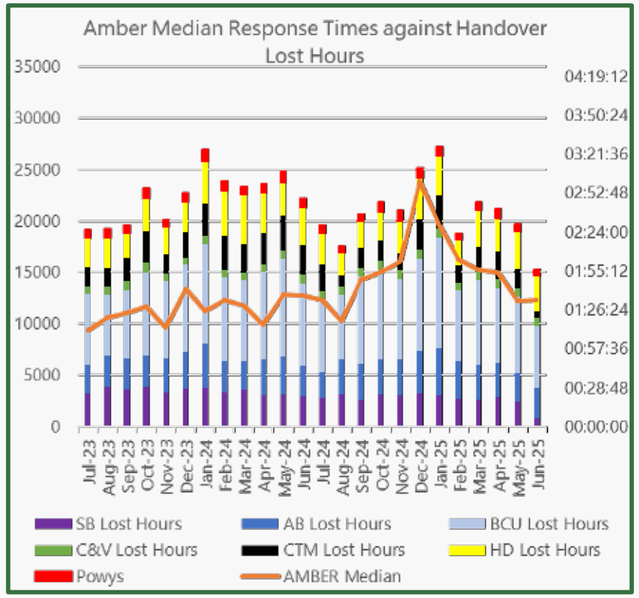
FPC

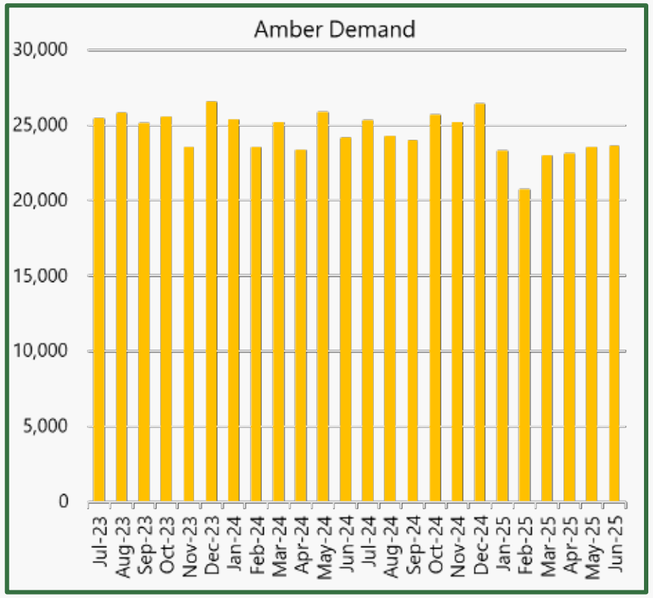
CI

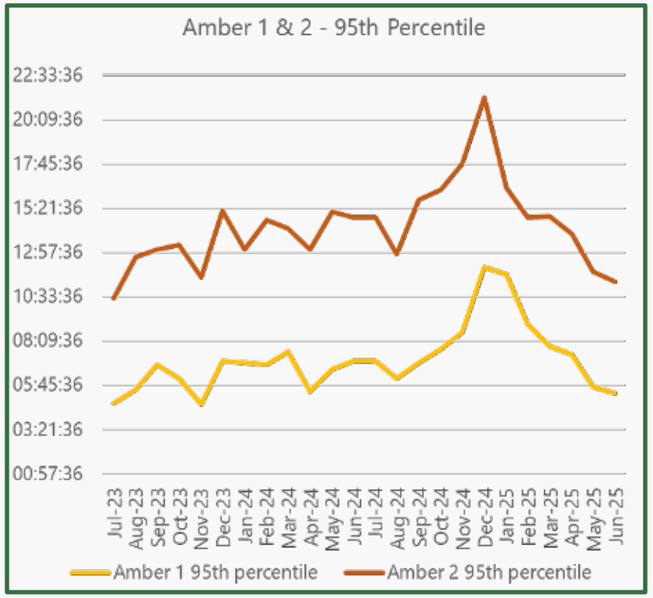
QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time remained consistent during June 2025 at 1 hour and 29 minutes. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile decreased during June 2025 to 5 hours 18 minutes, down from 5 hours 40 minutes in May 2025. This time remains currently below the 2-year average figure of 7 hours 59 minutes.

As with Red, 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 improve further.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience

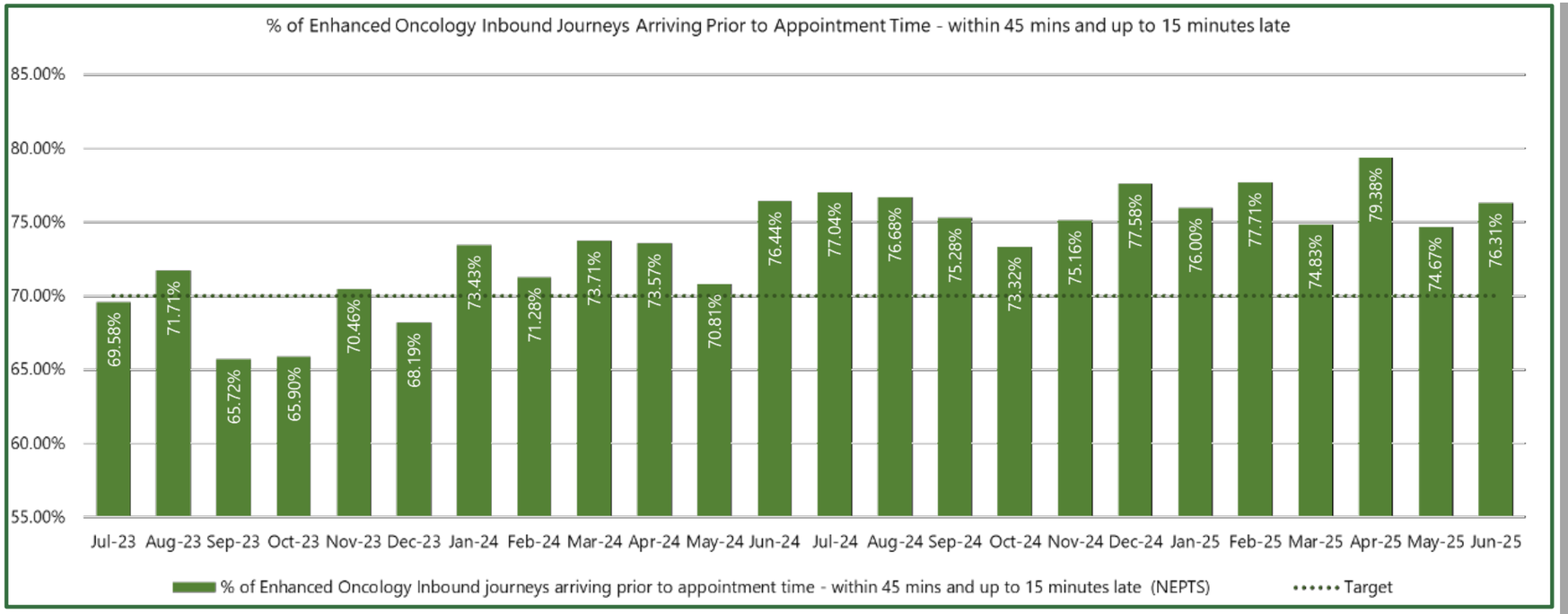
Patient Experience – Influencing Ambulance Care Indicators

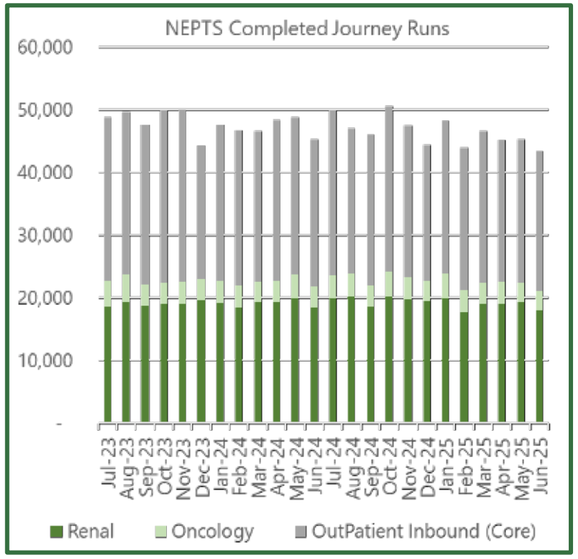
(Responsible Officer: Lee Brooks)

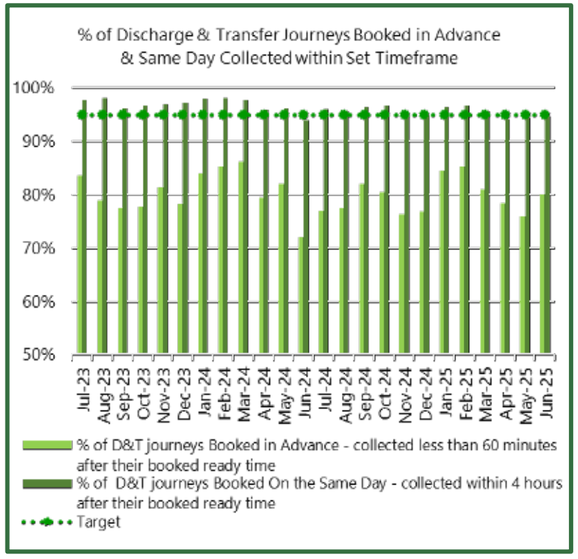
D&T	Oncology	Welsh Calls
R	G	G

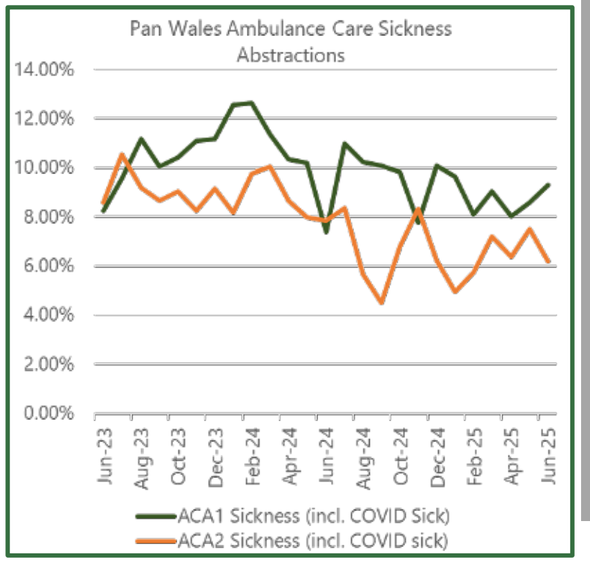
FPC

CI









Analysis

76.31% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in June 2025, once again achieving the 70% target.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment improved in June 2025 to 80% but remains below the 95% target. Discharge and Transfer journeys booked on the same day achieved the 95% target in June 2025.

Renal journeys decreased marginally from 72.61% in May 2025 to 72.57% in June 2025, but achieving the agreed performance standard of 70% for only the seventh time since September 2024.

Call volumes answered decreased to 14,851 calls during June 2025, from 14,914 in May 2025; but the average speed of call answering increased from 12 minutes 47 seconds to 13 minutes 48 seconds.

ACA1 sickness remains above the 5.99% target, at 9.32% in June 2025. ACA2 sickness also remains above the 5.99% target at 6.20% in June 2025.

Remedial Plans and Actions

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

New rosters keys have been finalised based on updated demand with the roster review now commenced; however, the review is proving complex and is being reset once further modelling has been undertaken. Enhanced sickness monitoring has been implemented at the ADO/HoS level and all long term and complex cases are being reviewed regularly.

Expected Performance Trajectory

An improvement is expected in the next few months, although it is not anticipated that the target will be achieved without wider system change.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

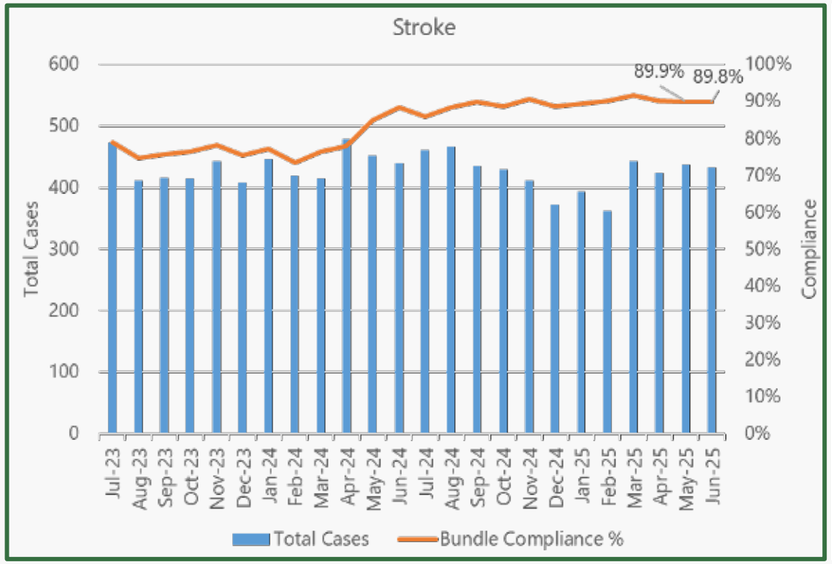
Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care and Time-Based metrics.

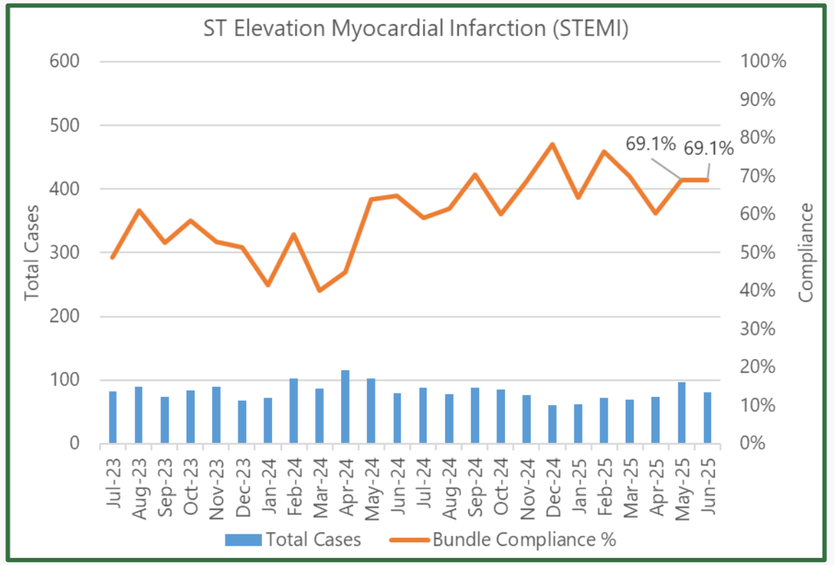
Stroke	Stroke Call to Door	STEMI
A	R	R

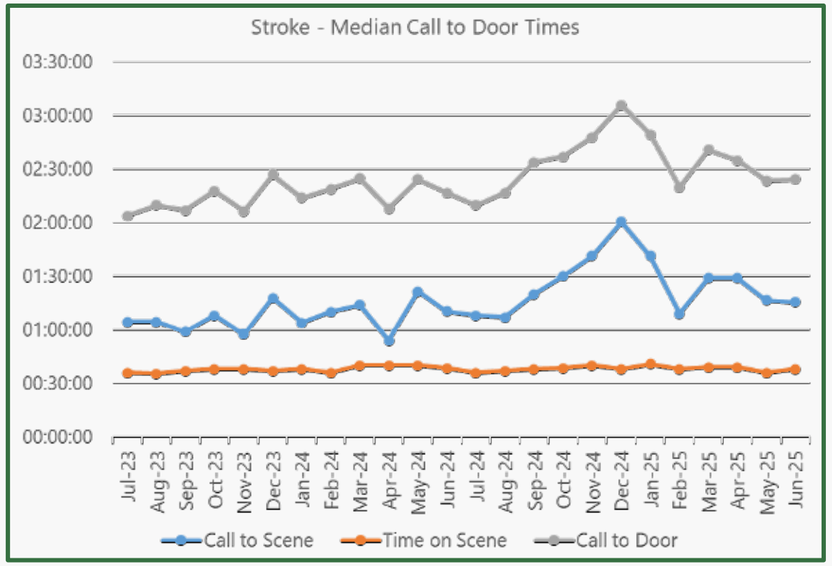
Self-Assessment: Strength of Internal Control: Moderate

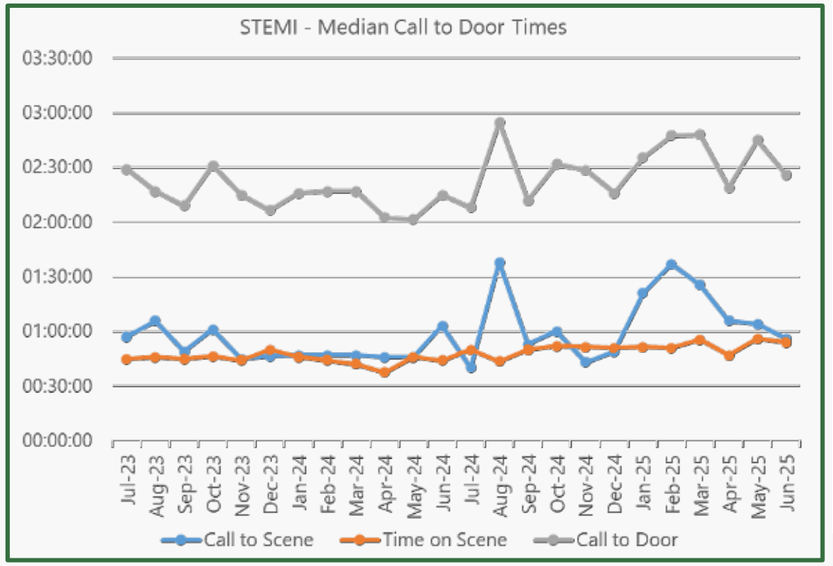
QUEST

(Responsible Officer: Andy Swinburn)









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

Stroke – 89.8% - Performance has remained consistent at around 90% for the past three months. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

STEMI (heart attack) – 69.1%, a significant improvement from 60% in April 2025 but consistent with May 2025. There has been an increase in compliance across all elements of the care bundle. The number of cases remained low (81) therefore, increasing the volatility of the compliance data so this could be natural variance.

Call to door times for Stroke – Call to door times minimally increased for stroke in June (02:14:30). All three elements of the bundle have seen consistency on time.

Call to door times for STEMI – Call to door time has decreased since last month (02:26:00).

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 2025.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

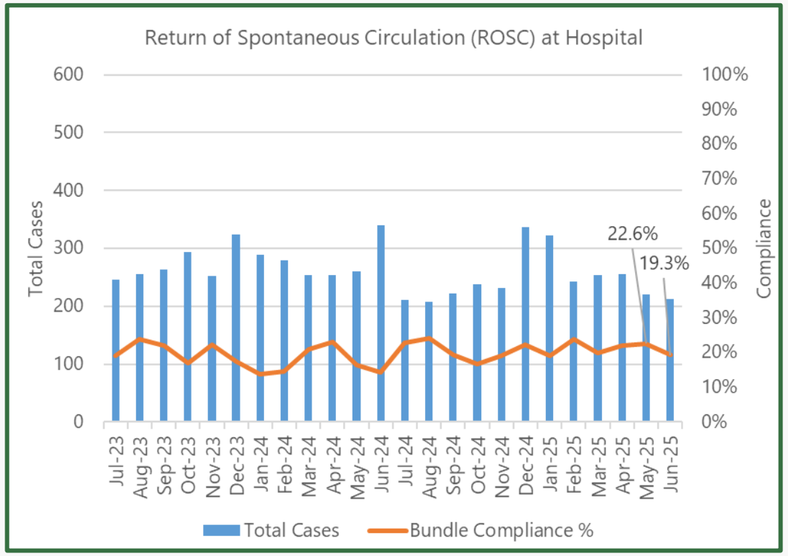
Return of Spontaneous Circulation, Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (#NOF)

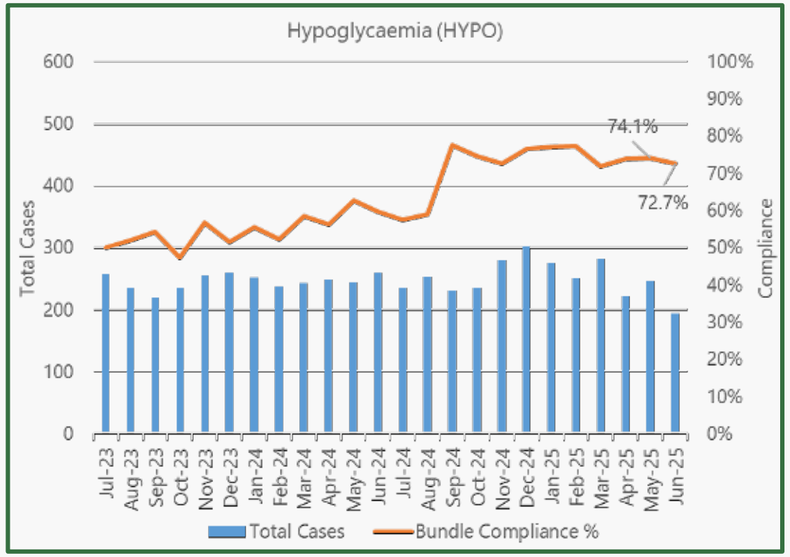
(Responsible Officer: Andy Swinburn)

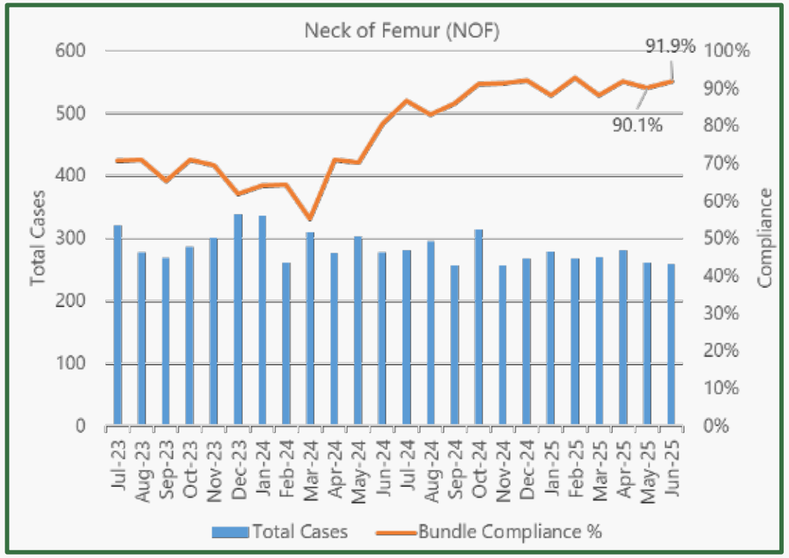
ROSC
A

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 June 2025 was:

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 19.33%, a decrease from 22.6% in May. 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. Both December and January continued to see higher numbers of cases in this indicator.

Hypoglycaemia (diabetic patients with low blood glucose) – 72.7%, a slight decrease from last month. Compliance has remained quite static through Q1, although there has been a slight drop in compliance across the bundle.

Fractured Neck of Femur (hip fracture) – 91.9%, maintaining consistent performance from May. Only a slight increase in compliance which is evident across the care bundle.

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
Patient National Reportable Incidents & Duty of Candour

(Responsible Officer: Liam Williams)

Concerns.

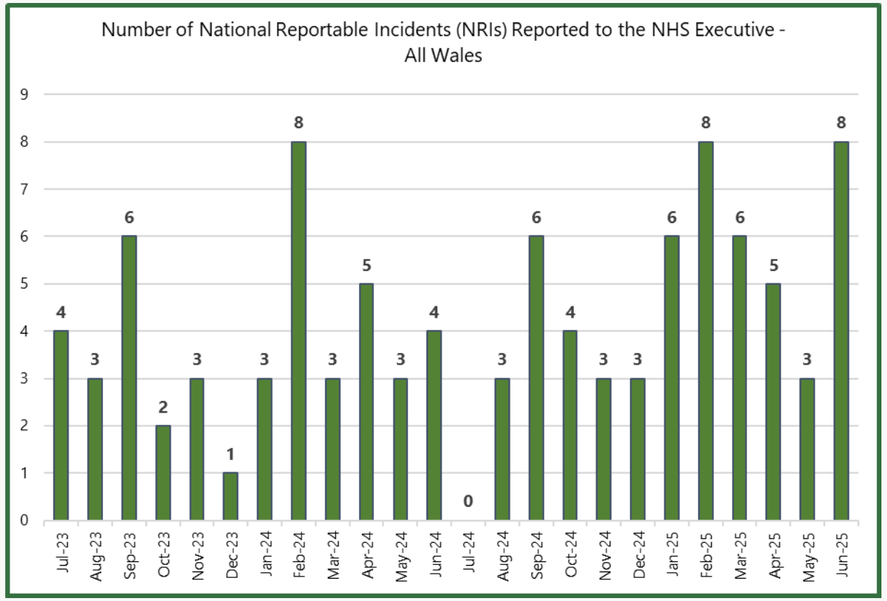
G

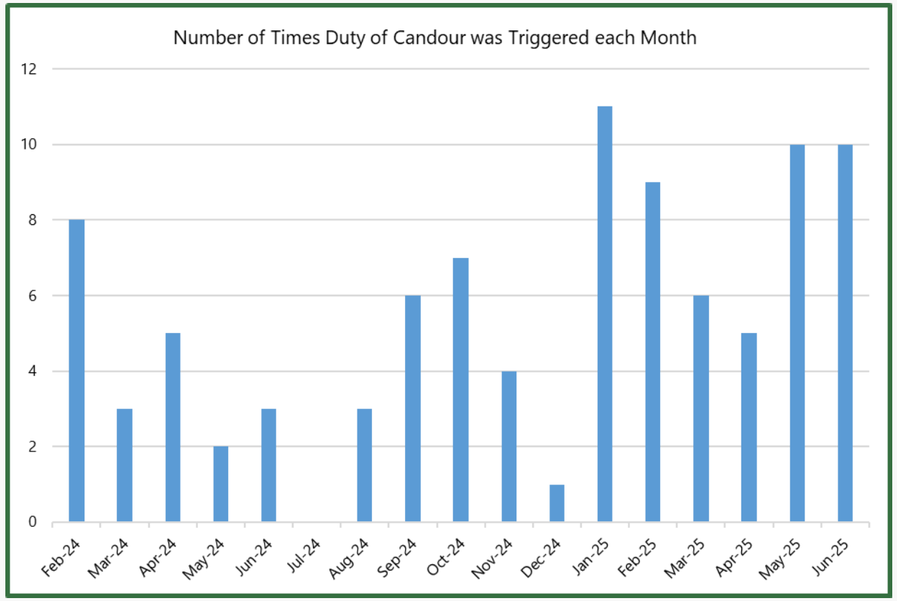
Self-Assessment: Strength of Internal Control: Moderate

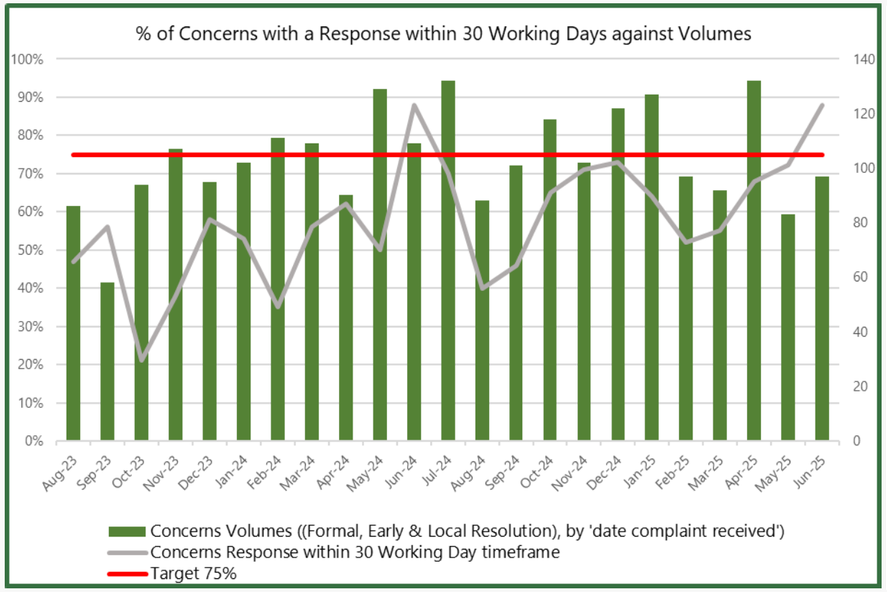
QUEST

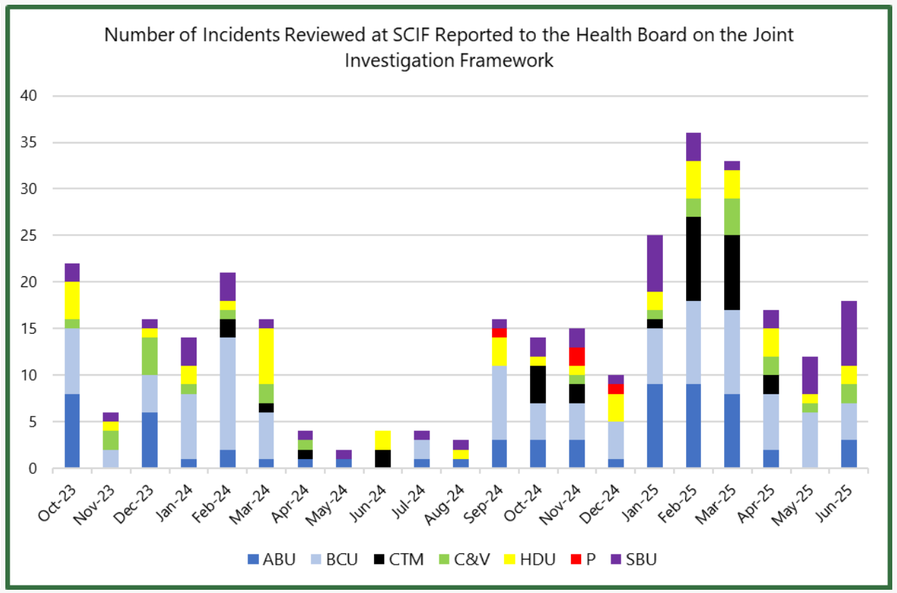
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis

Compliance with the 30 working day complaints target was not achieved but remains at a reasonable level and has improved on the previous months. Performance for closed complaints however masks a concerning picture of a growing number of open and overdue complaints. This is due to increased complexity of investigations within the Trust, an increased volume of incidents that may have arisen from planned changes in the Clinical Safety Plan and the need to recruit additional staff to support audit of the different interventions now in place across the Clinical Contact Centres; Clinical Navigators within Emergency Medical Service (EMS) and Emergency Communication Nurse System (ECNS) within 111Wales Integrated Care.

NRI reporting has returned to an average level following a winter peak.

Remedial Plans and Actions

Ongoing monitoring of National incident reporting, enactment of the Duty of Candour and Complaints performance is monitored by team leads on a regular basis and all teams are working to achieve national timescales and a benchmarking position comparative to other NHS Wales.

The Trust has approved increased investment within the Operations Auditing Team and the Remote Care Education Team to support timeliness of complaint and incident investigations

Expected Performance Trajectory

An organisational PTR & Legal Services Recovery Plan is being developed and will be presented at the next QuESt Committee.

The complaints management process itself is well-assured, with families continuing to receive regular contact from the Trust.

*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

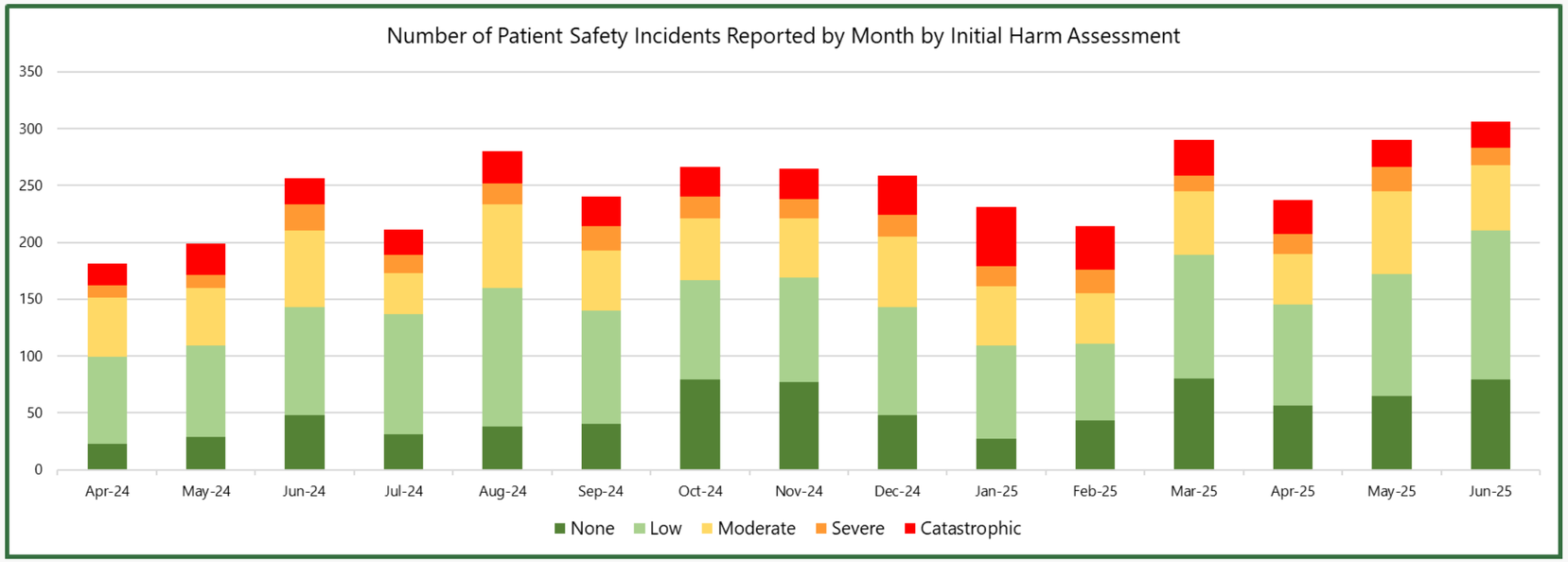
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

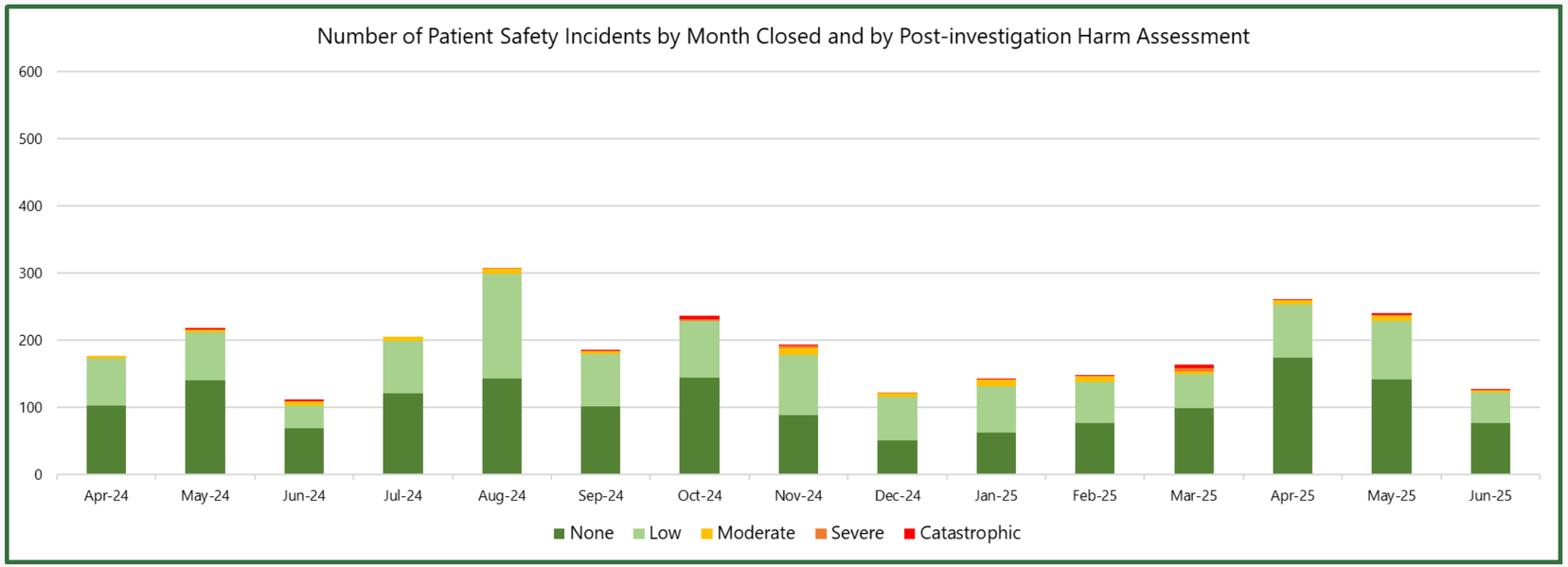
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care





Analysis
Incident reporting volumes have decreased back towards the organisational baseline. Incident closure rate however has shown a marked improvement in the number of investigations being completed and closed. This follows significant focus within service areas and improvement work of account permissions as part of the Datix Recovery & Improvement Plan. Near miss reporting is being encouraged during daily operational meetings to ensure we learn from all opportunities.

Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low. NRI's that have been closed with the NHS Executive Wales have improved during the last month.

Remedial Plans and Actions

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

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

Data source: Datix

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

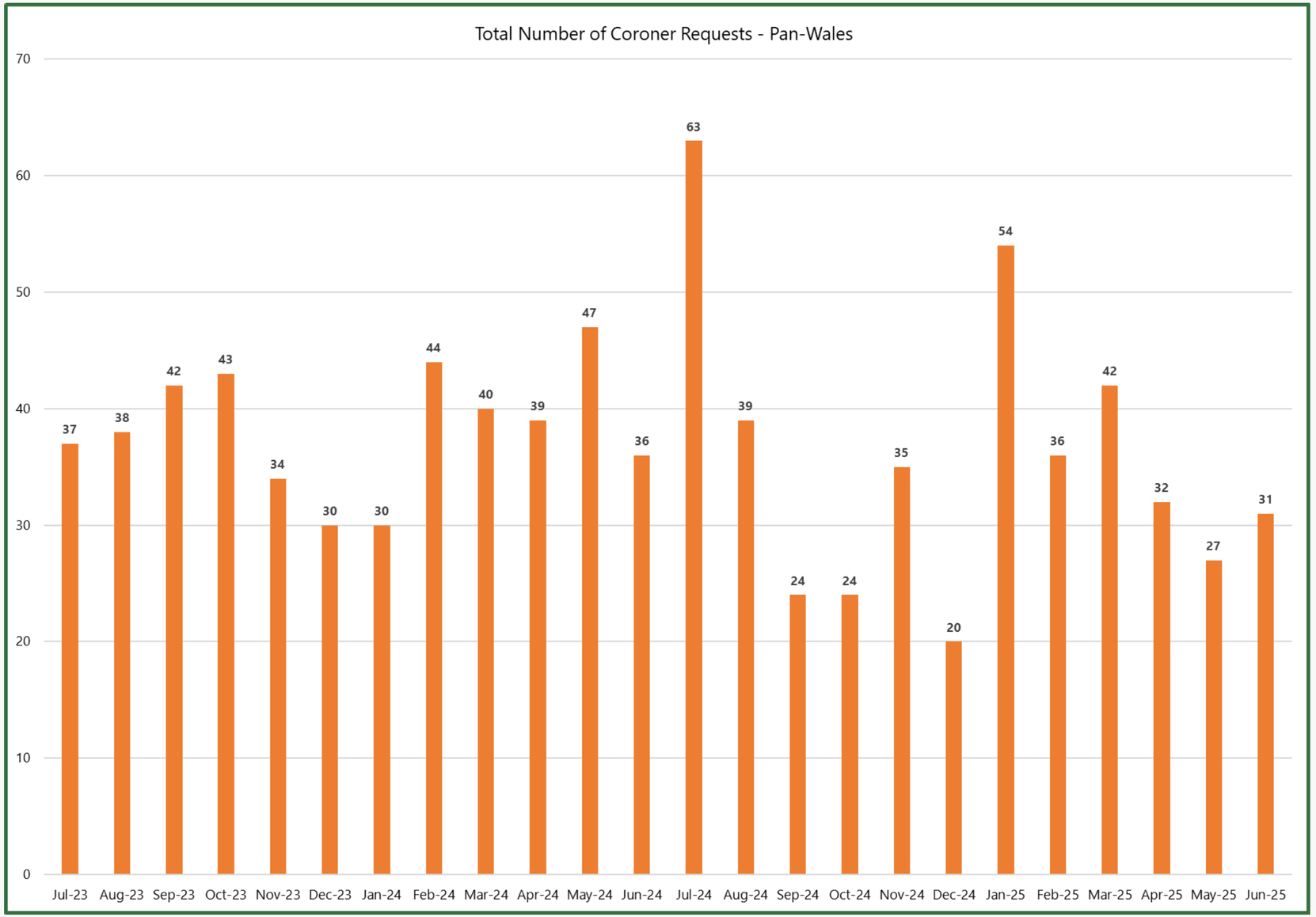
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



Analysis
The number of coroner approaches continues to bring a high level of activity to the Trust. Inquest cases continue to present with increased complexity and large numbers of statements and witnesses being called. These factors combined makes this an area of continued pressure across Trust services and for the individual staff involved in representing the organisation.

Challenges to meet deadlines, in relation to EMSC with any form of remote Clinical decision-making involvement continue to require extension of deadlines and the Trust has received two Schedule 5 notices in May 2025.

From 1 May 2025 the additional support that has been in place since 16 Jan 2023 has ceased. The Trust will do less of our own representation, leading to more Barristers being instructed by the Trust.

Medical Examiner Level 1 triage occurs regularly, ensuring prompt recognition of cases where learning and/or potential harm are identified. The Level 2 Medical Examiner Learning Panel is now effectively reviewing the management and learning from cases.

Remedial Plans and Actions
Operations Quality have provided estimated completion dates for coronial deadlines, which will provide some assurance and expectations of completion dates to the coroner.

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.

The frequency of Level 2 Medical Examiner Learning Panels has been increased to weekly to address the high number of cases awaiting completion.

Expected Performance Trajectory
Short, medium and long-term plans continue to be developed to provide a solution to the challenges currently faced in timely completion of statements.

Mortality Reviews Data source: Internal Web Application

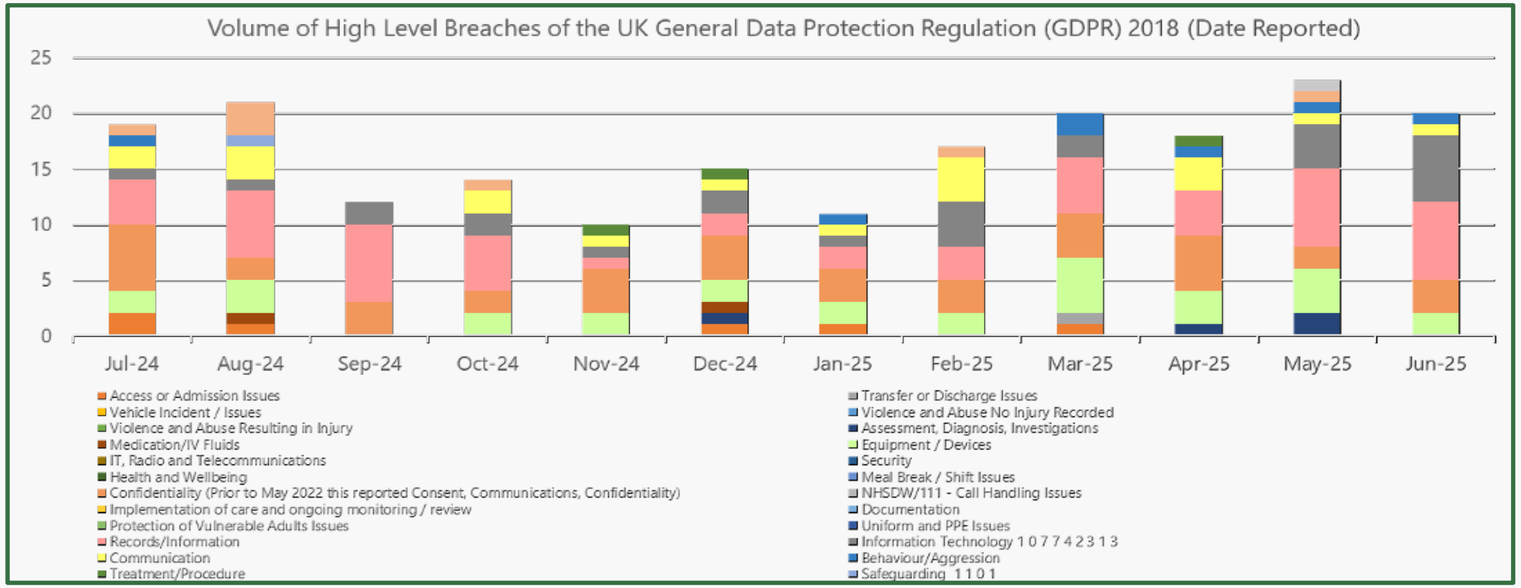
Our Patients: Quality, Safety & Patient Experience
Safeguarding, Data Governance & Public Engagement Indicators

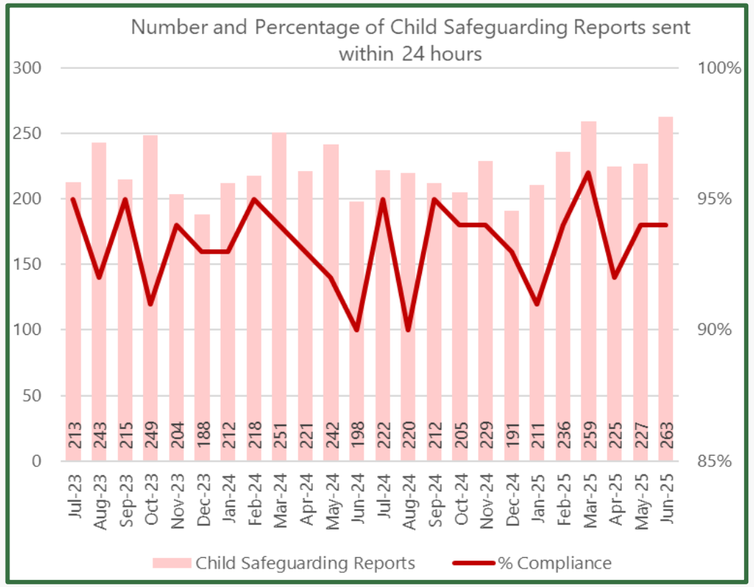
(Responsible Officers: Jonny Sammut & Liam Williams)

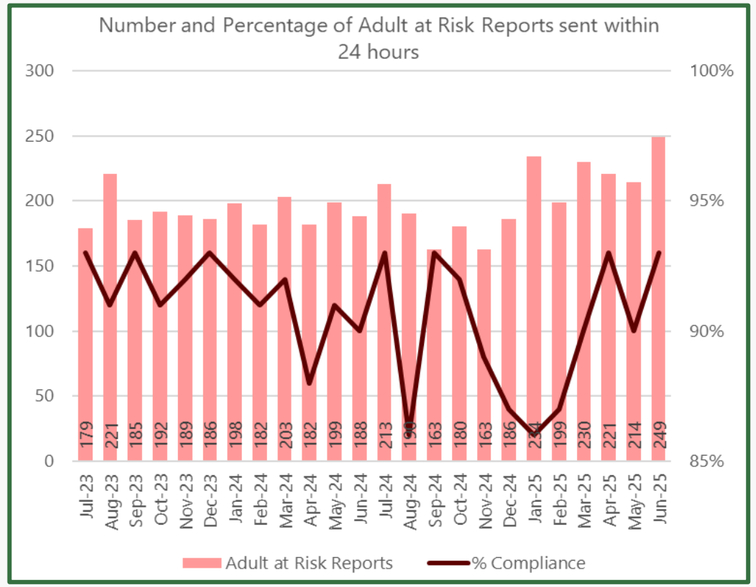
Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong

PCC







Analysis

Safeguarding: In June 2025 WAST colleagues submitted a total of 249 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); 790 reports were shared with local authorities across Wales during this reporting period. There have been 263 Child Safeguarding Reports submitted in June 2025, 94% of these were processed within 24 hours.

Data Governance: In June 2025, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 7 related to Records/Information, 3 IG/Confidentiality, 1 Communication, 2 Equipment, 1 Behaviour, and 6 Information Technology.

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

Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission was completed on 31st March 2025. The next iteration of the IG Toolkit has now opened for FY25/25 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

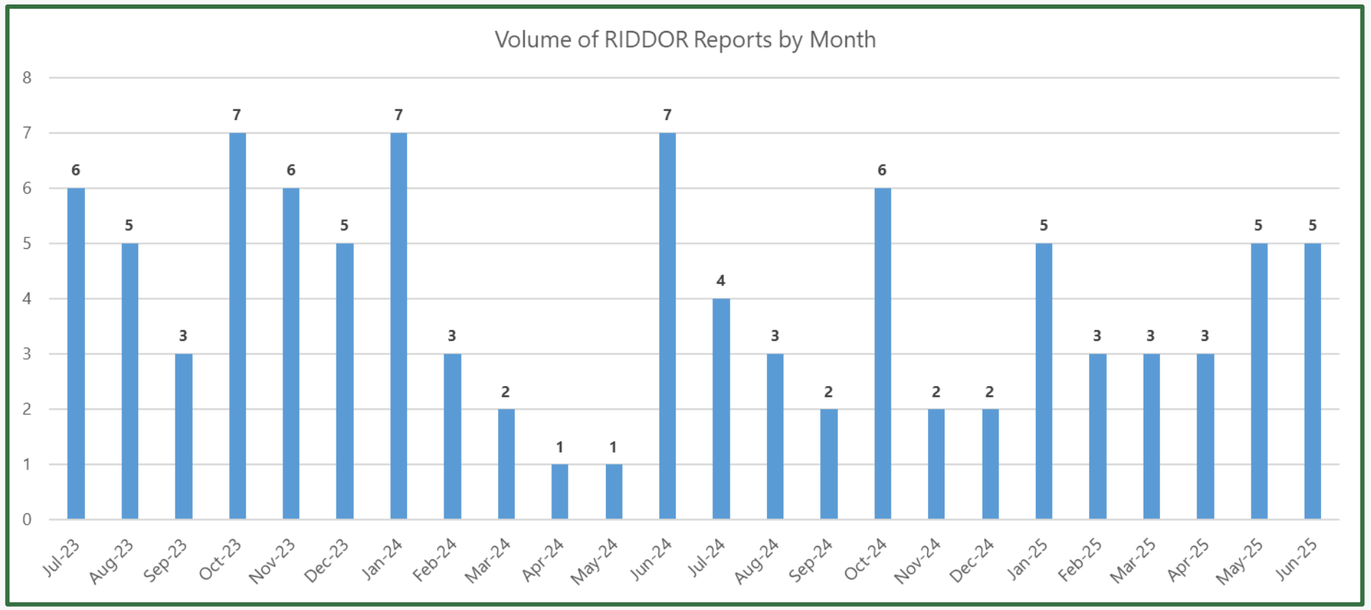
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

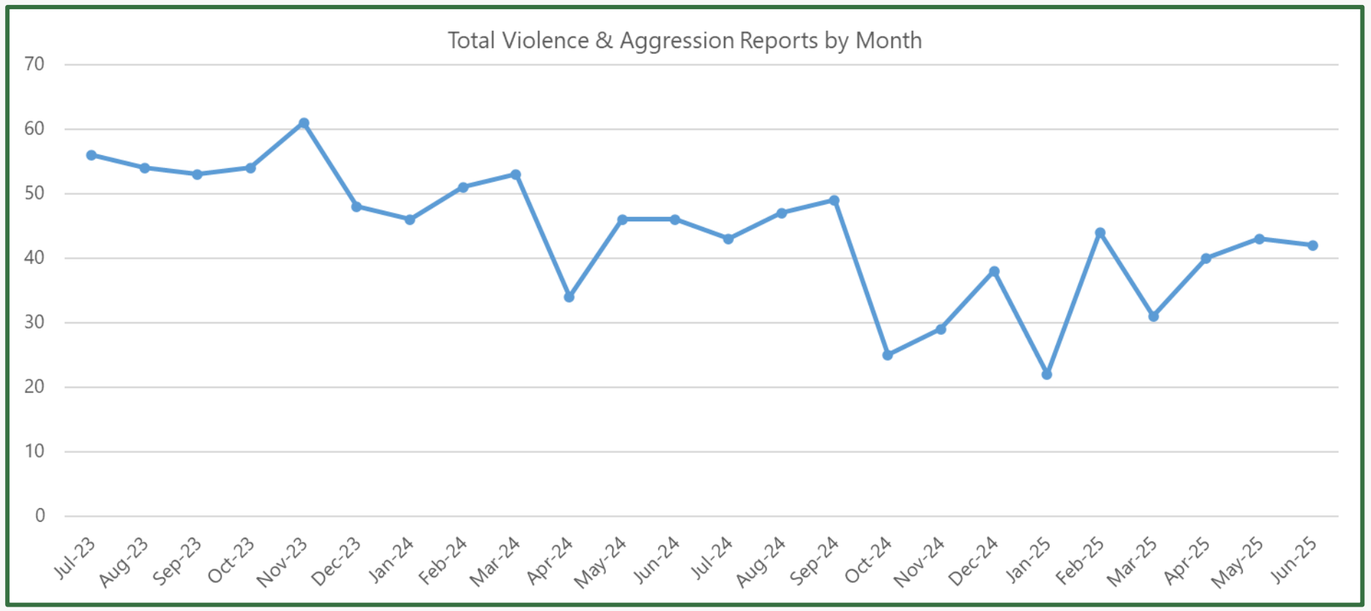
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Analysis

RIDDOR: There were 5 incidents requiring reporting under RIDDOR during June 2025 all were for an injuries requiring over 7 days of work.

- 100% of the RIDDOR's were submitted within the HSE reporting timelines, due in part to the effort put into investigating incidents by line managers.
- 4 RIDDOR's reported during the month were as a result of manual handling incidents 1 whilst handling equipment and 3 whilst handling patients and 1 was a slip trip on the stairs of a patient's home.

Violence and Aggression:

- A total of 42 incidents have been reported of V&A in June.
- 6 Physical Assault on staff was reported during the month with 6 incidents of verbal abuse all of which were incidents of swearing
- 7 incidents were reported as Moderate in harm and 19 noted as low harm with 15 cases being noted as causing no harm.
- The number of verbal assault incidents remained high during the month with aggressive and threatening behaviour accounting for 20 of the 42 incidents.

Remedial Plans and Actions

RIDDOR:

The weekly Datix incident meeting is being 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 managers is making improvements in causation and reporting to the HSE.

Violence and Aggression:

The challenges of the Right Care Right Person approach by Polices Services are being managed via the Risk Management process in partnership with the WAST Mental Health Team.

V&A Manager has met with TU partners to engage and explain workstreams aimed at reducing and preventing incidents advising on a process of risk assessment/incident reporting.

Work is underway with People Services and the V&A function in relation to recording sickness absences on staff electronic staff record (ESR) following being subject to an episode of V&A.

Expected Performance Trajectory

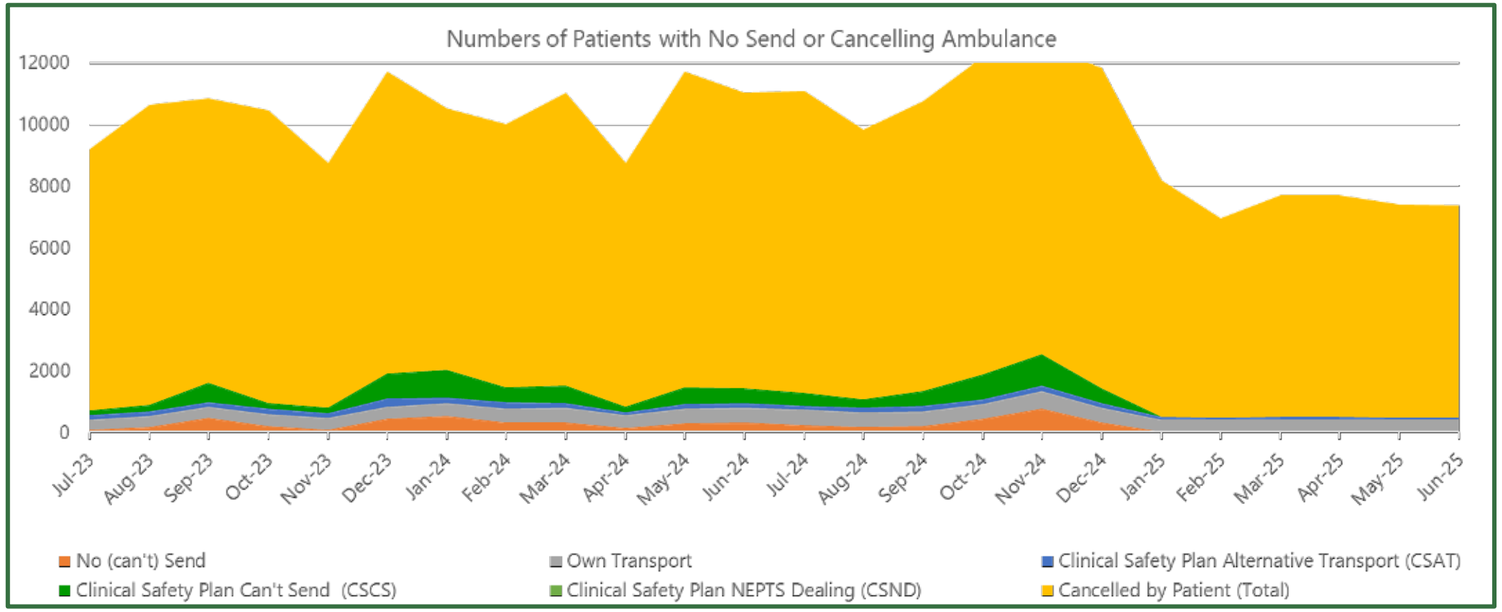
RIDDOR: The actions arising out of the recent deep dive into manual handling incidents aim to address the issues identified in the manual handling incidents this month.

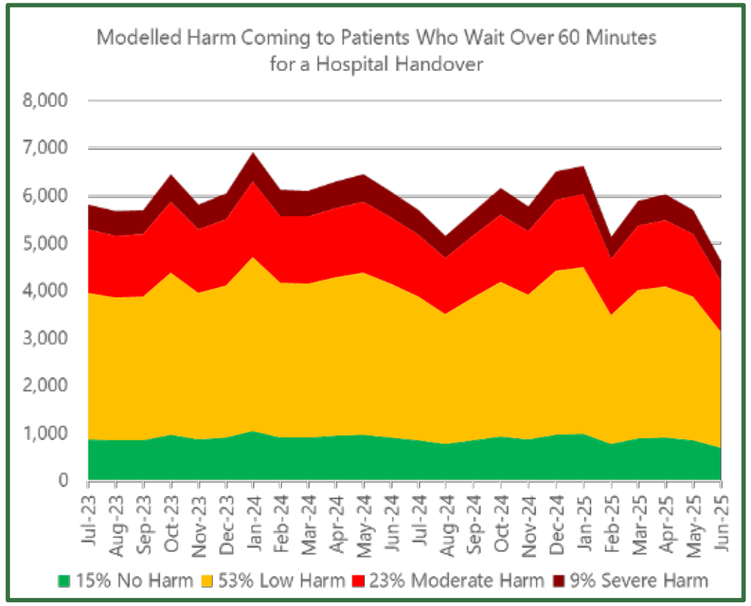
Violence and Aggression: There is a marked reduction in incidents reported over the last 12 months 29.8% which contradicts National reporting across the Sector, and this expected to be improved.

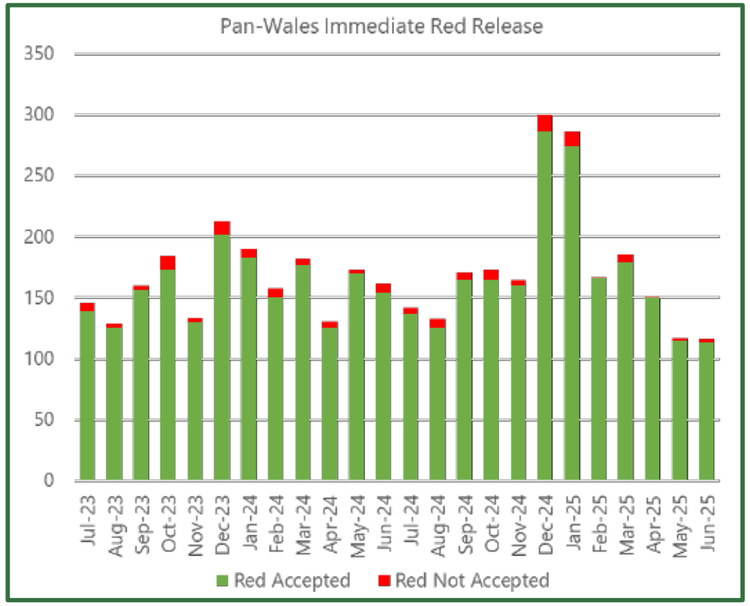
Data source: Datix

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

(Responsible Officer: Andy Swinburn) G QUEST







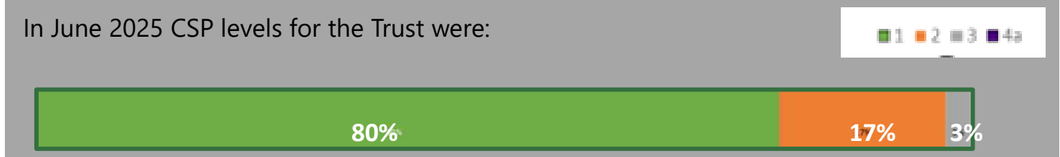
Analysis

In June 2025, 78 ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 6,926 ambulances were cancelled by patients (including patients refusing treatment at scene) a minimal decrease from the 6,962 in May 2025. There has been a downward trend in patient cancellations since December 2024 which the Trust believes is connected to the implementation of Rapid Clinical Screening.

There were 437 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in June 2025. Of these 113 were accepted and released in the Red category, with 3 not being accepted and 131 ambulances were released to respond to Amber 1 calls, but 190 were not.

The graph in the bottom left shows the estimated level of patient harm during June 2025. Of the 4,625 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% (694 patients) would experience no harm, 53% (2,451 patients) would experience low harm, 23% (1,064 patients) would experience moderate harm and 9% (416 patients) would experience severe harm.

In June 2025 CSP levels for the Trust were:



Remedial Plans and Actions

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

Expected Performance Trajectory

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

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

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

May & June 2025 Combined		
NEPTS (503 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	85
Were you happy with the transport you received?	85	95
999 (43 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	79
The 999-call taker who answered your call explained what was going to happen next.	85	80
The length of time I waited for an ambulance to arrive was acceptable.	85	56
111 (29 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	72
Did you follow the advice given to you by NHS 111 Wales?	85	87
Would you consider using NHS 111 Wales again?	85	91
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	92.22% Good	6.11% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	53.85% Good	23.08% Poor
o EMS (including CSD)	63.34% Good	18.18% Poor
o NHS 111 Wales Online	32.43% Good	51.35% 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

During May and June 2025, PECI attended 27 community engagement opportunities, engaging with approximately 496 people. Engagement this month included attending Pride Cymru, Cardiff Mela, All Wales People First Adfest and Swansea Disability Forum. At all these events we listened to people tell us about their experiences of using our services, answered questions and provided information about topics people wanted to know more about. Throughout May and June, 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

The PECI Team are still waiting the progression of an OCP which will see the Team restructured and re-aligned to meet the Trust's ongoing strategic objectives. For now, the PECI Team continue to engage in an ongoing dialogue with the public about their experiences and expectations of using our services, though it is yet unclear how this will change and what Team will be responsible for public engagement in the future. As a result, the PECI Team are not committing to a diary of future engagement events and are considering each community engagement request on a case-by-case basis. Response rates to some of our PREM's surveys continues to be disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. A DPIA was submitted to the ICO for consideration, which would allow us to contact certain 999 callers by SMS Text to ask them to provide feedback. The ICO has responded with 7 recommendations which will be presented to IGSG and from there it will escalate up to ELT as an AAA.

Expected Performance Trajectory

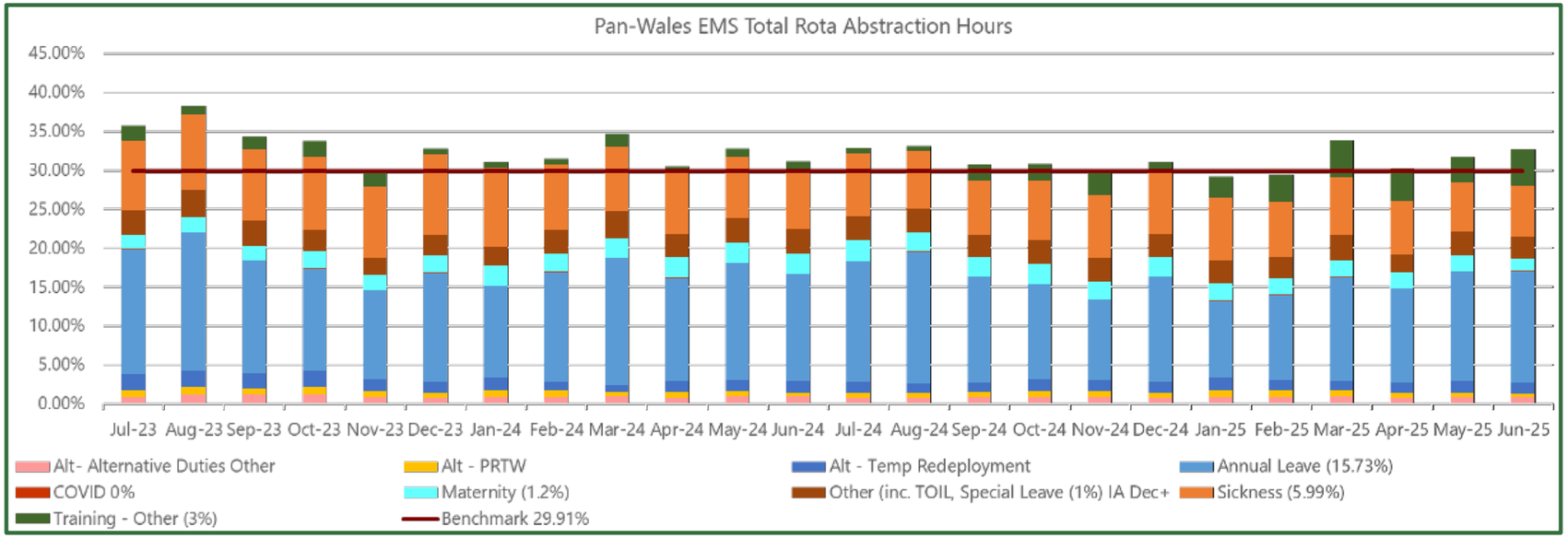
The Team has recently lost four members of staff to retirement or moving onto new positions elsewhere. The impending OCP means we are unable to back fill these posts. This will impact on our ability to support/attend community engagement opportunities.

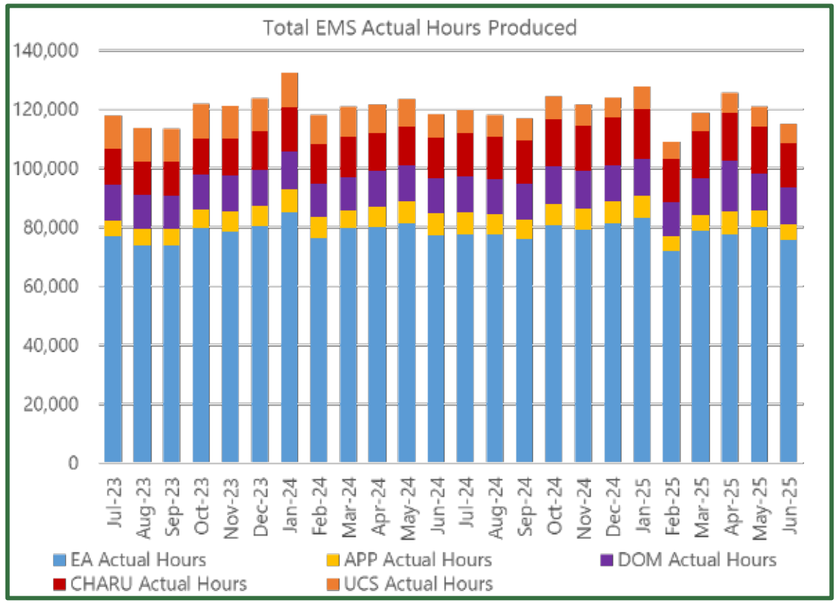
Our People
Capacity - Ambulance Abstractions and Production Indicators

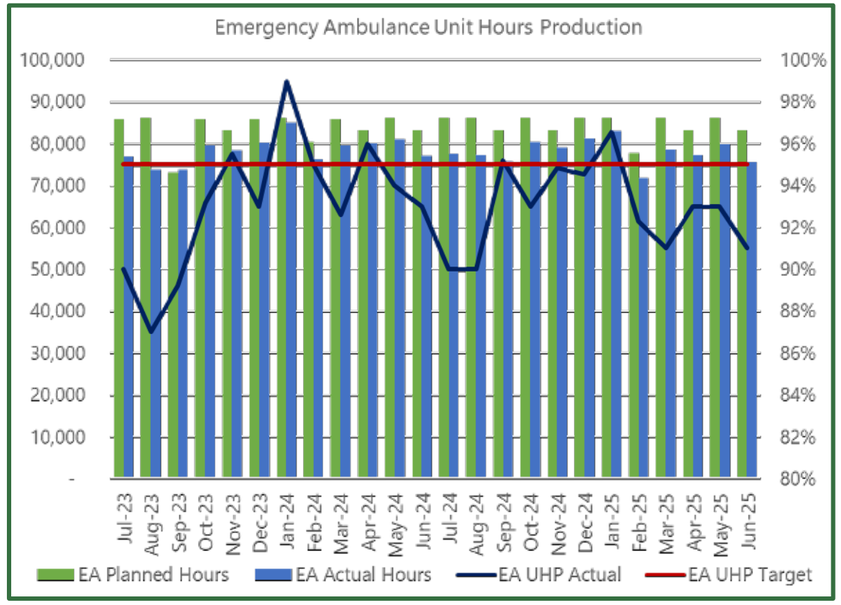
(Responsible Officer: Lee Brooks)

EA Production
A

CI PCC FPC







Analysis

Monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. June 2025, saw total EMS abstractions (excluding Induction Training) of 32.63%. This was a minimal increase on the 31.68% recorded in May 2025 and remains above the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 14.29% followed by sickness at 6.49%.

The total EMS hours produced is a key metric for patient safety. The Trust produced 115,205 hours during June 2025; a decrease compared to the 118,364 hours produced during June 2024. The Trust is delivering good levels of production.

Emergency Ambulance Unit Hours Production (UHP) achieved 91% in June 2025 which equated to 75,686 Actual Hours.

In June 2025 CHARU UHP was 85% against the full roll out requirement. A slight drop compared to the past seven months.

Remedial Plans and Actions

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

Expected Performance Trajectory

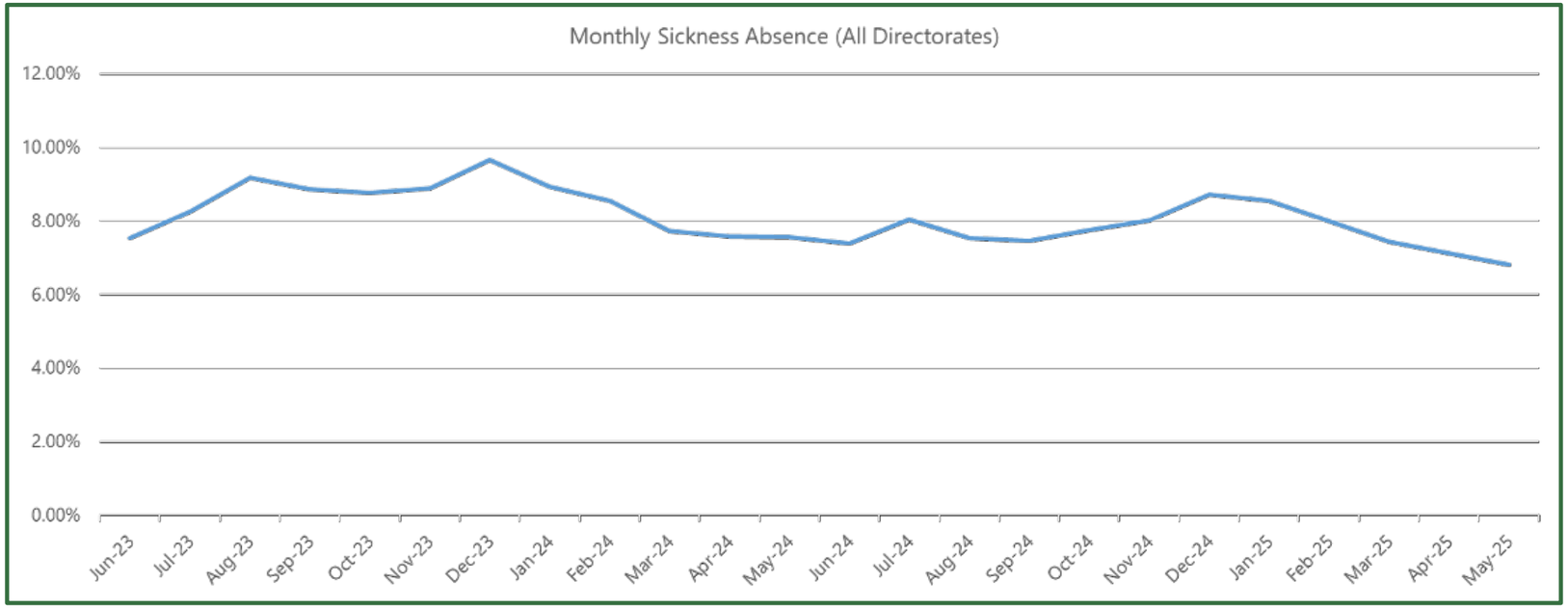
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is just below target. The Trust maintains an ambition to reduce sickness to 6% and maintain abstractions to 30%. This has not yet been achieved for sickness, but the direction of travel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

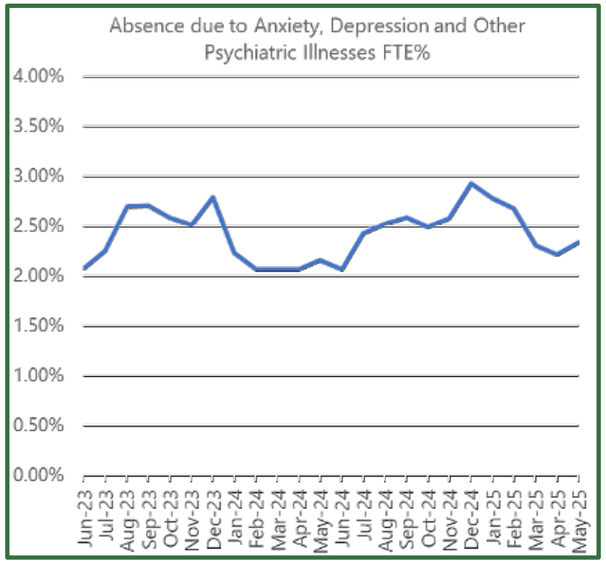
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

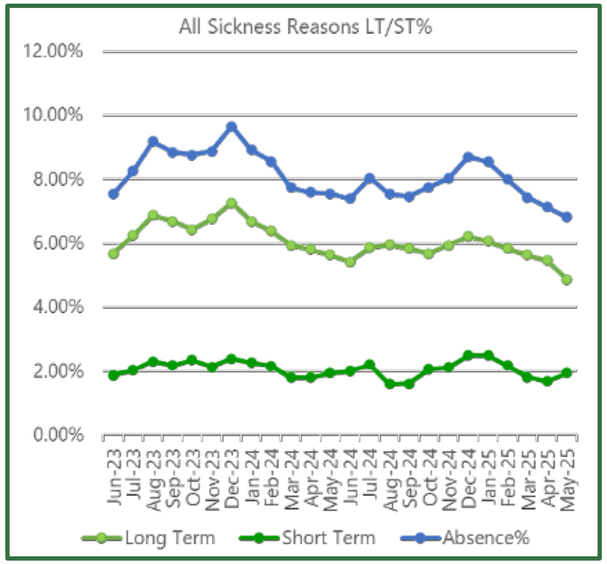
Sickness	Mental Health
R	R

PCC CI





Average working days lost per FTE (Annual)	
17.66	days
Single month Absence %	
6.81%	
Long Term	**Short Term**
4.87%	1.93%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.34%	0.77%



Analysis

There was a slight decrease in overall sickness absence rates between April 2025 and May 2025, dropping from 7.13% to 6.81%. Long term absence decreased from 5.46% in April 2025 to 4.87 % in May 2025, while short-term absence increased slightly to 1.93% in May 2025 from April 2025 (1.67%).

The highest reasons for absence in May 2025 were Anxiety/ Stress/ Depression, other musculoskeletal problems, gastrointestinal problems, and injury fracture. Absence due to Mental Health increased slightly for the first time in four months from 2.22% in April 2025 to 2.34% in May 2025.

WAST Occupational Health continue to meet national KPIs set by the All-Wales Occupational Health standards and scope of practice, i.e., regarding turnaround times for referrals the national KPI states: *The 1st offered appointment date will be within 29 calendar days of the date referral received. KPI that this is achieved 80% of the time.*
The waiting time for a management referral in June was 11.7 days from received to first offered.
The team continue to triage all referrals and enquiries to ensure prioritisation of anything that requires urgent attention.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

May 2025

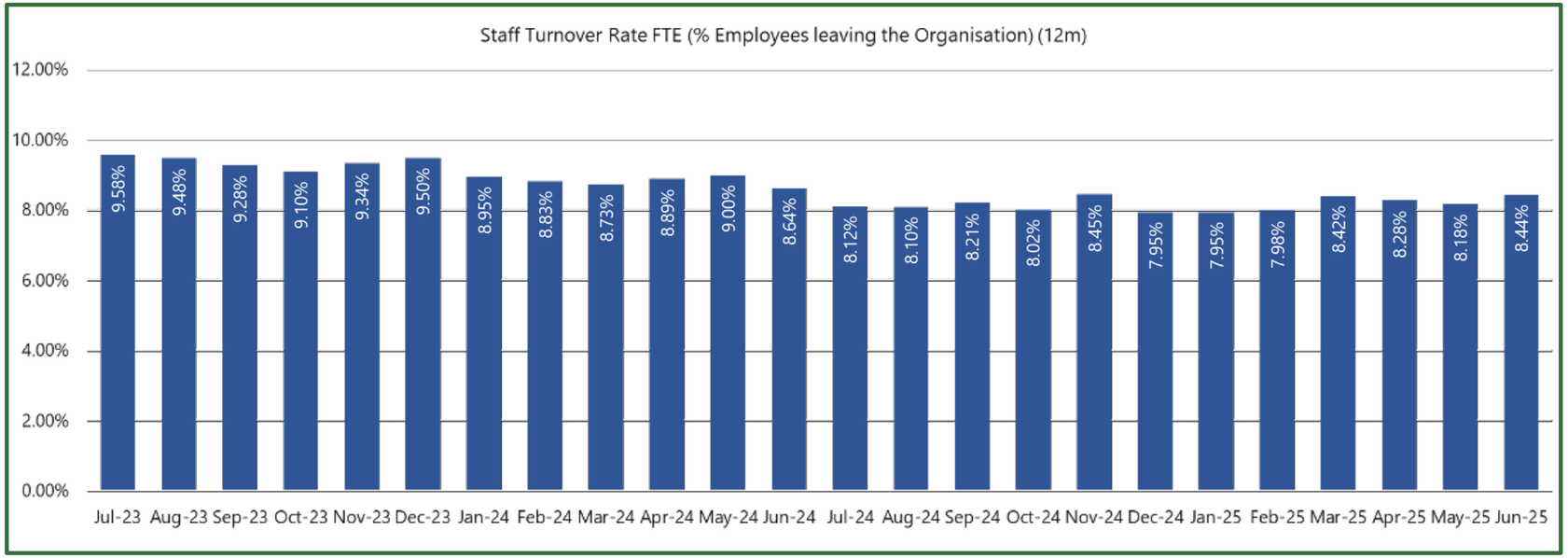
**NB:* Sickness data will always be reported one month in arrears

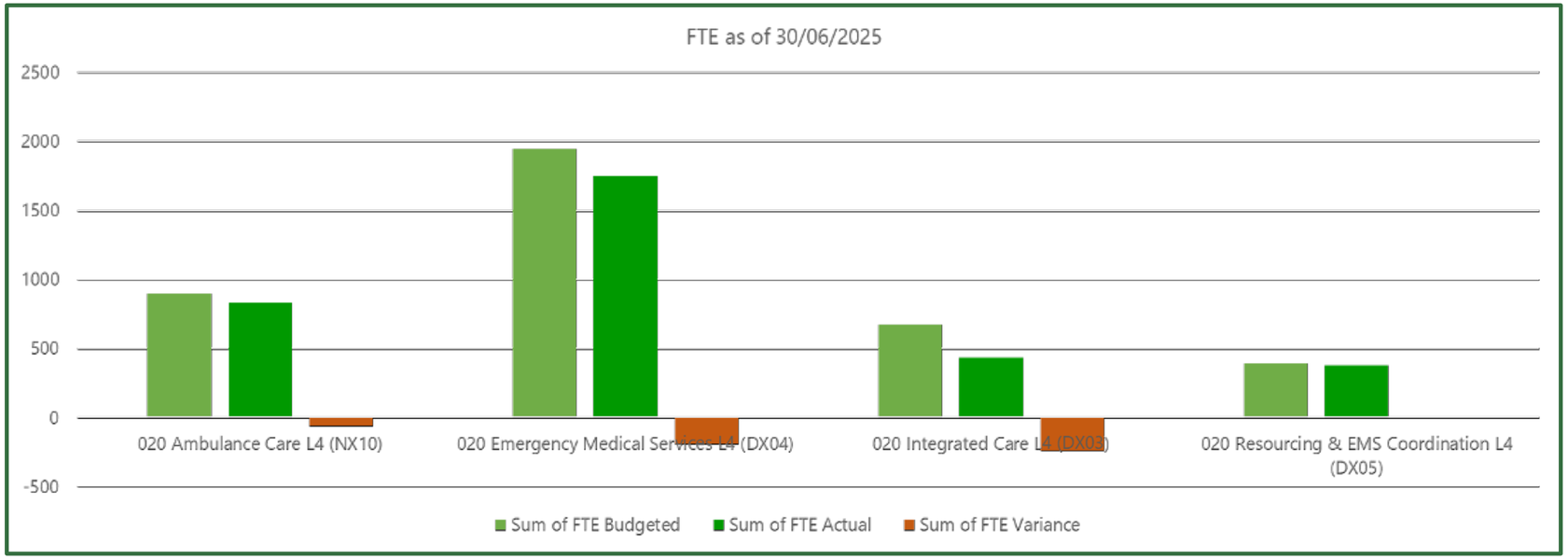
Our People
Capacity – Staff Turnover

(Responsible Officer: Angela Lewis)

G

PCC





Analysis

Staff turnover rates in June 2025 were 8.44%, minimally increasing from 8.18% in May 2025. June saw 31 leavers (27.03 FTE). Of those leaving, the groups with the greatest number were Operational and included;

- Technicians (6 people),
- Staff Nurse (5 people),
- Ambulance Care Assistants/Patient Transport Drivers (4 people), and
- Emergency Call Handler (3 people).

In June, this was compensated by 39 joiners (36.88 FTE). A headcount of 1 person into Corporate roles and 38 people into Operational roles including:

- Staff Nurse (8 people),
- Emergency Call Handler (7 people),
- Urgent Care Assistant (6 people),
- Paramedic (5 people), and
- Non-emergency medical Dispatchers (3 people).

Currently it has been noted that in early months of the year and start of the financial year sees a peak occurs, predominately due to retirements.

Remedial Plans and Actions

- The Trust is looking at longer term models to grow our APP cohort to support our future ambitions, which will include the recruitment of additional NQPs to support our B6 paramedics movement into APP roles.
- 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: A

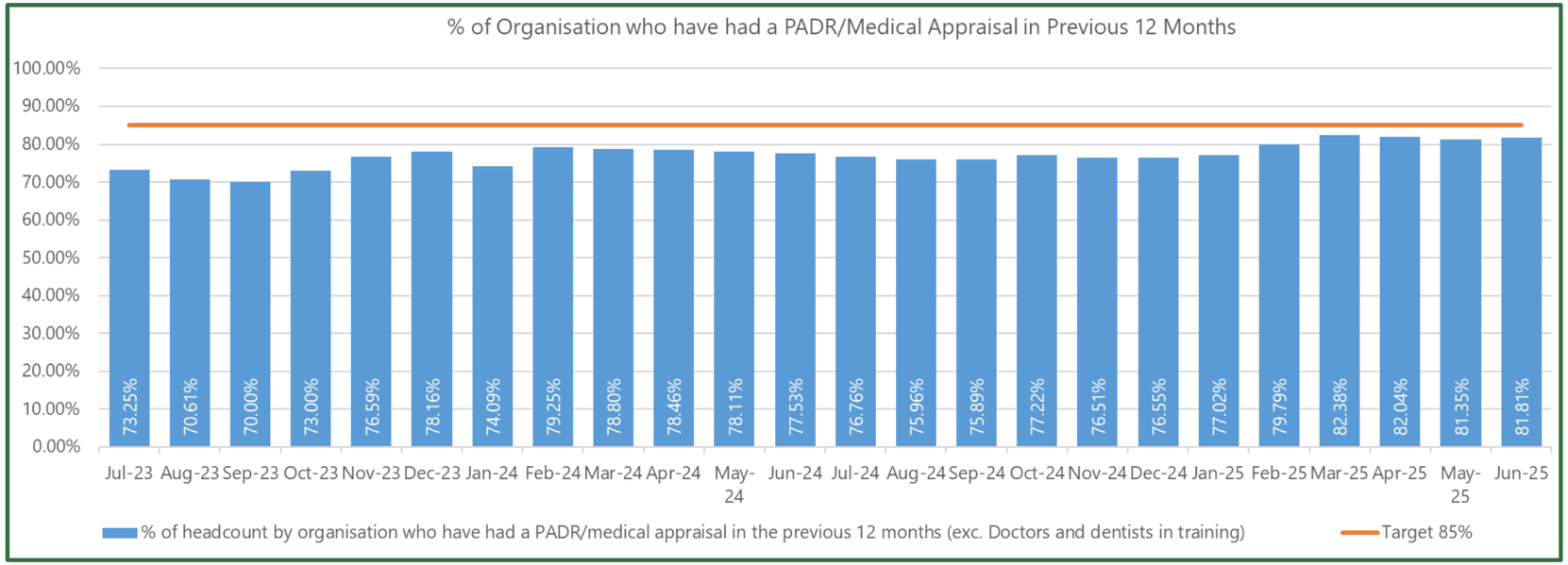
Stat & Mand: G

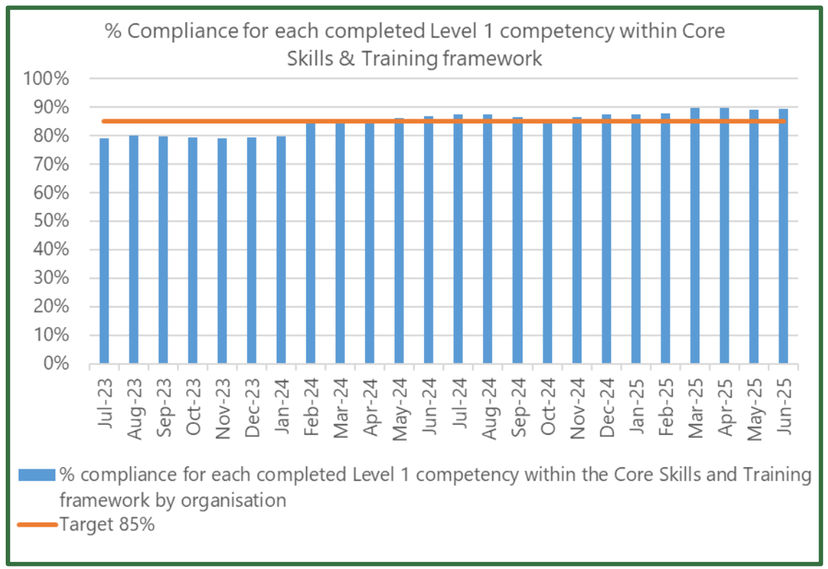
CI

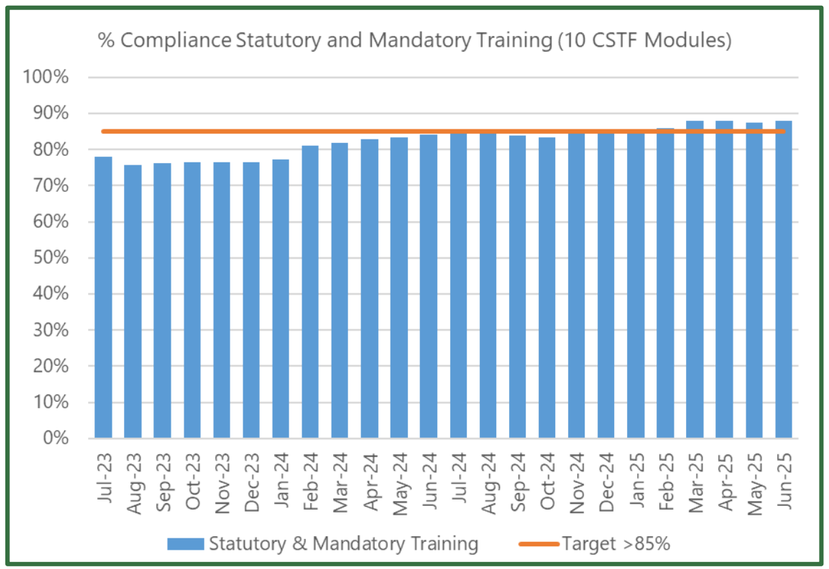
PCC

Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates minimally increased minimally from 81.35% in May2025 to 81.81% in June 2025 and remains close the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In June 2025 Statutory & Mandatory Training rates reported a combined compliance of 88.05% exceeding the 85% target for the seventh consecutive month. However, only Dementia Awareness (98.50%), Moving & Handling (95.93%) and Safeguarding Adults (95.61%), achieved the 85% target. Information Governance (88.11%), Equality & Diversity (84.53%), Paul Ridd (78.21%), Fire Safety (79.58%), Fraud Awareness (79.38%), Violence Against Women, Domestic Abuse & Sexual Violence (75.26%) and Welsh Language Awareness (73.40%) all remain below this target.

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

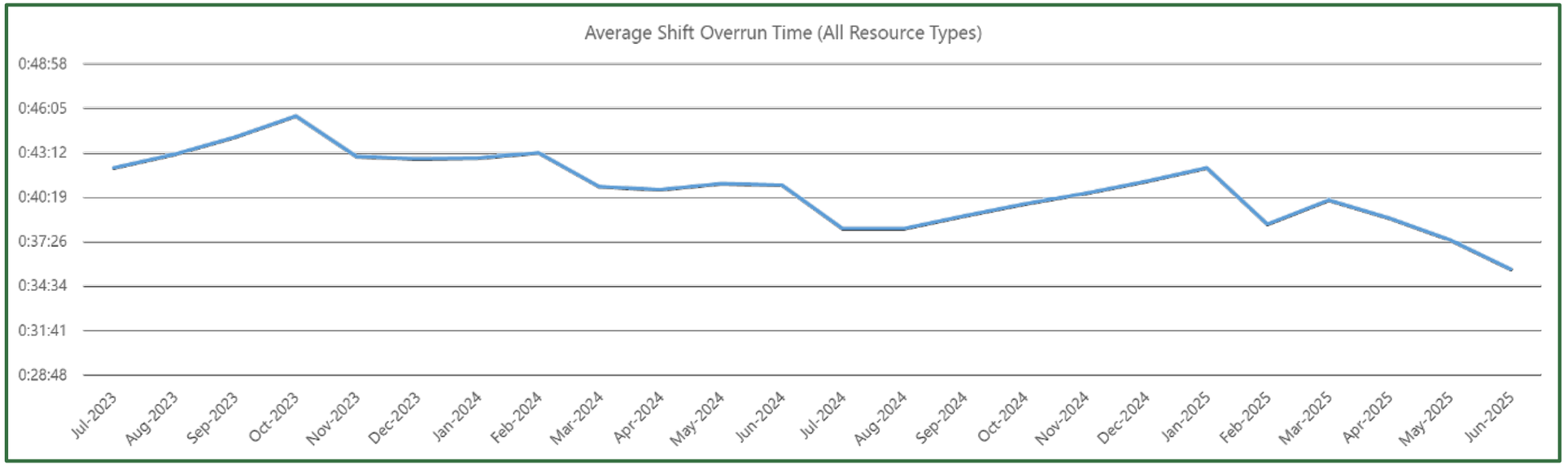
(Responsible Officer: Angela Lewis)

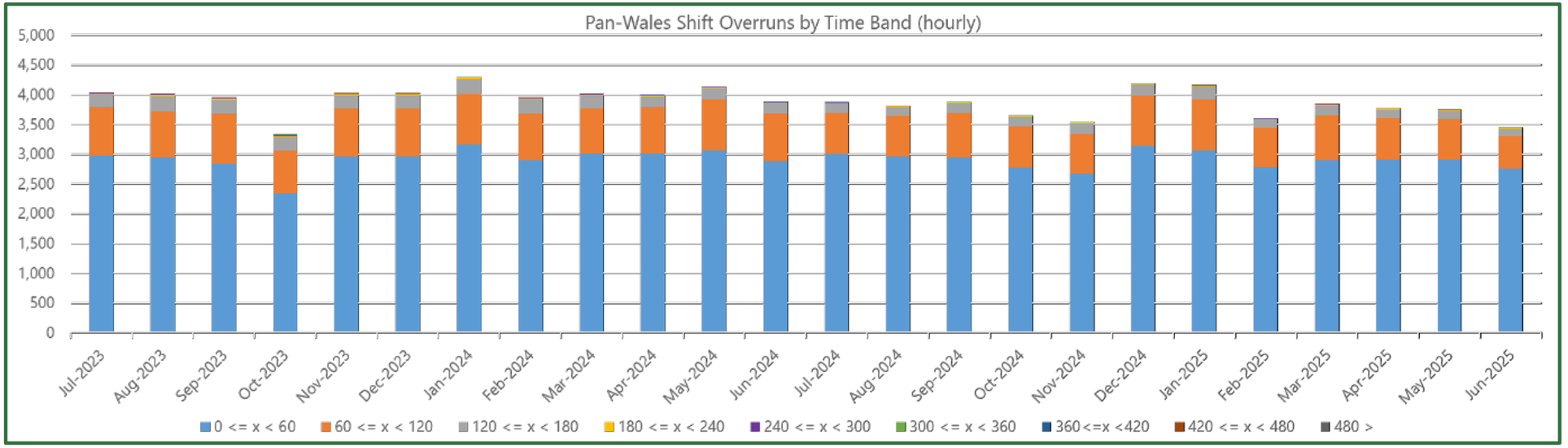
Overruns G

CI

PCC

FPC





Analysis

There were 3,441 shift overruns during June 2025.

The average overrun figure for June 2025 was 35 minutes and 38 seconds, a minimal decrease from May 2025 (37 minutes 32 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 76.5% of the total. 18.7% fall within the 61 to 120-minute category, 4.2% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.2% in the 241 minutes and over category.

Remedial Plans and Actions

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

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

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

Expected Performance Trajectory

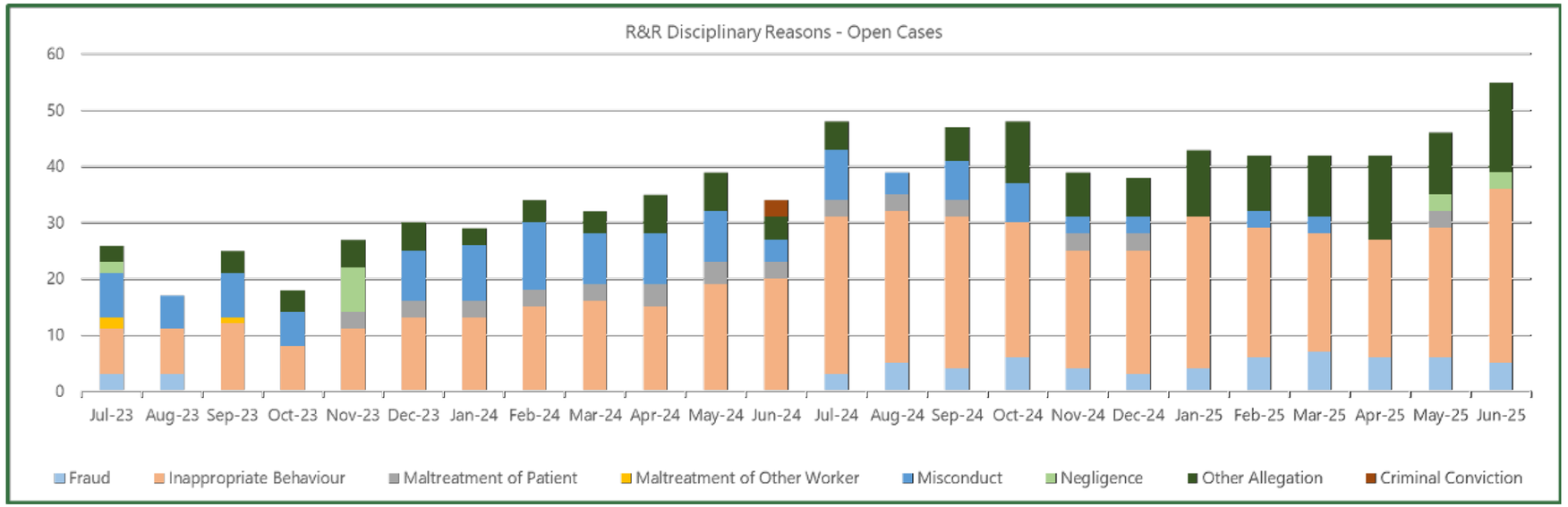
Overruns correlate with handover lost hours and may continue to increase.

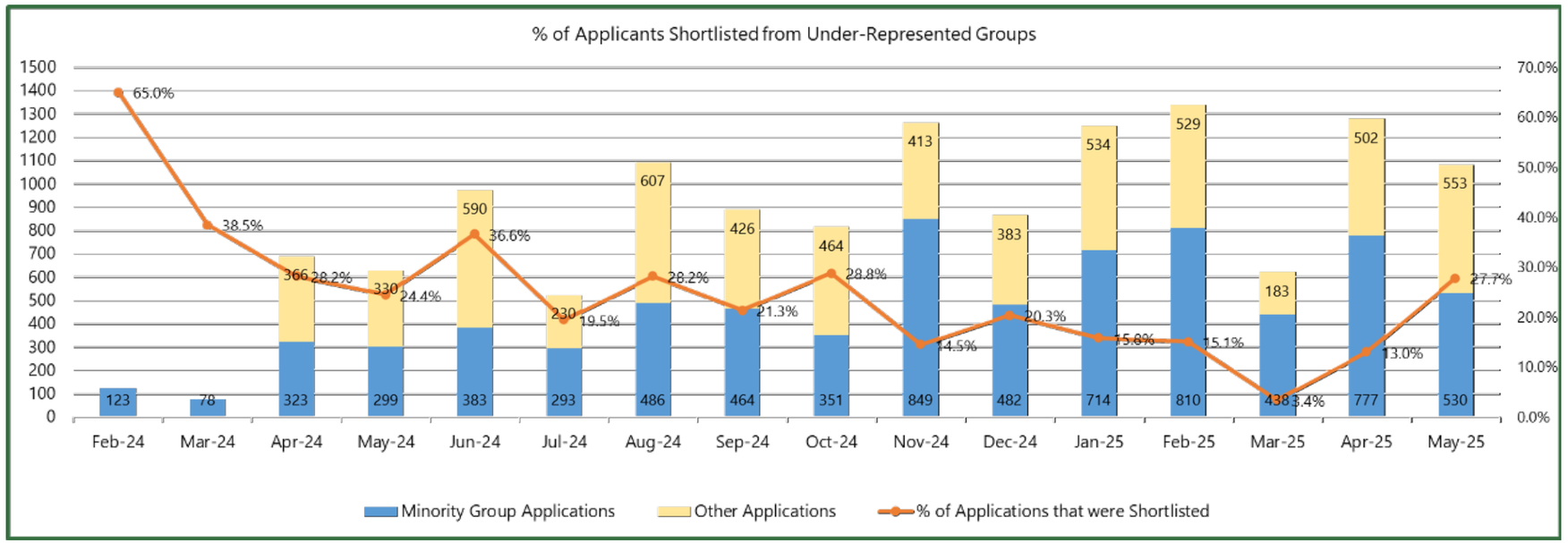
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 55 open formal disciplinary cases recorded at the end of June 2025, compared to 46 in the month of May. Of these Disciplinary cases, 56% are due to allegations of inappropriate behaviour.

There were 27 open formal Respect and Resolution cases in June 2025, an increase from 25 reported in May. (increase due to R&Rs in relation to Roster Reviews)

The bottom graph shows that in May 2025, 1,083 job applications were processed, and 372 interviews planned.

Of the 1,083 applications, a total of 530 were from under-represented groups with 279 in the category of Ethnicity, 136 within Disability and 115 identifying within Sexual Orientation.

In May 2025, 27.7% (n=147) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was an increase from the 13% in April 2025.

Remedial Plans and Actions

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

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events. Work continues with recruitment workshops for Black, Asian and Ethnically diverse applicants into our digital roles. These workshops have expended to applicants with protected characteristics who have been invited to interview as Graduate Paramedics. Unconscious bias training for the managers that will be involved in their recruitment is underway.

Expected Performance Trajectory

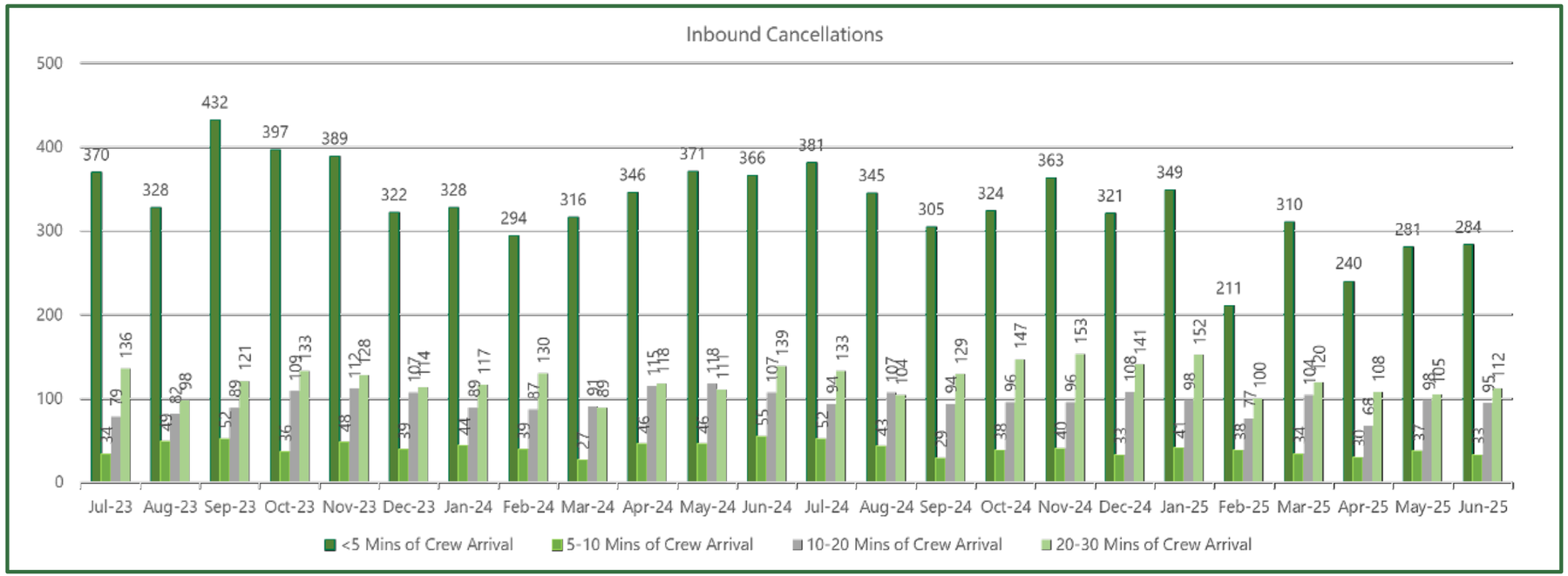
Continue to monitor levels, no trajectory for this measure.

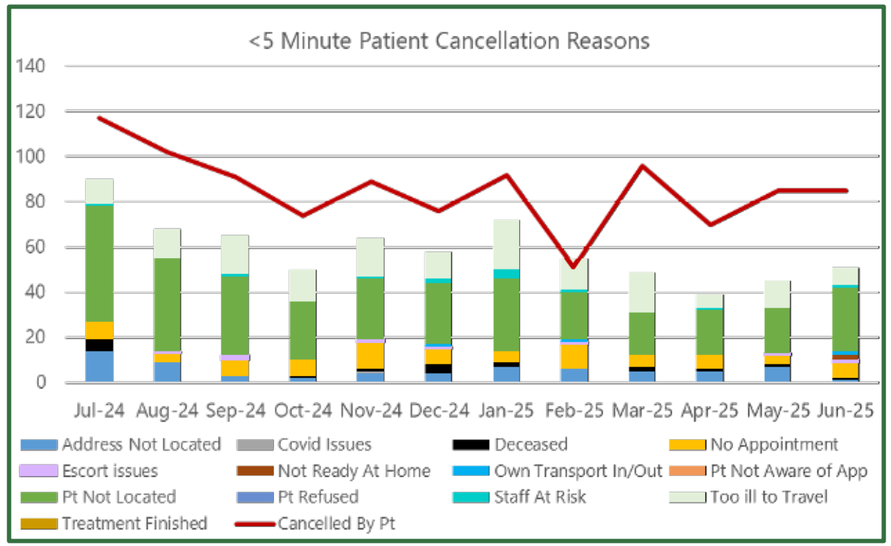
Finance, Resources and Value
Value: Ambulance Care Indicators

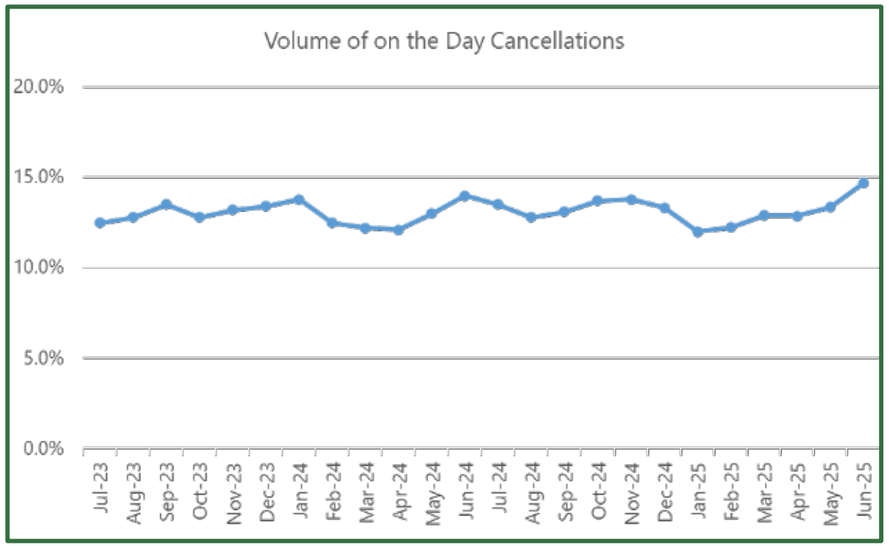
(Responsible Officer: Lee Brooks)

Cancellations
R

FPC







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a minimal increase in June 2025 to 284, compared to 281 in May 2025. The total number of cancellations within 30 minutes also marginally increased from 521 in May 2025 to 524 in June 2025.

In June 2025 there were 85 travel bookings cancelled by patients (including via SMS), remaining consistent with May 2025. Further SMS improvements will go live in July that should continue the improving trend observed.

The other top reasons for less than 5-minute cancellations included: 28 patients not located, 8 unwell/too ill to travel and 7 no appointment.

Same day cancellations increased slightly in June 2025 to 14.7% compared to May 2025 (13.4%).

Remedial Plans and Actions

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

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

Expected Performance Trajectory

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

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

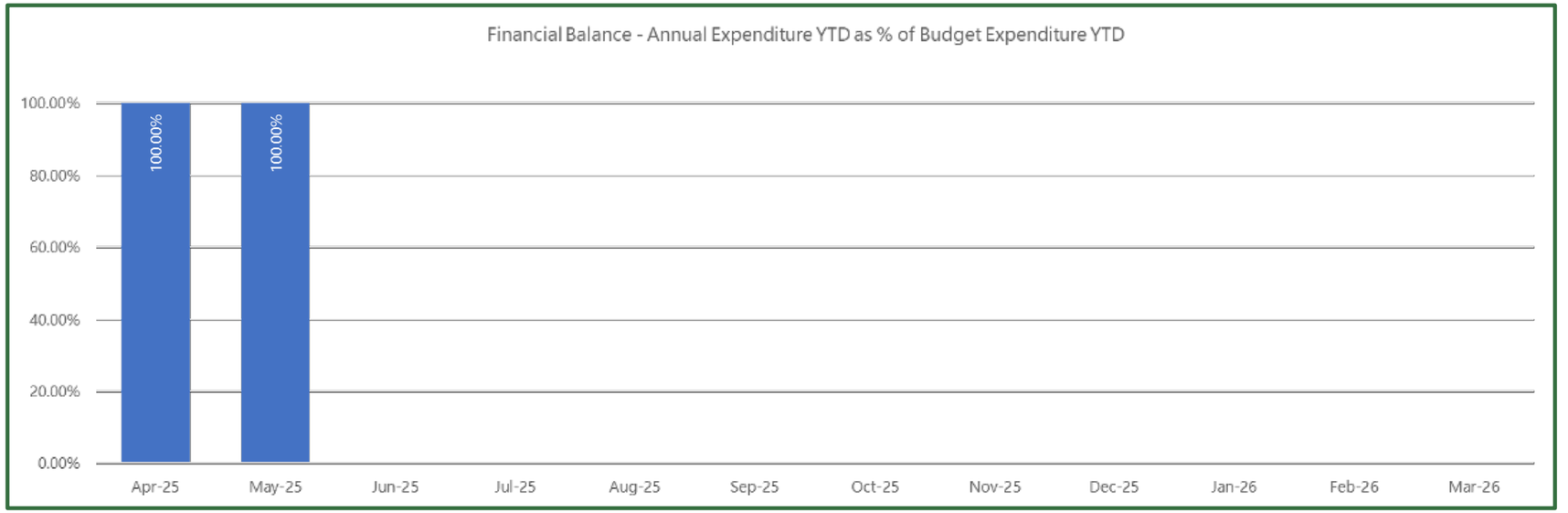
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

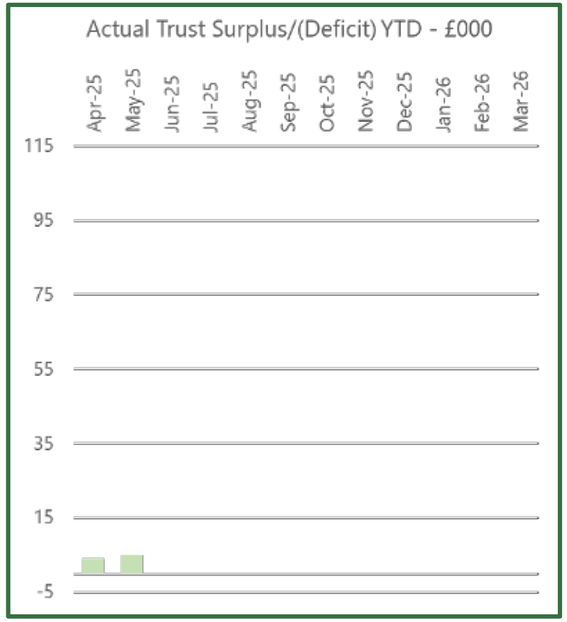
Finance, Resources and Value
Value - Finance Indicators

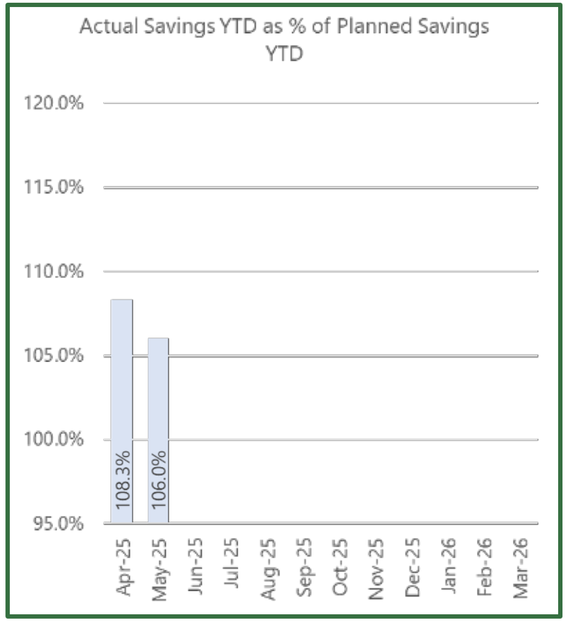
(Responsible Officer: Chris Turley)

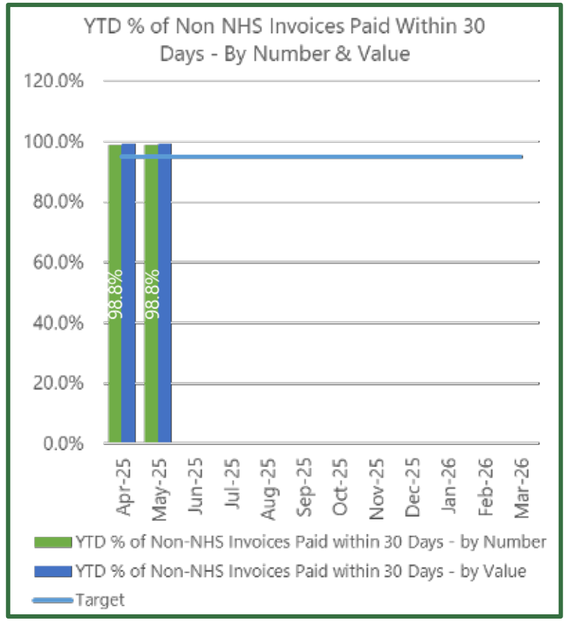
G

FPC









Analysis

The reported outturn performance at Month 2 is a surplus of £0.005m, with a forecast to the yearend of breakeven.

For Month 2 the Trust is reporting planned savings of £1.327m and actual savings of £1.406m (an achievement rate of 106.0%).

The Trust's cumulative performance against PSPP as at Month 2 is 98.8% against a target of 95%.

At Month 2 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.

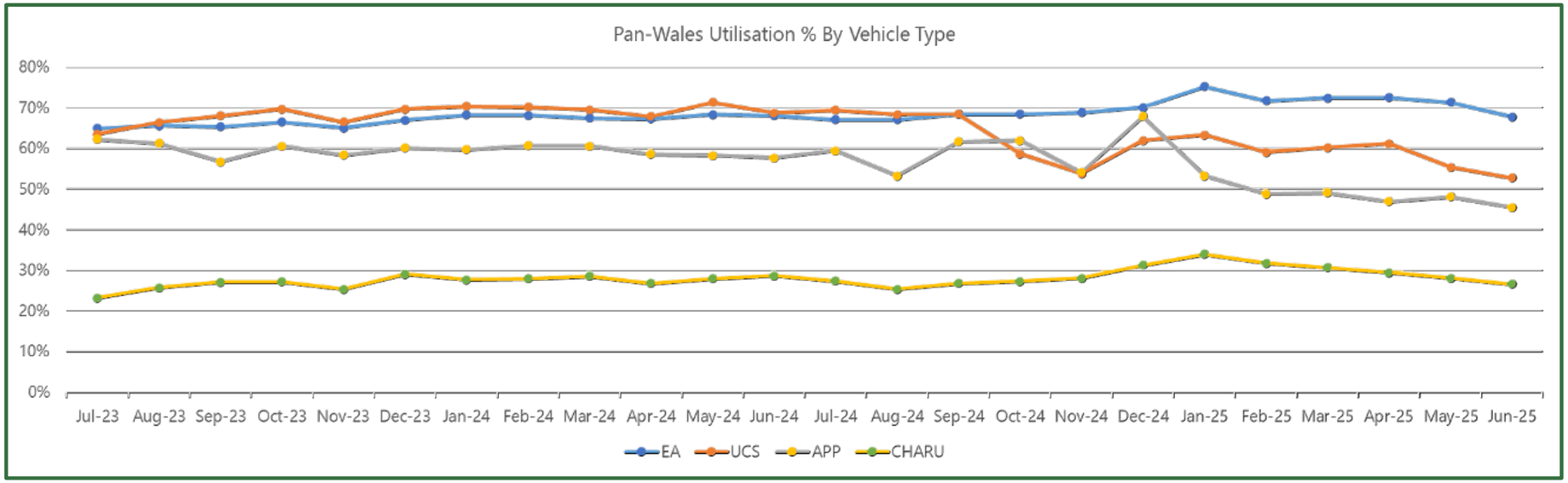
Finance, Resources and Value
EMS Utilisation

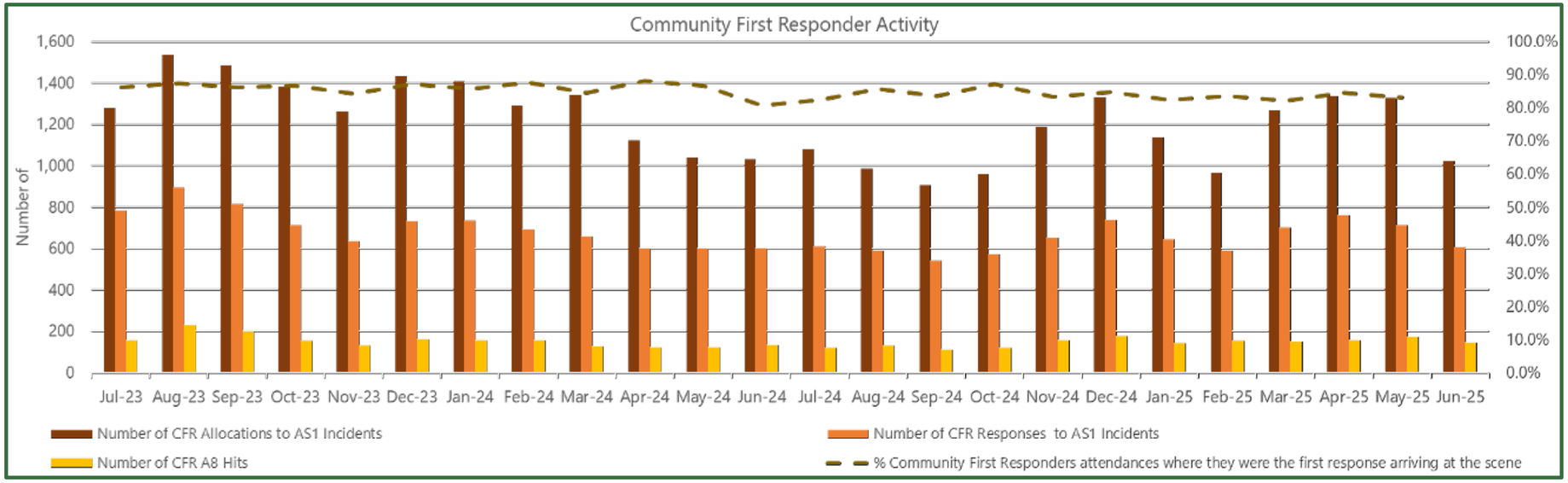
(Responsible Officer: Lee Brooks)

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 June 2025 were 53.6% for all vehicles types, a decrease from 56.5% in May 2025. EA saw the highest rate during the month at 67.8%, a decrease compared to the upward trend over the previous months. 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 June we can see that CFRs were allocated to 1,025 EMS incidents and responded to 606. In May 2025 81.3% 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.

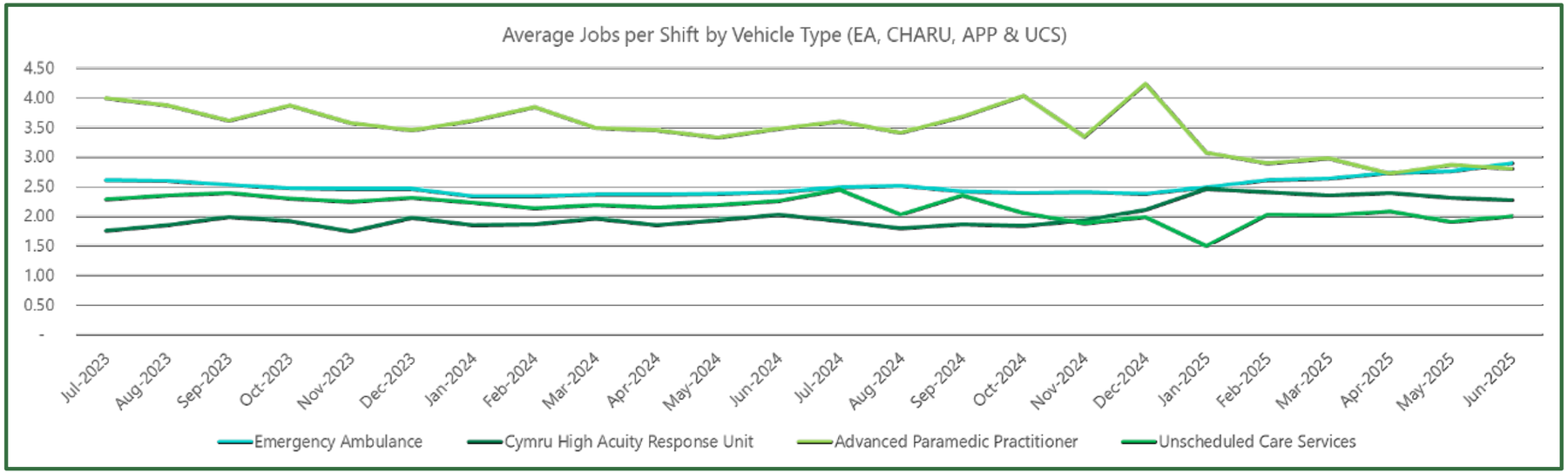
Finance, Resources and Value
Average Job/Shift Times

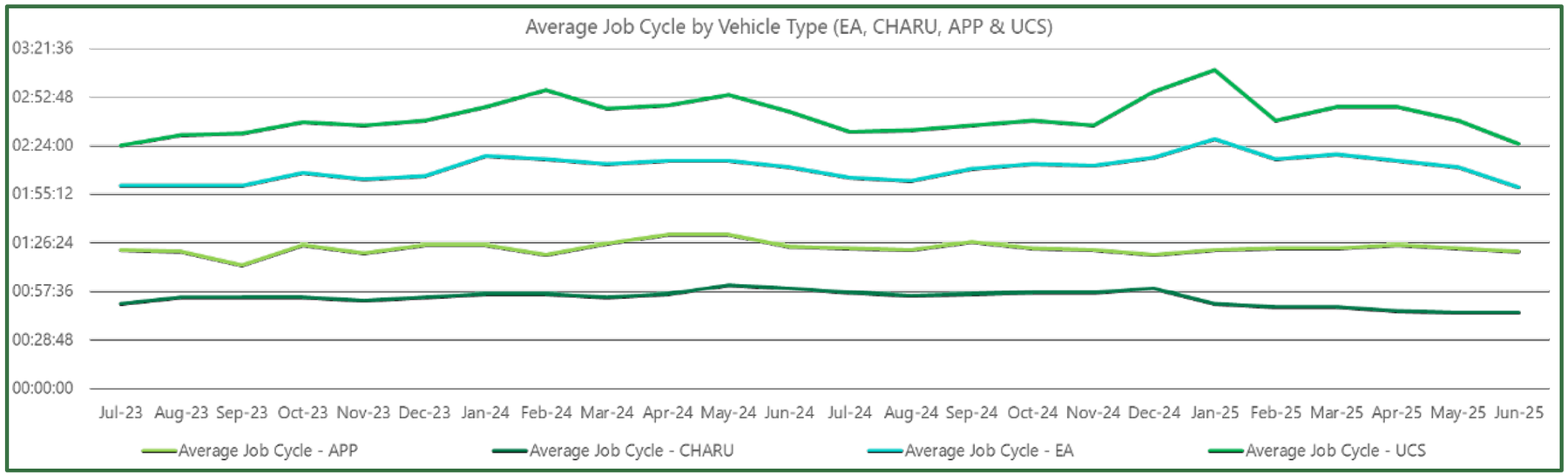
(Responsible Officer: Lee Brooks)

Jobs Per Shift
A

FPC

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





Analysis

Overall average jobs per shift was 2.33 in June 2025, a decrease from May 2025 (2.64). EAs averaged 2.89 jobs per shift and UCS crews 20. This is lower than what would be ideal and a product of handover delays.

APPs attended on average 2.89 jobs per shift and CHARU's 2.80. However, both sets of data are under review.

As demonstrated in the bottom graph, the average job cycle decreased slightly in June 2025 for EAs (1 hours 59 minutes) and APPs (1 hour 21 minutes) and UCS (1 hours 37 minutes). CHARU remained the same as the previous month (45 minutes).

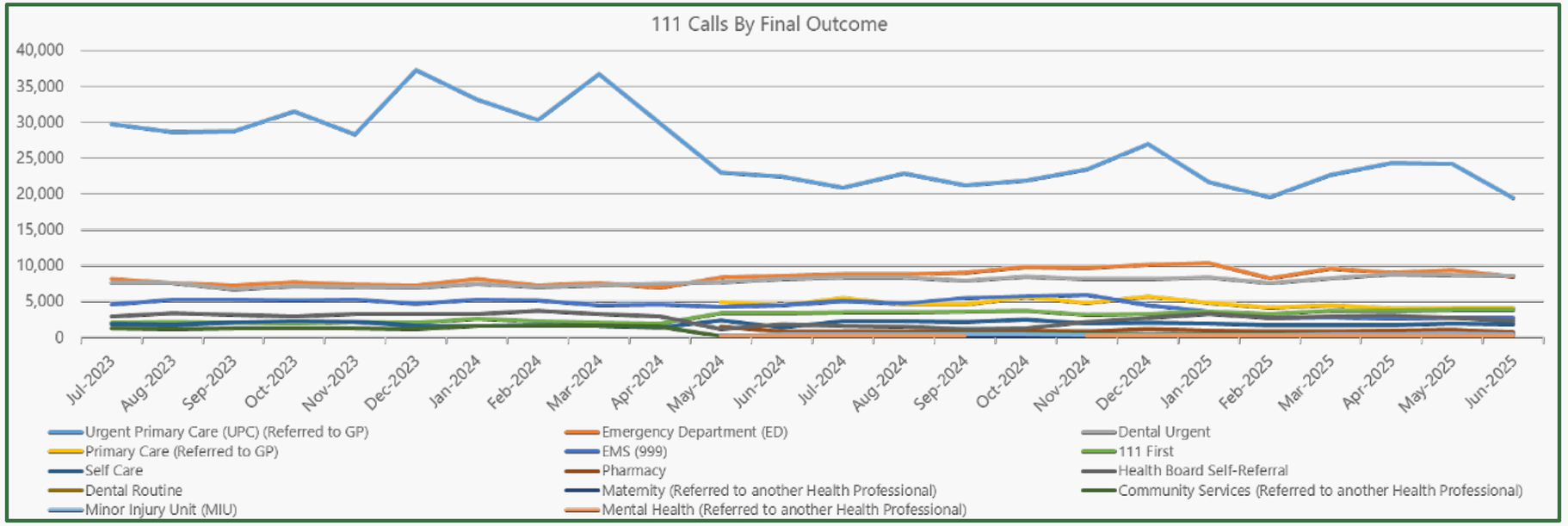
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

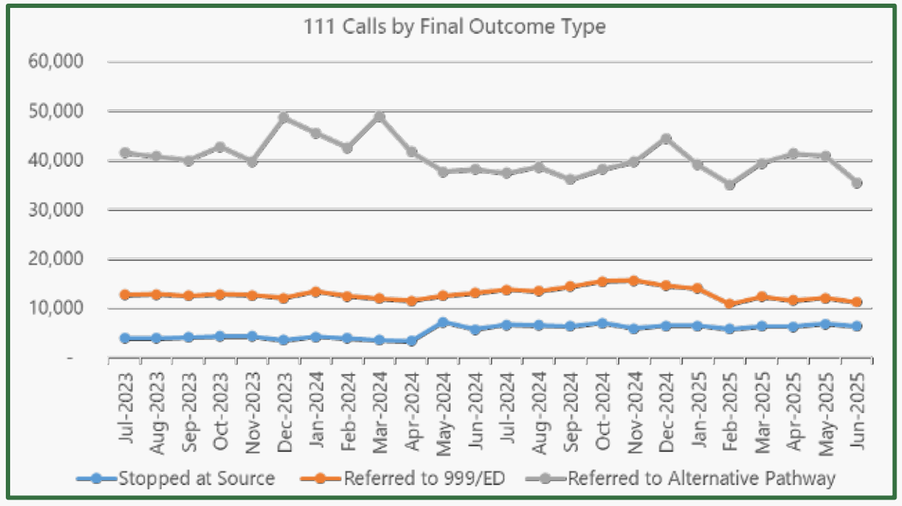
Dental G

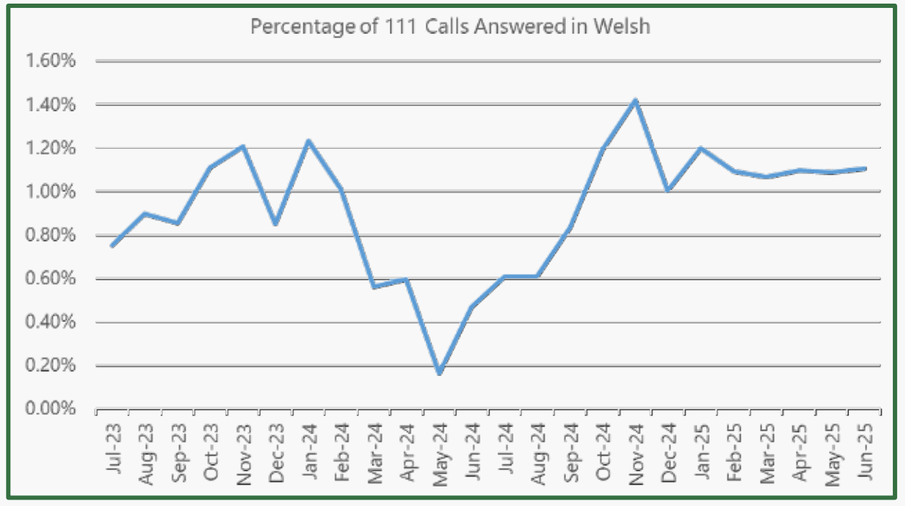
C&C Volumes G

FPC

(Responsible Officer: Lee Brooks)







Analysis

During June 2025, 53,175 calls were allocated into the 14 categories displayed in the graph opposite; a decrease compared to the 59,815 seen during May 2025. However, data quality issues continue within 111 reporting which are currently being addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 31.81% of all calls during June 2025, but there has been a material drop since the implementation of the new 111CAS system.

As the bottom left graph highlights, in June 2025, 6,439 calls were 'Stopped at Source', with no onward referral, a slight decrease from 6,816 in May 2025. 11,260 calls were referred to 999/ED in June 2025.

The percentage of 111 calls answered in Welsh increased slightly from 1.09% in May 2025 to 1.10% in June 2025. This equated to 64.8% 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

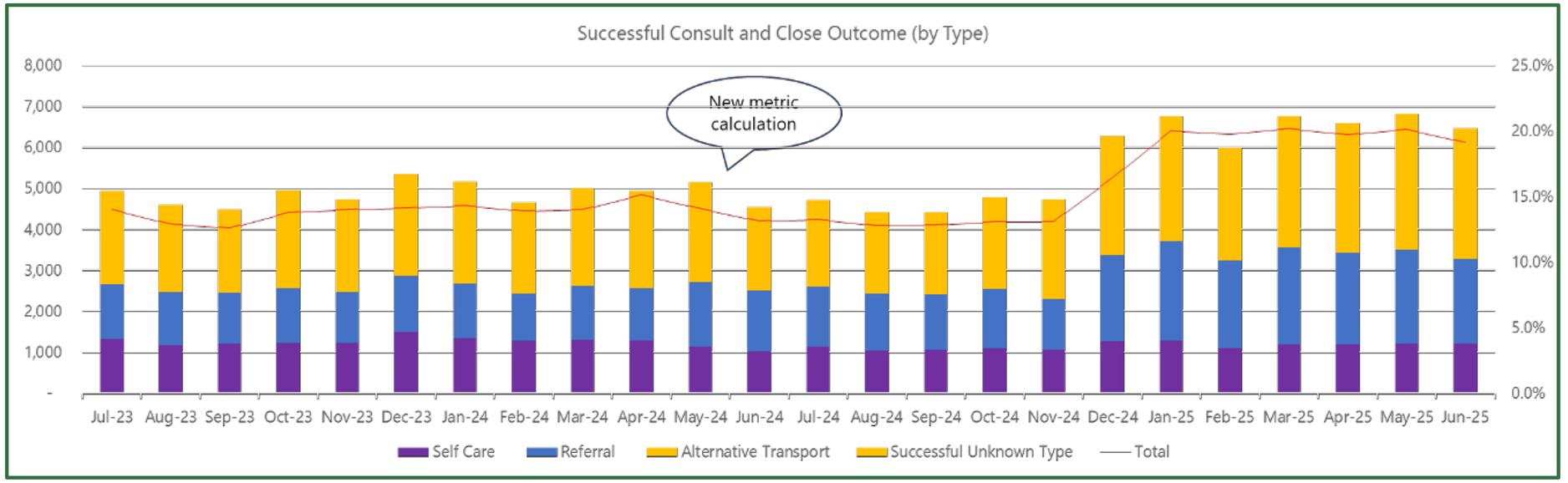
No performance trajectory is set at this time, as the Trust develops its measures and systems around these metrics. Once developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

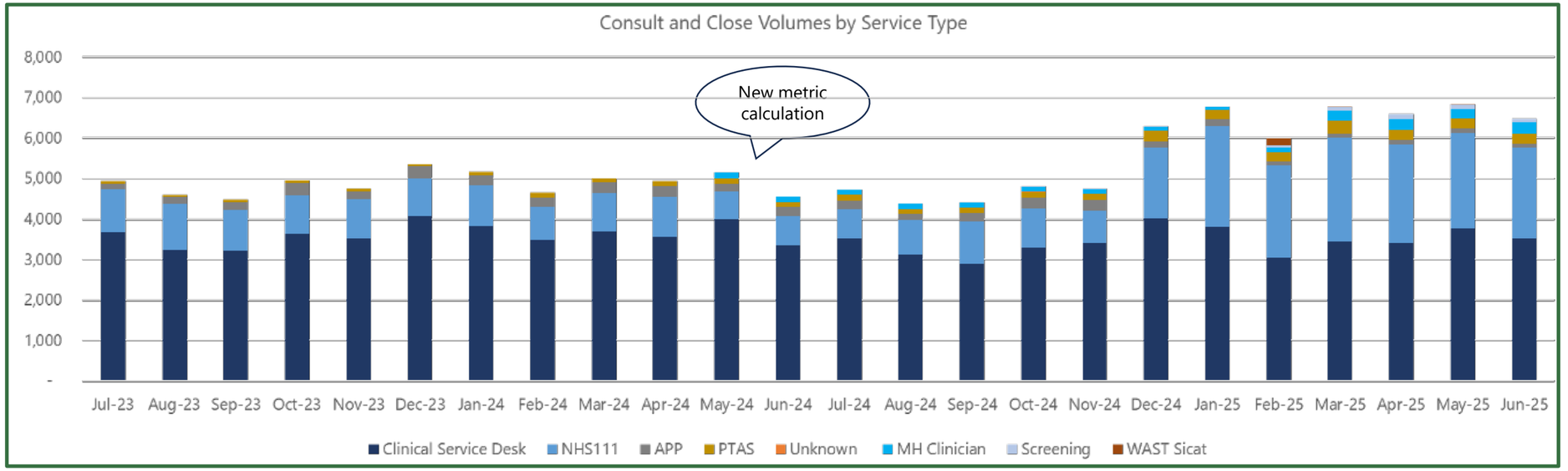
Partnerships / System Contribution
Consult & Close Indicators

(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) (10.4%), NHS111 (6.6%), WAST APP (0.3%), Health Boards using Physician Triage and Streaming Service (PTAS) (0.7%), Mental Health Clinician (0.8%) and Screening (0.3%) achieved 19.1% in June 2025, a decrease of 1.1% compared to May 2025, however achieving the 17% IMTP ambition for the sixth consecutive month. In June 2025, the number of 999 calls resulting in a Consult and Close outcome was 6,475, up from 4,555 in June 2024.

Of the calls successfully closed in June 2024, 62 patients received an outcome of self-care; 1,200 patients were referred to other services (including to Minor Injury Units and SDEC) and 976 were advised to seek alternative transport services to acquire treatment.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support which is recognised by those calling.
- Implementation of 15 recommendations from commissioner review.

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

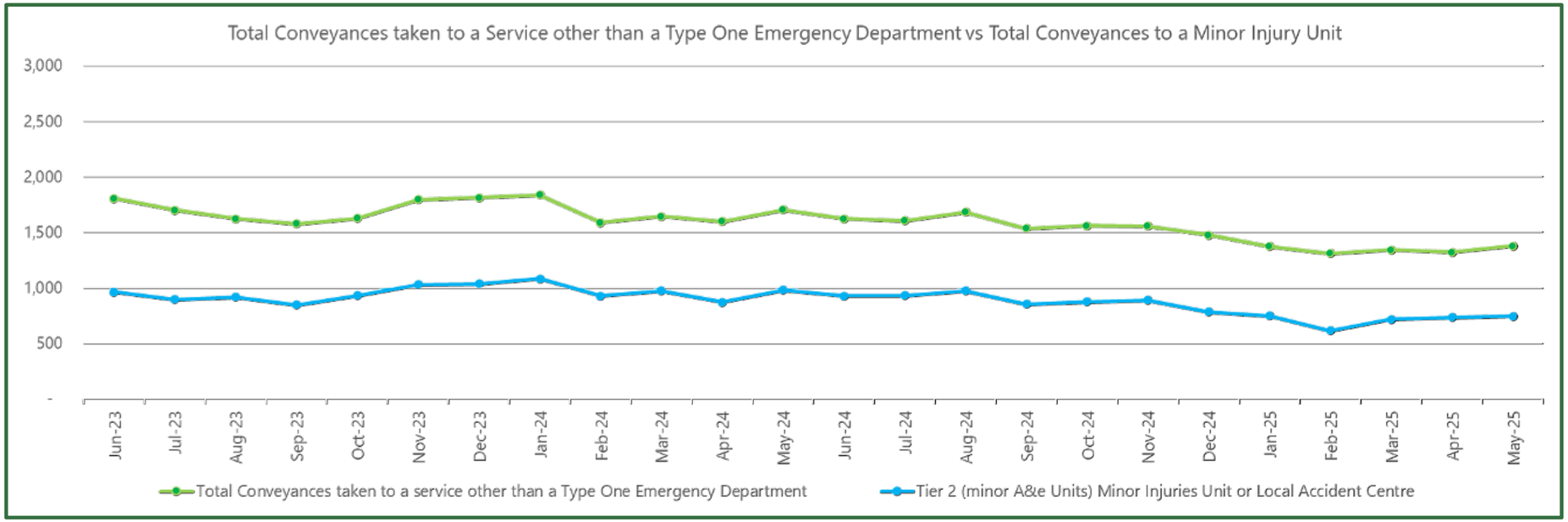
(Responsible Officer: Andy Swinburn)

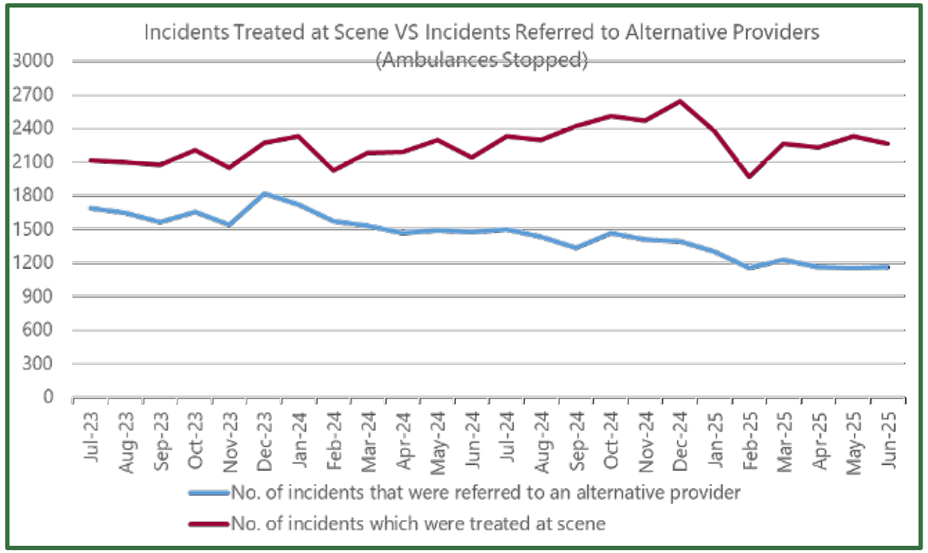
Conveyances
R

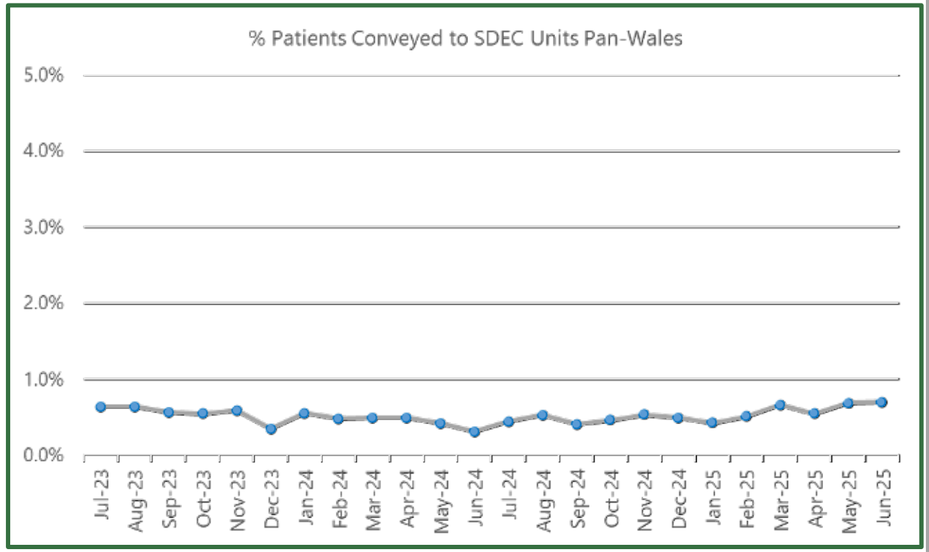
FPC

Ministerial Measure

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







Analysis

In May 2025 10.10% of patients (1,378) were conveyed to a service other than a Type One ED. 5.5% (746) were conveyed to a Tier two Minor Injuries Unit or Local Accident Centre while 36.20% 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 decreased, from 3,487 in May 2025 to 3,426 in June 2025.

Percentage of patients conveyed to SDEC units can remained consistent in June 2025 with the previous month (0.75).

Taxi conveyance has remained consistent for the past 12 months, averaging 832 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

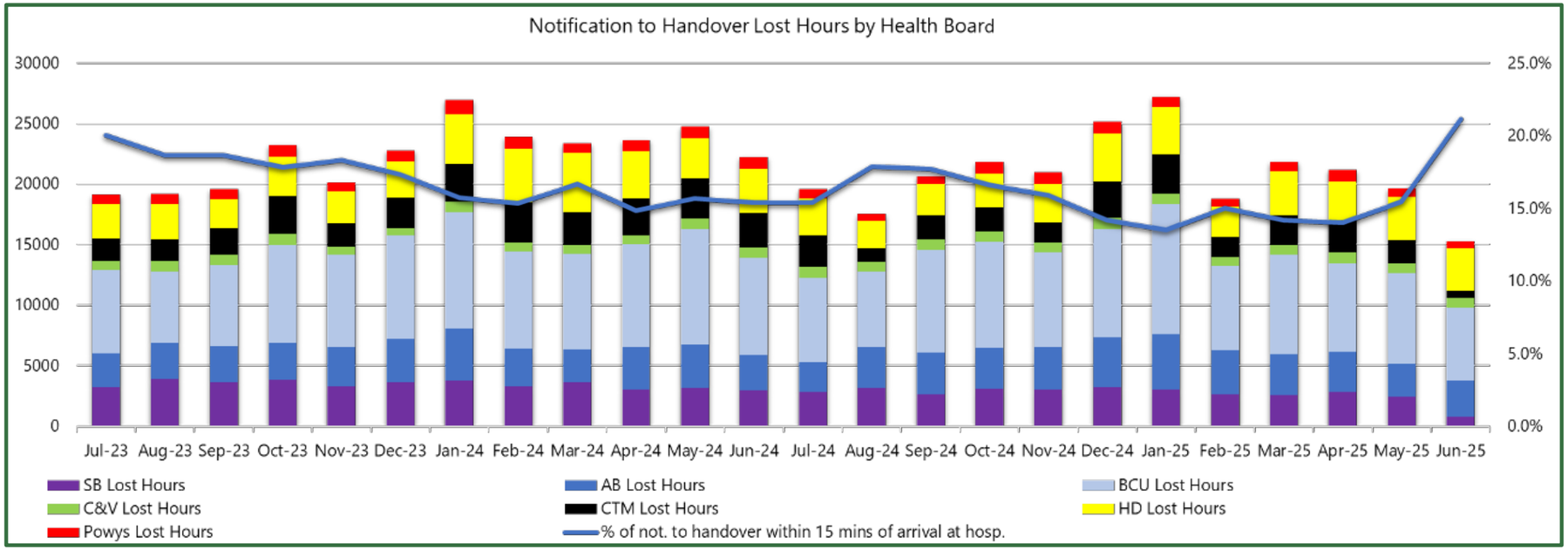
The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to evolve its clinical model with health boards also significantly reducing handover e.g. 12,000 hours or 7,500 hours, alongside varying levels of investment. Seasonal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

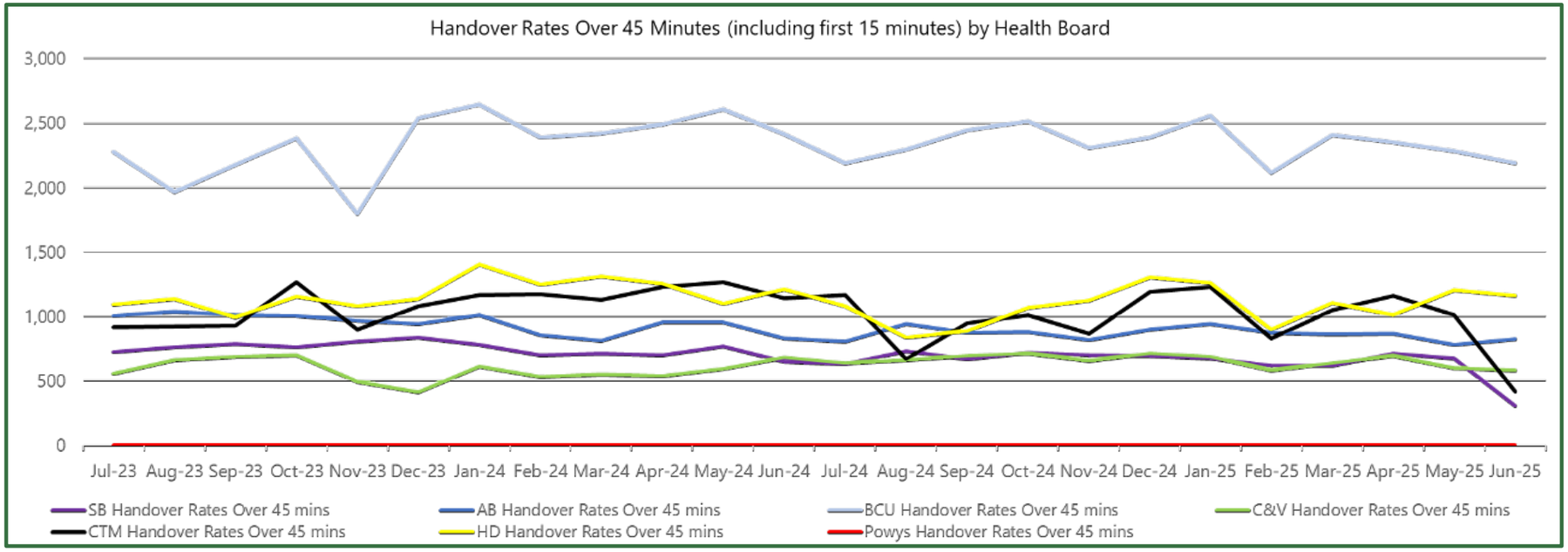
Partnerships / System Contribution
Handover Indicators

(Responsible Officer: Health Boards)

Lost Hours
R

CI QUEST





Analysis

249,911 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Jul-24 to Jun-25), compared to 268,957 hours over the same timeframe the previous year. There were 15,278 hours lost in June 2025, which is 31.2% lower than the 22,229 hours lost during June 2024 and is the lowest monthly figure since September 2021. Cwm Taf Morgannwg and Swansea Bay in particular, have seen significant reductions, compared to last month, of 67% and 68%, respectively.

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

- Grange University Hospital (ABUHB) at 2,883 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 2,288 lost hours
- Glangwilli Hospital (HDUHB) at 1,993 lost hours
- Ysbyty Glan Clwyd (BCUHB) at 1,902 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 1,738 lost hours

Notification to handover lost hours averaged 509 hours per day during June 2025 (30 days) compared to 635 hours per day (31 days) in May 2025.

In June 2025, the Trust could have responded to approximately 4,819 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, and this will continue through the year as we seek to influence and put pressure on the system to improve.

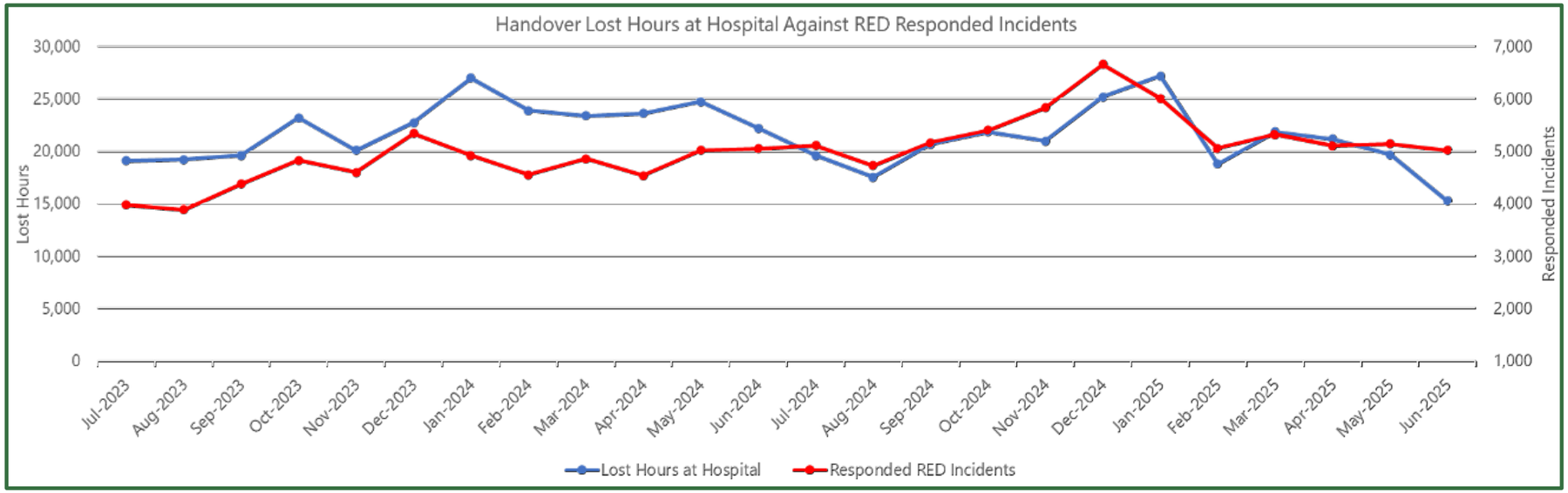
Expected Performance Trajectory

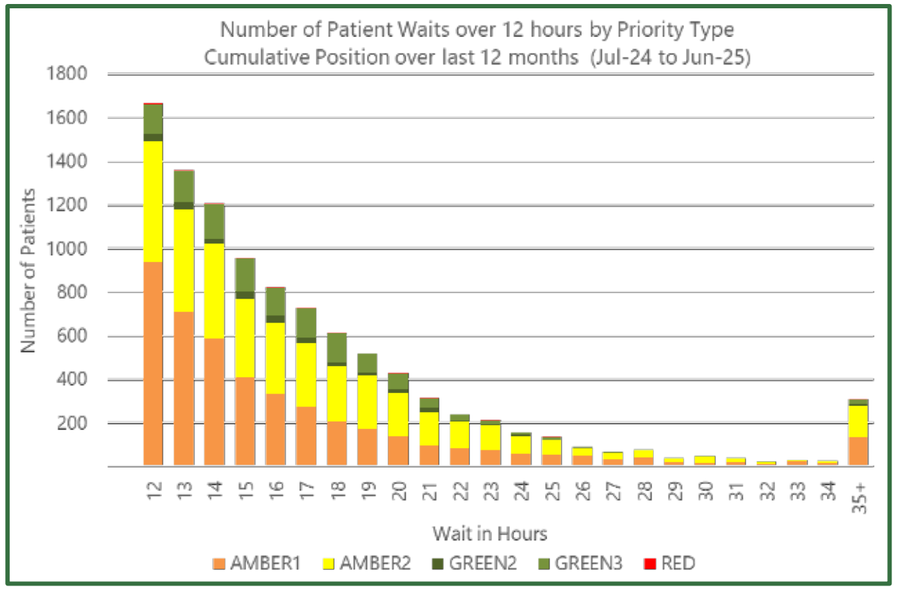
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. This target is now due to change to no waits over 45 minutes.

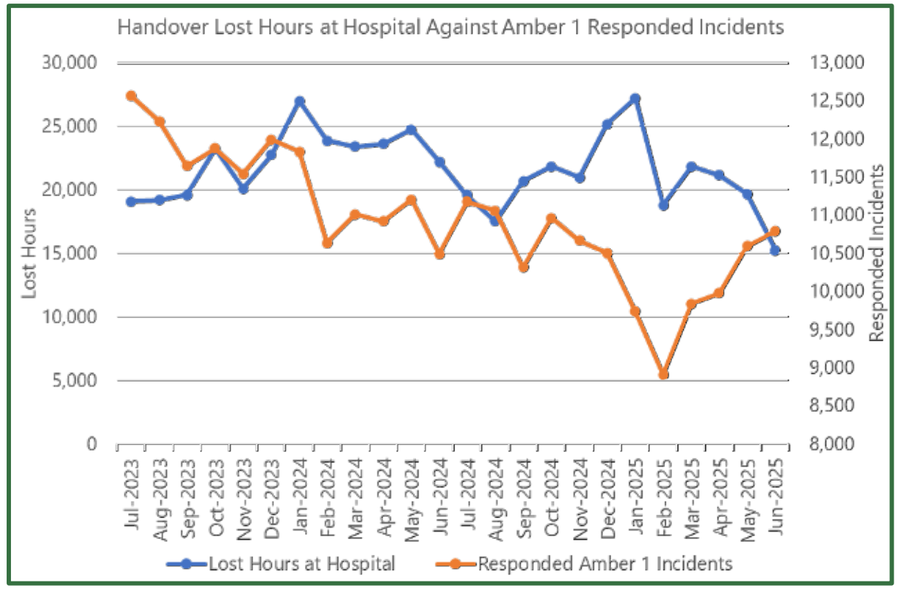
Partnerships / System Contribution
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

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

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

In June 2025, 402 patients waited over 12 hours for an ambulance response.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Welsh Government target is no patient handovers of more than one hour, which equates to 7,500 lost hours a month.

**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	11
OPEN	OPEN
No of ANNEXES ATTACHED	1

QUALITY & PERFORMANCE MANAGEMENT FRAMEWORK
Logic Benefits Map

MEETING	Finance & Performance Committee
DATE	21 July 2025
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this report is to obtain approval from Committee for the Logic Benefit Map (LBM) for the Quality & Performance Management Framework (Q&PMF).

2. 18 March 2025 Committee approved the refreshed 2025-28 Q&PMF. The Executive Director of Strategy, Planning & Performance had noted from informal discussions with committee members, a desire to answer the "so what" question i.e. what a successful implementation of the Q&PMF would look like and what would be the benefits arising from its implementation. Committee agreed to a follow up paper providing it with a "logic benefits map" or LBM.

3. The LBM for the Q&PMF is attached at *Appendix 1*. LBMs are being used in the Trust, in particular, around the Clinical Model Transformation programme. They provide a one-page visual representation of what a programme is trying to achieve and the interaction between inputs, activities outputs, outcomes, benefits, benefit measures and overall programme impact.

4. The Q&PMF Steering Group is currently focused on delivering key parts of the framework's work programme e.g. the completion of activities and tasks, but it will need to on to measure the outcomes/benefits and overall impact to the framework.

RECOMMENDATION

Committee is asked to: -

a) Consider the contents the Q&PMF 2025-28 LBM;
b) Identify any further amendments; and
c) Approve the Q&PMF 2025-28 LBM.

REPORT APPROVAL ROUTE

10.06.25 Quality & Performance Management Steering Group 21.07.25 Finance & Performance Committee

REPORT APPENDICES
Appendix 1 – Q&PMF 2025-28 LBM

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

SITUATION

1. The purpose of this report is to obtain Committee approval for the Quality & Performance Management Framework (Q&PMF) logic benefits map (LBM).

2. The Trust has as Board approved 2025-28 Q&PMF. The Q&PMF LBM offers a one-page visual representation of the framework's inputs, activities outputs, outcomes, benefits, benefit measures and overall impact.

BACKGROUND

3. The Trust has operated a Q&PMF for a number of years.

4. Generally, the Trust has a strong track record of delivery, which indicates a strong culture of planning and quality/performance management. A formal Q&PMF is designed to ensure there are formal structures and processes to further support the quality and performance management culture of the Trust.

5. The formal Q&PMF is also an important part of the Trust's response to the statutory Duty of Quality and the 12 Health & Care Standards.

6. Ultimately, good performance management should give assurance that a quality (fit for purpose) service is being delivered, whether that is to patients or other users of our services (external and internal).

7. An LBM aims to answer the "so what" question i.e. what a successful implementation of the Q&PMF would look like and what would be the benefits arising from its implementation. Committee agreed to a follow up paper providing it with a "logic benefits map" or LBM.

ASSESSMENT

8. The Q&PMF LBM is attached at Appendix 1.

9. Providing a long supporting narrative would miss the point of the LBM. The LBM is designed to provide a stand-alone one-page visualisation of the purpose of the Q&PMF and its eventual impact, connecting inputs, activities, outputs, outcomes, benefits and benefits measures. Committee members are asked to consider whether the LBM does this?

10. Currently the focus of the Q&PMF Steering Group is on its work programme, which is made up of inputs and activities e.g. completing self-assessments, developing scorecards etc. What the LBM methodology has done is make the Q&PMF Steering Group consider the eventual outcomes/benefits/benefits measures and overall impact of the framework.

11. As the Q&PMF Steering Group moves through the delivery phase it will need to start measuring the benefits as identified in the LBM.

RECOMMENDATIONS

Committee is asked to: -

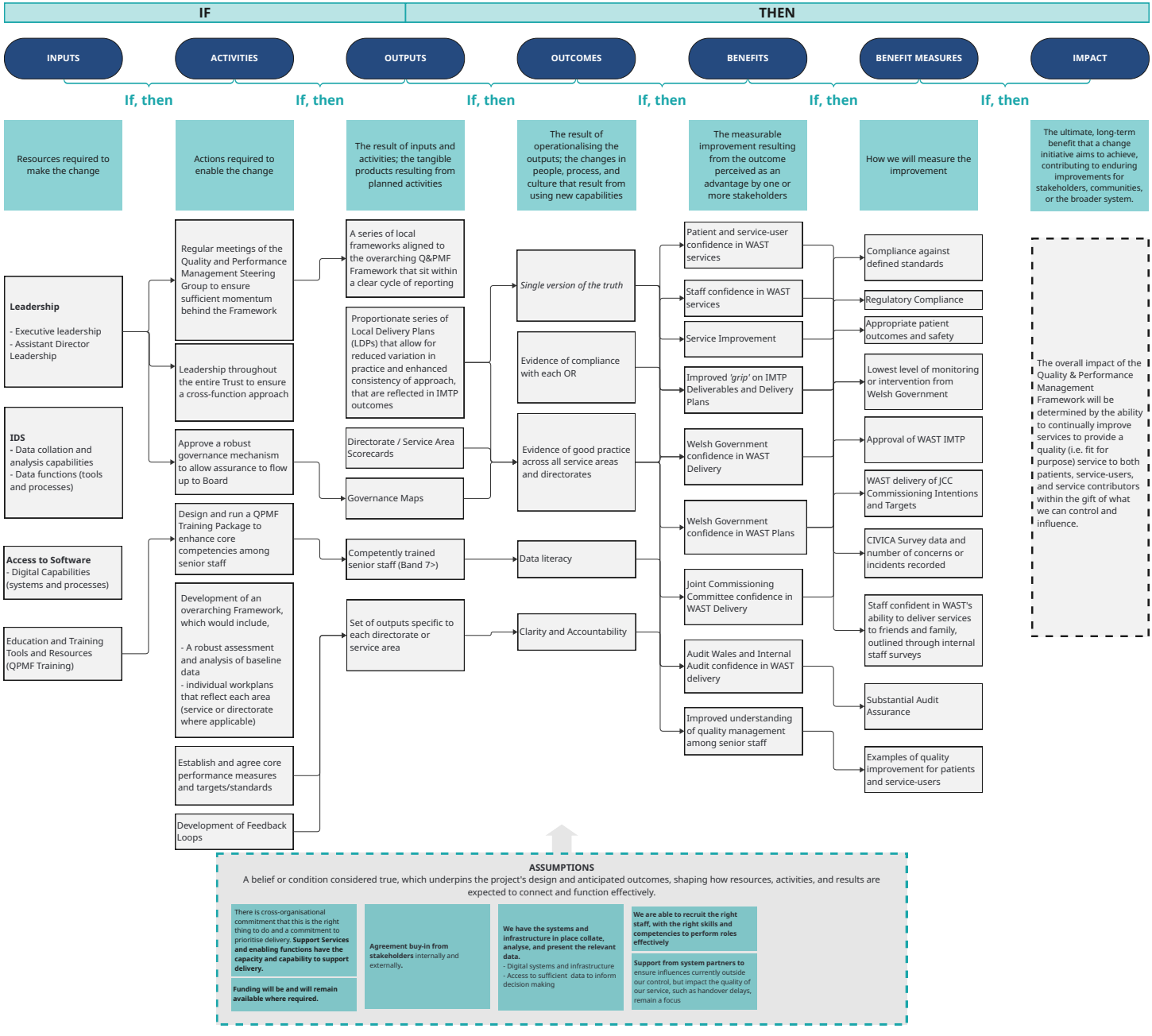
a) Consider the contents the Q&PMF 2025-28 LBM;
b) Identify any further amendments; and
c) Approve the Q&PMF 2025-28 LBM.

Quality and Performance Management Framework

Framework Purpose

The Quality & Performance Management Framework sets out an integrated approach to helping the Trust improve the quality of its services and outcomes for patients and achieve its ambitions and objectives by monitoring and improving the performance of people, teams, and the organisation.

It also delivers a shared understanding about what is to be achieved through quality and performance management, and subsequently leading and developing people through the process. In doing so it provides the Board with the assurances the services provided are fit for purpose.



ASSUMPTIONS

A belief or condition considered true, which underpins the project's design and anticipated outcomes, shaping how resources, activities, and results are expected to connect and function effectively.

There is cross-organisational commitment that this is the right thing to do and a commitment to prioritise delivery. **Support Services and enabling functions have the capacity and capability to support delivery.**

Funding will be and will remain available where required.

Agreement buy-in from stakeholders internally and externally.

We have the systems and infrastructure in place collate, analyse, and present the relevant data.
- Digital systems and infrastructure
- Access to sufficient data to inform decision making

We are able to recruit the right staff, with the right skills and competencies to perform roles effectively

Support from system partners to ensure influences currently outside our control, but impact the quality of our service, such as handover delays, remain a focus

AGENDA ITEM No	**12**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**4**

Emergency Preparedness, Resilience and Response (EPRR) Annual Reports

MEETING	Finance and Performance Committee
DATE	21st July 2025
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Judith Bryce, Assistant Director of Operations
CONTACT	Judith.Bryce@wales.nhs.uk

EXECUTIVE SUMMARY

This report is to provide Finance and Performance Committee with an annual assurance on key EPRR updates and activities. This SBAR highlights the key achievements and issues for committee.

KEY ISSUES/IMPLICATIONS

Contents to include updates on:

- Manchester Arena Inquiry report
- Annual HART/SORT Key Performance Indicator Report
- Welsh Government Annual Emergency Planning report
- Business Continuity Annual report
- REAP

REPORT APPENDICES

Appendix 1 Annual HART/SORT key performance indicators report. Circulated separately by e mail
Appendix 2 Welsh Government Annual Emergency Planning report
Appendix 3 Business Continuity Annual Update
Appendix 4 REAP

REPORT CHECKLIST

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

SITUATION

1.1 This report is to provide Finance and Performance Committee with an annual assurance on key EPRR updates and activities. This SBAR highlights the key achievements and issues for committee.

BACKGROUND

2.1 Over the past twelve months, there have been several notable advancements within the EPRR framework, including the submission of Capability Reports for the Manchester Arena Inquiry to the Joint Commissioning Committee.

2.2 Annual reports produced by the EPRR team to assure both Welsh Government and the Trust on our preparedness have been submitted, including the Annual Hazardous Area Response Team (HART) Key Performance Indicators (KPI) reports, the Welsh Government Annual Emergency Planning report scheduled for submission in July 2025 and the Annual Business Continuity Report.

ASSESSMENT

3. Manchester Arena Inquiry report

3.1 Following the submission of WAST's consideration to the MAI recommendations in August 2024 to commissioners and the NHS Executive, a series of scrutiny workshops have taken place throughout March and April 2025. These sessions have allowed the commissioners, who called upon the expertise of EPRR leads from Health Boards, to scrutinise the detail in the submission before considering and providing their formal response which is expected back to the Trust in August 2025. The Trust has also requested that commissioners and NHS Executive confirm which components of the submission are to be considered by each body.

3.2 Whilst every effort has been made to deliver all MAI recommendations by the end of the 2024/25 financial year, four recommendations that were initially on track for completion, have experienced some slippage due to factors beyond the project's control. These recommendations have now been transitioned to Corporate Risk 641 for ongoing management and progress has continued to be made on these recommendations.

By way of progress to date:

- All 68 recommendations have been closed from a project aspect
- 18 outstanding recommendations have been placed into the Corporate Risk Register

- Submission of Capability to Prepare, Capability to Respond, Capability of Specialist Assets to Joint Commissioning Committee (JCC) where four workshops have taken place for scrutiny on submissions.
- Work through the Joint Emergency Services Group (JESG MAI) workstream has been completed which have enabled us to resolve some recommendations collaboratively with other blue light services across Wales.

3.3 The NWSSP audit into the Manchester Arena Inquiry project is currently underway as part of the approved annual audit plan. This audit will review the governance arrangements of the project process and should provide some additional assurance on the governance framework. Fieldwork is actively underway in Q1, and the final audit report is scheduled to be presented to the Audit and Risk Assurance Committee (ARAC) in September 2025.

4. Annual Hazardous Area Response Team (HART)/ Specialist Operations Response Teams (SORT) Key Performance Indicator Report

4.1 The Q4 KPI report to Welsh Government has been submitted as part of our routine reporting arrangements. We have followed up on several clarifying questions from Welsh Government in June 2025.

4.2 Of note for Committee, on 8th March 2025, the HART resourcing levels experienced a shortage of operatives due to absences, including short notice sickness. Efforts to address this shortfall were unsuccessful, resulting in the Trust being unable to provide full HART team cover across Wales. This is the only time this has occurred. However, the MAI submission and the associated Corporate Risk sets out the case for an increased number of HART operatives in each team from 6 to 8 to enhance resilience. This recommendation is part of the Manchester Arena Inquiry Capability of Specialist Assets Report within the R106 submission.

The annual HART/SORT key performance indicators report is attached at **Appendix 1.** Circulated separately by e mail

5. HART Drone

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

- Large incidents to gain spatial situational awareness

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

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

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

5.4 The Trust has now gained Operational Authorisation from the Civil Aviation Authority and are able to fly in a training capacity until we have the Standing Operating Procedure approved. This SOP is awaiting clarification on the live steaming capability and information governance workstreams and will be completed imminently.

6. SORT Uplift

6.1 Since the Trust received confirmation of the SORT enhancement funding, work has been underway to roll out the associated plans. Two band 7 posts have now been recruited and post holders commenced in their roles in March 2025. One of these posts will support specialist operations clinically, a significant advancement across the team.

6.2 Procurement of some equipment items has been achieved at a cost lower than originally anticipated, contributing to overall cost efficiency. The remainder of the revenue expenditure remains on track and within the planned parameters. Although it was not possible to procure vehicles from the capital allocation during the previous financial year, progress in the current year is on track with work underway in relation to vehicle specification, conversion, and the securing of appropriate chassis, with timelines currently being met.

6.3 The associated SORT training programme is also underway with an anticipated completion in Q3.

7. Emergency Preparedness, Resilience and Response (EPRR) Annual Report

7.1 The Trust's 2024–2025 Emergency Preparedness, Resilience and Response Annual Report for submission to Welsh Government in July has been completed on the newly issued Welsh Government template. This report is an annual submission and outlines the Trust's governance, preparedness, and response arrangements, providing assurance on compliance against national expectations. It includes updates on key national inquiries; outlines progress against previous priorities and sets out the Trust's forward-looking objectives. The report also addresses corporate risks and the Trust's commitment to the Charter for Families Bereaved by Public Tragedy.

7.2 Within the assurance section of the report at point 39, for Committee's awareness, in response to the question relating to satisfaction levels in fulfilling the principles of the Civil Contingencies Act 2004, we have this year provided partially met assurance. This is a deviation from previous year assurance levels, given the assessments undertaken following the MAI work and is consistent with the submission to Commissioners. This partially met assurance for areas such as planning, shared information, cooperation with other agencies, and warning and informing reflects the identified gaps which cannot be met without additional resource.

Highlighted Areas include:

- This is a new template issued by Welsh Government, although largely similar to previous iterations.
- This new template incorporates the Charter for Families Bereaved by Public Tragedy: This Charter recently signed by the Trust, originated from the Hillsborough Tragedy and recognises the need to put families at the heart of any incident. The Charter sits alongside our existing Duty of Candour and has now been incorporated into the Trust's Incident Response Plan, Command Policy, and debriefing processes.
- Manchester Arena Inquiry: 18 recommendations require financial investment. Submissions made to JCC with a formal response expected August 2025. Corporate Risk CRR641 captures the risk of outstanding recommendations.
- Grenfell Fire Inquiry: Having reviewed the outputs from this Inquiry, we have found that these recommendations align with the MAI recommendations, thus requiring no additional actions or investment and have been submitted as supplementary evidence alongside the MAI submission.
- Airwave Communication Tactical Advisor Training: The College of Policing delivered a nationally recognised CTA course from March 18th-20th 2025 to enhance the CTA cadre within the Trust. Managing Airwave capacity is crucial for a coordinated incident response. The Trust has been able to provide

funding to achieve a situation whereby all NILOs have achieved this accreditation and therefore the Trust can now demonstrate 24/7 on-call CTA capability, a key recommendation from MAI.

- SORT Enhancement now fully funded by Welsh Government with staff recruited, equipment procured, and vehicle procurement and training underway.
- Ten Second Trage and Major Incident Triage Tool inclusion with national rollout completed in April 2025.
- Business Continuity: New structure implemented November 2024; Business Continuity software rollout underway.
- Covid-19 Inquiry: Awaiting outcomes from UK and Senedd inquiries with any lessons to be implemented.
- The role of our volunteers in major incidents: The development, scoping of role and associated training package is underway in line with our IMTP deliverable.
- Training and Exercising: Extensive programme delivered, including live and tabletop exercises, and major incident activations.

The EPRR Annual Report can be found in **Appendix 2**.

8. Business Continuity Annual report

8.1 The Business Continuity (BC) annual report is provided to Committee for assurance and information on all BC related activity for the previous year as part of Committee's work plan. This report highlights that the Trust meets its obligations under the Civil Contingency Act 2004, has implemented a new governance structure for BC and is in the implementation phase of new BC software across the Trust.

8.2 The report details the new BC structure that has been introduced that allows for more robust senior management overview of the BC planning across the Trust, with the Assistant Directors Leadership Team (ADLT) providing oversight and direction for BC planning, whilst reiterating the importance of BC and embedding BC across all directorates.

8.3 The introduction of the new structure will not alter the current BC plans in place and therefore the Trust's adherence to the Civil Contingency Act will remain unchanged. However, it will build and strengthen the BC planning across all departments of the Trust. Additionally, new BC software is currently in the development phase with full implementation anticipated by October 2025. This will strengthen and support BC reporting and planning for all directorates.

The Business Continuity Report is attached at **Appendix 3.**

9. Resource Escalation Action Plan (REAP)

9.1 A review has been undertaken on the REAP triggers ahead of the implementation on 1st July 2025 of the new Emergency Ambulance Performance Framework, transitioning the previous red category to three new categories – Purple Arrest, Red Emergency and RCS0.

9.2 This review follows last year's annual review with changes reflected only to the REAP Triggers table (and not to the content of the document itself), to account for the 1st July 2025 go-live of the new Emergency Ambulance Performance Framework.

The changes relate mainly to the REAP triggers table and are outlined as follows:

- The REAP Trigger table is split into 2 parts, consisting of an 'input' table and an 'outcomes' table. The Inputs are those metrics that the Trust has direct control of with the outcomes being the result. In the fullness of time, we hope to get to a position where the input is based on what we are planning, and the outcome is predicted against what is planned. Until such time, decisions will consider the outcomes from the preceding period as is the case now.
- The combining of remote clinician capacity into one trigger, which is consistent with the formation of RICS.
- Inclusion of Clinical Navigator UHP as a new trigger particularly given their criticality in the call flow process.
- Inclusion of a 999 call handling answer rate as a new trigger.
- Inclusion of triggers in 'Outcomes' for Purple Arrest, Red Emergency and Amber categories of call. Purple Arrest and Red Emergency are replacements for the previous Red category. Amber is an addition due to the risk of Serious Adverse Incidents (SAIs) occurring when patients experience long community waits in this call category.

Although the overall number of triggers has reduced, the number of triggers for consideration of escalation will remain as 4. The rationale for this is to avoid frequent escalation and de-escalation which is not the intention of this plan given its whole of organisational application.

The REAP document is attached at **Appendix 4.**

RECOMMENDED:

10. The Committee is asked to:

- **RECEIVE and DISCUSS** the annual EPRR reports.
- **CONFIRM** it is assured that a robust annual review of EPRR plans and activities has been undertaken, and to inform the Trust Board of its assurance.

NHS WALES EMERGENCY PLANNING, RESILIENCE & RESPONSE ANNUAL REPORT 2024/25

Name of NHS Organisation	**Welsh Ambulance Service University Trust**	**Date**	**June 2025**
Signature of Chief Executive Officer			

Purpose

The NHS Wales Emergency Planning Resilience and Response Annual Report is a mechanism for providing assurance to NHS organisations, the NHS Executive and Welsh Government of the emergency planning arrangements, preparedness and resilience within organisations across NHS Wales. The NHS Executive will review reports from across the system, seeking assurance that organisations:

- **Mitigate where possible against the risks identified within the NSRA and Wales Risk Register;**
- **Have a robust emergency plan in place for major incidents (CBRN, terrorist attacks, major power outages, high consequence infectious disease outbreaks, cyber attacks etc);**
- **Have appropriate business continuity management arrangements in place;**
- **Regularly test the efficacy of organisational plans through training and exercise; and**
- **Ensure staff have the appropriate training in command and control processes and maintain their skills and knowledge including through CPD opportunities.**

Governance

1. **Please provide the name and position of your nominated Executive level lead for civil contingency/emergency preparedness arrangements.**

Lee Brooks, Executive Director of Operations

2. **Please provide the name and position of your nominated Executive level business continuity lead if different from the above.**

As above

3. **Please provide the name and position of your officer(s) who has lead day to day responsibility for your civil contingencies/emergency preparedness arrangements.**

Judith Bryce, Assistant Director of Operations, National Operations & Support Clare Langshaw, Head of Service, EPRR & Specialist Operations Jason Fenard, Service Manager, EPRR & Specialist Operations

4. **Please provide the name and position of your officer(s) with day-to-day responsibility for your business continuity arrangements.**

As above, In addition to the officers above, from July 2024 WAST's Assistant Director Leadership Team (ADLT), a sub group of the Executive Leadership Team (ELT) has responsibility for Business Continuity across the Trust.

5. **Please provide the name and position of the officer in your organisation responsible for PREVENT activities (normally delivered as part of Safeguarding).**

Vicky Maxwell, Head of Safeguarding

6. **Is there a mechanism for discussing and co-ordinating health emergency planning arrangements internally within your organisation?**

YES ☒ **NO** ☐

7. **Please provide details of your internal mechanism for co-ordinating your emergency planning arrangements – for example: contingency/risk group structure, emergency preparedness strategy, EP work plan etc.**

Internally the following forums are utilised to ensure a joined up approach to EPRR within the Trust is achieved. • EPRR Action plan working group meetings are held every 6 weeks, reporting to the EPRR & Specialist Operations Group • EPRR Organisational Lessons Identified group meetings are held every month, reporting to the EPRR & Specialist Operations Group • EPRR LRF overview meetings are held every month, reporting to the EPRR & Specialist Operations Group • Business Continuity Steering Group – quarterly meeting chaired by Locality Manager EPRR and attended by BC Leads from all departments, reporting to the Senior Business Continuity Group, chaired by the Head of Service EPRR and reporting to the Assistant Director Leadership Team. • EPRR and Specialist Operations Group meetings are held every other month, reporting to the Assistant Director of Operations (ADO), National Operations & Support • Head of Service EPRR & Specialist Operations, attends the Senior Operations Team to ensure EPRR matters are raised within the wider Trust, this group reports to the Senior Leadership Team.

- ADO National Operations & Support attends the Senior Leadership Team meetings to ensure EPRR matters are raised within the wider Trust, this group reports to the Executive Director of Operations who provides updates to the Executive Leadership Team via a AAA mechanism.
- The Executive Director of Operations ensures that EPRR matters are shared within the ELT and the Chief Executive Officer of the Trust.
- The Executive Director of Operations attends the Finance and Performance Committee of the Trust board, this ensures that EPRR matters can be shared at the Trust Board level. There is a cycle of business for this committee in which EPRR matters are included.

An EPRR Framework is in the process of being produced to complement the existing Command Policy and to guide the EPRR work plan moving forward.

8. If applicable, who represents your organisation at the Local Resilience Forum meetings?

Executive level:
All LRFs – Clare Langshaw, Head of Service, EPRR & Specialist Operations

Coordinator level:
South Wales and Gwent LRFs – Scott Walker, EPRR Manager S&E
Dyfed Powys LRF – Patrick Rees, EPRR Manager C&W
North Wales LRF – Thomas Wardale, EPRR Manager North

Subgroup level:
South Wales and Gwent LRFs – Scott Walker and Katie Morgan
Dyfed Powys LRF – Patrick Rees and Emily Gibbins
North Wales LRF – Thomas Wardale and Nia Hughes

9. When were your business continuity arrangements for maintaining critical services last reviewed and adopted by your Board? Please provide detail of your business continuity management arrangements.

WAST has restructured our BC arrangements to ensure BC is managed across the Trust more robustly and to ensure the Trust board has better assurance that BC arrangements are in place across the organisation. The new structure was presented and progressed through the Trust management approval route in June and July 2024 and implemented in November 2024, with the Assistant Director Leadership Group (which reports to the Executive Leadership team) holding responsibility for Trust wide BC arrangements.

The BC annual report to the Executive Board was presented in June 2024 and accepted by the Board. The 2024/2025 BC annual report is scheduled to committee for assurance purposes in July 2025.

The BC Policy is currently under review and will be progressed through the Trust approval routes in 2025.

10. Does your organisation's corporate risk register include any business continuity or emergency planning risks? If yes, please provide details of these specific risks and the associated mitigating measures.

Corporate risk is reviewed and managed at Executive and Trust Board level, with a monthly review by each risk owner. All risks are detailed on the Corporate Risk Register and within the Board Assurance Framework. Risk updates are provided to commissioners, and to WG as required.

CRR594 details the risk to the Trust in our ability to release ambulances from protracted delays at hospitals to fulfil our pre-determined attendance as detailed in the Trust's Incident Response Plan to an incident declared. The single most mitigating factor to this risk is the timely release of ambulances from emergency departments. The Trust has sought assurance from Health Boards that these plans to release ambulances exist. To date, WAST has not received the plans or ED actions cards, and none have been tested with WAST.

CRR641 details the Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident or mass casualty event. This risk captures all of the outstanding recommendations which have been captured in a series of capability reports submitted to commissioners (with a copy to the NHS Executive) in August 2024 and which have been subject to four scrutiny sessions across March/April 2025 with a response expected in August 2025. A protected Annex document to this risk details those outstanding recommendations which require investment in order to fully progress.

Key Areas of Progress 2024/25

11. Please provide details of the key areas of progress against your organisation's EPRR priorities detailed in your 2023-24 Emergency Planning Annual Report.

Manchester Arena Inquiry Review

The Trust has undertaken a detailed review of its provision as part of its obligation under the Manchester Arena Inquiry (MAI) recommendations 105 and 106 and has produced an evidence-based series of reports aimed at addressing the identified gaps. Our findings showed that 68 of the recommendations, directly or through partnership working, relate to the Trust and a programme of work on these recommendations was instigated with all recommendations the Trust can fulfil without additional external investment nearing conclusion. The work identified 18 recommendations for which there is a financial dependency. A submission to commissioners (and the NHS Executive) of the Trust's reports relating to these recommendations was submitted in August 2024 with a series of scrutiny workshops taking place through March and April 2025. A response is expected by August 2025. Trust concern on progress would be heightened if meaningful outcomes are not known on this timeline.

A corporate risk has been added to the Trust's Corporate Risk Register and Board Assurance Framework, addressing the impact of failing to implement lessons on patient outcomes. We will continue to monitor 18 recommendations with financial dependency through a defined business-as-usual framework, supporting governance of capability gaps while awaiting financial decisions from commissioners and implementing necessary changes.

Grenfell Fire Inquiry Report

The EPRR team have undertaken a review of the two published Grenfell Inquiry reports. Our assessment of the recommendations from the two Inquiry reports have been compared with the recommendations from the Manchester Arena Inquiry (MAI). Our review found no additional actions that the Trust need consider, with the Grenfell recommendations mirroring the recommendations from MAI. This output however has been considered by the Executive Leadership Team and subsequently submitted as supplementary evidence to the MAI submission to commissioners.

Major Incident Triage Tool

From 1st April 2024 the Trust has completed the roll out of Ten Second Triage and the Major Incident Triage Tool nationally and with partner agencies.

Airwave Communication Tactical Advisor Course

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

Specialist Operations Response Team (SORT) Enhancement

Following the successful award of funding from Welsh Government earlier in this reporting period on the SORT enhancement business case, work is progressing well to roll out the enhancement across Wales. A Senior Paramedic has been recruited to the team, making a welcome addition to the HART and SORT clinical capabilities. A SORT Operations Manager has also been recruited. SORT awareness sessions have taken place across North and South Wales and the equipment funded as part of the business case has been procured and is therefore complete. Vehicles however could not be secured in year with the time available since the award was confirmed, and we are pleased with the determination to roll capital funding into this financial year. We shall continue to enhance this provision by ensuring visibility of on-duty SORT operatives and establishing a way we monitor on-duty rates of availability.

Major Incident / Emergency Plan

12. When was your Major Incident/Emergency Plan last reviewed and considered by your Board?

The revised and update Incident Response Plan (IRP) was presented to the Senior Operations Team, Senior Leadership Team in May 2024 when it was then accepted and approved by the Executive Leadership Team and received by Finance and Performance Committee.

This year's review is underway and will flow to the Finance and Performance Committee according to its cycle of business.

13. When was your Major Incident/Emergency Plan last updated to reflect any organisational changes and essential plan contacts?

WAST Incident Response Plan v2.1 was reviewed and updated in May 2024 and reflects lessons identified internally and externally and changes in guidance and terminology, including alignment with the JESIP doctrine, changes to patient Triage, and the updated Ambulance Command & Control Guidance.

This year's review is underway and will flow to the Finance and Performance Committee according to its cycle of business.

14. Do you have resilient activation systems, action cards and suitably trained and equipped staff to provide for a 24-hour emergency response to support your Major Incident/Emergency Plan?

YES ☒ NO ☐

15. If NO, what are the gaps and how are these being addressed?

NATIONAL SECURITY RISK ASSESSMENT (NSRA)

The following sections focus on preparedness and risks in relation to some of the highest rated risks within the NSRA and Wales Risk Register. Your organisation's responses to these questions will inform the NHS Executive's programme of work in these areas with a view to improving assurance and resilience across NHS Wales. Please provide any supplementary information in support of your responses below.

Threat Mitigation/ Security

16. Does your organisation have written procedures that may be needed to respond to a change in threat level to critical?

YES ☒ NO ☐

17. When was your organisation's Lock Down arrangements last worked through or tested?

Dates	Details of what was undertaken
	The EMS-C (5 contact centres) have lockdown processes that work mainly when there are potential infection outbreaks. There are no emergency lockdown procedures in place for threats at WAST sites.

18. Were any issues identified as a result and if so how has / is your organisation addressing these?

Power Outage

19. Do your business continuity arrangements include response arrangements for maintaining critical services in the event of a major power outage?

YES ☒ NO ☐

20. Please describe the preparedness actions the organisation has undertaken over the last 12 months (e.g. protocols, guidance, exercising etc) to respond to a major power outage?

The WAST Power Outage plan has been reviewed and updated in May 2024. This followed a workshop held by the EPRR team and learning gained from Exercise Mighty Oak.

WAST Estates maintain a schedule of generator testing at key sites across Wales, with all sites tested on a regular basis.

21. What are the key risks to your organisation in respect of a major power outage and how are you mitigating these? Please provide details of key vulnerable sites / facilities, how these have been assessed and dates of last assessments.

Of the 6 Core Functions that WAST has identified that are required to maintain the Trust's critical services the control rooms would have the greatest impact from a power outage. This is mitigated by having generator back-up assigned to power the three control rooms in the event of a power outage. These generators will mitigate the initial risk, however if the power outage is prolonged, and fuel pumps are affected, refuelling the generators is a risk.

Refuelling the Trust vehicles is a risk if the power outage affects filling stations as the Trust bunkered fuel tanks do not have a manual override and relies on power for the fuel pump.

The emergency Airwave communication network will also be affected from a prolonged power outage. The network has a generator back-up system that will last for 7 days, but this will only power the main network and there will be a risk of limited network coverage in rural areas.

Mass Casualty Incidents

22. Please describe how your emergency planning arrangements ensure your organisation can appropriately respond to a Mass Casualty incident in line with extant Mass Casualty guidance, outlining any limiting factors that could affect timeliness of response.

The Trust IRP included the response to a Mass casualty incident. This includes partnership working with Welsh Health colleagues. In recognition that additional support will be required to enable a response to a Mass Casualty Incident WAST has accepted the UK Ambulance Mutual Aid plan and has in place an Unscheduled Care contract with third party ambulance providers to support the WAST response if required.

In line with the AACE framework, work has commenced to utilise the WAST Volunteer cadre in the event of a Mass Casualty Incident to support where required. This a deliverable within the IMTP.

Cyber Resilience

23. Do your business continuity arrangements include written procedures for responding to a cyber-attack / ICT incident impacting across the organisation?

YES ☒ NO ☐

24. Has your organisation assessed the risk of a Cyber attack and identified mitigating actions for the vulnerabilities highlighted? Please provide details.

WAST has assessed that the response to a cyber attack will be akin to the response to an ICT disruption from another source, therefore WAST has maintained a BC ICT Disruption plan since 2022. This plan is due for review in November 2025.

25. Please describe the preparedness activity the organisation has undertaken in the previous 12 months (e.g. protocols, guidance, exercising etc) to build its cyber resilience.

The past 12 months has seen the ICT disruption plan utilised on a number of occasions due to internal and external incidents; These have included CAD outages and national ICT system losses. The ICT Disruption Plan has allowed a robust response from the Trust.

Debriefs have been held for these incidents with lessons Identified from being incorporated into the ICT Disruption Plan.

In addition, the Trust has developed a cyber improvement plan based on regulatory audits and third-party assessments which supports the underlying actions on the Trust's corporate risk relating to the threat of cyber-attack. A programme of cyber awareness training and information has been implemented to improve cyber security resilience across Trust.

Communicable Diseases and Pandemics

26. Do your business continuity arrangements include plans to respond to a new pandemic?

The WAST Business Continuity arrangements include a Pandemic Response Plan. This plan was updated during the COVID 19 pandemic from the original Pandemic Flu Plan to the current Pandemic Plan. This was to reflect the recognition that the Trust needed to be prepared to respond to pandemics other than flu. This plan was reviewed and updated in 2023 and will be scheduled for further review in 2025.

27. What are the major risks in terms of your organisation's resilience / capabilities to be able to respond to a new pandemic?

The major risk to the Trust during the response to a pandemic is the loss of its staff due to the effects of the disease. The Trust is prepared to redeploy staff where needed and to call on support from agencies outside of the Trust, but a shortfall in key staff remains a risk.

28. Following the preparedness activity colleagues across NHS Wales undertook during 2024, please describe the organisation's priorities for 2025/6 in relation to HCID preparedness.

For WAST HCID preparedness is split into two areas, the Specialist Response and the Frontline response.

The Specialist response is well rehearsed and there are robust links into the English ambulance Trusts to facilitate mutual aid support for HART and SORT. The risk remains within North Wales where there is a reliance on NWAS to support WAST with a HART response and this risk is being mitigated through work with Welsh Government via the MAI submission to assess the need for a North HART unit. WAST maintains two Epi-shuttles on behalf of Welsh Government and continues to train HART and SORT personnel on the use and limitations of these units.

The frontline response has been bolstered following the Clade 1 MPOX incidents to include the expediated roll out of Respiratory PPE to frontline vehicles and the EPRR Team facilitating training on HCID response. The Trust priority is to ensure frontline staff maintain their awareness on the appropriate response to HCID cases with this work being led by the Infection Prevention Control Team within WAST. This effort has reduced our reliance on central stocks of FFP3 masks though supply is still necessary.

CBRN

29. Do your business continuity arrangements include plans to respond to a chemical, biological or radiological incident?

The WAST response to a CBRN/HazMat incident is included within the Trust IRP.

30. Please describe the actions undertaken over the previous 12 months to ensure the organisation can respond to a CBRN incident.

Recognising that the pre-hospital response to a HazMat or CBRN incident is similar but that the likelihood of a HazMat incident is higher, the Trust has reviewed its response to both types of incidents. WAST hosted a large multiagency exercise in September 2024 which incorporated a HazMat response. This exercise included multiagency blue light partners from across Wales and looked at the response to a chemical incident.
The Initial Operational Response to Incidents Suspected to Involve Hazardous Substances or CBRN material (JESIP vs 1.1) was published in June 2024. The EPRR team undertook to deliver training sessions to frontline staff on the updated IOR, incorporated the latest information into its command training and into the Trust IRP.
Specialist Operations training has taken place with the HART training focussed on the response within the Hot Zone incorporating Gass Tight Suits, Next Gen PPE and Powered Respirator Protective Suits (PRPS) and SORT training focussed on the response within the Warm Zone utilising PRPS.

31. What are the key risks / vulnerabilities for your organisation and how are you addressing these?

The SORT enhancement roll out is underway with the training of the additional SORT operatives commenced in April 2025.

A key vulnerability remains the lack of a specialist response capability (HART) in the North of Wales. However, all of our risks and vulnerabilities are stepped out in the MAI submission and the subsequent corporate risks.

Training and Exercise

32. Does your organisation have robust arrangements for reviewing emergency plans that take account of lessons from incidents and exercises (including following the process set out in the NHS Wales Lessons Identified Register)?

YES ☒ **NO** ☐

Please describe these below and provide a copy of your lessons identified register if one is held locally.

Lessons Identified are collated through debriefs carried out post exercise and post incidents, these lessons are captured on the Trust's Organisational Learning Spread Sheet (OLSS) and influence changes to the Trust's emergency plans. The OLSS is monitored by the Senior Operations Team, with their output reported to the Operations Senior Leadership Team.

33. Please provide the dates during 2024/25 when your organisation tested its Major Incident / Emergency Plan, through:

a. Carrying out a communications/activation test every six months. Please provide details below

Dates	Details of communications/activation test undertaken		
26 April 2024	Planned Test -	In hours	Pan Wales planned test
20 July 2024	Planned Test -	OOH Weekend	Pan Wales planned test
21 October 2024	Live declaration -	OOH	Powys Train Incident, Declared
25 March 2025	Planned Test -	In hours	Pan Wales planned test
23 April 2025	Live declaration -	OOH	RTC North Wales, Standby / Extraordinary

b. Carrying out a tabletop training exercise within the last year. Please provide details of the nature of all exercises below

Dates	Details of tabletop training exercise
04/09/24	COMAH ex at Vale Europe
16/05/24	COMAH ex at Valero
24/11/24	COMAH ex Southhook LNG
30/10/24	HMRC Coastguard ex
01/07/24	Tata Steel ex
20/08/24	Ex Dagma – Reservoir ex
20/06/24	Passenger ferry ex
22/05/24	Ex RAF Valley
05/09/24	Ex Isador
07/01/25	HCID Exercise
16/01/25	CTP Wales, Exercise PRIORITY ZONES
17/01/25	HCID Exercise

21/01/25	CTP Wales, Exercise PRIORITY ZONES
22/01/25	HCID Exercise
11/03/25	Flo Gas COMAH Exercise
24/03/25	CAD Outage Business Continuity Exercise
26/03/25	CTPW Exercise CELTIC CONSOLIDATION

c. Carrying out a major live or simulated exercise within the last three years. Please provide details below (include national and local exercises)

Dates	Details of major live or simulated exercises undertaken
10/05/24	Mass Casualty ex at Swansea University
04/02/25	Ex Tendley testing MI response to a rail incident
24/11/24	Ex Viper testing response to HazMat incident
05/11/24 21/11/24 05/12/24	COMAH site ex testing response to HazMat incident at Dow Silicones
04/02/2025	Exercise TENDLEY, Live multi-agency exercise

34. Has your organisation had to initiate your major incident / emergency plan between April 2024 to March 2025?

YES ☒ **NO** ☐

a. If YES, what was the nature of the incident?

24th April 2024 - Ammanford School Stabbing – Extraordinary Incident
21 October 2024 - Powys Train Crash - Major Incident Declared
29th August 24 - Cardiff Gas Leak - Major Incident Standby
31st December 24 – Critical Incident Declared due to pressures
5th December 24 – Storm Daragh – Adverse Weather Plan activated / ICC Arrangements in place
10th March 25 – Talbot Green Shooting - Extraordinary Incident Declared

b. Were post-event reports produced for these incidents? YES ☒ **NO** ☐

c. If post incidents reports were produced, have these been shared with the Emergency Planning Advisory Group and any lessons identified uploaded on the Wales NHS Lessons Identified Register?

Lessons have been identified internally and mainly refer to internal processes which are not applicable to wider learning. They are entered onto the WAST Organisational Learning Spreadsheet as recommendations and actions and monitored by the Senior Operations Team.

Any Lessons Identified that are applicable for our Health partners are shared.

Multiagency lessons or areas of good practice can be added to JOL, this is reflected on the OLLS.

35. Have you undertaken an assessment of staff training needs in relation to your Major Incident /Emergency Plan?

YES ☒ **NO** ☐

Please provide further information of the needs identified through this process.

An organisational Training Needs Analysis (TNA) has been carried out, which identifies the following staff groups that require major incident training:

- Major Incident Induction - Trainee Emergency Medical Technicians (EMT's) / Newly Qualified Paramedics (NQP)
- Operational Command Foundation Course / Operational Commander Refresher Course – Duty Operations Managers (DOM's)
- Tactical Commander Course / Tactical Commander Refresher Course / Exercise Wales Silver – Locality Managers / EMSC Duty Managers / Operational Delivery Unit (ODU) National Delivery Managers (NDM's)
- Strategic Command Training – Strategic Command Course / Strategic Commander Refresher Course / Exercise Wales Gold – Heads of Service

A Training Needs Analysis was undertaken as part of the response to the Manchester Arena Inquiry. This identified training and exercising gaps relating to Major Incident response across the organisation, particularly relating to 'non-specialist' responders (such as EMS paramedics or control room staff). To drive significant and meaningful change, additional funding and personnel are required. This funding request has been made to the Trust's commissioners as per recommendation 106 and WAST awaits the outcome of this submission.

Specialist and Commander staff receive training in relation to Major Incident response, aligned to nationally recognised frameworks and operating standards. However, the opportunity to develop the practical application of these skills through exercising remains limited. The WAST EPRR department continues to actively engage with partners in exploring opportunities to deliver training and exercising, and support delivery of this where capacity exists.

36. Do you have a staff training programme to support your Major Incident/Emergency Plan?

YES ☒ **NO** ☐

Please provide further details including

	Number	**Training Provider**
Number of staff trained in Gold roles	15	Internal course All Wales Gold Course
Number of staff trained in Silver roles	25 + 9 EMSC Tactical Commanders	Internal course All Wales Silver Course National NARU course
Number of staff trained in Bronze roles	200	Internal course JESIP course National NARU course
Number of your Executive Team who've attended Wales Gold in the last 3 years	All WAST Strategic commanders attend the All Wales Gold Course and recertify every 3 years. While not performing the Strategic Commander role, the Executive Director of Operations has sustained All Wales Gold.	
Number of Senior Managers who've attended Wales Gold in the last 3 years		

37. Please provide details of any actions undertaken to prepare for the introduction of the Charter for Families Bereaved by Public Tragedy within your organisation.

The Trust has made a commitment through signing the Charter for Families Bereaved by Public Tragedy and already adheres to the Duty of Candour, which closely aligned to the Charter. The Duty of Candour is already established as a mandatory competency for all staff members. However, the Charter for Families Bereaved by Public Tragedy will be integrated

into our Incident Response Plan (IRP), Command Policy, and all debriefing processes as their reviews take place. This inclusion underscores our dedication to providing comprehensive support and maintaining the highest standards of care and transparency to the bereaved.

Communication

38. Have relevant NHS organisations and partner agencies been consulted about any role they may have in your Major Incident/Emergency Plan?

YES ☒ **NO** ☐

Please provide details.

The NHS Wales Pre Hospital Major Incident Response Partnership is a forum chaired by WAST, that enables two-way discussions around pre-hospital major incident response arrangements with partners external to WAST.

WAST has been instrumental in establishing the Tri Service Incident Plan Review Group (TriSIP RG), which unites blue light agencies across Wales to review each other's Incident Response plans. This initiative aligns with Manchester Arena Inquiry Recommendation 1, ensuring organisations consult each other regarding their roles and content in a Major Incident response. As the group evolves, it is expected that the multi-agency response to incidents across Wales will become more cohesive and complementary as a result of this review group.

Assurance

39. Are you satisfied your organisation is fulfilling the principles required by the Civil Contingencies Act 2004 as described below?

	YES	NO	Please provide any further relevant information to support your answer
1) Assess risks to inform your contingency arrangements	**X**		Risk assessment is performed on a Pan Wales basis, via the Wales Risk Group, through the four LRF risk groups and on a service specific basis, that includes horizon scanning.
2) Put in place Emergency Plans		**X**	Partially met - Our level of assurance mirrors the level of assurance we were able to provide last year, although the outputs of our work in relation to the Manchester Arena inquiry has since identified gaps which we cannot fulfil within existing resource. WAST has an Incident Response Plan (IRP) that details response arrangements to major incidents, including CBRN / Hazmat, MTA and a range of other scenarios. The Trust also has a number of scenario specific incident response plans for key locations. However, Manchester Areana Inquiry has highlighted a need for significantly more high-risk site plans. The plan to address this recommendation is set out in the submission to commissioners August 2024,

			which currently remains outstanding. This features on Corporate Risk CRR641
3) Put in place Business Continuity Management arrangements	**X**		Work is continuing to ensure robust BIA and BCP are in place across the Trust. New BC Software is being introduced that will facilitate this.
4) Share information with other organisations to enhance co-ordination and efficiency		**X**	Partially met - Our level of assurance mirrors the level of assurance we were able to provide last year, although the outputs of our work in relation to the Manchester Arena inquiry has since identified gaps which we cannot fulfil within existing resource This is primarily through the four Local Resilience Forums (LRF's) in Wales and associated governance structures and professional networks. However, Manchester Arena Inquiry has highlighted a need to align EPPR liaison to each LRF area. The plan to address this recommendation is set out in the submission to commissioners August 2024, which currently remains outstanding. This features on Corporate Risk CRR641
5) Cooperate with other organisations to enhance co-ordination and efficiency		**X**	Partially met - Our level of assurance mirrors the level of assurance we were able to provide last year, although the outputs of our work in relation to the Manchester Arena inquiry has since identified gaps which we cannot fulfil within existing resource This is primarily through the four Local Resilience Forums (LRF's) in Wales and associated governance structures and professional networks. However, Manchester Arena Inquiry has highlighted a need to align EPPR liaison to each LRF area. The plan to address this recommendation is set out in the submission to commissioners August 2024, which currently remains outstanding. This features on Corporate Risk CRR641
6) Have appropriate arrangement to warn, inform and advise the public/others, including in an emergency		**X**	Partially met - Our level of assurance mirrors the level of assurance we were able to provide last year, although the outputs of our work in relation to the Manchester Arena inquiry has since identified gaps which we cannot fulfil within existing resource WAST uses a commercial alerting system (Everbridge) to share major incident alerts with the wider NHS in Wales. These arrangements are tested four times a year. However, Manchester Arena Inquiry has highlighted the need for additional communication capacity. The plan to address this recommendation is set

			out in the submission to commissioners August 2024, which currently remains outstanding. This features on Corporate Risk CRR641
7) Do you have an EPRR lessons identified and lessons learned procedure within your organisation that feeds into EPAG?	**X**		The WAST OLSS is extensive. Lessons Identified that involve Health partners are fed into EPAG.

Priorities

40. What are your priorities for 2025/26 to strengthen your organisation's emergency planning, resilience and preparedness arrangements??

Manchester Arena Inquiry submissions have been submitted to Joint Commissiong Committee (JCC) for financial ask to complete the 18 outstanding recommendations. Four scrutiny workshops taken place on the submissions, with response expected in August 2025. Following that, we will action any programme work required to enable the Trust to fulfil these outstanding recommendations. A determination not to invest potentially leaves the Trust unable to implement all the learning from the Inquiry, and the response to a major or mass casualty incident could be suboptimal resulting in patient harm or death.

We will develop the role for volunteers in major incidents, including any package of training required.

We will roll out the enhancement to our SORT capability and deploy production monitoring arrangement.

We will implement our Business Continuity software.

We will receive and consider the outcome of the UK and Senedd Covid-19 Inquiry, implementing any lessons identified.

When submitting the completed report, please include an electronic copy of the following:

- **your current Major Incident /Emergency Plan;**
- **an organisational chart setting out your organisation's emergency preparedness structure;**
- **a copy of your local EPRR risk register where available;**
- **an organisational chart setting out your organisation's emergency response structure; and**
- **any additional information you wish to share which demonstrates your organisation's preparedness for the risks described above.**

Whilst organisations are not required to submit Board approved reports, please provide confirmation of the date the report will be considered by your Board within your submission.

Completed and signed report forms with any attachments to be returned by 31 July 2025.

By email to: Sophie.Barrett@wales.nhs.uk

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

Business Continuity Annual Report 2024-25

MEETING	Senior Leadership Team
DATE	10/06/2025
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Thomas Wardale, Acting Service Manager, EPRR Mathew Jones, Acting Locality Manager, EPRR Judith Bryce, Assistant Director of Operations
CONTACT	Thomas.wardale@wales.nhs.uk

EXECUTIVE SUMMARY

The Business Continuity (BC) annual report is provided to Committee for assurance and information on all BC related activity for the previous year as part of Committee's work plan. This report highlights that the Trust meets its obligations under the Civil Contingency Act 2004, has implemented a new governance structure for BC and is in the implementation phase of new BC software across the Trust.

The report details the new BC structure that has been introduced that allows for more robust senior management overview of the BC planning across the Trust, with the Assistant Directors Leadership Team (ADLT) providing oversight and direction for BC planning, whilst reiterating the importance of BC and embedding BC across all directorates.

KEY ISSUES/IMPLICATIONS

The introduction of the new structure will not alter the current BC plans in place and therefore the Trust's adherence to the Civil Contingency Act will remain unchanged. However, it will build and strengthen the BC planning across all departments of the Trust. Additionally, new BC software is currently in the development phase with full implementation anticipated by October 2025. This will strengthen and support BC reporting and planning for all directorates.

REPORT APPROVAL ROUTE

Senior Leadership Team, Executive Leadership Team.

REPORT APPENDICES

N/A

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

1. Situation

1.1 Business Continuity (BC) is the ability of an organisation to continue the delivery of services to a pre-agreed level during disruption. Commissioning, the Civil Contingencies Act (2004), best practice guidance and supporting documents dictate and guide how the Trust should mitigate risks and prepare for the need to respond to issues, maintaining core services and activities.

1.2 The Trust has a Business Continuity Management System (BCMS) which continues to develop and adapt with the organisation. This report covers WAST BC activity between June 2024 and May 2025.

1.3 ISO 22301 is the international standard for Business Continuity Management Systems (BCMS). It provides a framework for organisations to plan, establish, implement, operate, monitor, review, maintain, and continually improve a documented management system to protect against, reduce the likelihood of, and ensure recovery from disruptive incidents.

This standard is crucial for organisations to enhance their resilience against various unforeseen disruptions, ensuring continuity of operations and services. It helps in identifying risks, preparing for emergencies, and improving recovery time.

The benefits of ISO 22301 compliance:

- Enhances organisational resilience
- Improves risk management processes
- Ensures a systematic response to crises
- Increases trust among stakeholders

2. Background

2.1 BC plans including Severe Weather, Pandemic, Resource Escalation Action Plan (REAP) and Clinical Safety Plan (CSP) have been in place for a period of time and have been used during business-as-usual operations and in disruption. They have been reviewed and updated where required. The Trust has in place departmental Business Impact Assessments (BIAs) and Business Continuity Plans (BCPs).

2.2 Incidents such as CAD and Airwave outages have tested WASTs preparedness to respond to disruption and maintain our business-as-usual activities.

3. Assessment of the current position

3.1 Business Continuity and the recognition of the benefit of early declaration of a Business Continuity Incident (BCI), is becoming more prevalent in management structures and is being increasingly highlighted. National incidents such as the fire at the substation adjacent to Heathrow airport in March 2025, the recent M&S cyber-attack - highlighting the continued risk of cyber threats, alongside increasingly adverse weather across the UK, continue to highlight the importance of robust BC planning. The Trust benefits from building on this experience to further explore how business continuity management can assist 'normal' working by strengthening process design, implementing fallback options, and recognising the effect of the loss of key staff, systems, and infrastructure.

3.2 In June 2024, a new BC governance structure was implemented across the Trust to ensure BC is fully embedded. This structure is made up of the Business Continuity Steering Group (BCSG), which consists of BC leads from all directorates which then reports to the Senior Business Continuity Group (SBCG) which Heads of Departments attend. SBCG then ultimately reports to the Assistant Directors Leadership Team (ADLT) a formal subgroup of the Executive Leadership Team (ELT). This structure provides robust overview of the Trust's preparedness across the whole Trust with senior level representation. The Executive Director of Operations remains the professional lead for BC.

3.3 The Trust has been working towards a process for system mapping ICT structures to pinpoint single points of failure, interdependences, and recovery priorities. Some of these have been noted through previous notable incidents (e.g. Public Sector Broadband Aggregation (PSBA) and Adastra failure) and others through exercises (departmental system outages or staff loss through industrial action), and mitigation is included in the ICT Disruption Plan. With the implementation of the new BC software, IT Systems interdependencies will be easily identified, allowing the Trust to understand the impacts of interdepartmental IT failures. It should be noted that some reliance rests external to the Trust for example, some underlying

ICT infrastructure is managed by DHCW and other suppliers.

3.4 Specific Business continuity plans, such as Power Outage, have been updated by the EPRR Team in May 2024, in conjunction with departments who would be affected. The escalation structure in each plan reflects the structure as shown in the Trust's Incident Response Plan. Departmental plans will reflect this at an operational, department-specific level, using action cards and roles/responsibility lists.

3.5 The EPRR Department are available to support all departments and directorates in the creation and review of their documents, whilst the responsibility of completion remains with the department BC Lead as the subject matter expert for their role.

4.1 In order to ensure robust business continuity systems across the Trust, the structure that provides governance and supports the BC work has been approved for change in September. This new structure will build on the existing leadership roles within departments and directorates and recognises that business continuity should be embedded across all directorates.

4.2 It will ensure:

- Participation in the new BC structures by all departments
- Adoption and ownership of departmental BC plans and BIA's via the new BC software
- Improved culture of business continuity considerations in all systems, processes, fleet, estate design and operations delivery.

1. Introduction

1.1 The Trust meets business continuity challenges on a regular basis, from adverse weather, IT disruptions and system loss. These continue to test the Trust's ability to provide the services to the public for which we are commissioned, and system delays cause thousands of lost hours of production. National incidents such as the fire at the substation adjacent to Heathrow airport in March 2025, the recent cyber-attack on M&S highlighting the continued risk of cyber threats, alongside increasingly adverse weather, continue to highlight the importance of robust BC planning.

1.2 Risks and issues do not occur in isolation. The Trust has been able to meet these concurrent issues due to strong decisive leadership, a structured management process and staff working together toward common goals. In accordance with duties afforded to WAST under the Civil Contingencies Act (2004), risk assessments, planning, and regular exercises have taken place to ensure there is a robust response and recovery process in place, with space for learning and innovation.

1.3 This report highlights progress and provides assurance on BC planning and BCMS and provides recommendations to improve the processes and mature the systems.

2. Business Continuity Management Systems (BCMS)

2.1 Business continuity is the ability of an organisation to continue the delivery of services to a pre-agreed level during disruption and then recover. To achieve this, potential outcomes (risks) are identified and mitigated, and plans put in place to manage them should they become realised (issues). A mature Business Continuity Management System (BCMS) provides numerous advantages to the organisation:

- Increases an organisation's ability to continue during a period of disruption.
- Processes provide staff a clear understanding of the organisation.
- Provides an environment where improvement can occur.

2.2 At a Strategic, organisational level, risks are generally grouped as:

- Political
- Economic
- Socio-Cultural
- Technological
- Legal
- Environment
- Reputational

2.3 At a delivery level, areas of focus are grouped accordingly:

- People/Staffing
- Premises/Estates
- Technology
- Fleet
- Utilities
- Information
- Supplies

2.4 To identify and understand the risks, a business impact analysis (BIA) is undertaken to identify what the business delivers, and detail the processes associated with the 'critical activities' required. Risks identified as part of the BIA should be recorded as per Trust policy including mitigation. Mitigation takes the form of designing systems to be resilient, and writing, sharing and testing of Business Continuity Plans (BCP) to be used should a disruption occur.

2.5 The Trust as a Category 1 responder under the Civil Contingencies Act (2004) and Regulations (2005), has a statutory responsibility to ensure we have business continuity plans in place. There is no requirement for the Trust to be accredited to International Standard ISO22301 but the BCMS is based on this framework and we continue to work towards the standard required for accreditation in the future.

2.6 To support the work toward becoming ISO22301 registered, the implementation of a digital BC platform is currently in the deployment stage. This system has been funded in 2024 and following a national procurement exercise, a contract has been awarded to Continuity2, a national provider who supplies other ambulance Trusts with BC software. Implementation is now underway with an anticipated completion date of October 2025. This will future proof BC arrangements and provide a robust and flexible management system for all departments. This cloud-based system will be a live platform that will store BIA & BCP's as well provide a testing and exercising mechanism that each department can use, record and learn from.

2.7 Welsh Government emergency planning documentation[1] gives the Chief Executive Officer the responsibility of ensuring policies and plans are in place to comply with the CCA (2004). Welsh Government request an annual report to provide assurance that the following are considered and/or in place:

- BC arrangements considered and adopted by the Executive Board
- Arrangements for reducing the risk of:
    - Cyber attacks
    - ICT disruption
    - Power outages
- Major incident planning
- 24/7 activation and response systems

- Appropriate training, testing and implementation arrangements
- Co-operation and coordination with stakeholders
- Meeting the duties under the CCA

3. Audit and Assurance

Audits

3.1 With the introduction of a digital platform for recoding BC management, there will be a robust mechanism for audit that can be filtered in different ways such as departmental, dependency & specific sites. This will provide assurance of the Trust arrangements each level of the Business Continuity Governance Structure, which meet quarterly.

Business Continuity Governance Structure

3.2 The Business Continuity Steering Group (BCSG), chaired by the Service Manager - EPRR & Spec Ops, is the principal mechanism for management review of the BCMS and informing senior leaders on emerging BC issues. Each directorate has identified a Business Continuity representative who takes the lead in coordinating arrangements for their department.

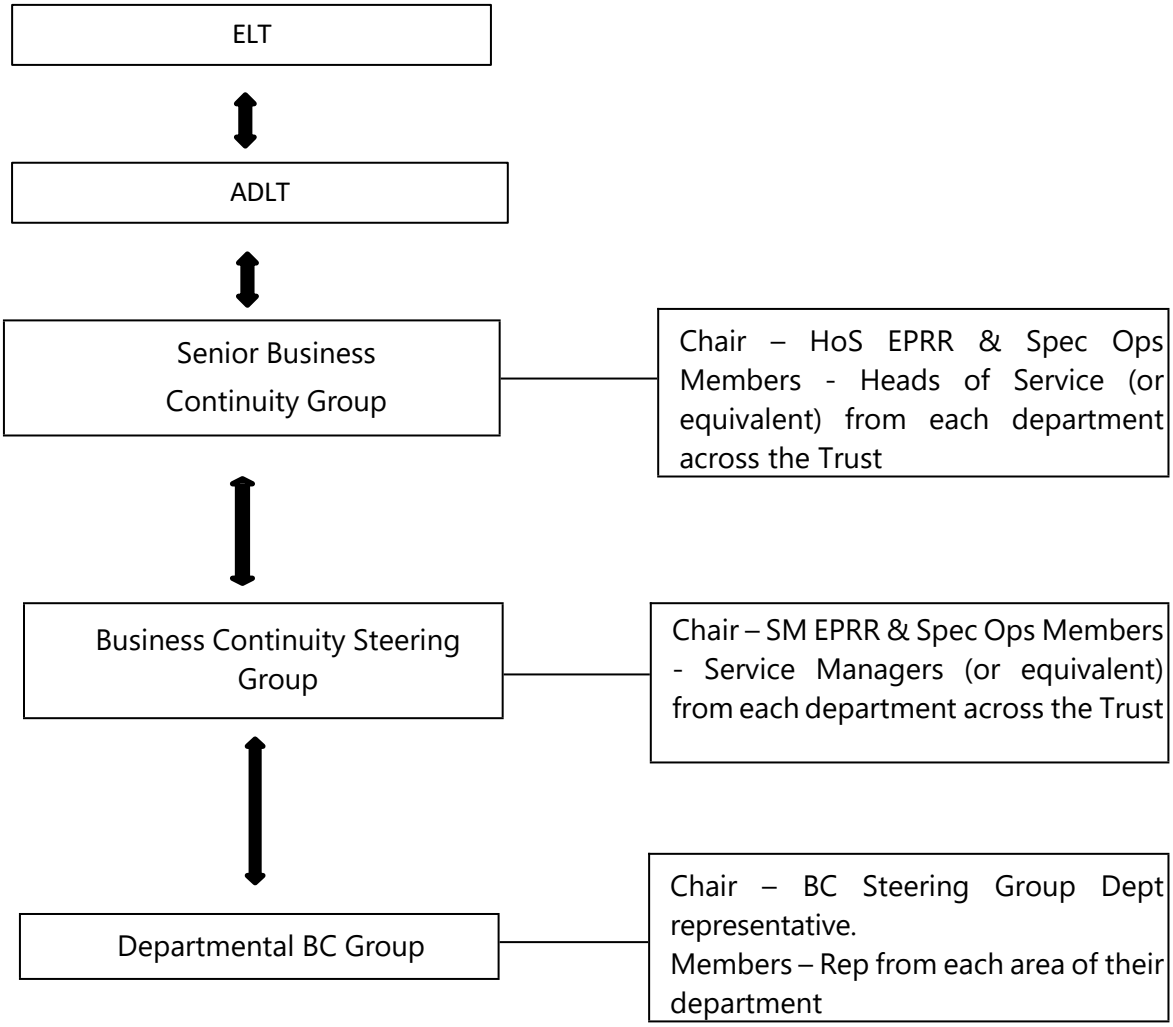
3.3 The group reviews the BCMS as a whole and shares incident and exercise learning. Departments and directorates are required to review their BIAs and BCPs annually, and after any incident to make amendments where required. Risk specific plans are also provided to the group for comment to ensure they have a Trust-wide view.

3.4 The BCSG reports into and is supported by the Senior Business Continuity Group (SBCG) chaired by the Head of Service EPRR & Spec Ops, with the membership of this group being Head of Service (or equivalent) from each directorate across the Trust.

3.5 The BCSG and SBCG are Trust-wide groups that extend beyond Operations as a suitable reporting method has been identified to encompass all the departments.

3.6 This BC structure reports into ADLT as a formally constituted sub-group of the Executive Leadership Team, for assurance that all directorates within the Trust are represented.

The agreed BC structure is as follows:



Responsibilities of the BC groups:

Group	**Responsibilities**
ADLT	Ensuring the Trust has robust BC plans in place to meet the obligations under the CCA 2004. Reporting to ELT.
Senior BC Group	Provide assurance to ADLT that BC plans are in place across the Trust and support the BC Steering group to break down any barriers to providing BC plans. Reporting to ADLT.
BC Steering Group	Provide assurance to the Senior BC group that BC plans and BIA have been undertaken and are in place for each department across the Trust. Monitor BC plans to ensure they remain in date. Ensure cross departmental working is in place when required. Report to Senior BC Group.
Departmental BC Groups	Ensure the department's BIA and BC plans are up to date and appropriate for the department. Undertake departmental testing of the BC plan. Report to BC Steering Group.

3.7 Departments should be represented at a minimum of 75% of the meetings (3 or more) across the year. This could be the BC Lead for the department, or a deputy, but it should be someone with a working knowledge of both their department and the BC arrangements. Attendance at the meetings is recorded showing departmental engagement and, where it falls short of the recommendation from the audit the relevant Assistant Director is made aware.

3.8 As part of their remit to ensure the Trust meets its civil contingencies obligations, the EPRR team works with departments to assist in the development and delivery of plans, processes and systems. Performance Management is monitored by the EPRR Officers, through continuous status assessments of BIAs, BCPs and departmental exercising. The details are collated and shared with the BCSG on an MS Teams channel, so they are aware of the progress.

3.9 82% of the BIA and BCPs on the MS Teams Channel have been reviewed within the last 6 months in preparation for uploading to the new BC software. BCP and BIA review dates are a standing agenda item on BCSG meetings.

3.10 Continuity2, the provider of our BC Software, have now received all the data required to 'front load' the system and ensure maximum usability. They are currently building the final section of the portal with a timeframe for completion expected in mid-June 2025.

3.11 Super-user training to the EPRR team will commence in late June 2025 with a view to creating/uploading Operations directorate BIA's and BCP's through July and into August, with the full roll out to other departments in taking place in late August and into September.

4 Business Impact Analysis and Risk

4.1 A business impact analysis (BIA) is undertaken to identify

- What the business delivers
- The 'critical activities' required
- Potential outcomes of disruption
- Required staffing levels
- Interdependencies
- Risks from disruption

4.2 To ensure appropriate oversight and buy-in from each department, the EPRR team facilitated a number of BIA workshops in January 2025 to

guide and support the creation of BIAs.

4.3 This work was followed up in March 2025 with the supported creation and review of departmental BC Plans.

5 Incidents

5.1 Debriefs from Business Continuity Incidents (BCI) are recognising that early declaration of a BCI brings together an effective management structure including specialists who can deal with the cause while the rest of the structure deals with potential impact.

5.2 Incident table for 2024/25 is shown below:

Date	Incident	Incident Notes
Dec-24	Storm Darragh – Simultaneous loss of power to 2x EMSCs.	ODU/ICC was not on the generator so in the event of power failure ODU/ICC would not be functional. Learnings were captured in formal debrief for action. Update ME 12.06.25 – Spoken to Estates, they are going to check with IT. If ICC and ODU are not on the UPS, it can be done, and a plan would need to be done to mitigate the risk of power failure within ODU/ICC again. Spoke to Nat in ODU and she informed me that the systems were fine, but the light's went out
Jan-25	North Wales water main loss.	Estates to include Water Loss in departmental BIAs.
Mar-25	Airwave outage	The impact was mitigated utilising established BC plans. Learnings were captured in formal debrief for action.
Mar-25	Blackwood Station	Roof Repairs, necessitated instigation of BC plans to include relocation to Bargoed, Tredegar and Pontypool stations.
Apr-25	Planned CAD outage	Whilst this was a planned outage, it presented an opportunity to test the functionality of local plans. Learnings were captured in formal debrief for action.
Apr-25	Carmarthen Water Outage	Estates to include Water Loss in departmental BIAs.

National BC Engagement

5.3 WAST is continuing to work with partner agencies at a national,

strategic and tactical level to look at identifying and mitigating risks associated with pandemic preparedness, alongside responding to the national Covid public inquiry and the Senedd inquiry process

5.4 At a local level WAST fully engage with partners in Local Resilience Forums, to address these risks.

5.5 The following workstreams are being discussed at the National BC group:

5.5.1 The majority of ambulance Trust's across the UK are moving to a digital software solution for their business continuity management. As part of this approach, benefits and risks have been discussed collectively, alongside discussion around which tools will be implemented by Trusts.

5.5.2 A risk has been identified by some Trust's around ABLOY Keys and issues that some have experienced with this. Due to their critical nature, discussions have been held on whether a specific plan needs to be identified for loss of this infrastructure. WAST have not experienced any specific issues with ABLOY Keys but will support and collaborate on a plan with partners.

6 Trust Plans

6.1 The Trust holds generic response plans, such as the Incident Response Plan (IRP), risk-specific plans based on risks in the National Security Risk Assessment (NSRA), and departmental business continuity plans. Although not all risks need a plan specifically for them, the common consequences, as shown in section 2, should be planned for and the cause understood. The highest risks on the NSRA, which the Trust should be prepared to respond to while carrying on normal business, include:

- Terror attacks (various methodology)
- Disruption of telecommunications (multiple causes, both accidental and deliberate)
- Extremes of weather
- Utility disruption (gas, electric, water supply)
- Pandemic (of any kind, not just influenza) and outbreak of emerging diseases
- Cyber attacks
- Flooding

6.2 The IRP and Notification and National Escalation Procedure (NEP) both set out the definition of a BC Incident, and who should be notified both in and out of hours. The NEP was reviewed in December 2024 and approved by

the Senior Operations Team to streamline and clarify, roles, responsibilities, and communication of and between the Operational Delivery Unit (ODU), EMS-C and the command/management structure. Departmental plans support the delivery of these procedures.

6.3 The Departmental BC plan template has been reviewed to align with the structure detailed in the Trust's Incident Response Plan to ensure that all directorate are appropriately equipped to act should a disruption occur.

6.4 The Severe Weather Plan has been reviewed and published in January 2025, the Pandemic Plan and the Fuel Disruption Plan are currently under review, and the Power Outage Plan was updated in May 2024.

7 Exercises

7.1 Each directorate tests their departmental plans with support from the EPRR Team. A set of PowerPoints are available on the BC Steering Group Teams channel for directorates to modify and use to test their own plans as appropriate. Topics include:

- ICT loss
- Staff loss
- Denial of access to premises
- Service and supplier disruption.
- Power outage

7.2 Outcomes and action plans would be held in a post-exercise report and discussed by the Business Continuity Steering Group and can be summarised for submission as an appendix to future reports. The BC Lead for the directorate is responsible for delivery of the action plan linked to their directorate risk registers.

8 Training

8.1 Discussions have taken place in BC Steering Group to review training needs, although a package is yet to be agreed. A review of the governance around BC will help to identify who should be involved directly, how, and what knowledge they would need.

8.2 The implementation of the BC management software will also bring additional functions to support staff with training. This system allows for BC topical subjects to be available to users of the software.

RECOMMENDATION:

It is recommended that Committee:

a) Receive and Discuss the Annual Business Continuity Report**.**

Appendix 1

Department	% of attendance
Resource	0% (0 out of 3)
EMSC	0% (0 out of 3)
Finance	33.33% (1 out of 3)
Planning and Performance	33.33% (1 out of 3)
Clinical	33.33% (1 out of 3)
Insights & Data	33.33% (1 out of 3)
SE&SC EMS	33.33% (1 out of 3)
FinCor & Capital	66.66% (2 out of 3)
Clinical Logistics	66.66% (2 out of 3)
Volunteering	66.66% (2 out of 3)
Fleet	100% (3 out of 3)
N & C EMS	100% (3 out of 3)
Comms	100% (3 out of 3)
Planning & Performance	100% (3 out of 3)
MRD	100% (3 out of 3)
People Services	100% (3 out of 3)
Corporate Governance	100% (3 out of 3)
Ops Business Support	100% (3 out of 3)
EPRR	100% (3 out of 3)
Integrated Care	100% (3 out of 3)
CEO Office	Recently joined the last meeting.

EPRR & Specialist Ops

Resource Escalation Action Plan (REAP)

Version 6.0 June 2025

Version Control Sheet

Version	Date	Author	Summary of Changes	Review Due
0.1	02/09/2020	C. Simms	Rewrite of plan into Trust template. Previous version history held in archive.	
2.1	29/09/2020	C. Simms	Sent to SOT; ADLT and EMT for approval	
2.2	12/10/2020	C. Simms	Amendment to point 14 page 21 for NEPTS; addition to diagram on annexe 2 page 16, SPT to replace TPT; reviewed against English REAP v0.4; add BAU to approvals table for REAP 1	
2.3	12/10/2020	C. Simms	Document approved	10/2021
2.4	5/08/2021	C. Simms	Annual review; reviewed alongside National REAP Plan 1.4 (NDOG version) and include additional considerations at REAP 4	
2.5	03/11/2021	C. Simms	Updated front to document, incorporation of Winter exercise lessons identified.	
3.0	04/11/2021	C. Simms	Approval of document	11/2022
4.0	21/11/2022	C. Langshaw	Annual review. Updated terminology, addition of actions to be considered during periods of extended high REAP levels, document links added. Suggested amendments made by SLT and approvals table.	11/2023
4.1	28/11/2023	C. Langshaw	Annual review. New Trust template used. Mass Casualty definition added. REAP 2/action 10 wording amended. REAP 3 additions - Dom to control room added/use of CSP as proactive tactic/immediate handover of patient moved to REAP 3 from REAP 4. REAP 4 additions – In Hours and Out of Hours clarification re the Strategic Plan/Strategic Commander to inform WG/Use of the Unscheduled Care Framework/unitisation of a patient management plan.	11/2024

Version	Date	Author	Summary of Changes	Review Due
5.0	13/12/24	EPRR	Annual review	December 2025
6.0	23/05/25	EPRR	Change to REAP Triggers and splitting of triggers into 'Inputs' and 'Outcomes'. Review of weighting of the Triggers and the associated Metrics Changes to include new EMSC and Integrated Care structure. Removal of BT Call Filtering Process	June 2025
Keywords				

Document Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
SLT		Agree the review of the document
ELT		Approve the document

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 Operations Support Manager

Contents

1. INTRODUCTION

1.1 As a Category 1 Responder in line with the Civil Contingencies Act 2004, the Welsh Ambulance Services University NHS Trust (WAST) must ensure we embrace identified best practice and national guidance. Resource Escalation Action Plan (REAP) provides NHS ambulance services with a consistent and coordinated approach across the organisations as to the management of its response in situations where demand or other significant factors within the ambulance service see an increase, and any challenge to the capacity to manage these.

1.2 REAP is designed to be informed by any intelligence led or dynamic challenges. It is used to inform staff internally, and to share across the wider NHS, along with other partner agencies. This covers the pressures facing the organisation and is intended to have a consistency with actions. The considerations and actions contained within the REAP are designed to assist in protecting staff, patients and the organisation.

1.3 Assessment and escalation / de-escalation of REAP levels will be the decision of those who attend the planned weekly Performance, Demand and Capacity meeting, or out of hours, the duty Strategic Commander. Heightened levels of REAP should be sustained only so long as necessary and de-escalated as soon as practicable.

1.4 WAST covers large geographic boundaries within Wales with many different challenges. The relevant pressures may well be reviewed on a Health Board or regional boundary basis but the REAP position remains a pan-Wales assessment.

1.5 REAP is an organisational action plan and should be underpinned with departmental actions cards agreed by each Trust Director relative to the internal structure. REAP should be both a strategic pre-planned assessment or when appropriate, a dynamic tool, to address any unplanned, unexpected event. Strategically it has a pre-planned seven-day forward view taken through a formal review process on a weekly basis under the direction of the Executive Director of Operations or their delegate.

1.6 REAP should be formally reviewed at least weekly. By routinely assessing the REAP level it allows the likely identification of the key influencing factors. The review process should include collection of information, decision and rationale using the Joint Decision Model (JDM) and a record keeping system.

1.7 To aid the REAP level assessment, the Joint Decision Model (JDM) should also be used to support the rationale for any changes.

1.8 Any review will fully consider both the ambulance related risks, balanced against any wider NHS Wales challenges that may directly impact service delivery or patient experience/safety. This also considers staff health and wellbeing.

2. AIM

2.1 The aim of this plan is to describe the arrangements to be considered by WAST in response to a planned or spontaneous assessment of pressures affecting, or likely to affect service delivery and patient safety.

3. OBJECTIVES

3.1 To provide WAST with a set of triggers based on various metrics that identify pressure on service delivery and/or patient safety to act as a guide to support decision making.

3.2 To then provide WAST with a categorisation of pressure on a scale of 1 to 4 with associated actions for consideration.

3.3 To also provide WAST with a process for decision making and recording rationale

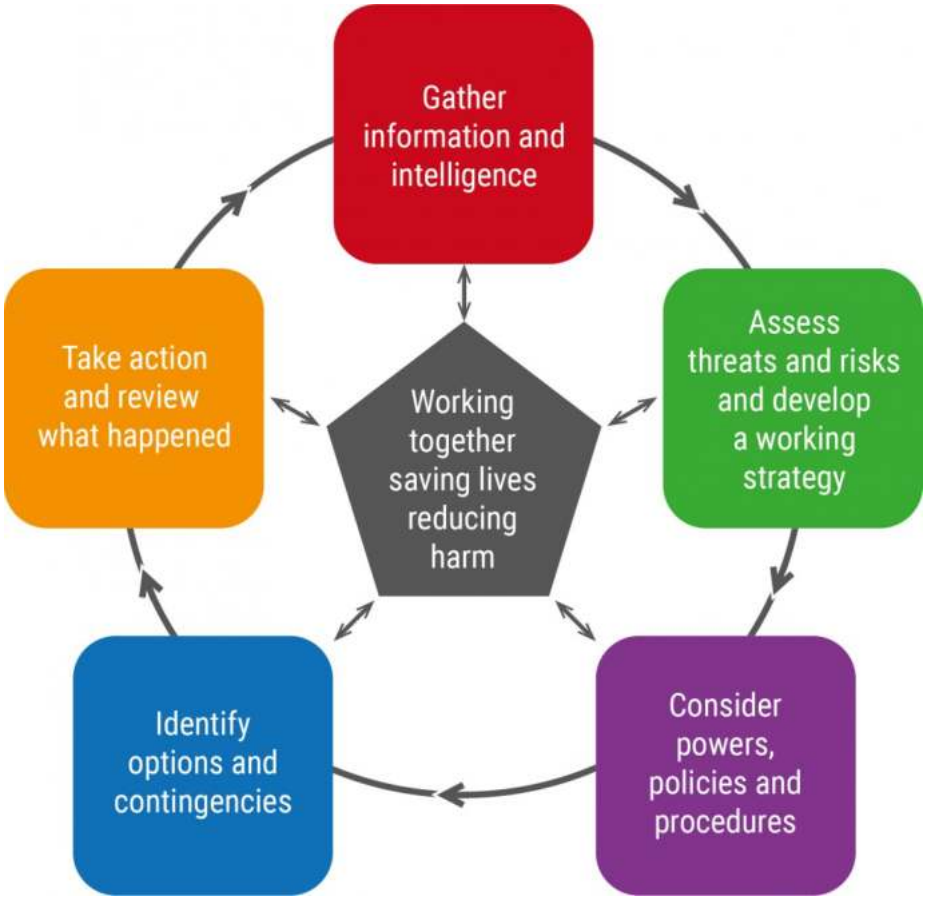
4. SCOPE

4.1. This plan provides WAST with a process for identifying potential service pressures and a system for managing and mitigating the impacts.

4.2. The plan does not provide for dynamic hour by hour mitigation of system pressures as this will be managed primarily through the Clinical Safety Plan (CSP).

5. JOINT EMERGENCY SERVICES PRINCIPLES

5.1. The decision-making model that all services should use, is the JDM. Using this model, during the assessment of the level of REAP required, facilitates an auditable decision-making record.



6. USING THE JDM TO SUPPORT DECISION MAKING

6.1 Information and Intelligence

During this stage of the JDM cycle, the Performance, Demand and Capacity Meeting or Strategic Commander using all known available information, actual or potential, will identify the situation (i.e. what is happening, has happened or is likely to happen) and will clarify any matters relating to initial information and intelligence:

- What is happening?
- What is known so far?
- What further information (or intelligence) is needed?
- What external factors need to be considered?
- Are there demand, weather, supply chain disruption, security threat, hospital delays, 111 and community service issues?
- Are there internal factors affecting capacity?
- Are there absence and other extractions, fleet issues, and infrastructure problems?

The key influencing factors for the Meeting or Strategic Commanders are the triggers that are contained in Annex 1.

The principle of REAP is that ambulance services in England, Scotland and Wales will operate at REAP level one, when the service is operating within steady state parameters i.e. 'business as usual' and meeting national or commissioned standards of performance.

The additional three levels to this reflect an increasing pressure on the organisation, all the way through to level four, where there is the potential for service failure. Each level has been colour coded to make recognition of current operating pressures and signal to the wider system the similarities of pressure.

REAP Level One (1)	**Steady – Green**
REAP Level Two (2)	**Moderate – Amber**
REAP Level Three (3)	**Severe – Red**
REAP Level Four (4)	**Extreme – Purple**

Additional considerations:

The Trust has adopted the following incident type definitions as outlined in the Incident Response Plan and Notification and Escalation Procedure via the EPRR Plans and Publications Siren Page:

- A **Major Incident** is defined as, "*An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies.*"
- An **NHS Major Incident** is defined as, "*any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented NHS wide.*"
- A **Mass Casualty Incident** is defined as "*an Incident causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage, which therefore requires further measures to appropriately deal with the casualty numbers*." (NHS England, 2017).

Or

"A disastrous single or simultaneous event(s) or other circumstances where the normal major incident response of several NHS organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response." (Welsh Gov, 2015)

- *A* **Major Incident Standby** *is defined as, "Alerts the NHS that a major incident may need to be declared. Major incident standby is likely to involve the participating NHS organisations in making preparatory arrangements appropriate to the incident, whether it is a 'big bang' ,a 'rising tide' or a pre-planned event".*
- A **Critical Incident** is defined as, "*any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services."*
- A **Business Continuity Incident** is defined as, "*an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure."*
- An **Extraordinary Incident** is defined as, *"an incident that will have a significant impact on the Trust, be of a complexity that requires a large number of resources or casualties requiring access to national clinical networks. An incident of this type may attract atypical media or public interest and would fall short of a Major Incident Stand-by incident. An example of an extraordinary incident may include, though not be limited to a high-profile figure concerned in an incident that could result in media attention, a serious road traffic collision involving a WAST vehicle resulting in serious injury to staff or third party, a staff member who suffers a serious injury whilst at work through any means, unexpected flooding incident that whilst not requiring a particular response from the organisation, could result in questions about our preparedness, or an incident that may have serious or on-going political ramifications."*

The National Escalation of Threat Levels (as determined by the Joint Terrorism Analysis Centre [JTAC]) are not included within the REAP review stages but should be fully considered in case they impact on any of the REAP levels.

UK THREAT LEVELS

There are 5 Levels of Threat:

- LOW means an attack is highly unlikely
- MODERATE means an attack is possible, but not likely
- SUBSTANTIAL means an attack is likely
- SEVERE means an attack is highly likely
- CRITICAL means and attack is highly likely in the near future

The Trust has a Critical Threat Level Plan that contains additional immediate actions in the event of Critical Security status being declared.

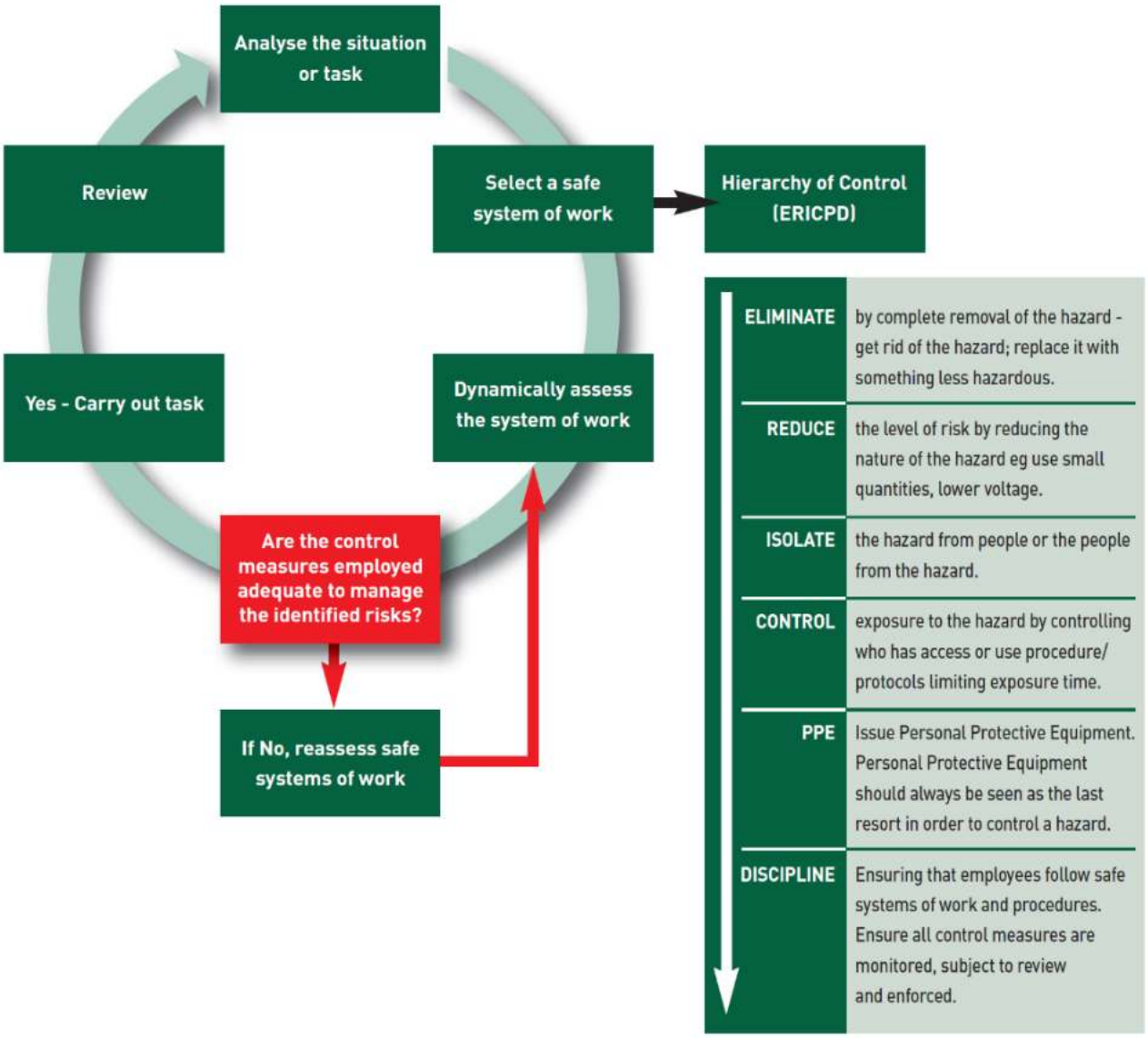
The table below shows the response levels that should be applied against the current threat levels.

Response Level	Description	Aligned Threat level
Exceptional	*Maximum protective security measures to meet specific threats and to minimise vulnerability and risk*	**Critical**
Heightened	*Additional protective security measures reflecting the broad nature of the threat combined with specific business and geographical vulnerabilities and judgements on acceptable risk*	**Severe** **Substantial**
Normal	*Routine protective security measures appropriate to the business concerned*	**Moderate** **Low**

6.2 Assess Threat & Risk, Development of a Working Strategy

In this stage of the JDM cycle, REAP is the process that enables the assessment of the situation, including any specific threats, the risk of harm and the potential for improving the position:

- Do we need to act immediately?
- Do we need to seek more information?
- What could go wrong (and what could go well)?
- How probable is the risk of harm?
- How serious would it be?
- Is that level of risk acceptable?
- Is the Trust able to deal with the situation alone?
- Am I the appropriate person to deal with this?



The weekly review meeting or the Strategic Commander should consider developing a strategic intent for incidents declared using the Incident Notification definitions listed on pages 6 and 7.

Using the information and intelligence available and with the input and advice of others, the Meeting or Strategic Commander should complete an assessment against the REAP level triggers shown in Annex 1.

6.3 Consideration of Powers, Policies and Procedures

This stage involves considering what policies and procedures might be applicable in this situation:

- What Trust resources might be required?
- Is there any national guidance covering this type of situation?
- Do any local organisational policies or guidelines apply?
- What legislation might apply?
- What polices or procedures may need to be enacted?

The weekly review meeting or Strategic Commander must document their rationale for taking actions. This is different to a Strategic Intent. Situations can be variable and complex, therefore it may be reasonable to act outside the plan using operational discretion. The decision should

be made using the REAP Assessment sheet process (Annexe 3) and the rationale must always be recorded and timed using the agreed logging procedures.

Annex 3 contains the actions cards that will be used at each REAP level. For REAP to work within any Trust, it is imperative that these actions are followed as this will assist in maintaining the best possible safety and service to our patients. All directorates and their sub-functions within the Trust are required to take required action, with the appropriate urgency, as the REAP level escalates.

The weekly review meeting or Strategic Commander must provide regular updates and assurance to the Trust Executive. Out of hours this should be accomplished through Executive on Call.

Considerable failure of critical infrastructure may also trigger a change in REAP level. When assessing the REAP levels, Strategic Commanders should always consider business continuity arrangements. WAST will also consider any declaration of an incident through the incident notification process as previously set out in this plan.

6.4 Identify Options and Contingencies

The action cards contained within Annex 3 should be followed. It is recognised that each action will need to be considered by the Meeting or dynamically by the Strategic Commander, in consultation with others, if necessary, in the context of the situation being managed.

It should be noted that the actions cards contain actions for consideration, these are not MUST DO actions, however the lead decision maker should be prepared to provide a clear rationale as to why a particular action is undertaken, or not.

This stage involves considering the different ways to make a decision (or resolve a situation) with the minimum risk to patient safety.

WAST will seek to work alongside any wider NHS Wales & Health Board Escalation Plans in addition to recognising the unique Hospital Capacity Plans.

What options are available? Consider the immediacy of any threat, the limits of information to hand, the amount of time available, resources and support required/available, knowledge, experience and skills and the impact of potential actions on the situation and the public.

Should the Strategic Commander have to account for their decision, can it be considered to be:

- JPLAN – Justifiable, Proportionate, Legal, Accountable, Necessary?
- Is it ethical (consider clinical aspects)?
- Reasonable in the circumstances at the time, with the information available?
- Does it affect our responsibilities under the Duty of Candour?

It also requires all decision makers to review the impact and effectiveness of decisions and rationale.

6.5 Take Action

Respond:

- Implement the selected REAP level action card. Each weekly Performance, Demand and Capacity Meeting should determine if a full review of the action cards is required. Action cards should be reviewed on escalation or de-escalation. Should a REAP level be maintained, consideration should be given to the value of further review.

- Who needs to know what has been decided?

Record:

- Record what actions were taken, by whom and why?

Inform:

- Consider who internally and externally should be informed
  - Trust staff – Everbridge via ODU
  - Partner Emergency Services – Everbridge via ODU
  - REAP level 4 – Welsh Government, NHS Executive

Monitor:

- What happened because of the decisions taken?
- Did they achieve the desired effect?
- What else can we try?

If the situation is protracted, repeat the JDM cycle as required. The actions contained within each level of REAP above level 1 will require ongoing senior leadership support and Executive assurance.

6.6 Review

If the incident is over, review the decisions taken using the JDM.

Identify any lessons and what might be done differently in the future.

6.7 Decision Making

Decision making can be complex, based on single or multiple elements as shown in Annex 1. The Meeting or Strategic Commander will need to use judgement alongside actual or potential evidence in reaching a decision, recognising that as information changes, decisions can also change.

Below are the most common, but not exhaustive reasons, why REAP levels may change. One or all may be sufficient to make a decision and based on the variability of cause, all decisions are based on the information available at the time and recorded and reviewed using the Joint Decision Model.

- Call Demand – actual or forecast
- Resourcing / Abstraction levels (capacity)
- Operations centres (EMSCC and/or Integrated Care) issues
- Rapid Clinical Screening functionality (Clinical Navigators)
- Fleet capacity
- Other factors such as wider system impacts e.g. delays at hospitals
- Infrastructure – estates; ICT
- Weather – severe weather i.e. storms, flooding, snow, heatwave
- Supply chain – medical consumables, PPE, medical gases
- Performance across all categories
- JTAC national threat level

As such, decision making is complex, and the experience and judgement of the Meeting or Strategic Commander may and can be subjective. However, where it is unclear, the Meeting or

Strategic Commanders may consider a multi-disciplinary discussion to support optimal decision-making, recording of decisions and rationale.

7. REAP ESCALATION APPROVALS

The table below outlines the approvals required for escalation of the declared REAP level. Escalation is from the base BAU position on REAP 1 and it is not necessary to progress through these levels sequentially so depending on the situation, the level can be raised to any necessary level. Following a decision to raise to Levels 3 and 4 the Meeting or Strategic Commander must commit to a schedule of regular review of the REAP level.

This schedule can be determined as appropriate to the circumstances. At REAP 3 it may remain appropriate to sustain the pre-existing weekly review.

If Level 4 is declared in an unplanned situation, out of hours, the Executive Director of Operations and Chief Executive must be informed at the earliest possible opportunity in-hours.

REAP Level (BAU)	Planned	Unplanned	
		In Hours	Out of Hours
REAP Level Two (2)	Weekly Performance, Demand & Capacity Meeting	Level no lower than Head of Service	Strategic Commander
REAP Level Three (3)	Weekly Performance, Demand & Capacity Meeting	Level no lower than Assistant Director of Operations	Strategic Commander
REAP Level Four (4)	Recommended: Weekly Performance, Demand & Capacity Meeting Additional: In extreme circumstances can be reviewed via an extraordinary meeting Approved: Director	Level no lower than Director and notify Chief Executive	Strategic Commander

8. EXTENDED USE OF REAP 3 AND REAP 4

8.1. High levels of REAP are not intended for prolonged periods of time, mainly because the actions set out are intended to help the Trust recover the situation. There can be long term impacts of the absolute application of REAP actions.

8.2 If high levels of REAP are in place for an extended period of time the following actions should be reviewed.

- The deployment of all clinicians to patient facing duties where appropriate is not sustainable for prolonged periods, as it results in managerial, clinical and regulatory tasks being delayed which may have consequences in the medium or long term.
- Cancelling all meetings which do not relate to improving the current position is effective in the short term, however there is a constraint here when meetings are necessary to effect the transformation needed to try and alleviate matters that lead to the pressures to begin with. It is not therefore sustainable for prolonged periods without medium to long term consequences.
- Cancelling all staff training can be effective for a short period of time, however during extended periods of high REAP levels, the review meeting will need to consider the long-term implications of cancellation of training. This action already recognises that cancellation for prolonged period can be detrimental. This can be considered detrimental to skill maintenance, registration requirements, and recruitment.
- Review deployment of HART and other specially commissioned services. The HART training team is often considered to aid access to rest breaks at hospital sites when handover delays occur, however sustained periods of HART training being cancelled will impact on the team's ability to re-qualify and recertify in their specialist areas which could impede the effectiveness of the HART response. This is not therefore a sustainable option for prolonged periods.
- Strategic commanders therefore should balance the application of REAP 4 actions between the immediate needs of the presenting operational and clinical situation, versus the medium to long term impacts on transformation, regulatory requirements and management and clinical functions.

8.3 The Strategic Commander may exercise discretion when implementing REAP 4 actions, in order to provide due consideration to the impacts and benefits of each tactical option.

9. PLAN VALIDATION

9.1 This plan is owned by the Operations Directorate and managed by the EPRR Team.

9.2 The plan will be reviewed annually to meet existing best practice.

9.3 The plan will be approved by the Executive Leadership Team.

10. TRAINING

10.1 The REAP plan contains sufficient information for anyone to be able to review escalation without formal training.

10.2 Where a specific training need is identified then this will be dealt with on an individual basis.

11. LINKS TO OTHER PLANS

11.1 Other plans, policies and procedures to reference in conjunction with this plan include but are not limited to:

WAST Incident Response Plan	NARU Command and Control Guidance (2024)
WAST Notification and Escalation Procedure	JESIP Doctrine (2024)
Local Resilience Forum Plans	WAST Business Continuity Plans
Civil Contingencies Act (2004)	WAST Critical Threat Level Plan
Health and Safety at Work Act (1974)	Human Rights Act (1998)
NARU – NACC plan	UK Ambulance Mutual Aid plan
WAST Critical ICT Disruption Plan	WAST Clinical Safety Plan

ANNEX 1 – REAP LEVEL TRIGGERS

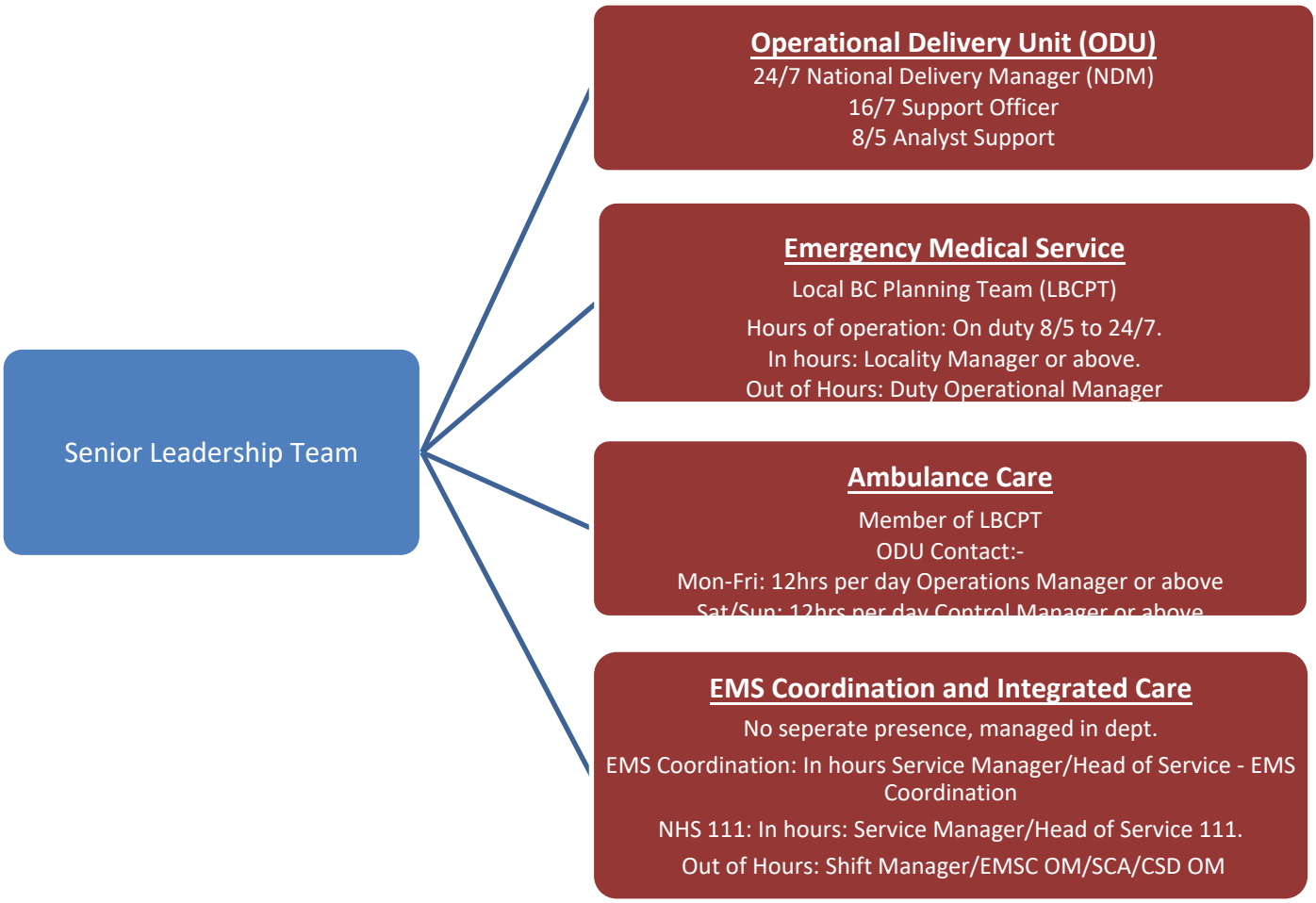
Assess on a minimum of a weekly basis (7-day period) or as disruptive challenges require.

Inputs				
REAP Level	**1**	**2**	**3**	**4**
Service Delivery Pressure	**Steady**	**Moderate**	**Severe**	**Extreme**
Weather (Met Office Warnings)	Consider Met Office weather warnings	Yellow weather warnings in place (consider other warnings)	Amber weather warnings in place (consider other warnings)	Red weather warnings in place (consider other warnings)
EMS Verified Incidents (Annual Baseline)	Up to 5% above annual baseline	Between 5% and 10% above annual baseline	Between 10% and 15% above annual baseline	Greater than 15% above annual baseline
UHP Combined Conveying (Resource Levels)	Actual within 95% of planned resource levels	Actual between 90% and 95% of planned resource levels	Actual between 85% and 90% of planned resource levels	Actual less than 85% of planned resource levels
999 Call Demand (Annual Baseline)	Up to 5% above annual baseline	Between 5% and 10% above annual baseline	Between 10% and 15% above annual baseline	Greater than 15% above annual baseline
UHP 999 Call Handlers (Resource Levels)	Actual within 95% of planned resource levels	Actual between 90% and 95% of planned resource levels	Actual between 85% and 90% of planned resource levels	Actual less than 85% of planned resource levels
UHP 999 Clinical Navigators (Resource Levels)	Actual over 90% of planned resource levels	Actual between 75% and 90% of planned resource levels	Actual between 60% and 75% of planned resource levels	Actual less than 60% of planned resource levels
Integrated Care Combined Clinicians	Actual over 90% of planned resource levels	Actual between 80% and 90% of planned resource levels	Actual between 70% and 80% of planned resource levels	Actual less than 70% of planned resource levels
111 Demand (Annual Baseline)	Up to 5% above annual baseline	Between 5% and 15% above annual baseline	Between 15% and 25% above annual baseline	Greater than 25% above annual baseline
Shift Fill 111 Call Handlers (Resource Levels)	Actual within 95% of planned resource levels	Actual between 90% and 95% of planned resource levels	Actual between 85% and 90% of planned resource levels	Actual less than 85% of planned resource levels
Other	Consider: any incident type declaration, industrial action, sporting events, concerts, public order, system infrastructure, access to system support, pandemic. Consider each of the 7 HB and A&E specific escalation impacts and predicted demand.			
*Ordering denotes the weighting of the indicator, heaviest to lightest.				

Outcomes				
REAP Level	**1**	**2**	**3**	**4**
Service Delivery Pressure	**Steady**	**Moderate**	**Severe**	**Extreme**
PURPLE ARREST Performance (Median 6-8 minutes)	Median ARREST Performance less than 8 minutes	Median ARREST Performance from 8 to 10 minutes	Median ARREST Performance from 10 to 15 minutes	Median ARREST Performance greater than 15 minutes
RED EMERGENCY Performance (Median 6-8 minutes)	Median EMERG Performance less than 8 minutes	Median EMERG Performance from 8 to 10 minutes	Median EMERG Performance from 10 to 15 minutes	Median EMERG Performance greater than 15 minutes
AMBER Performance	Median AMBER Performance up to 1 hour	Median AMBER Performance from 1-2 hours	Median AMBER Performance from 2 to 3 hours	Median AMBER Performance greater than 3 hours
Handover Delays (Hours per Day)	Handover delays less than 250 hours per day	Handover delays 250 to 400 hours per day	Handover delays 400 to 750 hours per day	Handover delays Over 750 hours per day
999 Call Answering Performance	Median call answering performance less than 10 seconds	Median call answering performance 10-20 seconds	Median call answering performance 20-30 seconds	Median call answering performance more than 30 seconds
*Ordering denotes the weighting of the indicator, heaviest to lightest.				

ANNEX 2 – OPERATIONS STRUCTURE

When establishing command / management structures at REAP Level 4, the following is provided to guide decision making for a potential appropriate model. The purpose of the model is to support core business as a result of purposeful and responsive management. It would be appropriate for a REAP Level 4 declaration where there is **potential for sustained escalation due to service pressures**, rather than a major incident for a single incident[1].



[1] It should be noted that this offers a guide and is dependent on our core structures.

ANNEX 3 – REAP ACTION CARDS

REAP Level Two – Moderate – Actions				Date:		
Action:	**Allocated Lead**	**Decision & Name**	**Rationale**	**Action Discharged – Evidence**	**✓**	**Time**
1. Upon escalation, establish Strategic Commander led meeting with key internal stakeholders to review and allocate actions						
2. Review and reallocate resources to meet current emergency workload						
3. Increase response level of operational clinical managers proportionate to requirement						
4. Alert CFR/CWR and co-responder schemes for additional support						
5. Profile additional resources to match periods of peak demand						
6. Consider physical attendance at non-essential meetings (those that do not improve or focus on improving the current position)						

7. Review all training and consider re-planning						
8. Consider voluntary aid services or Ambulance Care to undertake low acuity workload						
9. Consider developing key messages for communications with public, commissioners, staff and regulators						
10. Increase focus on daily resource capacity						
11. Consider any impact of a HB invoking any Business Continuity Plan						
12. Identify barriers to improvement which need support from internal or external partners						
13. ODU to update national ambulance Proclus dashboard						
14. Consider personal resilience/welfare arrangements within the Strategic, Tactical and support on-Call arrangements						

15. Consider informing Executive on-Call / Executive Director of Operations						

REAP Level Three – Severe - Actions				Date:		
Action:	**Allocated Lead**	**Decision & Name**	**Rationale**	**Action Discharged - Evidence**	**✓**	**Time**
1. Review all actions contained in REAP 2 action cards to assure all steps have been taken						
2. Upon escalation, establish a Strategic Commander led meeting with key internal stakeholders to review and allocate actions and to consider declaration of an incident through the Notification & Escalation Procedure. If declared a Strategic Plan needs to be created and circulated to those with actions to ensure understanding. All strategic decisions will need to be logged with rationale						
3. Review CSP operating level and consider the use of CSP as a proactive tactic						
4. Identify a clinical lead to act as Strategic Clinical Advisor.						

REAP Level Three – Severe - Actions				Date:		
Action:	**Allocated Lead**	**Decision & Name**	**Rationale**	**Action Discharged - Evidence**	**✓**	**Time**
5. Consider establishing a Tactical Command Cell at the ICC in support of ODU.						
6. Consider introducing an Operational Manager into the Control room or control rooms of the areas most affected.						
7. Consider request for mutual aid from other ambulance Trusts						
8. Consider supportive actions available within the Clinical Safety Plan, or which could be implemented if triggers are not met.						
9. Review all non-contractual attendance at private events						
10. Consider cancelling all non-mandatory training including HART training team						
11. Cancel all non-essential meetings. Consider any						

REAP Level Three – Severe - Actions				Date:		
Action:	**Allocated Lead**	**Decision & Name**	**Rationale**	**Action Discharged - Evidence**	**✓**	**Time**
essential meetings be limited to 1 hour in duration						
12. Actively contact staff for additional overtime shifts						
13. Consider deploying all active clinicians from all parts of the Trust (except for specially commissioned services) to patient facing duties, remote clinical assessment, remote clinical support or a clinical advisory role						
14. Consider deploying any alternative working duties staff to duties that support front line activity						
15. Identify available additional voluntary aid/Ambulance Care and deploy to undertake low acuity workload						

REAP Level Three – Severe - Actions				Date:		
Action:	**Allocated Lead**	**Decision & Name**	**Rationale**	**Action Discharged - Evidence**	**✓**	**Time**
16. Consider offering overtime to staff accessing annual leave to undertake patient facing duties						
17. Review deployment arrangements to optimise patient safety (i.e. additional solo responders)						
18. Request immediate handover of patients at receiving facilities in accordance with Welsh Health Circular HB Capacity Plans						
19. Consider additional management support to respective functions to support recovery						
20. Consider and implement any internal or external messaging via Corporate Communications Team and review any existing communication messages						

REAP Level Three – Severe - Actions				Date:		
Action:	**Allocated Lead**	**Decision & Name**	**Rationale**	**Action Discharged - Evidence**	**✓**	**Time**
21. All staff provided with uniform are to wear uniform so any immediate deployment needs are not delayed						
22. ODU to notify partner emergency agencies of escalation via Everbridge						
23. Consideration of health board estate for the creation of patient holding areas						
24. Consideration to pause Intelligent Routing Platform (IRP) when call demand shows sustained pressure across the system.						

REAP Level Four - Extreme - Actions				Date:		
Action:	**Allocated lead**	**Decision & Name**	**Rationale**	**Action Discharged - Evidence**	**✓**	**Time**
1. Review all actions contained in REAP 2 and 3 action cards to assure all steps have been taken. During Mon-Friday 0900-1700 the Director of Paramedicine or appointed deputy/out of hours Senior Clinical On-Call to be consulted						
2. A Strategic Plan must be formulated and circulated to those with actions to ensure understanding. Out of hours Strategic will consult with the Exec on call, In Hours Strategic will consult with the Director of Operations. The plan must be shared with the CEO or Deputy CEO. All Strategic Decisions need to be logged with the relevant rationale.						
3. Declare the appropriate incident type using the Incident Response Plan and Notification and Escalation Procedure using						

the definitions on page 7 of this document						
4. Notify HBs and Clinical Support Hubs in the 111 pathway with a view to maximising active flow.						
5. Strategic Commander to inform Welsh Government, NHS Executive and consider the activation of a Strategic Coordination Group (SCG).						
6. Strategic commander to consider the utilisation of additional resources via the Unscheduled Care Framework.						
7. Deploy all clinicians to patient facing duties where appropriate and in line with the deployment action card						
8. Cancel all meetings which do not relate to improving the current position						
9. Cancel all staff training. **NOTE**: Prolonged use of REAP 4 needs to consider the long term implications of cancellation of training.						

10. Review deployment of HART and other specially commissioned services.						
11. Consider clinicians to be a point of contact to discuss extended admission times for HCP/Doctors admissions						
12. Agree enhanced media activity						
13. Any mixed skill crew will be dispatched according to the highest clinical skill on the resource.						
14. Each department to consult their Business Continuity Plan (BCP) to identify staff that may be suitable for temporary redeployment to support core functions where appropriate.						

ANNEX 4 – REAP ASSESSMENT SHEET

Resource Escalation Plan (REAP) – Assessment Sheet

Location:	**Time:**	**Day & Date:**

Scope of use and rationale
For weekly Meeting and dynamic Strategic Commander review of the Trusts REAP status
To ensure that the situation is assessed against the REAP trigger points and that the resulting actions are considered in order to protect / support service delivery, patient safety and Trust reputation.

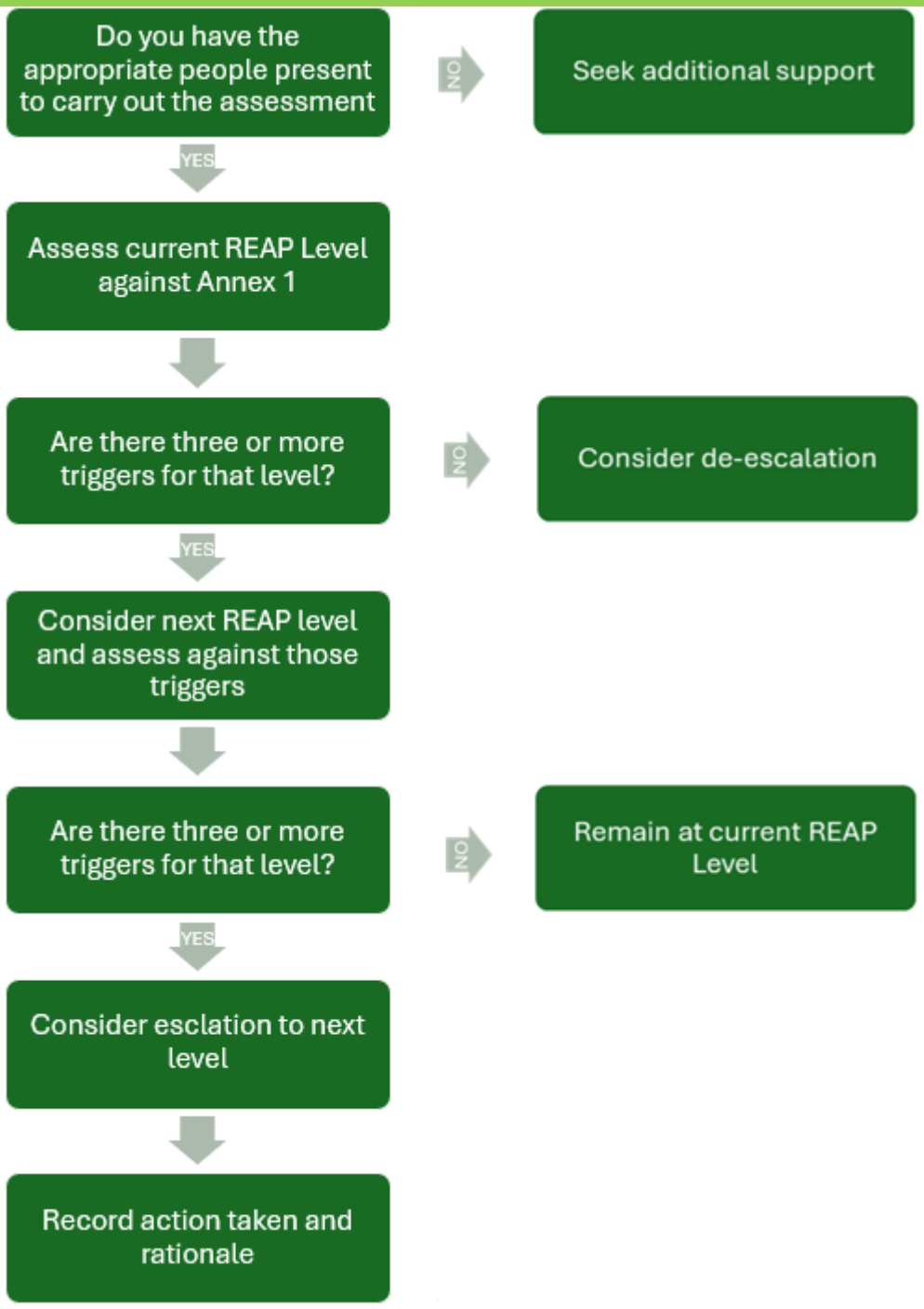
National Escalation of Threat Levels (as determined by the Joint Terrorism Analysis Centre (JTAC))

Tick applicable level:

LOW		SEVERE	
MODERATE		CRITICAL	
SUBSTANTIAL			

Before undertaking the REAP assessment, ensure the appropriate people are present to carry out the full assessment.

Item No:	Action No:	Gather Information and Intelligence	Level
Inputs			
1	1.1	Weather warnings	
	1.2	EMS Verified Incidents (Annual Baseline)	
	1.3	UHP Combined Conveying (Resource Levels)	
	1.4	999 Call Demand (Annual Baseline)	
	1.5	UHP 999 Call Handlers (Resource Levels)	
	1.6	UHP 999 Clinical Navigators (Resource Levels)	
	1.7	Integrated Care Combined Clinicians	
	1.8	111 Demand (Annual Baseline)	
	1.9	Shift Fill 111 Call Handlers (Resource Levels)	
	1.10	Other	
Outcomes			
1	1.11	PURPLE ARREST Performance (Median 6-8 minutes)	
	1.12	RED EMERGENCY Performance (Median 6-8 minutes)	
	1.13	AMBER Performance	
	1.14	Handover Delays (Hours per Day)	
	1.15	999 Call Answering Performance	

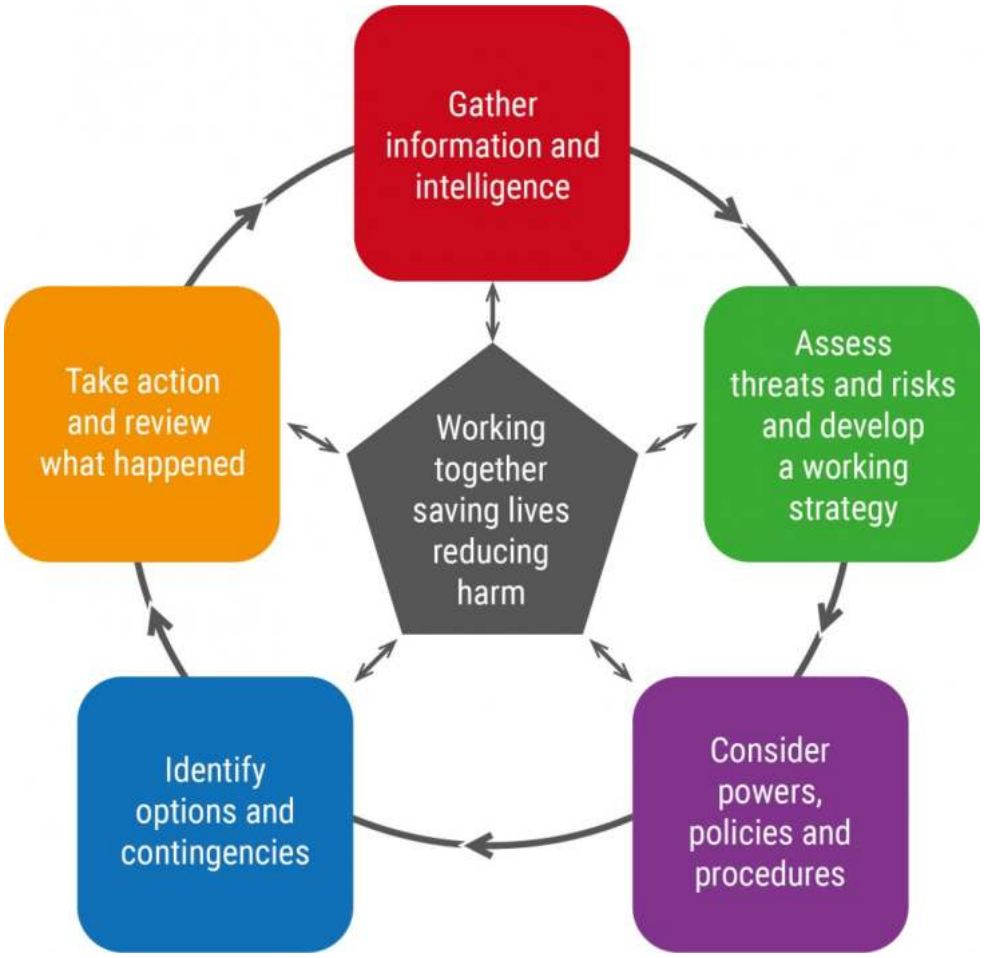
Item No:	Action No:	Assess, Threats, Risks & Develop a Working Strategy
2	2.1	 *Ordering of triggers in Annex 1 denotes the weighting of the indicator, heaviest to lightest.
Decision and rationale:		

Item No:	Action No:	Consider Powers, Policies and Procedures
3.		

Item No:	Action No:	Identify Options & Contingencies
4.		

Item No:	Action No:	Take Action	Who?	Completed?
5.	5.1	Request Comms to update Siren ODU to send out Everbridge informative message		
	5.2	Consider whether to advise partner emergency services – use Everbridge via ODU		
	5.3	Agree review timescale		
	5.4	Review decisions using the JDM process		
	5.5	Record any decisions and rationale		
	5.6	Review of Action Cards Yes/No		
	5.7	Notification of escalation to WG, NHS Executive		
Decision and rationale:				

Signature:	
Name:	
Position:	
Date / Time:	


Gather information and intelligence
Assess threats and risks and develop a working strategy
Consider powers, policies and procedures
Identify options and contingencies
Take action and review what happened
Working together saving lives reducing harm

ANNEX 1 – REAP LEVEL TRIGGERS

Replicated here for ease of access and printing.

Inputs				
REAP Level	**1**	**2**	**3**	**4**
Service Delivery Pressure	**Steady**	**Moderate**	**Severe**	**Extreme**
Weather (Met Office Warnings)	Consider Met Office weather warnings	Yellow weather warnings in place (consider other warnings)	Amber weather warnings in place (consider other warnings)	Red weather warnings in place (consider other warnings)
EMS Verified Incidents (Annual Baseline)	Up to 5% above annual baseline	Between 5% and 10% above annual baseline	Between 10% and 15% above annual baseline	Greater than 15% above annual baseline
UHP Combined Conveying (Resource Levels)	Actual within 95% of planned resource levels	Actual between 90% and 95% of planned resource levels	Actual between 85% and 90% of planned resource levels	Actual less than 85% of planned resource levels
999 Call Demand (Annual Baseline)	Up to 5% above annual baseline	Between 5% and 10% above annual baseline	Between 10% and 15% above annual baseline	Greater than 15% above annual baseline
UHP 999 Call Handlers (Resource Levels)	Actual within 95% of planned resource levels	Actual between 90% and 95% of planned resource levels	Actual between 85% and 90% of planned resource levels	Actual less than 85% of planned resource levels
UHP 999 Clinical Navigators (Resource Levels)	Actual over 90% of planned resource levels	Actual between 75% and 90% of planned resource levels	Actual between 60% and 75% of planned resource levels	Actual less than 60% of planned resource levels
Integrated Care Combined Clinicians	Actual over 90% of planned resource levels	Actual between 80% and 90% of planned resource levels	Actual between 70% and 80% of planned resource levels	Actual less than 70% of planned resource levels
111 Demand (Annual Baseline)	Up to 5% above annual baseline	Between 5% and 15% above annual baseline	Between 15% and 25% above annual baseline	Greater than 25% above annual baseline
Shift Fill 111 Call Handlers (Resource Levels)	Actual within 95% of planned resource levels	Actual between 90% and 95% of planned resource levels	Actual between 85% and 90% of planned resource levels	Actual less than 85% of planned resource levels
Other	Consider: any incident type declaration, industrial action, sporting events, concerts, public order, system infrastructure, access to system support, pandemic. Consider each of the 7 HB and A&E specific escalation impacts and predicted demand.			
*Ordering denotes the weighting of the indicator, heaviest to lightest.				

Outcomes				
REAP Level	**1**	**2**	**3**	**4**
Service Delivery Pressure	**Steady**	**Moderate**	**Severe**	**Extreme**
PURPLE ARREST Performance (Median 6-8 minutes)	Median ARREST Performance less than 8 minutes	Median ARREST Performance from 8 to 10 minutes	Median ARREST Performance from 10 to 15 minutes	Median ARREST Performance greater than 15 minutes
RED EMERGENCY Performance (Median 6-8 minutes)	Median EMERG Performance less than 8 minutes	Median EMERG Performance from 8 to 10 minutes	Median EMERG Performance from 10 to 15 minutes	Median EMERG Performance greater than 15 minutes
AMBER Performance	Median AMBER Performance up to 1 hour	Median AMBER Performance from 1-2 hours	Median AMBER Performance from 2 to 3 hours	Median AMBER Performance greater than 3 hours
Handover Delays (Hours per Day)	Handover delays less than 250 hours per day	Handover delays 250 to 400 hours per day	Handover delays 400 to 750 hours per day	Handover delays Over 750 hours per day
999 Call Answering Performance	Median call answering performance less than 10 seconds	Median call answering performance 10-20 seconds	Median call answering performance 20-30 seconds	Median call answering performance more than 30 seconds
*Ordering denotes the weighting of the indicator, heaviest to lightest.				

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

DIGITAL REPORTING

MEETING	Finance & Performance Committee
DATE	21st July 2025
EXECUTIVE	Jonny Sammut, Director of Digital Services
AUTHOR	Aasha Cowey, Assistant Director of Digital Services Leanne Smith, Assistant Director of Digital Services Kimberly Abraham, Digital Directorate Support Administrator
CONTACT	Aasha.Cowey@wales.nhs.uk Leanne.Smith4@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report brings to the committee updates relating to Insight & Data Services (IDS), ICT, Digital Innovation and Transformation projects and programmes, and details progress against the Digital Plan (see **Appendix 1** for metrics and project status reporting). This status report is updated regularly to offer an evolving picture of progress.

2. This report offers highlights and lowlights. **Appendix 2** contains a 'Digital Directorate Deep Dive' which will also be presented at the July meeting of the Finance and Performance Committee. The deep dive includes a glossary of all in-year projects alongside case studies and our overall ambition.

Highlights

3. **Recruitment** into Digital is progressing well. There are 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.
   - The new roles in the Innovation and Digital Transformation structure are going through job evaluation with the aim to complete recruitment by the Autumn.

- In the Clinical Digital Unit, the Health Board Clinical Lead (ePCR) has been recruited and will be starting in July 2025. The Digital Clinical Safety officer role is currently going through Recruitment Control Panel (RCP).
- Recruitment activity continues to across the ICT team into existing vacant roles. There are several new roles with job descriptions under development.
- Insight and Data Services filled all new posts from the 24/25 funding, but have several new posts from the 25/26 funding to progress: 4 of which are currently at advert; 2 others require Job Descriptions to be developed; and 2 short-term contractor posts are already filled, supporting with high-priority deliverables (e.g. new Performance Model Framework reporting).
- The Operational Communications Programme team has appointed a new Programme Manager who will lead the next phase of the Trust migration to the new emerging Emergency Services Network.

4. The scale of work to support the **Clinical Model Transformation (CMT)** has significantly expanded in 25/26. **Appendix 1** now contains an overview of our CMT contributions and alignment continues.

5. Digital made a significant contribution to the Trust's transition to the **new call categories & performance model framework**, including ensuring systems were able to receive these new call categories for go-live on 01/07/25 and in the development of metrics and internal and external reporting.

6. In collaboration with Robotics AI, we have successfully soft launched our 'chatbot' **Virtual Assistant for integration with NHS 111 Wales (Health A-Z)** which will provide immediate responses to user enquiries and streamline access to information. Accessible in multiple languages including Welsh, the virtual assistant will offer a more interactive user experience. A period of beta testing will now follow to allow us to iteratively develop the Virtual Assistant ahead of a formal launch. The success of this launch is thanks to a multi-disciplinary group of colleagues across several directorates within the CMT's Digital Front End workstream. Work will now continue to integrate patient experience and feedback into this process.

7. Implementation of **video consultation for 111 clinicians in the 111 CAD** went live technically on Tuesday 8th July. This will now be followed by a phased implementation as 111 clinicians complete their training. Video consultation is already in use across Integrated Care, particularly within the Clinical Support Desk (CSD), and its introduction to 111 clinicians will support standardisation of clinical practices across the service.

8. A series of sprint meetings to design the **Digital Transformation Innovation Programme (DTIP)** group are underway. The purpose and strategic value of DTIP will be to:
    a. Ensure digital efforts are prioritised, visible and aligned to the Trust's broader objectives.
    b. Position Digital as a driver of transformation, not just a support service.
    c. Enable the Trust to say "no" or "not yet" to non-priority work, with transparency and justification.

9. Milestone plans for the **innovation labs** and approach to **digital engagement** have now been developed. This includes the identification of several innovation pilots to progress design of the innovation lab concept and ensuring alignment with the established WIIN process and "Simply Do" platform. Our digital engagement work will help raise the profile and awareness of what we do in digital, ensuring learning and adoption needs are better met, colleagues can contribute to new developments more easily while increasing peer-to-peer support. This work will also improve visibility of our front door alongside self-service opportunities where appropriate.

10. We have entered phase 2 of our Microsoft **Copilot pilot** on 1st July, which will run for the next 12 months with circa 150 licenses distributed to different directorates across WAST. As part of Phase 1, we identified several teams where a deep dive into Copilot (or Generative-AI) use cases would be valuable. This deep dive work will inform wider adoption, the development of meaningful and safe use-cases, and importantly our **AI policy,** as well as influence our **automation scale-up opportunities**. This work will bring efficiencies to WAST and free up time for higher value work.

11. **999 MIS & Paramount servers** – as we near completion of the 999 MIS C3 server replacement, work has commenced to replace the 999 Paramount and AQUA server environments across both data centres. The benefits of doing this work include:
    a. Additional business continuity resilience through enhanced performance and reliability
    b. Reduced disruption when doing future server upgrades
    c. Ensure products continue to be supplied with security and improvement patches
    d. Improved reporting opportunities

12. The **Windows 11** early access pilot is complete with no major issues reported. The general roll out continues for eligible devices; priority users have been upgraded with minimal disruption.

13. The initial scoping report on **Smart Stations** has been received. The next steps are to have an internal cross-directorate meeting to agree what ideas we may want to take into consideration for the next planning round.

14. The report from the **Cyber Resilience Unit (CRU) audit** in May has been received. This has been scrutinised with comments sent back to the CRU and an updated report has been provided which is awaiting internal approval before actions and recommendations will be added to the cyber improvement plan.

15. **Insight & Data Services (IDS) Collaborations** – along with Research & Innovation and Clinical colleagues, and partners at Sheffield University, IDS conducted a scoping review, titled "The use of Artificial Intelligence in the out of hospital care setting" exploring the prevalence, benefit and limitations of AI across the global ambulance sector. The findings informed a National Institute for Health & Care Research (NIHR) bid by the group - the outcome of which is eagerly awaited - which seeks to explore the feasibility of a "Digital Twin" (i.e. AI-powered simulation tool) to support ambulance services with operational and tactical decision-making for greater system impact. If funded, this collaborative group will test sector readiness and develop a blueprint for implementation of such a technology across the UK Ambulance Trusts.

16. The refresh of the **Electronic Patient Care Record (ePCR)** application has been formally approved and is now in active development. This follows extensive engagement with users and stakeholders to identify opportunities to enhance the app's usability and improve the quality of data captured. The upcoming refresh will focus on optimising the application's core functions, aiming to reduce on-scene times for record completion without compromising the quality of information used for reporting. These improvements are intended to support staff in delivering efficient, high-quality care. We anticipate the updated ePCR application will be released in early 2026. Further updates on progress and rollout plans will be shared in due course.

Lowlights

17. The **iPad** rollout has been paused awaiting agreement on how to manage the implications of offering colleagues the opportunity to purchase their current iPads for a charitable donation to the WAST charity. We are hopeful of commencing the replacement programme in the next reporting period.

18. The **Video Compliance Progress** has been delayed. This is due to competing demands on the Information Governance team, and the need to prioritise work on the Clinical Model Transformation (CMT) workstreams, namely the Virtual Assistant for Digital Front End.

19. Work to progress **Enhanced IVR (111)** has been deprioritised due to CMT development work by WAST and suppliers.

20. Although the new call categories successfully went live on 1st July as planned, the technical arrangements which allow **reporting of the new metrics** on the data produced by the 999 CAD are only a temporary solution. For the full solution, a CAD upgrade is required later this summer – this is yet to be planned. In the meantime, the IDS team and supplier continue to thoroughly verify and apply the metrics offered by the interim solution. To ensure the deadlines for the Ambulance Service Indicator (ASI) and Official Statistics reports (published by JCC and Welsh Government) are met, the team will now need to focus attention on data quality checks and the development of these new reports.

21. The IDS team continue to engage in the topic of **all-Wales data sharing** via the National Data Resource (NDR). A single solution is being sought across Wales and has involved Data Protection Officers (DPOs), SIROs, Caldicott Guardians, and CEOs from all organisations. The WAST DPO and IG team in particular, are heavily involved in finding a resolution to the legal and regulatory risks. In the meantime, IDS continue to receive requests from partners for more local data sharing, which is a draw on the same resources trying to support the national solution.

IMTP 2025/26 - Digital Contribution & Progress

22. Digital's contribution to WAST's strategy and IMTP is monitored against the 5 pillars of the Digital Plan (namely: Everyday Essentials; Cyber, Security & Safety; Digital Pioneers; Transformation; and Data, Information and Insight). The list of Digital Contributions for 2025/26 and their progress / status are visible in **Appendix 1**.

23. An overarching Digital Contributions 25-26 for CMT infographic has now been developed to highlight the expansion of work in this area. This includes an opportunity to RAG rate the impact of overarching asks on digital. A highlight has been the technical onboarding and transfer of the digital footprint of Save A Life Cymru (SALC) colleagues who transferred into WAST on 1st July. A lowlight has been the sustained pressures on the IG team with

several urgent asks from across the programme. Data & reporting is rated as amber due to emerging asks not yet completely defined and ongoing work with the supplier to develop required metrics, however, the CMT Metrics workstream and Call Flow group have supported greatly by offering clarity on priorities of the known requests.

24. We are exploring introducing a RAG system for each workstream as we continue to strengthen the governance. Overall reporting will continue for each CMT workstream via workstream leads in the usual manner.

25. Digital KPIs for Data & Analytics and ICT System updates are also available in **Appendix 1** and now refreshed for the new financial year. Work is underway to develop and introduce KPIs for the new Innovation & Transformation and CCIO areas of the Digital Directorate.

26. The COMMITTEE are asked to NOTE the contents of the accompanying report and the trends in metrics presented.

KEY ISSUES/IMPLICATIONS

27. The Clinical Model Transformation programme requires significant input from various Digital teams – including those supporting on changes to CAD or other systems, DOS updates, and data, reporting and analytics for the new call flow and categorisation process. The complete requirements for 25/26 and 26/27 remain unknown, and Phase 2 of the Performance Framework will likely add to the capacity risk within the directorate. This may lead to reprioritisation of other deliverables within the local Digital plan.

28. Progression on a number of areas of work, in particular the Digital Front End aspirations within Clinical Model Transformation, are dependent on funding decisions and processes.

REPORT APPROVAL ROUTE

Reviewed by DLG members 8th July 2025

REPORT APPENDICES

Digital Reporting July 2025 – Metrics (pdf)
FPC 25/26 Deep Dive: Our Digital Journy (PowerPoint)

REPORT CHECKLIST

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

Digital Contribution 25/26

Everyday Essentials

Simplified Sign-on	ICT team trial in progress
iPad Replacement	phase 1 & 2 by Q3 (XL)
Automation / RPA	plan established to scale up
Cloud GRS	in planning
eTimesheets	cont. from 24/25
EMS CAD Servers	Replace 999 & Paramount
Windows 11	50% due before Q3

Cyber, Safety & Security

AI Safety / Policy	draft in development
Smart Stations	awaiting costings/funding
Cyber Improvement	actions as per corporate risk
IG Improvement	actions as per corporate risk
Video Compliance	CCTV policy in review + DPIA

Digital Pioneers

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

Transformation

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

Data, Information & Insight

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

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

RAG and progress based on Directorate Plan
Last updated 02/07/2025

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/palliative)

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)

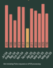
- Data, metrics & reporting
- Additional devices & licencing
- Overarching IG

Digital: Data & Analytics

Data Lifecycle

The 6 stages of the data and analytics lifecycle and related metrics.

Records Requests



Not including Police requests or ePCR processing

Data Warehouse completion (reduction of manual data sets e.g. for MIQPR)

tbc

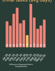
Metric to be developed

Warehouse availability

Metric to be developed

Information Requests Received vs Completed

Turnaround for non-trivial tasks (avg days)



Difference in Requested Date to Completed Date

Total Data Load Failures

Data Protection & Data Quality metrics found in Information Governance and Security Report

Digital: ICT Systems

System availability metrics

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%

System Availability %: A M J J A S O N D J F M (2025/26 and 2024/25)

EMSC CAD C3

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: Jun 25

ICT Service Desk

8.3 Service Desk hours saved through use of RPA

Top 5 June Service Desk Requests

- Generic Request
- Cleric - request
- Password reset
- Cleric - new address
- ePCR accounts

Note: not all incidents or requests can be resolved by WAST

82% Incidents resolved within target
93% Requests resolved within target

Records

RPA for PCR requests saved people hours in June **13**

Assumes 10 minutes per request

See Information Governance reporting for other Records Services metrics

IDS Inbox

Same day turnaround of 'quick' tasks **50%**

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

47% June-25 engagement rate

The current position shows a decreasing trend from 59% earlier in 2024, 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**

Welsh Ambulance Services University NHS Trust

FPC 25/26 Deep Dive:
Our Digital Journey

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

Version 1.0
Released: July 2025
Jonny Sammut

Finance & Performance Committee
Monday 21st July 2025

Digital Strategy 2024-2029

Everyday Essentials

Address everyday challenges to enhance efficiency.

Security, Safety and Cyber

For a secure online environment.

Digital Pioneers

Becoming trailblazers at the forefront of innovation.

Transformation

For a comprehensive and strategic overhaul.

Data, Information and Insight

To translate and add value to our vast amounts of data.

Meet the Team

Innovation and Transformation

Digital transformation initiatives, innovation and emerging technologies, change management, adoption, user experience and service design

ICT

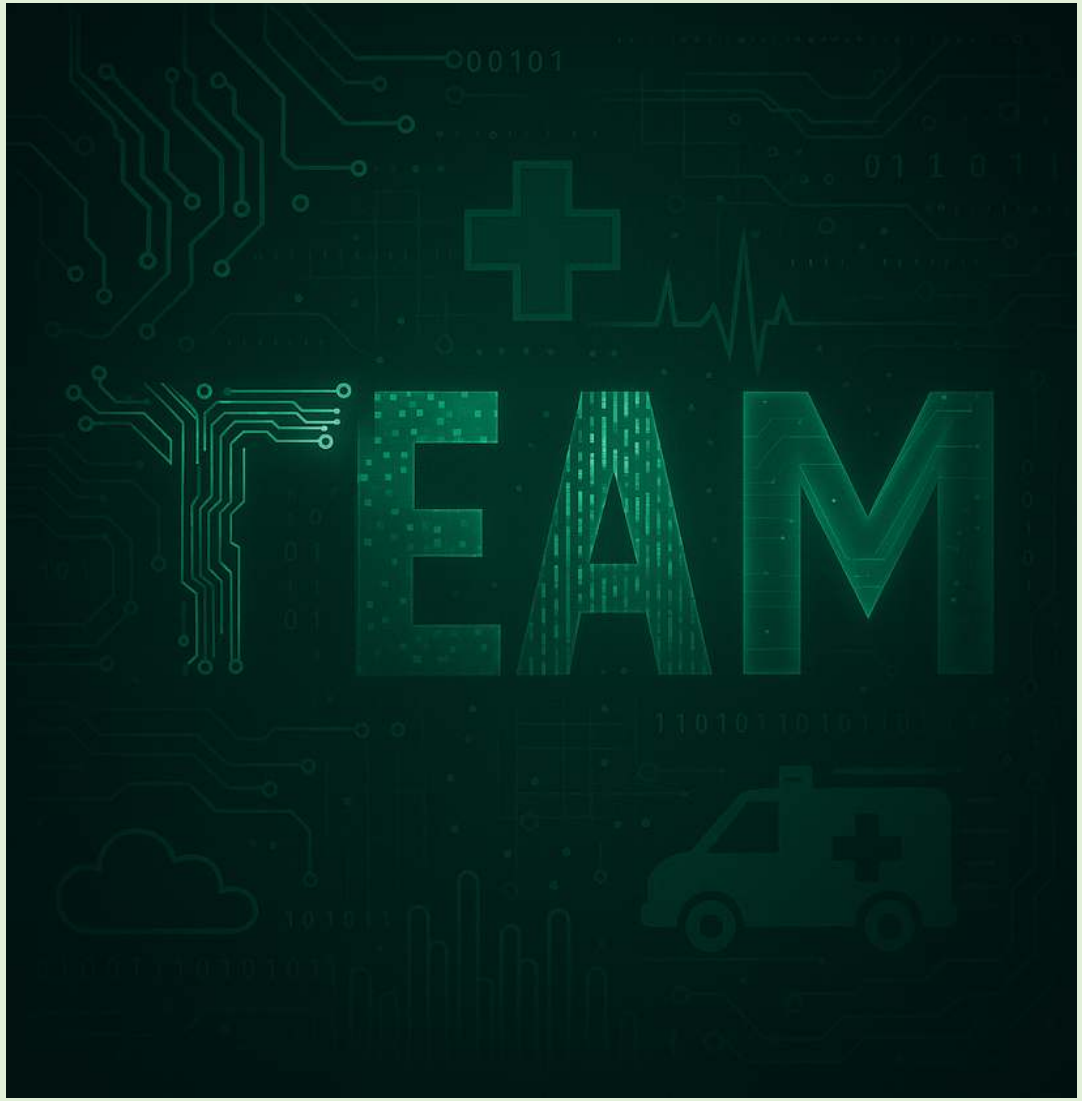
IT infrastructure, Cybersecurity, User Support & Service Desk, Asset and Config Management, Telecommunications Infrastructure, Operations Communication Programme

Insight & Data Services

Insight, reporting and dashboarding, data engineering, data applications (web), data protection, governance and quality, predictive analytics and AI, and records services

Clinical Digital Specialist Unit

Clinical Safety and Governance, Electronic Patient Clinical Record (ePCR), Clinical Systems Optimisation, Digital Clinical Governance, Stakeholder Engagement and Clinical Leadership



Copilot generated image

Some of our 2024/25 highlights

999 Telephony Upgrade went live in November 2024

111 CAS Implementation was deployed at record pace

Improved Cyber Defences so we remain protected from cyber attacks

ePCR Improvements which included a variety of refinements

Deployed PowerBI and migrated our legacy reporting tools

Call Routing System which includes real-time data displays for the PTR Team

MIQPR Always-On dashboard for an accurate helicopter view of performance

End-of-life Care and Remote Triage Systems, explored and implemented

Mobile Data Vehicle Solution replaced our mobile data terminals in every vehicle

Kept the lights on with hundreds of background tasks

Digital Contribution 25/26 – Directorate Plan

Everyday Essentials

- iPad Replacement
- Simplified Sign On
- Automation
- Cloud GRS Replacement and E-Timesheets
- Windows 11
- EMS Server Improvements

Digital Pioneers

- Enhanced IVR (111)
- Patient Messaging
- Artificial Intelligence (AI) Development
- Innovation Lab

Digital Transformation

- CAD Replacements
- ESN Phase 2
- Drones
- Digital Engagement
- Electronic Patient Clinical Record Phase 2

Security, Safety & Cyber

- Artificial Intelligence Safety and Policy
- Smart Stations
- Cyber Improvement
- Information Governance Improvement
- Video Compliance

Data, Information & Insights

- Individual Insights
- National Data Resource Programme
- Data Skills Enablement
- IDS Improvements
- Data Collaborations

Everyday Essentials: Deep Dive

Spotlight: EMS Server Improvement

Additional business continuity resilience through enhanced performance and reliability

Reduced disruption when doing future server upgrades

Ensure products continue to be supplied with security and improvement patches

Improved reporting opportunities

Why Now? In the same way hardware such as a laptop slows down over time, servers have a typical lifecycle. Our replacement programme ensures we are actioning this in good time. This initiative is not merely a technical refresh. Yes it will keep the lights on now, but it is also about enabling secure, scalable, and future-proof digital services that support frontline care and strategic transformation.

Collectively this refresh programme will refresh the server infrastructure for 999 MIS C3 (CAD), 999 Paramount and AQUA (used for MPDS Audit)

Did You Know.....?

Replacing a server isn't as simple as swapping a 'box'. The process may include procurement, logistics, unboxing, racking, building, config, network development, change requests, migration of users, building access, building SQL, testing, agreeing downtime with ops and decommissioning. The 999 C3 includes circa 90 servers alone!

Cyber, Safety and Security: Deep Dive

Spotlight: Artificial Intelligence (AI) Safety and AI Policy

WHAT?

To pragmatically support a future where AI-enabled technologies are used safely across WAST, Digital and TU leads are developing an AI Policy in partnership, scanning guidance and use cases from across the sector.

WHY?

The Policy is set to give clarity on AI risks (such as accuracy, trust and safety) as well as the considerations for "Responsible AI" (ethics, transparency, inclusion, and sustainability).

HOW?

The Policy will be informed by the use cases identified by staff currently participating in the Copilot pilot, learning from what other Ambulance Trusts are doing and will be supported by a suite of guidance and training materials.

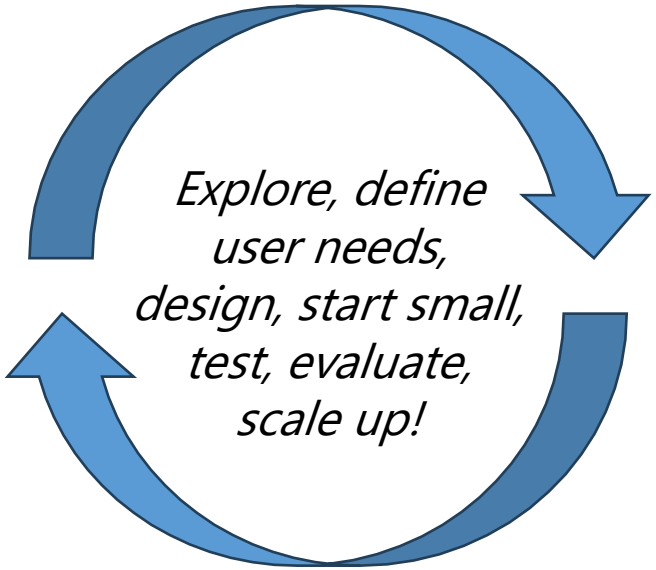
Call to Action!

For work purposes, always speak to your friendly Digital team for advice on AI. At home, for personal uses, we also recommend you check the **privacy settings** for any AI applications you use: do you know what data is collected? where your data is stored? if your 'prompts' are used to retrain the models?

Digital Pioneers: Deep Dive

Spotlight: Innovation Lab

We have identified several project leads to work with across the organisation to help design and build the right **Innovation Lab** offer for WAST. This will enable us to iterate the offer while ensuring collaboration with different directorates and alignment to existing forums.



Prototype **Mobile Digital Support Hub:** Providing **Digital support, training and a refreshment to ambulance crews at hospital**

Exploration of **digital solutions to enhance patient experience during handover delays**. Starting small horizon scanning and with a "**Hackathon" event working with patients and carers, focused on dementia.**

Pilot to **improve patient feedback with liaison team**, understanding if barriers are due **to digital skills/confidence, data poverty** or other reasons

Transformation: Deep Dive

Spotlight: ePCR Phase II Improvements

Improve the quality of data captured

Enhance the app's usability

Optimising the application's core functions

Aiming to reduce on-scene times for record completion

Enhanced protection for GPDR compliance

Enhancements to ePCR refusal and capacity assessments

Clinical level metrics supported by ePCR

CFR volunteer platform updated in parallel

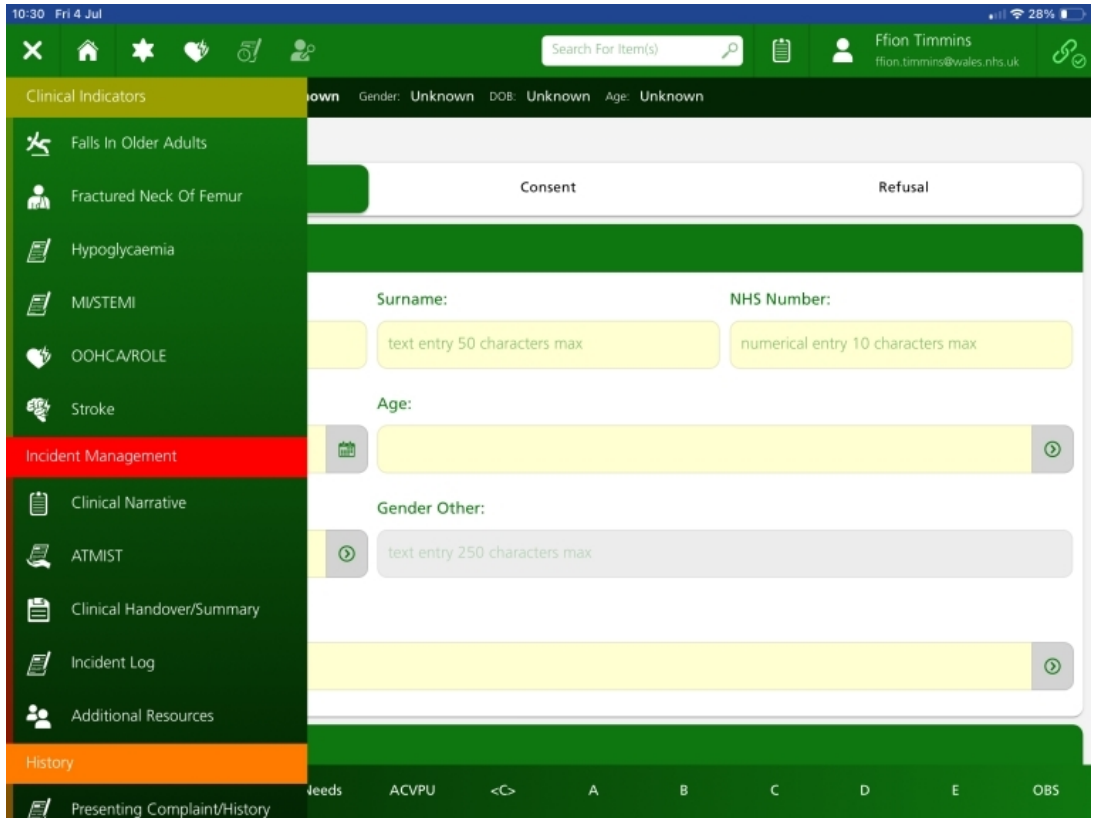
Digital pathway referrals

Following extensive engagement with users and stakeholders, a refresh of the **Electronic Patient Care Record (ePCR)** application has been formally approved and is now in active development.

These improvements are intended to support staff in delivering efficient, high-quality care. We anticipate the updated ePCR application will be released in early 2026. Further updates on progress and rollout plans will be shared in due course. These updates and improvements will be developed in a way as to not compromise the quality of information used for reporting.

Electronic Patient Clinical Record (ePCR) Phase II

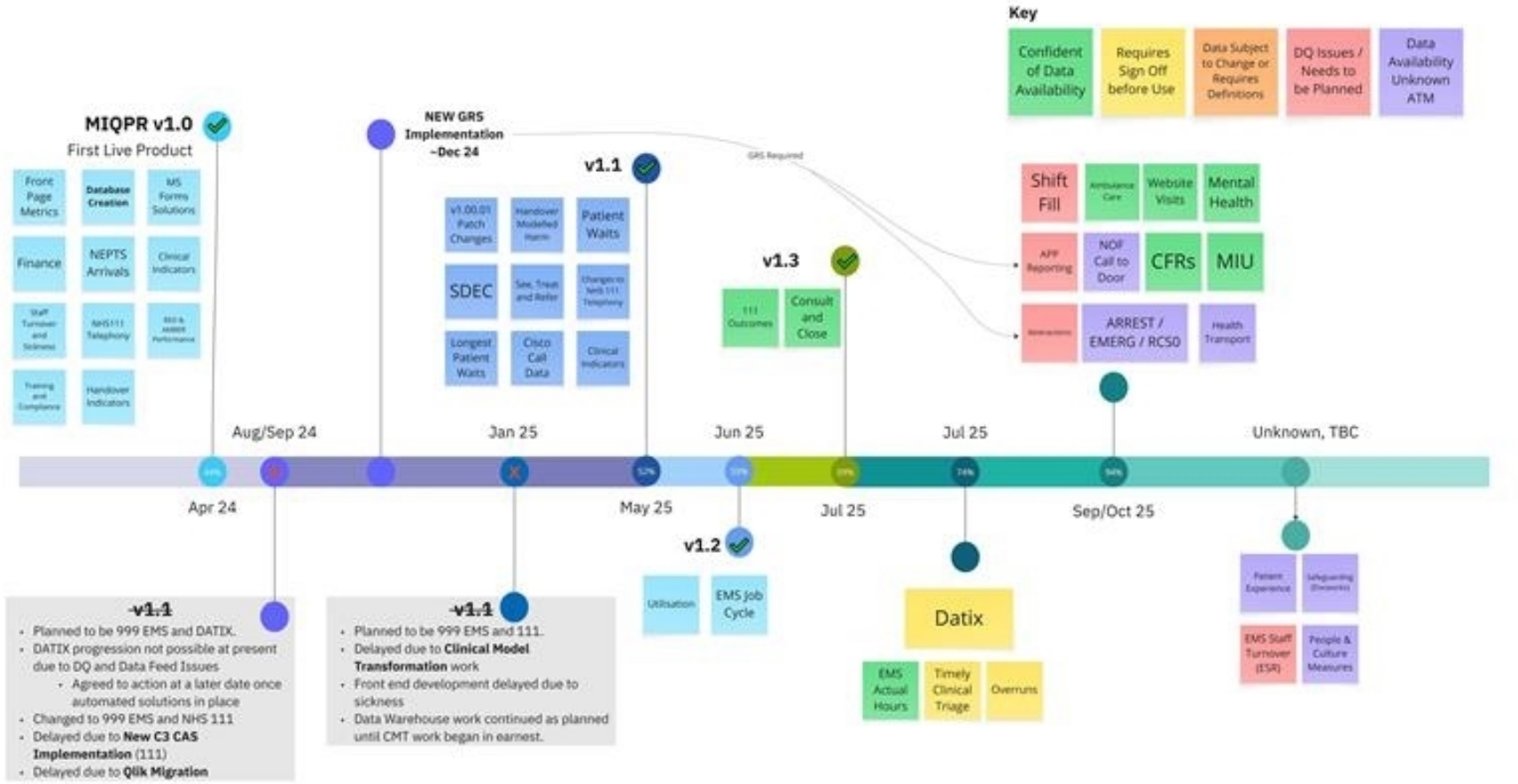
From this....



To this.....

Data, Information & Insight

Spotlight: Monthly Integrated Quality & Performance Report (MIQPR)

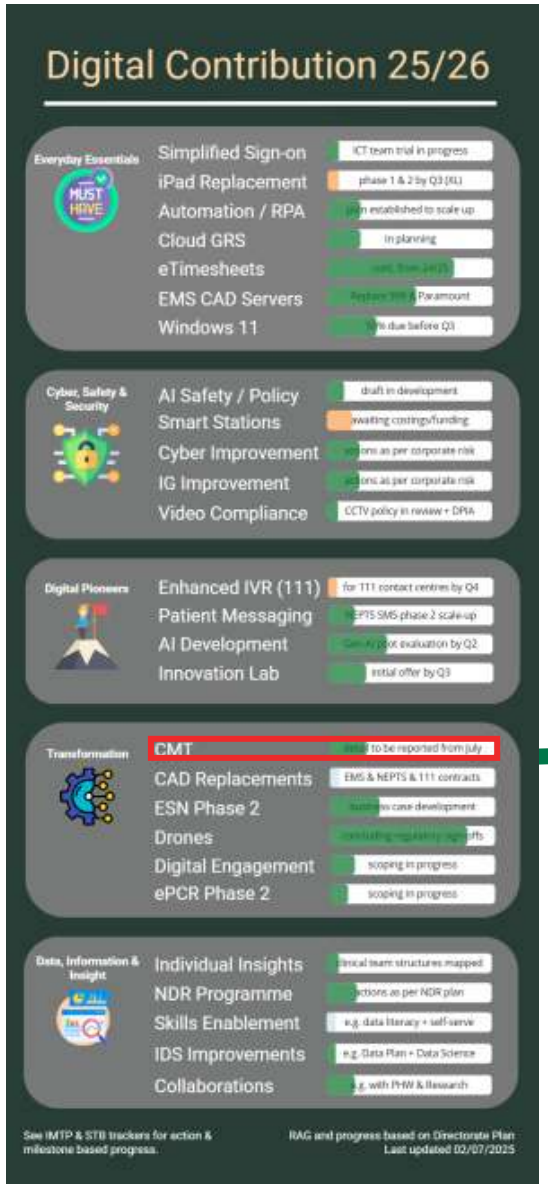


In 2024, the Insight & Data Services (IDS) function released a new MIQPR dashboard, bringing together input and domain knowledge from colleagues across WAST, as well as various data sources to produce accessible visualisations of key organisational metrics. The latest versions (released June & July 2025), add new content for EMS utilisation, 111 outcomes and the newly agreed (integrated 111 & 999) Consult & Close metric. This intelligence not only provides insight and assurance to leadership and committees, but the dashboard allows 24/7 'always-on' access to all WAST staff via our modernised PowerBI reporting platform.

Following further development, the next version of the MIQPR dashboard will include the first wave of centralised reporting from Datix, and the new call categories to follow shortly after.

A snapshot of the MIQPR development roadmap is shown on this slide.

Our 25/26 Plan: Clinical Model Transformation



This year we want to better articulate our role and contribution in enabling many aspects of **Clinical Model Transformation** (it also helps us prioritise and plan better!)

Infographic for each workstream

Ability to highlight pressure areas

CMT contribution 25/26 – a few highlights…

Virtual Assistant

Our Virtual Assistant soft launched on 9th July 2025. A period of beta testing has now commenced to support iterative developments

Call Category Changes

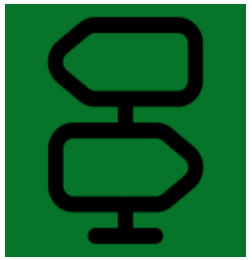
Significant contribution enabling the trust to transition to the new call categories and performance model framework on 1st July 2025

Video Triage

Technical implementation of video consultation for 111 clinicians went live on 8th July 2025. This will now be followed by a phased implementation as 111 clinicians complete their training

Service Development

Development of overarching plans and aspirations for running NHS 111 Wales Online as a sustainable service. Conversations continue to progress to secure investment for this



Symptom Checkers

Procurement and implementation of updated symptom checkers is now proceeding given recent approval

Additional Devices & Licenses

Technical onboarding and transfer of the digital footprint of Save A Life Cymru (SALC) colleagues who transferred into WAST on 1st July

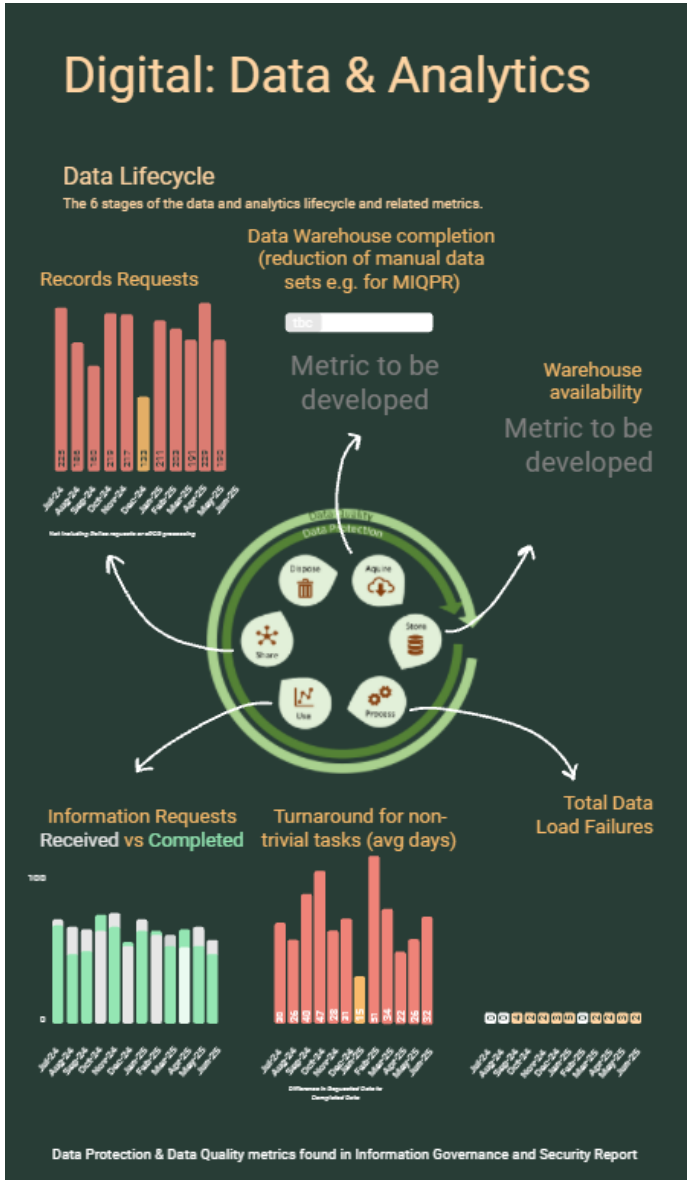
CMT Deep Dive: Virtual Assistant

In collaboration with Robotics AI, we have developed a 'chatbot' virtual assistant for integration within NHS 111 Wales (Health A-Z) which will provide immediate responses to user inquires and streamline access to information. Accessible in multiple languages including Welsh, the virtual assistant will offer a more interactive user experience.

Our Virtual Assistant successfully soft launched on 9th July. A period of beta testing will now follow to allow us to iteratively develop the Virtual Assistant ahead of a formal launch. The success of this launch is thanks to a multi-disciplinary group of colleagues across several directorates within the Digital Front End workstream.

We are working to integrate patient experience and feedback into this process via the VA. This will initially be feedback on the tool itself to support iterative developments, then we are looking to integrate with our Civica platform for feedback on patient experience of the NHS Wales 111 website experience more holistically.

This is all alongside significant BAU service delivery



...And we have been listening. We are working on the below

Access to the right front door

- Make it easier to access the relevant expertise
- Have clearer routes into the teams to help manage demand on them

The Digital Directorate Offer

- Increase awareness of the digital directorate offer
- Where can Digital help
- To enable engaging us early on

A More Strategic Approach

- Need better mechanisms to collaborate and align our work to the needs of the organisation
- Must better-manage expectations
- Create a better overall experience for colleagues impacted by change

Support "The Art Of The Possible"

- Improve how we support innovations
- Make better informed, quicker decisions earlier on

Building Digital For The Future

- Keep investing in the directorate so we can meet the needs of the organisation
- Increase our capacity to support new areas
- Embed user-centred design approaches

Final Thoughts

"Brilliant basics with a touch of magic"

Linda Moir (WAST Leadership Symposium June 2025)

Glossary: Every Day Essentials

Simplified Sign-On: aims to remove friction and frustration for staff in using multiple systems and applications on iPads – allowing them to log-in once and avoid multiple username and password inputs for different interfaces. This is likely to be done via the Microsoft Hello product. This will not cover full implementation of 'single sign-on' and is dependent on enabling infrastructure work by DHCW.

iPad Replacement: 2725 iPads have been purchased to enable the replacement of devices for frontline EMS staff. Planning work is ongoing and includes the opportunity for staff to purchase their old iPad.

Automation: many automated workflows to improve efficiency and free staff up from repetitive and mundane tasks are already in place within the Trust, however, the goal is to craft a plan which will help scale automation delivery with good governance and process wrappers.

Cloud GRS Replacement: there is a need to transition to GRS Cloud (delivered as Software as Service) to ensure WAST can benefit from necessary updates (including security) in the future. A GRS SaaS Technical Task and Finish group has already been established.

eTimesheets: ICT will continue to support the implementation of e-timesheets. (Linked also to the Cloud GRS Replacement project)

EMS Server Improvement: As we near completion of the 999 MIS C3 server replacement, work has commenced to replace the 999 Paramount and AQUA server environments across both data centres.

Windows 11: standardise all laptops and PCs to run Windows 11 to ensure security, performance and readiness for the future.

Glossary: Digital Pioneers

Enhanced IVR (111): deployment of Enhanced IVR to capture key patient details virtually whilst callers are in a queue for 111. Engagement with suppliers has progressed to develop potential costings.

Patient Messaging: Phase 2 of development for the SMS functionality in Ambulance Care, supporting asynchronous communication with patients and service users who may wish to confirm, cancel or amend their scheduled transport booking.

AI Development: evaluate suitability of Gen-AI tooling for Corporate and administrative use cases and define ambition statement for broader AI usage / development by WAST. (See also separate AI Policy project).

Innovation Lab: engage on, design, and implement the digital innovation labs. These should enable exploration of new ideas with ambition to test and scale the right ideas rapidly.

Glossary: Transformation

CAD Replacements: preparations for a CAD procurement in future years, commence conversations with Operations to understand requirements.

ESN Phase 2: outline business case developed for replacement of critical communications infrastructure (Airwave) which is progressing through Trust governance (see agenda for FPC May 2025).

Drones: deliver the HART drone project and support HART to become operational with drones for surveying hazardous and challenging incident scenes.

Digital Engagement: improve engagement between the Digital Directorate and the wider organisation, including raising the profile and awareness of what we do in digital, ensuring that learning and adoption needs are met, and that colleagues can contribute to new developments more easily whilst increasing peer-to-peer support.]

Electronic Patient Clinical Record (ePCR) Phase 2: the current design of ePCR has largely remained unchanged since its introduction in 2021, but significant engagement with users and stakeholders note opportunity to enhance the application and improve the quality of the data captured. The application will be streamlined, duplication removed, contributing towards a reduction in on-scene times from record completion.

Glossary: Cyber, Safety and Security

AI Safety / Policy: co-develop a Policy for WAST regarding the procurement, development and implementation of AI technologies, ensuring safe, compliant, ethical and accurate use.

Smart Stations: explore what value smart stations could add to WAST, identifying and implementing initiatives that will provide the biggest benefits. A scoping piece of work has taken place to provide a menu of options to explore, including affordability for each option.

Cyber Improvement: delivery against the cyber improvement plan continues and is regularly monitored by the Trust. Work is ongoing to review iPad copy and paste capabilities and any potential IG consequences.

Information Governance Improvement: aim to produce and implement the next iteration of the IG Toolkit Improvement Plan, based on the 2025/26 IG Toolkit submission criteria. Plans will also extend to IG Compliance deliverables (e.g. see Video Compliance project).

Video Compliance: ensure data protection and IG documentation is in place for all video surveillance systems used by the Trust. The CCTV Policy is being reviewed and will be re-published with support from this task & finish group.

Glossary: Data, Information & Insight

Individual Insights: reporting to be developed to provide insights to individual clinicians about their professional practice, supporting career development conversations.

NDR Programme: deliverables as agreed with DHCW, relating to WAST's support of the National Data Resource (NDR) Programme; these include: ongoing work to share Out of Hospital Cardiac Arrest data with UK and Welsh registries; utilisation of advanced analytical and data science tooling available on the platform.

Data Skills Enablement: build data literacy and confidence across WAST workforce and enable self-serve of insights and intelligence through the PowerBI platform. Continue to develop the top organisational metrics and surface insights in always-on reporting (e.g. MIQPR). Aim to empower staff to make better clinical and operational decisions, understand patterns in data, and how to interpret and apply intelligence accurately.

IDS Improvements: position the Insight & Data Services team to be able to *proactively* support the strategic direction of WAST and develop a Data Plan to accompany the Digital Plan to ensure WAST data lifecycle and related compliance and governance are fit for the future.

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

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

INFORMATION GOVERNANCE REPORTING

MEETING	Finance & Performance Committee
DATE	21st July 2025
EXECUTIVE	Jonny Sammut, Director of Digital Services / Senior Information Risk Owner
AUTHOR	Leanne Smith, Assistant Director of Digital
CONTACT	leanne.smith4@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. This paper covers intelligence from the period of 1st April to 31st May 2025, and the topics discussed at the **June meeting of IGSG**.

ALERT

3. **DPIA non-compliance:** several projects across WAST remain at risk regarding their Information Governance arrangements. This includes the Ambulance Care 2-way SMS process, the Paxton Access Control System and a project exploring use of Body Worn Video Cameras. There are concerns over late or limited engagement with IG and Cyber teams in preparation for procurement activities or implementations, which can risk compliance and security and cause delivery delays. In particular, a lack of responsiveness to questions from the IG team to information asset owners and a potential loss of data, have led to a data protection complaint made to the ICO about WAST. This has been escalated, and a resolution is being worked through collaboratively, but

demonstrates the challenge the IG experts face in attempting to support projects and products to be secure and compliant.

4. **AI Risk:** guidance on the use of AI at work was first issued internal by the Digital Directorate in November 2023, with an update to this general guidance published in January 2025. Since then, Copilot specific guidance has been developed for those on the Copilot trial. However, there is a need to issue guidance which speaks specifically to the appropriate use of authorised Gen-AI tooling given the breadth of tooling openly available to all. A notice is in draft, and an organisational risk is also being developed to capture the consequence of, and controls and actions to mitigate against, inappropriate usage. The need for clarity on the NHS Wales Policy on Gen-AI is also to be raised at the national IG leads forum, and a WAST Policy for AI more broadly is also in development. Development has also started on an AI Cyber Security assurance process which will be used in conjunction with the AI Policy once available.

5. **Cyber Risk:** There have been 2 accounts compromised through a password spray attack. The email addresses were compromised in a past data breach, but the account passwords were successfully guessed. Fortunately, MFA was enabled and protected the accounts as expected and therefore access wasn't granted to the attacker – a good test and outcome for this level of security. A lessons learnt exercise has been undertaken and process improvements have been recommended.

6. **ePCR Copy & Paste functionality:** the issues surrounding this functionality, and the appropriate use of copy & paste within the ePCR application were discussed by the group. This includes the potential for inaccurate patient records and legal risks. A phased re-introduction of the function to support neurodiversity was proposed, with manual enablement, mandatory training, policy adherence and monitoring being crucial for secure and compliant use. IGSG members will shape a proposal for further consideration by ELT.

Highlights

7. **IG Training:** the overall Trust IG training compliance figure as of 06/05/25 was at 83.96%, but by the time of the June meeting of IGSG, the Trust had exceeded the 85% compliance threshold for the first time in it's history.

8. **Datix Reporting:** progress has been made with Datix and the aim to automate the reporting of statistics from the system. Datix incidents are currently manually cleansed and verified by the IG team, however, with

planned development work, this process will be automated in coming months.

9. The **111 Wales Website Privacy Policy h**as had a wholescale review, and has been updated by the IG team. This refresh reflects recent updates to the website, provides more transparency for users, and creates a clearer foundation for future web developments. The policy provides detail and assurance on topics such as the type of data collected, its purpose, and legal basis, a user's rights, and use of Cookies and Google Analytics.

10. **Data Quality Assurance:** the newly expanded Data Quality team are creating a Data Quality Training module for all WAST staff. This will be the first of its kind, and by the end of the eLearning module, learners should be able to:
    - Describe what is meant by data quality (including definition and measures)
    - Describe the impacts of poor data quality
    - Apply good practice in data quality within their role in WAST.

    The impact of the training will be measured through key Data Quality metrics, such as via the "accuracy" domain, and reported through to IGSG. Other DQ domain related metrics are also already in development, and will be presented to IGSG at the next meeting. Such monitoring will allow better understanding of gaps and areas for improvement – in operational practice and with data set and reporting design.

11. **FOI compliance:** there is high variability in FOI compliance month on month, with a compliance rate of 82.4% for the 14 requests processed in April, and 54.5% for the 27 processed in March. This pattern was seen similarly in earlier months with poorer compliance in February, but higher in January. The volume of questions within the requests is also usually high, with some of these questions requiring significant detail and input from across multiple Directorates. The FOI function has recently been strengthened with the internal transfer of a member of the Corporate Governance Directorate into the Compliance & Assurance Officer post, allowing more focus on the management of requests. It is anticipated this will positively impact response compliance rates over coming months.

Lowlights

12. **Letters to Staff regarding Mandatory Training:** Despite the Trust reaching 85% training target for the first time, a letter has been drafted to staff to ensure they understood the potential consequences for not completing their mandatory training - a significant number of these members of staff have not

completed training for several years. This will be a two-phase approach for improving mandatory training compliance:

Phase 1: A letter will be sent to locality managers to remind staff about the importance of completing their mandatory IG training by 14th July.

Phase 2: For those who still haven't completed their training by the deadline, a second letter will be sent directly to the individual staff members on 21st July, emphasising their obligations. This is to include a statement for awareness that should their mandatory training lapse staff could compromise their registration and pay progression.

13. **The COMMITTEE are asked to NOTE the contents of paper.**

KEY ISSUES/IMPLICATIONS

14. **Risk 623 Failure to comply with Data Protection Legislation:** A risk to Data Protection Compliance was initially on the Corporate Risk Register in April 2024 and has since been received by the Trust Board on several occasions as part of the Board Assurance Framework. Although some actions are complete, the score has not yet been reduced.

15. **Risk of Physical Security:** The group previously discussed the risk of physical security. At the March meeting, although not discussed, a paper was received detailing progress in articulating and documenting the risk. The draft risk is being progressed through usual risk management cycles and due back to IGSG for discussion at the next meeting.

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

REPORT APPROVAL ROUTE

The points presented in this paper are taken from the Information Governance Highlight Reports presented at the 16th June meeting of the Information Governance Steering Group (IGSG), and the resulting AAA drafted for presentation to ELT.

REPORT APPENDICES

n/a

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

AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Finance & Performance Committee
DATE	21 July 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the seven risks that are relevant to Committee's remit.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF). 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 09 July 2025 having considered the review of each risk undertaken throughout June 2025 by Risk Owners and the Assistant Director Leadership Team (ADLT). 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 as 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) and was discussed in detail at the meeting on 20 May 2025. Work is underway to consider repositioning the risk and a new approach to the way this is presented. The new approach separates 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. **Risk 623** *Failure to comply with Data Protection Legislation* remains unchanged at a score of 15 (3x5) and continues to be reviewed.

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 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* and **Risk 139** *Failure to Deliver our Statutory Financial Duties in accordance with legislation* remain unchanged at a score of 12 (3x4) during this period; however, the Executive Director of Finance and Corporate Services has foreshadowed that this risk is likely to increase in the near future given the financial position.

12. 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:

13. **Members are asked to consider the contents of the report including:**
    a) The controls in place against the risks.
    b) The actions described to further mitigate the risk.

KEY ISSUES/IMPLICATIONS
14. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
15. The BAF was considered by: • Executive Leadership Team (09 July 2025)

REPORT ANNEXES
• Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 – Board Assurance Framework

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**20 (4x5)** →
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	**IF** the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared **THEN** there is a RISK that the Trust's Incident Response will be suboptimal **RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	**20 (4x4)** →
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage	Executive Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)** →
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.	Director of Digital Services	**15 (3x5)** →
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of	**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	Executive Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	patient safety and experience.	**RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered		
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Executive Director of Finance & Corporate Resources	**8 (2x4)** →

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	oderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	cal media coverage - short-term reduction in public confidence/trust. ort-term negative social media. blic expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Annex 4 – Board Assurance Framework

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:	08/07/2025	TREND	20 (4x5)
		Date of Next Review:	08/08/2025	➡	

IF	THEN	RESULTING IN
the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	there is a RISK that the Trust's Incident Response will be suboptimal	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-**eight (48)** 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	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'

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:	08/07/2025	TREND	20 (4x5)
		Date of Next Review:	08/08/2025	➡	

associated learning **(REF: MAI recommendations 26, 88).** These are not included in the R106 funding request.	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.
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 1, 26, 88, 111).**	Assistant Director of Operations, National Operations & Support	**CLOSED**	This programme of work is underway, with nearly all recommendations completed. 4 recommendations remain outstanding, with a plan in place to implement all these recommendations. **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.
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:	03/06/2025	TREND	16 (4x4)
			Date of Next Review:	03/07/2025	➡	

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.

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 May 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 2024/25 details intention for move to EV for smaller and support vehicles
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
	External - Independent Assurance: • Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	03/06/2025	TREND	16 (4x4)
		Date of Next Review:	03/07/2025	➡	

3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)	
4. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establishment of potential further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	Not needed. Action closed.	Workstreams were set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	March 2025 **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	March 2025 **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	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 being developed by 31st Jan 2025. TEF bids were submitted, and it has been confirmed that 3 of the 6 submitted projects have been supported. **Work has commenced on the establishment of 2025/26 schemes.**

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:	08/07/2025	TREND	15 (3x5)
		Date of Next Review:	08/08/2025	➡	

				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 **March were 21,855 and April were 21,193.** 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.
	External Independent Assurance

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:	08/07/2025	TREND	15 (3x5)
		Date of Next Review:	08/08/2025		

	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 recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes.

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	08/07/2025	TREND	15 (3x5)
		Date of Next Review:	08/08/2025		

			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:	28/04/2025	TREND	15 (3x5)
		Date of Next Review:	28/05/2025	➡	

				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 of a number Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk, and should we demonstrate meeting Statutory Requirements even if a serious incident/event/failure arises evidence provided would reduce / mitigate against the consequences.

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.) Measured on the **31**/03/25, WAST had achieved **76.91**% compliance against an 85% target for statutory IG training. In addition, 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**, recently required organisations across NHS Wales to demonstrate compliance with legislation via the IG Toolkit, or risk requests for using sensitive patient information being rejected – further resulting in risk to WAST's academic partnerships and reputation, strategic research endeavours, **and patient data linkage initiatives should CAG support be pursued**.

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.

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) 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.
6. Awareness: Staff training on updated training module (Apr 2023)	6. Training compliance monitored monthly via IGSG (captured on ESR and LMS365)

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	28/04/2025	TREND	15 (3x5)
		Date of Next Review:	28/05/2025		

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.
GAPS IN CONTROLS	GAPS IN ASSURANCE
1.	1. 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
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. 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.
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.
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.
5. Awareness: Currently not meeting levels of IG staff training.	5. Awareness: Some data errors in ESR reporting for IG mandatory training has been identified, requiring manual effort to calculate Trust-wide compliance percentages.
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 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).	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 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. - not achieved 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**	3a. Lock screen issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24. AI guidance issued 01/25. Cyber & IG procurement guidance in development. Evidence that regular comms is being published, and so action complete, and assurances added to Controls. **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.** 3b. IG training compliance required to meet 85% target. An Action Plan for training has been created, and a training needs analysis being progressed with

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	28/04/2025	TREND	15 (3x5)
		Date of Next Review:	28/05/2025		

			L&D team. Paper to ADLT Jun24 seeking support for increased awareness & training compliance Direct contact to individuals who have been non-compliant for a significant period of time, with escalation through their line management structures as required. See Action 5 for more specific detail on achieving the target. 3d. Procedures, such as audit of Welsh Clinical Portal usage, has been updated.
2. Report on physical security to IGSG – working with fleet and estates team	Leanne Smith and Aled Williams	Q2 2024/25 Q1 2025/26	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.
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 24-25 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	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.

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:	14/04/2025	TREND	12 (3x4)
		Date of Next Review:	14/07/2025		

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	3	4	12
			Target	2	4	8

IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32

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 27,000 (Jan-25). The JCC had an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which has not been achieved, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust has 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. 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. Ambulance Care performance is stable. 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
3. Weekly catch up between Interim Director of 111 & Ambulance Commissioning /CEO	3. Meetings are diarised every week
4. Collaboration between JCC and WAST on specific projects e.g.	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
~~5. Monthly CASC Quality and Delivery Meeting established (currently paused as part of move into JCC).~~	5. Note: this meeting has stopped and needs to be restarted, probably in a slightly different form.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly
7. Commissioning intentions.	7. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111 Wales and expected to be approved by Mar-24 JCC (approved).
8. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	8. Minutes of meetings and a standard agenda item
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available

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:	14/04/2025	TREND	12 (3x4)
		Date of Next Review:	14/07/2025		

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.
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.
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.
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.

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.
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.
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.
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.

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:	14/04/2025	TREND	12 (3x4)
			Date of Next Review:	14/07/2025	➡	

			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.
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

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	30/05/2025	TREND	8 (2x4)
		Date of Next Review:	30/08/2025		

				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: Q1 2025/26 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 1 of the 2025/26 Financial Year. The score is consistent with that of Qtr. 4 2024/25 due to **also** presenting **an** opening balanced financial plan for 2025/26 and **full allocation of the £8.5m** savings delivery **target**. 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 current challenging financial climate for all public sector organisations that may also impact on WAST financial performance especially as the financial year progresses.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place	4. Diarised dates for **ADLT,** FPC **and Trust Board** and monthly reports **with budget managers**
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 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)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

GAPS IN CONTROLS	GAPS IN ASSURANCE

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	30/05/2025	TREND	8 (2x4)
		Date of Next Review:	30/08/2025		

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	31/03/245 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.

AGENDA ITEM No	**16**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

INTERNAL AUDIT: CAPITAL SYSTEMS – FEEDBACK FROM ARAC

MEETING	Finance and Performance Committee
DATE	21 July 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Steve Owen, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Audit, Risk and Assurance Committee (the ARAC) received and discussed the **Capital Systems audit report** at its meeting on 24 June 2025. This report summarises the discussion from this meeting in reference to this report.

2. **Capital Systems – Substantial Assurance**. The audit was focused on the selection, appointment and contractual arrangements applied at Capital and Estates projects. The audit provided substantial assurance for value for money, indicating effective use of resources in capital projects.

3. The audit reviewed the control framework, systems, and processes in place to manage discretionary EFAB and other capital estates funded schemes. While several processes support capital project progression, they are not fully documented, affecting consistency and standardisation, and there was a lack of evidence for declarations of interest and non-collusion, particularly from shared services procurement office. One project lacked a signed contract, and contract amendments were not consistently annotated as accepted by both parties. The retention period within the NHS Wales Records Management code of practice is insufficient to cover the liability period for contracts executed as deeds.

4. Similar reviews at other NHS Wales organisations revealed consistent issues with declarations of interest, non-collusion, and contract retention periods. Management acknowledged the findings and emphasised the need for improved processes with shared services procurement. Actions are in place to address the identified issues. The audit findings will be shared with shared services procurement to ensure compliance and mitigate risks. The policy is due for review in July, and the findings will be reiterated in the updated version.

5. Two objectives were rated reasonable and one substantial (value for money). The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.
6. The Committee welcomed the assurance level but expressed concern over potential delays in contract signing due to one of the recommendations and called for a pragmatic application of this, if required. It was confirmed the Trust had already fulfilled its responsibilities within the required management action, including sharing the findings with NWSSP to support compliance improvements.

RECOMMENDATION: The Finance and Performance Committee is asked to note the discussion at the meeting of the ARAC on 24 June 2025, and the assurance that was received following receipt of the Capital Systems audit report and agreed management actions.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Capital Systems audit report

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

Capital Systems

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAS-SSU-2425-19
Fieldwork	March – May 2025
Executive Sign Off	12 June 2025
Audit Committee	24 June 2025
Executive Lead	Chris Turley, Executive Director of Finance & Corporate Services
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

This audit was commissioned in accordance with the agreed 2024/25 Internal Audit Plan. Capital systems coverage focused on the selection, appointment and contractual arrangements applied at Capital and Estates projects.

Overview

We have concluded that this area offers **reasonable** assurance. Whilst good compliance was noted in most areas of the expected control environment for projects, the following matters were identified for management attention:

- Capital procedures: whilst there are a number of processes in place to support the progression of a capital project from inception to closure they are not formally documented, the detail of which (and the expectations for key document retention) would enable consistency and standardisation of approach.
- Declarations of interest and non-collusion: retention of evidence for the affirmation of such.
- Contract documentation: a signed contract for one of the projects was not yet in place; however, the purchase order had been actioned on Oracle with work also having been commenced on site. Further, for those signed contracts, the contract amendments had not been annotated as accepted by both parties. Where the contracts had been signed, there is an expectation that all pages containing amendments to the standard form contract are annotated as accepted by both parties; however, this was not evidenced.
- Contract retention period: whilst complying with the NHS Wales Records Management Code of Practice 2022, the retention period is not sufficient to cover the liability period for contracts executed as deed.

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

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion)		Related Findings	Assurance
1	Governance - to assess the application of appropriate procurement policies and procedures to Capital and Estates contracts and ensure that roles and responsibilities and approval requirements were adequately defined.	1	**Reasonable**
2	Selection and Appointment – to ensure the appropriate application of Standing Orders, Standing Financial Instructions (SFIs), national and local procurement policies for the selection and appointment of contractors and technical advisers. To ensure the application of appropriate competitive tender/quotation arrangements, the use of frameworks (as applicable) and the appropriateness of associated management and reporting.	1, 2	**Reasonable**
3	Value for Money and Award – to ensure that there was an appropriate assessment of value for money (e.g. via tendering/ quotation, benchmarking etc), with formal recommendations for award. Appropriate approvals were in place, that fully considered the above and any associated limitations.	-	**Substantial**

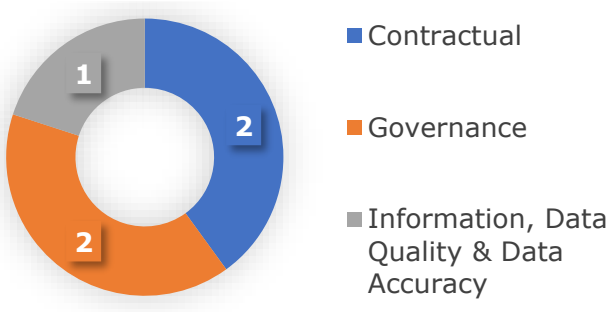
4	Contract Completion – to obtain assurance on the timely completion, recording, and approval of agreement/ contract versions in accordance with the approved contract strategy (with appropriate inclusions and clauses).	3 ,4	**Reasonable**
5	Retention of contract and project documentation - to obtain assurance that Capital and Estate's contract information was retained for the requisite period (in accordance with national guidance) and that all contract documentation was held securely.	5	**Reasonable**

Management Actions

1 High Priority

4 Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Capital Systems - At a Glance

The following five projects were sampled for this audit covering a range of values and funding sources as follows:

Project title	Year	Contract Value (£)	Funding Mechanism
Llangunnor Clinical Control Centre Works	2024/25	£664,743.96	Discretionary Capital Projects (DCP)
Newtown Ambulance Station: refurbishment	2024/25	£349,452.31	Estate Funding Advisory Board (EFAB)
Pontardawe Ambulance Station: refurbishment	2024/25	£253,269.85	Estate Funding Advisory Board (EFAB)
Blackwood Ambulance Station: re-roofing works	2024/25	£145,568.74	Discretionary Capital Projects (DCP)
EV Charging Infrastructure – Rapid Charging	2024/25	£96,669.16 [1]	Discretionary Capital Projects (DCP)

[1] *At the date of audit fieldwork, a signed contract was not available for review.*

Findings & Agreed Action Plan

Objective 1: Governance	Reasonable

The Trust has adopted the NHS Model Standing Financial Instructions and Standing Orders, Reservation and Delegation of Powers, with the latest amendment made in September 2023.

Section 15 of the Standing Financial Instructions addressed the detail for *Capital Plan, Capital Equipment, Fixed Asset Register and Security of Assets,* with reference provided to Welsh Government requirements and guidance for capital investment decisions (NHS Wales Infrastructure Investment Guidance and development of business cases (Better Business Cases: investment decision making framework). Section 15.4 references capital procedures and responsibilities with section 15.4.7 stating that *the Executive Director of Strategy, Planning and Performance and Executive Director of Finance and Corporate Resources shall issue detailed procedures governing the project, financial and contractual management, including variations to contact, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Executive Director of Finance and Corporate Resources shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.*

However, there was no evidence of such documented procedures being in place at the Trust (see **Key Finding 1**). We were advised that the management of projects is by following the RIBA (Royal Institute of British Architects) stages through Prince2 methodology, and note that a recent presentation (October 2024) as part of a Capital team away day reiterated such providing reference to such stages which addressed the core tasks applicable to each project. However, this does not address the process prior to approval. It may be worth considering the introduction of a project checklist, which we have evidenced at other NHS Wales organisations, which would provide the high-level guidance to proceed with a project.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Capital Procedures** Whilst there are a number of processes in place at the Trust to support the progression of a capital project from inception to closure, they are not formally documented. It is acknowledged that the principles of Prince 2 methodology are applied, and guidance has been provided in relation to the core tasks applicable within each of the RIBA stages. We have evidenced at other NHS organisations the application of a project checklist for completion as each stage of the project progresses; and such could be extended to include expectations for receipt of key documentation such as: • declarations of interest, collusion certificates (see objective 2), • confirmation of parent company guarantees (if applicable), • insurance documentation and the minimum coverage amounts based on project size and risk; • confirmation that the successful / unsuccessful award notifications have been issued to the contractors.	No procedural standards exposing the Trust to regulatory or reputational risks. **Medium Priority**	**Proposed Management Action:** Develop project checklist for adoption by all schemes (and tailored accordingly to each as required). **Expected Evidence of Implementation:** Project checklist issued to Project Managers for adoption within project documentation. **Officer:** Head of Capital Development **Date:** 30 September 2025

	Theme: Policies & Procedures	Control Design	

Objective 2: Selection and Appointment	Reasonable

For the five sampled projects at this review, the Trust with the support of NWSSP Procurement Services completed a competitive tendering exercise, managed through the digital platform of Sell 2 Wales. Compliance was noted with the Standing Financial Instructions (section 11.11.1) for procurement between £25k and £1m for all.

Within our sample of projects, pre-tender estimates had been prepared prior to market testing and these costs were included within the submission to the Internal Capital Monitoring Group for consideration for funding route. This is seen as positive practice and contributes to the setting of realistic financial expectations and facilitating effective financial planning.

Following market testing, technical and financial vetting was conducted to ensure that all potential contractors met the necessary standards and addressed the respective project's specification of works. This vetting includes organisational details, capability, financial, insurance, disputes, declaration of good standing and other relevant information. These measures are key to mitigating risks and ensuring that only qualified and compliant contactors are considered. Formal Contract Award Recommendation Reports (CARR), detailing the evaluations undertaken and the recommendations for awarding contracts, were prepared and signed off by an appropriate officer within the Trust. This process ensures transparency and accountability on the decision-making process.

Challenge was observed on the occasion when the tender analysis identified a higher value than budget (Newtown Ambulance Station), and recommendation was made to revise the tender awarded accordingly; with appropriate evidence retained of the value engineering exercise that was undertaken by the interested contractors.

Whilst the evaluation has been undertaken by the NWSSP Procurement officers, in consideration of the agreed evaluation requirements set at the tender stage, there was no evidence to confirm their independence of the contractors detailed within the report (see **Key Finding 2**). Trust Senior staff (band 8a and above) confirm annual declarations of interest; and there is an expectation that reaffirmation is sought before involvement in procurement exercises – with confirmation also sought for those project officers who would fall outside of the annual declaration process. Such is provided to NWSSP Procurement Services as part of the tender exercise.. From review of the contract award recommendation reports, where there are issues of concern, such will be flagged (and it was noted there were no such instances of compromise identified for the sample selected). However, there would be benefit in ensuring all completed declarations are retained / referenced centrally by the Trust (see **Key Finding 1**).

Further, there was no evidence of a declaration of non-collusion having been completed by the contractor upon return of their tender documentation (see **Key Finding 2**). Whilst appreciating that such may be held by NWSSP Procurement Services team, for completeness, reference to such could be incorporated into the CARR or a project checklist (see **Key Finding 1**)

Key Findings		Risk & Impact	Agreed Management Action
2	**Declarations of interest / non-collusion** There was no evidence to confirm independence from the contractors submitting tenders by the NWSSP Procurement officers involved in the procurement exercises. Further, there was no evidence of a non-collusion form having been completed by the contractor upon return of their tender documentation. Management advised that the commercial, technical and financial information received from contractors will not be released unless affirmations of independence have been received (the same being applicable in respect of non-collusion). However, in the instances of the four signed contracts reviewed,	Financial or reputational risk heightened by entering contracts with organisations from which independence has not been affirmed.	**Proposed Management Action:** Project Managers to hold a copy of completed DOIs returned to NWSSP before tender submissions are released for scoring. This will be recorded on the project checklist. Provide a copy of the Internal Audit report to request NWSSP Procurement confirm in writing that they will fulfil their requirements in respect of ensuring due independence / governance in all future procurement. Further to include in the Procurement Outcome Report (POR); previously the CARR, the necessary confirmation of independence by all NWSSP officers involved in the process and receipt of non-collusion forms.

	NWSSP Procurement confirmed the officers were not asked, therefore lessening this 'control'.		**Expected Evidence of Implementation:** Project checklist updated by Project Managers to reflect retention of Trust DOI forms. Email to provide Internal Audit report to NWSSP Procurement with a re6quest that they update the POR as per the findings of the audit report and provide written confirmation of independence and confirmation of non-collusion forms.
		High Priority	**Officer:** Head of Capital Development and Deputy Head of Procurement **Date:** 30 November 2025
	Theme: Governance	Control Operation	

Objective 3: Value for Money (VfM)	**Substantial**

As per the Standing Financial Instructions, section 11.10.3 states *agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for Money is defined as the optimum combination of whole-life cost and quality to meet the requirement.*

For each of the projects sampled at this review, the supporting CARR clearly stipulated that such were to be awarded on the basis of the most economically advantageous tender. This was evidenced for all following completion of both the technical and commercial evaluation of the tenders received.

Objective 4: Contract Completion	Reasonable

From the five projects sampled, at the date of audit fieldwork, four had contracts in place which had been signed in accordance with the Trust's Scheme of Delegation; with purchase orders appropriately actioned on Oracle. Through our audit work, we look for assurance that the contracts were signed before commencement of works. We noted that none of the signed contracts were dated but appreciate there is no request for a date on the face of contract; and the compensatory control is that the purchase order is approved in advance of commencement of works (as confirmed through review of Oracle) and no pre-contract start meeting is held with the appointed contract prior to approval of the purchase order. Therefore, we have not sought to raise a finding at this report.

All contracts were executed as a deed, irrespective of financial value or project complexity. This approach ensures robustness and enforceability noting the liability periods extend to 12 years, from 6 years, when contracts are executed "under hand".

The contract for the EV Charging Infrastructure, whilst confirmed as the decision to appoint being approved in the CARR, was not available. Management advised that the successful contractor had been provided with the required documents for signing but such had yet to be received (see **Key Finding 3**)

JCT Contracts have been used for all – two being *Minor Works Building Contracts*; and two being *Standard Building Contracts without Quantities 2016*. All include delay damages clauses with such ranging from £500 to £1,500 per week; with a correlation between the value of the contract and the respective value of delay damages provided. Contracts clearly identified details such as key dates, agreed price, rectification period, payment terms and contractor's Public Liability insurance value.

Whilst the contracts have been signed, there is an expectation that pages/changes to the standard form contract are annotated by both parties accepting the changes specific to the respective project. This was only evidenced for one contract: Pontardawe Ambulance Station (see **Key Finding 4)**

Key Findings		Risk & Impact	Agreed Management Action
3	**Completion of contract documentation** The finalised contract for the EV Charging Infrastructure was not available for review at the date of audit fieldwork. From review of the EV Project Board minutes, that at the date of fieldwork completion, two of the three charging stations had been installed. At the date of this report, we note that all work has been completed. We understand that the signed documentation is currently being chased by both the Trust and NWSSP Procurement Services for finalisation, but such should be in place prior to actioning the purchase order on Oracle (which we noted had been done), including evidence of parent company guarantee (see Key Finding 1).	In the absence of a formal contract, the Trust lacks legal recourse if a contractor fails to meet agreed deliverables, causing potential financial loss or project delays.	**Proposed Management Action:** Continue to chase the signed Framework Agreement for the EV Charging Infrastructure work. **Expected Evidence of Implementation:** Evidence of chasing and/or signed Framework Agreement.
	The appointment was made following a mini competition from the ESPO Vehicle Charging Infrastructure (VCI) Framework– financial risk reduced with the purchase order placed on Oracle; but from a service delivery perspective, should issues be encountered post completion, there is no contractual documentation to support responsibility.	**Medium Priority**	**Officer:** Capital Programme Manager **Date:** 30 September 2025
	Theme: Contractual	Control Operation	

4	**Annotation of contracts** All of the four contracts reviewed are standard JCT contracts. Amendment to the standard form i.e. inclusion of values, dates, delay damages etc should be annotated (page by page) so as to demonstrate acceptance by both parties; in addition to the expected formal signing of the contract. However, this was only evidenced for one contract noting this had been applied due to an error in the contractual value that had been recorded.	Different contract terms in place should a challenge, claim or dispute arise – weakening the position of the Trust.	**Proposed Management Action:** Cost Advisor to highlight specific detail included in the standard JCT contact. Changes to be annotated a point of signature. **Expected Evidence of Implementation:** Example of a signed JCT contract with changes annotated.
	Theme: Contractual	**Medium Priority** Control Operation	**Officer:** Executive Director of Finance & Corporate Resources and Board Secretary **Date:** 30 April 2026

Objective 5: Retention of Documents	Reasonable

Project documentation, including contract information, is retained in accordance with the Trust's Records Management Policy which cites that the *retention schedule is to be applied as per the NHS Wales Records Management Code of Practice 2022.* As per the Code of Practice, *contracts sealed or unsealed – retain for 6 years after the end of the contract*.

Of the signed four contracts that were available at this review all have been executed as deed (see objective 4). Contracts executed as deed conveys longer liability periods for 12 years, or the useful life of the associated building(s) (or their disposal). The guidance provided in the Code of Practice, therefore, is inadequate (see **Key Finding 5**), Whilst management advised that contract documentation is retained for the life of the building, this is not cited within a policy / procedure.

We noted that the Trust has initiated the development of an organisational contract register. The contracts which have been sampled at this review (which are currently included within a dedicated Capital Contracts listing) were not included on the organisational register but we acknowledge that the completion of the register remains ongoing at the date of audit fieldwork. Noting that this point is being raised at the wider Contract Management audit (advisory), including enhancements to provide a clearer picture of contract performance, we have not sought to replicate a recommendation/action at this report.

We were advised that all contract documentation is held securely – both electronically, with defined access; and physically, at the Carmarthen office with appropriate security control in place.

Key Findings		Risk & Impact	Agreed Management Action
5	**Contract Retention Period** The four contracts that were available at this review were executed as a deed, which conveys longer liability periods of 12 years or the useful life of the associated building/s (or their disposal). Accordingly, the proposed retention period of six years is insufficient.	Financial or performance-based loss could be incurred by the Trust due to lack of evidence of contract-based mitigation.	**Proposed Management Action:** All contract documentation stored in the Operating & Maintenance (O&M) manual structure and noted on the project checklist. Internal Audit report to be provided to Records Management Team with request that the next update to the Trust's Record Management Policy recognises compliance with the NHS Code of Practice but provides additional confirmation of the process to be applied for contracts executed as deed.
			Expected Evidence of Implementation: Screenshot of JCT contract held in O&M folder for scheme competed (2024/25 schemes for purpose of evidence). Evidence of Internal Audit report provided to Records Services and Archives Manager.
		Medium Priority	**Officer:** Head of Capital Development
	Theme: Information & Data Management	Control Design	**Date**: 31 July 2025

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Prioritisation of Findings

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

Public Sector Internal Audit Standards

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

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

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

INTERNAL AUDIT: CONTRACT MANAGEMENT ADVISORY REVIEW – FEEDBACK FROM ARAC 24 JUNE 2025 and SBAR To ARAC

MEETING	Finance and Performance Committee
DATE	21 July 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Steve Owen, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Audit, Risk and Assurance Committee (the ARAC) received and discussed the **Contract Management – Advisory Review** at its meeting on 24 June 2025. This report summarises the discussion from this meeting in reference to this report. A further detailed SBAR to the ARAC is attached at Annex 2.

2. **Contract Management – Advisory Review (therefore no rating applied)**. The purpose of this review was to assess whether appropriate contract management arrangements were in place within the Trust. This was an all-Wales review and compared the appropriateness of contract management arrangements across eight health bodies, with common issues and challenges noted.

3. The Trust used this opportunity to assess its own contract management practices, and to develop a centralised contract register in readiness for the audit - the only health body to do so. While a centralised contract management system will not be pursued due to resource implications, the review identified strong pockets of good practice in higher-risk areas. For example, the Digital Directorate has a well-defined supplier contract SOP, and the Finance & Corporate Resources Directorate maintains a comprehensive capital contracts register. These areas demonstrated more advanced and structured contract management processes, reflecting their financial and reputational risk exposure.

4. The report also highlights the significant role of NWSSP Procurement Services in supporting all-Wales improvements. NWSSP is expected to lead on the development of consistent guidance, training, and education to strengthen contract management capabilities across NHS Wales bodies. In the meantime, a joint Siren Notice from the Finance and Corporate

Governance Directors will reinforce key principles locally, including the need for designated contract managers, directorate-level registers, and clear reporting and escalation mechanisms.

5. ARAC welcomed the report, acknowledging the timing challenges and the need to strengthen Contract Management culture. They also acknowledged the importance of the report and emphasised the need for improvements within contract management processes, highlighting the significance of addressing the recommendations provided in the report to enhance the overall efficiency and effectiveness of contract management within the organisation.

6. ARAC noted these local actions and the continued collaboration with NWSSP on centralised improvements and will revisit this in nine months' time.

RECOMMENDATION: The Finance and Performance Committee is asked to note the discussion at the meeting of the ARAC on 24 June 2025, following receipt of the Contract Management Advisory Review.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
1. Contract Management – Advisory Review **2. Detailed SBAR To ARAC**

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

Health Improvement	Y	Socio Economic Duty	NA
Health and Safety	Y	TU Partner Consultation	NA

Contract Management

Final Advisory Report

2024/25

Welsh Ambulance Services University NHS Trust

Contents

Review Reference	WAST-2425-03
Fieldwork	February 2025 – May 2025
Executive Sign Off	4 June 2025
Audit Committee	24 June 2025
Executive Lead	Chris Turley, Director of Finance & Corporate Services; Trish Mills, Director of Corporate Governance
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

The review assessed whether appropriate contract management arrangements were in place within the Trust. This review has been undertaken further to the Contract and Procurement advisory review at Betsi Cadwaladr University Health Board (BCUHB), completed at the request of Welsh Government in 2023/24, which identified several areas of concern and non-compliance with the organisation's Standing Financial Instructions. Through inclusion within NHS Wales organisations 2024/25 Internal Audit plans, this review has compared and contrasted the appropriateness of contract management arrangements across eight more organisations, with common issues and challenges noted.

An assurance rating has not been applied to this review, recognising the consistency of approach with the BCUHB review, and that actions raised will need to be taken forward in partnership with other NHS Wales organisations, including NWSSP Procurement Services. These actions, alongside those specific to the Trust, are aimed at improving and/or enhancing expected controls in contract management arrangements.

Overview

Noting the infancy of the Trust's contract register, for the purposes of this audit, sample testing was based on the Electronic Contract Management module of the Bravo e-tendering system. Contract selection was undertaken to ensure consistency with similar reviews undertaken at a number of NHS Wales organisations. All Wales Contracts were excluded from our sample; in addition to Capital and Estates contracts noting that separate Capital Systems reviews have been undertaken by our Specialist Services Unit (SSU) at a number of NHS organisations as part of the 2024/25 Internal Audit Plan – the coverage of which has also included contract management.

The following observations have been identified for management attention across all reviews completed:

- The need for consistent contract management procedures to support the requirements of the Standing Financial Instructions, this could be through engagement with NWSSP Procurement Services to adopt their Contract Management Procedure;
- Comprehensive contract registers were not in place. We note, however, that the Trust has made progress with the development of a contract register but this is at an early stage and there could be enhancements to its format and completeness;
- A mechanism to determine the capacity and support needed to meet existing and future contract monitoring requirements, with appropriate training provision;
- Responsibility for contract management should be formally assigned and accepted;
- Variations in the formality of contract management, performance reporting, and documentation, which indicates a level of inherent risk, and which could be addressed by increasing the robustness of the control environment; and
- The minimum internal reporting, accountability and escalation requirements should be considered and defined at the outset of contracts.

The Trust should ensure appropriate arrangements are in place to engage with wider NHS Wales organisations and NWSSP Procurement Services in developing a coordinated agreed action plan via the Directors of Finance forum, to address the common themes and issues identified within this and corresponding reports.

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

Scope & Actions Summary

	Objectives	Related Actions
1	There is a clear framework of policies, procedures and processes for contract management, with roles and responsibilities clearly defined.	1
2	Contract registers are used as the basis for effective contract management and procurement planning.	2
3	Contract managers have access to relevant training and development.	3, 4
4	Service levels/deliverables are specified in the contract, with standard terms and conditions applied, and are linked to service needs and monitored by the assigned contract manager/end user.	5
5	Contract performance and risk is reported and managed within the Trust's governance structure.	6

Management Actions

6

Themes

Risk Types

Public Perception & Reputational Risk

Financial Loss

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Findings & Agreed Actions

Objective 1: There is a clear framework of policies, procedures and processes for contract management, with roles and responsibilities clearly defined.

The Trust's Standing Financial Instructions (SFIs) includes a section on contract management. Section 11.16.1 outlines that the relevant budget holder is responsible for overseeing and managing each contract on behalf of the Trust to ensure that implicit obligations are met. This includes:

- *Retaining accurate records;*
- *Monitoring contract performance measures;*
- *Engaging suppliers to ensure performance delivery;*
- *Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and*
- *Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.*

In addition to the above, there is an All-Wales Procurement e-manual, which contains high-level contract management guidance, available via the Trust 'Oracle' system home page. In discussion with staff, this document is not a regular point of reference.

The Digital Directorate within the Trust has a Standard Operating Procedure 'Supplier Contract Management' (the Digital SOP). This provides the basis for a standardised approach through the definition of contract management roles and responsibilities across the lifespan of a contract; and outlines the factors to consider in assigning each contract a priority level (high/medium/low), with each level having corresponding contract management and monitoring requirements. Following its approval in January 2024, implementation of the Digital SOP is progressing, and we noted the intention to engage with contract managers outside of the Digital Directorate as the next stage in its development. Review of other NHS organisations indicated that the majority did not have local contract management guidance in place, an exception was noted for Aneurin Bevan University Health Board where, in conjunction with local NWSSP Procurement, there has been the development of a Contract Management Financial Control Procedure (FCP). The FCP outlines roles and responsibilities for contract management, requiring designated contract managers to complete standardised 'Contract Management Plans' for contracts over £100,000 in value. Wider dissemination of the content from the FCP was discussed at the NWSSP Heads of Procurement meeting in February 2025, and there was support for its further roll out across other NHS Wales organisations.

The above could inform the basis for a Trust wide guidance document, with consideration of enhancements identified from good practice elsewhere through supportive template documentation, expected reporting and escalation arrangements, and integration with the Trust's risk management framework to provide robustness for wider use across the organisation (see **Action 1**).

Action 1: Contract Management Procedures

The Digital Directorate's *Supplier Contract Management SOP* provides a good basis for contract expectations, responsibilities and accountabilities; but recognising that some established good practice is now available from within the wider NHS, the Trust may wish to engage with NWSSP Procurement Services in relation to implementation of the NWSSP Contract Management Procedure**.**

Objective 2: Contract registers are used as the basis for effective contract management and procurement planning.

A contract register is important as it provides:

- Contract Tracking: to track important dates, such as start and end dates, renewal periods, and milestones associated with each contract.
- Compliance and Risk Management: to ensure that the organisation stays compliant with contract terms and legal requirements, and to help identify any potential risks by keeping a record of contract clauses, obligations, and renewal terms.
- Audit Trail: provided for each contract, including amendments and performance evaluations. This makes it easier to track changes and decisions related to a contract.
- Centralised Repository: allowing easier access for teams like legal, procurement, and finance when they need to refer to specific terms, obligations, or other contract details.
- Improved Communication: enhances communication across departments, as everyone involved can refer to the register to ensure that they are aware of their obligations and responsibilities under various contracts.
- Budget and Financial Tracking: for financial management to track contract values, payment terms and other financial aspects to ensure proper budgeting and forecasting.

The Social Partnership and Public Procurement (Wales) Act 2023 includes that a contracting authority must create, maintain, and publish a contract register. Reliance has previously been placed on information held in the Electronic Contract Management module of the Bravo e-Tendering system which sample testing, see *objective 4,* has highlighted this is not a reliable source with incomplete and/or out of date information. However, we note that the Trust is currently developing a central list of contracts through engagement with the Assistant Director Leadership Team (ADLT). A copy of the draft Trust contract register was shared with us, noting its status as in-progress. Management has advised that further resources and digital support would be required to complete and maintain.

It is positive to note the inclusion, within the Trust's register, of procurement route, governance, legal and regulatory aspects, which would offer a clearer view of the Trust's contract management arrangements. We note the opportunity to align with the contract categorisation identified within the Digital SOP (see *objective 1*); and whilst there is a column for key performance indicators, there could be more detail relating to the contracts' performance status and any escalation required (see **Action 2**).

Within our sampled contracts (see *objective 4*), only one contract manager indicated a directorate contract register was in place - an ICT contract register within the Digital Directorate. This includes Contract title; supplier; value; department; Trust lead, procurement process used and start and end dates, however the details held within the directorate register were yet to be transferred to the Trust wide register (see **Action 2**).

We acknowledge that a central listing of capital contracts is also maintained by the Finance Directorate (this provides details of funding source, contract value, contractor, contract type and date of approval) and note that the details of such have also yet to be transferred to the Trust wide register. No further review of capital contracts was undertaken noting the separate Capital Systems audit being undertaken (for which Reasonable Assurance has been determined).

Action 2: Contracts register

Complete the development of the Trust-wide contract register to record and manage contract records and information.

The register in its current format provides a basis for the capture of contracts and the organisations contracting risks; however, there could be enhancements to provide a clearer picture of contract performance.

Objective 3: Contract managers have access to relevant training and development.

This audit, and similar reviews at other NHS Wales Organisations, observed that contract management was undertaken by combination of:

- Dedicated contract managers;
- To fulfil an existing element of a job description / role; and
- As an unspecified additional responsibility.

The demands on staff was dependent on the specific performance monitoring requirements of the contract and varied significantly.

For the sampled contracts, there was no evidence of an assessment of the capacity / capability requirements to fulfil the role and / or the identification of any training requirements to address any gaps (see **Action 3**). Similarly, no specific contract monitoring training had been provided, although within our sample (see *objective 4*), all but one (5/6) had a reference to contract management within their job description (noting that two were managed by the same individual).

The Trust's SFIs include within Section 11.16.3 that 'Advice on best practice on Contract Management is available from NWSSP Procurement Services.' As per objective one, staff contacted through fieldwork did not have awareness of the NWSSP Procurement e-Manual, which contains contract management guidance (see **Action 4**).

Action 3: Training Needs Analysis

A mechanism should be established to ensure senior managers identify any specific training requirements to support operational contract management – reflecting the capacity / capability of individuals and the requirements of the specific contracts.

Action 4: Training provision

The Trust should engage with other NHS Wales organisations to develop contract management training, to ensure staff are equipped with the tools and skills to manage the key stages and lifespan of contracts.

Objective 4: Service levels/deliverables are specified in the contract, with standard terms and conditions applied, and are linked to service needs and monitored by the assigned contract manager/end user.

Standing Financial Instructions (11.6.1) require that "*The relevant budget holder, shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met*."

A sample of six contracts were selected from the contract management module of the Bravo e-tendering system, and this was undertaken in conjunction with reviews taking place at other NHS Wales organisations to provide consistency of service/contract type where possible. Common themes across these reviews have been identified which will need a consistent approach to be addressed on an All-Wales basis, in conjunction with NWSSP's Procurement Services.

Evidence from Trust contract managers demonstrated ongoing contract management and operational understanding of the requirements of such, where exceptions have been identified below these were accompanied by mitigations.

Through discussion with contract managers and review of documentation we identified the following:

Designated responsible officer/contract ownership - Whilst the audit was directed to certain individuals for the sampled contracts for the audit, not all individuals had been formally assigned responsibility for contract monitoring - with some having had no prior involvement within the tendering process, which could impact on the understanding of the expectations of the role (see **Action 6**). Within our sample of contract managers, we identified one individual who performed a dedicated contract management role. Further, three of the six contract managers were not the individuals/contract leads listed within the Bravo e-tendering system report (GCloud, Employee Assistance Programme, Tail Lift Repairs and Servicing, and Windowscreen and Bodyglass replacement (the latter two managed by the same individual)).

The recording of the Senior Responsible Officer and budget holder within contract documentation varied in the documentation reviewed, and this, alongside the differences in the contract leads recorded within Bravo, indicates a need for the Trust to progress its own contract register, and ensure this is updated to reflect changes in ownership (see **Action 2**).

Contract documentation - Final signed contracts were not available for two of our sample contracts (Tail Lift Repairs and Servicing, and Windowscreen and Bodyglass replacement). Trust managers noted that these had not been provided by NWSSP Procurement Services, but prior to audit fieldwork had not identified this gap (see **Action 5**). We note that specifications were available which had been utilised in awarding contracts through the tendering process to demonstrate the contract criteria, however the completeness of contractual terms and conditions had not been addressed.

Contract deliverables/performance measures - Review of contract documentation established that agreed and defined service deliverables were in place for four out of the six contracts tested. For the two exceptions, technical assessments and pricing comparisons respectively, formed part of the tender and award process and these were used as the basis for ongoing management. Contracts included detailed criteria for services or goods to be provided alongside associated key performance indicators and ongoing contract management arrangements, however these were not available for those contracts without final documents. (see **Action 5**)

Contract management/monitoring - The formality of monitoring arrangements within our sample reflected the differences in their value and business criticality, and this varied with weekly, monthly, and annual arrangements noted. We found that reporting received from providers was broadly in line with that specified within contracts, with one exception noted for the Employee Assistance Programme (see **Action 5**), where review of required and supplementary KPIs identified no concerns in the service provided. We identified an ICT contract not being monitored in line with the requirements set out within the Digital SOP and we noted enhancements could be made to capture where monitoring arrangements are of an informal nature, currently within two other contracts (see **Action 5**).

Action 5: Contract Ownership, Documentation and Management

Our review of contract management arrangements within the Trust identified that not all individuals had been formally assigned responsibility for contract monitoring, with some having had no prior involvement within the tendering process, which could impact on the understanding of the expectations of the role.

Further we identified the following issues from our testing of a sample of six contracts:

- We could not evidence final contract documents in place for Tail Lift Repairs and Servicing, and Windowscreen and Bodyglass replacement.
- For Tail Lift Repairs and Servicing, and Windowscreen and Bodyglass replacement contracts we note that regular informal discussions with suppliers are held, but records of issues or follow up actions are not maintained to demonstrate ongoing contract management.
- The ICT contract for Nutanix hardware and software had no reporting or monitoring arrangements in place. However, based upon the Digital SOP the contract should be classed as medium priority (suggested monitoring - annual review). Discussion with the contract manager indicated there had been no issues or further support required to date.
- Three out of nine KPIs for service delivery listed within the Employee Assistance Programme specification were not within provider reports;
    - All calls answered within 2 minutes (including time on hold).
    - All cases requiring formal therapy to begin sessions within 3 weeks.
    - All cases requiring legal or financial advice to beginning receiving advice within one week.

Noting the above, the Trust should ensure contract managers are aware of their responsibilities as required by the SFIs. This should reiterate the need to retain full and accurate records in support of contract ownership, contract documentation, and monitoring of contract performance.

Objective 5: Contract performance and risk is reported and managed within the Trust's governance structure.

The SFIs relating to contract management (section 11.6) do not provide information on the expected minimum reporting, accountability and escalation arrangements in relation to contracts.

Our review observed varying approaches to monitoring arrangements, with most individuals with responsibility for contract monitoring outlining that escalation reporting was exception based; however, the reporting routes for escalation were not clear for all contracts within our sample with no criteria to guide circumstances where this should occur. For example, we noted an issue with the contract with Gcloud where delayed contract delivery could have been raised, however we also note that the issue had been resolved by the date of close of our fieldwork. It is important that the Trust defines the expected internal monitoring / reporting arrangements at the outset of the contract – cognisant of the risk, value, complexity and strategic importance of the contract (see **Action 6**).

Action 6: Reporting, Escalation and Risk Management Arrangements

Expected internal monitoring / reporting arrangements should be defined at the outset of the contract – cognisant of the risk, value, complexity and strategic importance of the contract.

Minimum requirements could be defined within the contract management procedure (see **Action 1**), with any divergence subject to appropriate approval.

Discussion with contract managers confirmed that they were aware of operational risks related to non-delivery of contracts, however we did not identify formal risk management practices relating to contract risk.

We are, however, cognisant of the manner in which the Trust can adapt its governance framework where a change in direction is required i.e. implementation of SALUS with the update on status, and subsequent action, reported through the IMTP delivery reports to the Finance & Performance Committee and the Trust board.

The Trust's Audit, Risk and Assurance Committee receives an update on procurement activity at each closed in-committee session. This includes the number of in-process and awarded contracts, alongside the number of times SFIs have been waived with explanatory notes to support their use. This overview does not extend to the ongoing management of contracts, nor any retrospective file notes where contract extensions have taken place without procurement support, which is a feature of reporting seen at other NHS organisations. In developing a Trust contract register, there will be the ability to provide regular assurance that contracts are managed appropriately, with exceptions identified and proportionate actions undertaken where required.

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

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

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

AGENDA ITEM No	**5.2.2**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

CONTRACT MANAGEMENT ADVISORY REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	24 June 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Trish Mills, Director of Governance / Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. A review of Contract Management arrangements has been undertaken by Internal Audit as part of the 2024/25 IA plan. This has resulted in the Contract Management Advisory Report, and has been conducted at all NHS Wales health bodies, enabling a compare and contrast of all organisations to take place. No assurance rating has been applied to the report.

2. The scope of what was originally an internal audit review into contract management, enabled the Trust to undertake a review of contract management arrangement in place. This coincided with the Service Review which also sought to understand the contracts each directorate had in place. A task and finish group approach was applied with the support of the Assistant Directors Leadership Team (ADLT) to develop a register of contracts, and to identify where stand-alone registers and contract management arrangements are in place.

3. As indicated in the report, this is in its infancy. The intention of this exercise was not to develop a contract management system. The resources and digital solution to do so simply do not exist at this stage, and to redirect those resources was felt to be disproportionate to any risks that were identified.

4. Those areas of the organisation where there may be financial and reputational risks that flow from poor contract management processes do have more advanced arrangements. For example, the digital directorate has a supplier contract SOP which sets out expectations and process. The March 2024 ICT Contract Management Internal Audit assessed whether the Trust has appropriate contract management arrangements in place in this area and received reasonable assurance. Six of the seven recommendations of that audit were closed on their expected closure date, with one outstanding and due for closure in September. Additionally, it was noted that there is a central listing of capital contracts maintained by the Finance & Corporate Resources Directorate providing details of funding source, contract value, contractor, contract type and date of approval. ARAC

will note the Internal Audit on Capital Systems for 2024/25 has also received reasonable assurance.

5. Whilst this report indicates that there could be enhancements to the format and completeness of the overarching register developed to support this review, no further work is intended at this stage to maintain that register due to the resource implications thereof.

6. The exercise did however provide a good impetus for a closer review of requirements for each contract manager, and whilst any central actions are awaited as a result of the report, it is intended to develop a joint Siren Notice from the Finance and Corporate Resources (FinCoR) and the Corporate Governance Directorate. Noting that much of the NHS Wales procurement processes are centralised with NWSSP Procurement Services, this notice will serve as a reminder to directorates of:

    - Standing Financial Instructions sections on procurement (noting these have recently changed with the introduction of the Social Partnership and Procurement Act 2023, an update on which is due to be presented to the September ARAC meeting)
    - Relevant delegations in the Scheme of Reservation and Delegation
    - The need for an identified contract manager who has performance and financial oversight
    - Monitoring – potentially through developing and maintaining directorate contract registers
    - Reporting and escalation requirements

7. The Executive Director of FinCoR will continue to engage with NWSSP Procurement Services through the Directors of Finance Peer Group and by attendance at the NWSSP Partnership Committee, on actions within their purview. These include a proposed NWSSP Contract Management Procedure,

8. The actions set out in the advisory report did not require management actions, but for completeness and assurance, ARAC will note the following:

Action	Response
Action 1: Contract Management Procedures The Digital Directorate's Supplier Contract Management SOP provides a good basis for contract expectations, responsibilities and accountabilities; but recognising that some established good practice is now available from within the wider NHS, the Trust may wish to engage with NWSSP Procurement Services	As per paragraph 7, we will continue to engage with NWSSP. In the meantime, we will develop and communicate a Siren Notice as per paragraph 6. Siren Notice: 15 July 2025

	in relation to implementation of the NWSSP Contract Management Procedure	
	Action 2: Contracts register Complete the development of the Trust-wide contract register to record and manage contract records and information. The register in its current format provides a basis for the capture of contracts and the organisations contracting risks; however, there could be enhancements to provide a clearer picture of contract performance.	For the reasons set out above we will not be developing a centralised register. However, the Siren Notice will include a recommendation for a directorate based register.
	Action 3: Training Needs Analysis A mechanism should be established to ensure senior managers identify any specific training requirements to support operational contract management – reflecting the capacity / capability of individuals and the requirements of the specific contracts.	It is recommended that more is known about the training provision in action 4 before a WAST training needs analysis is developed.
	Action 4: Training Provision The Trust should engage with other NHS Wales organisations to develop contract management training, to ensure staff are equipped with the tools and skills to manage the key stages and lifespan of contracts	As per paragraph 7, we will continue to engage with NWSSP.
	Action 5: Contract Ownership, Documentation and Management Our review of contract management arrangements within the Trust identified that not all individuals had been formally assigned responsibility for contract monitoring, with some having had no prior involvement within the tendering process, which could impact on the understanding of the expectations of the role.	The Siren Notice recommends that a contract manager is identified for each contract and that that is set out on the register.
	Action 6: Reporting, Escalation and Risk Management Arrangements Expected internal monitoring / reporting arrangements should be	

defined at the outset of the contract – cognisant of the risk, value, complexity and strategic importance of the contract.	The Siren Notice emphasises the need for reporting and escalation mechanisms for contracts.

RECOMMENDATION

9. ARAC is requested to receive assurance on the actions being taken locally with respect to the Siren Notice for all staff, and to note the continued partnership working with NWSSP Procurement Services on centralised training and processes.

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
N/A

REPORT APPENDICES
N/A

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

AGENDA ITEM No	**18**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

INTERNAL AUDIT: EMERGENCY NURSE COMMUNICATIONS SYSTEM IMPLEMENTATION (ECNS) – FEEDBACK FROM ARAC

MEETING	Finance and Performance Committee
DATE	21 July 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Steve Owen, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Audit, Risk and Assurance Committee (the ARAC) received and discussed the **Emergency Nurse Communications System Implementation (ECNS) audit report** at its meeting on 24 June 2025. This report summarises the discussion from this meeting in reference to this report.

2. The purpose was to provide assurance that benefits realised reflect those identified at the outset of the ECNS implementation.

3. A significant backlog of audits was noted, with over 400 audits pending completion. An uplift of six auditors is expected in Q2 to address this backlog. There were discrepancies in monitoring tools and a lack of routine audits for clinicians, with 44% not receiving monthly audits as expected. No post-implementation review had been conducted, resulting in the absence of an evaluation of benefits realised and identification of lessons learned. There was no evidence of escalation of ECNS non-compliance, which could impact the Trust's accreditation status. Reporting arrangements have been refreshed but need time to mature. Management acknowledged the findings and noted that the uplift in auditors and improved processes will address many of the key findings. Members were assured that the benefits of ECNS were realised upon implementation and that the project plan pathway framework and templates will help ensure consistent benefits realisation and monitoring across projects.

4. The need for formal evaluation and post-implementation reviews has been a common theme in previous audits, highlighting the importance of pausing to assess the effectiveness and benefits of projects. Oversight of these audit actions are with the Finance and Performance Committee, who are

requested by ARAC to discuss further the role that committee has in monitoring the process of such evaluations in the Trust.

5. Three objectives were rated reasonable assurance, with two being limited. The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.

6. ARAC noted that Management had acknowledged the issues and confirmed that the onboarding of six new auditors in Q2, along with improved processes, will help address them.

RECOMMENDATION: The Finance and Performance Committee is asked to note the discussion at the meeting of the ARAC on 24 June 2025, and the assurance that was received following receipt of the Emergency Nurse Communications System Implementation audit report and agreed management actions.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Emergency Nurse Communications System Implementation (ECNS) audit report

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

Emergency Communication Nurse System Implementation

Final Internal Audit Report

2024/25

Welsh Ambulance Service University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAST-2425-12
Fieldwork	February - April 2025
Executive Sign Off	29th May 2025
Audit Committee	June 2025
Executive Lead	Lee Brooks, Executive Director of Operations
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To provide assurance that benefits realised reflect those identified at the outset of the Emergency Communication Nurse System (ECNS) implementation.

Overview

The implementation of the ECNS system within the Trust's Clinical Support Desk (CSD) provided a key tool to support secondary triage of patients calling 999, aligning with the strategic ambition to enhance its remote clinical care provision. The adoption of ECNS built upon the lessons learnt from prior Clinical Contact Centre reviews and reflection from the operational response to the Covid-19 pandemic. It provides a more robust, evidence-based, digitally integrated system in comparison to the previous paper/pdf-based triage tool, offering consistency of questioning, advice and efficiencies of process through areas of automated functionality. The Trust has subsequently received accreditation as a Centre of Excellence in September 2023.

This review is not an assessment of the system implementation itself and is cognisant of the significant system challenges faced by the wider Urgent and Emergency Care system which would continue to impact the Trust and in turn the realisation of some related ECNS benefits. Further, this review did not include the recent integration of the ECNS within the wider 111 service; the safe and effective operation of 111 has been assessed within the 111 Digital Operations review (issued December 2024: substantial assurance).

We have concluded **reasonable** assurance on this area.

The matters requiring management attention include:

- The proposal for investment relating to ECNS included a high-level outline of benefits or outcomes related to system implementation, however this was not accompanied by further refinement of targets, criteria or timescales.
- No post implementation review has been undertaken, resulting in the absence of an evaluation of benefits realised, and identification of lessons learnt.
- Current audit arrangements vary in the degree of coverage resulting in 48% of clinicians not receiving a review in August 2024 and November 2024.
- Capacity issues have resulted in a three-month backlog of ECNS audits (quality assurance reviews of triage calls against the International Academies of Emergency Dispatch (IAED) performance standards), with corresponding effect on timeliness and impact of feedback. In November 2024 the Trust's non-compliance rate was 28%, against the IAED target of 7%.
- Performance Delivery Plans to address periods of underperformance, as outlined within the Quality Assurance Framework, are not in place. Existing gaps in audit coverage across CSD would also impact the ability to identify outliers and prompt plan usage.
- There could be greater standardisation of feedback format and terminology, to provide a clearer link to the ECNS Performance Standards and the categorisation of deviations identified.
- A business case for the transfer of the responsibility for undertaking ECNS audits has been developed, however timescales for completion of the move are yet to be confirmed.
- Reporting arrangements for ECNS have recently been refreshed and will require time to develop and mature. Reporting includes actions to address non-compliance, however these lack the formality of an action plan to monitor progress.
- There was no evidence of escalation of ECNS non-compliance, noting such may impact the Trust's accreditation as a Centre of Excellence, within wider Trust reporting or at committee level.

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

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Programme benefits were appropriately identified and clearly defined at the outset.	1	**Reasonable**
2	The achievement of benefits were monitored and reported regularly during the implementation period, and mechanisms to ensure the quality of service remain in place.	2, 3, 4, 5, 6	**Limited**
3	Benefits not realised at the close of the programme continue to be subsequently monitored to completion.	6	**Limited**
4	Lessons learnt have been identified from the programme, including feedback gained through patient and staff experience, to inform immediate and future service changes.		**Reasonable**
5	Appropriate governance and reporting arrangements have been established post-implementation and operate as intended.	7, 8, 9	**Reasonable**

Management Actions

2 High Priority

7 Medium Priority

Themes

Risk Types

Public Perception & Reputational Risk

Legal & Regulatory Non-Compliance

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: Programme benefits were appropriately identified and clearly defined at the outset.	**Reasonable**

The case for the adoption of ECNS, a clinical decision support software, was outlined in 2021 within the '*999 Remote Clinical Triage Support systems, Quality and Safety. A Proposal for Investment*' ('the investment case'). This referenced both the Trust's ambition to further develop its remote clinical triage capacity, to build upon a clinical review of Clinical Contact Centre ('the CCC clinical review') undertaken in 2019; and lessons learnt from operational changes made as part of the organisation's response to the Covid-19 pandemic.

The adoption of ECNS was to replace the Manchester Triage System (MTS); a set of 53 paper/pdf process flow charts primarily designed for face-to-face use. In comparison ECNS offers over 250 distinct algorithms: providing age and gender specific clinical triage protocols, with the ability - through assessment and critical thinking - to arrive at an appropriate recommended care outcome, alongside consistent self-care instructions.

The investment case also compared the limitations of MTS: noting a lack of integration with other Trust electronic systems resulting in limited opportunities to generate data for the quality assurance and quality improvement of calls, which ECNS functionality addressed. ECNS also included an integrated audit tool ('Ascent Quality Assurance' or 'AQUA') which, through its alignment to the International Academies of Emergency Dispatch (IAED) performance standards, would provide a system to ensure the consistency and quality of calls. This in turn would lead to both improved patient experience and outcomes. System implementation would include the establishment of a new Professional Practice Education (PPE) team to provide training, coaching and audit capacity, with the investment case specifying the need for an educator to clinician ratio of 1:10 (c.6WTE).

The investment case also noted that through the system's data capture and call structure, there would be opportunities to reduce the average call time from 19 minutes to between 11-15 minutes; with associated productivity and financial savings forecast. Opportunities to increase the 'hear and treat' (now known as 'consult and close') rates were also noted. The benefits which could be seen within the wider health system were also referenced, which included increased numbers of patients triaged, reduced number of ambulance conveyances, reduced number of patients attending Emergency Departments, and associated impact on handover delays.

Whilst the investment case contained the identification and description of benefits and outcomes; targets, criteria or timescales to achieve these were not set out (**See Key Finding 1**).

The implementation period coincided with a number of other service changes, notably the expansion of the Clinical Support Desk (CSD) through the integration of an additional 36 paramedics, and establishment of a dedicated Mental Health clinician team. The Senior Responsible Owner and project manager have both since left the organisation, but other key contacts noted the pace and impact of these changes as contributing factors to the lack of supporting documentation.

In 2024, the Trust introduced a formal Project Plan Pathway toolkit which provides guidance, templates and defines roles and responsibilities between senior responsible owners, change managers, and project support; and the implementation of this should help address the issues above within future projects.

Key Findings		Risk & Impact	Agreed Management Action
1	**Benefit realisation gap analysis** While the investment case outlines high-level benefits or outcomes, noting some would be immediately evident in comparison to the previous triage system, these were not accompanied by definitions of baseline measures, target criteria, or timescales and leads. The mapping of the above would have allowed assessment and measurement of the extent to which the benefits have been realised.	Gaps within the approach to the identification and definition, to the failure to realise benefits.	**Agreed Action:** The Trust accepts this finding and agrees with the need for broader learning and clarity at the outset of developments such as this. As set out, the publication of the Project Plan Pathway published in 2024 is anticipated to address this finding going forward and therefore the Trust is satisfied that this action is addressed.
			Expected Evidence of Implementation: Closed
		Medium Priority	**Officer:** N/a **Target Implementation Date:** N/a
	Theme: Planning, Delivery & Deadline Management	Control Design	

Objective 2: The achievement of benefits were monitored and reported regularly during the implementation period, and mechanisms to ensure the quality of service remain in place.	**Limited**

Benefit achievement: An ECNS Project Plan was developed to direct implementation commencing in November 2021 and system launch on 17 May 2022. This contained key actions and timescales for the rollout of underlying infrastructure, user acceptance training, and deadlines for the submission of evidence to support accreditation as a centre of excellence (ACE). As per *objective one*, ECNS implementation was initially a deliverable within the CCC Clinical Review project, and in December 2022 ECNS was included within the transfer of the remaining CCC project actions to the Trust's Gateway to Care (G2C) Programme. Review of programme highlight reports provided RAG rated updates in progressing these structural and workforce changes. We note this did not include specific review of ECNS benefits, and no post implementation report could be provided to demonstrate any detailed assessment of these. (See **Key Finding 6**).

CSD performance dashboards capture ECNS related indicators, which include call times, protocol use, outcomes, and call conversion to consult and close on both a CSD service wide and individual clinician basis. Review of the reports indicate reductions in call times have not materialised in line with the expectation of the investment case, remaining consistent with pre implementation averages; but consult and close levels have seen an increase (March 2021 – 6%, September 2024 – 9.6% - *Trust Monthly integrated Quality & Performance Report*).

The Trust has been successful in gaining ACE for its use of ECNS, receiving approval from the IAED in September 2023; in doing so gaining dual accreditation having previously achieved ACE for its Medical Prioritisation Dispatch System (MPDS). It is also notable that the Trust has achieved this through utilising a paramedic and nurse staffing mix (*see objective 4*).

Quality mechanisms: To retain accreditation status, there is a requirement that the Trust audits 132 calls per month[1] and meets a target of 93% call compliance. Compliance is determined through the assessment of a random selection of calls against IAED Performance Standards ('the performance standards'). Key elements of the performance standards have been combined with local guidance and procedural information within a Trust developed ECNS Quality Assurance Framework (QAF).

Concerns regarding the audit process were raised in September 2024 (including the categorisation of non-compliant audits into thematic reporting which were therefore excluded from the compliance total; and increasing audit sample numbers to lower the overall compliance rate). Such practices were immediately stopped (see objective 5); however, in the period following this non-compliance increased from 18% in August 2024, to 28% in November 2024, against the ACE target of 7%.

The performance standards also include timescales for feedback to be provided, however capacity constraints within the PPE team (currently 2.8WTE) has resulted in delays in completion, noting December 2024 audits were still to be completed as at April 2025. Whilst the need to review the operational capacity of the PPE team and to appoint dedicated ECNS auditors within an Operations Quality team has been recognised, a timescale was not known at the time of audit fieldwork (See **Key Finding 2**).

Additionally, walkthrough and testing of the audit process identified:

- Enhancement of audit feedback could be enhanced through standardisation of format and terminology (see **Key Finding 3**).
- The schedule which captures clinician performance does not reconcile with the AQUA performance reports (see **Key Finding 4**).
- Audit coverage of clinicians varies across months (See **Key Finding 4**).
- The performance development plan structure as outlined within the QAF is not in operation (see **Key Finding 5**)

[1] The monthly audit requirement is determined by an IAED formula based upon the CSD annual call intake.

Key Findings		Risk & Impact	Agreed Management Action
2	**ECNS Audit arrangements** Capacity constraints within the PPE team (currently 2.8WTE) has resulted in delays in completion, with December 2024 audits still to be completed as at April 2025, resulting in a backlog in excess of 400 audits. The need to review the operational capacity of the PPE team has been recognised by Integrated Care management, and a business case to secure dedicated ECNS auditors within an Operations Quality team (within the Emergency Medical Service Co-ordination structure) has been approved, although a timescale of implementation was not available at time of audit fieldwork.	Continued lack of capacity to deliver audits could result in loss of accreditation.	**Agreed Action:** The Trust will have the uplifted number of 6 ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case. **Expected Evidence of Implementation:** The uplifted levels will be evidenced through establishment reports.
		High Priority	**Officer:** Jonathan Edwards, Assistant Director of Operations **Target Implementation Date:** 30th September 25
	Theme: Resourcing	Control Design	
3	**ECNS Audit report format** Review of audit reports confirmed that they provided a mix of recognition of good practice alongside areas where corrective feedback was required. IAED performance standards notes that when providing feedback there should be focus on the exact performance that did not meet the standard. Our review of 30 audit reports noted that 13 did not reference the performance standard where an issue had been identified; and 17 did not indicate the categorisation of deviation. Currently audit reports are circulated via email to the clinician and line manager, however, there is no requirement for receipt or acknowledgement of content.	Unclear and delayed feedback impact on the value and ability to influence practice of audits.	**Agreed Action:** Quality Audit realigned to Operations Quality and bespoke job description being created to appoint into permanent Quality Audit (Clinical) posts. Operations Quality to have management and leadership oversight. Levelling to be undertaken to set out expectations for inclusion of all required information such as performance standards and deviation categories and a request to support levelling will be made to the International Academies of Emergency Dispatch (IAED). Consideration will be given more widely on how to ensure monitoring of receipt of feedback and respective managers/local management teams updated.
			Expected Evidence of Implementation: Quality assurance processes will be developed and refined internally, and the IAED Accredited Centre of Excellence (for which the Trust has for ECNS) sets out required standards which will be monitored closely in monthly compliance reports, submitted to the IAED and internally monitored by the Integrated Care Quality Meeting which reports onward into the Senior Operations Team (SOT).
		Medium Priority	**Officer:** Andrew Garner, Service Manager, Operations Quality

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Performance Monitoring	Control Operation	**Target Implementation Date:** 31st December 2025 (this is when the full establishment should be realised following OCP).
4	**ECNS Monitoring arrangements** The QAF and IAED performance standards include the need for ongoing monitoring of individual clinician performance on a routine basis. A locally held spreadsheet has been developed to support this due to constraints within the AQUA reporting tool and need for cleansing of prior user data. Inconsistencies were noted when comparing this spreadsheet to AQUA generated reports regarding the clinicians included (10 identified as receiving audits but not detailed within the spreadsheet) and the number of audits recorded (only one out of six months totalling the required 132 audits). Additionally, we identified: • six clinicians yet to receive audits, and • on average, 44% of CSD clinicians did not receive an audit each month within our sample period June 2024 – November 2024.	Lack of consistent oversight may result in noncompliance being missed.	**Agreed Action:** A review will be conducted to move to a single monitoring mechanism with appropriate data cleansing processes. The reporting mechanism will be embedded into Integrated Care Quality Meeting (ICQG) and through the Senior Ops Governance Structure along with CQGG. Those not in receipt of an audit are being prioritised. **Expected Evidence of Implementation:** AQUA Reporting will be the primary methodology used to report compliance.
		High Priority	**Officer:** Peter Brown, Assistant Director of Operations **Target Implementation Date:** 30th September 2025
	Theme: Performance Monitoring	Control Operation	
5	**ECNS Performance Development Plans** Where a clinician is identified as 'below a performance threshold' the QAF outlines a performance development plan (PDP) structure to be applied to offer action plans which include additional support, enhanced audits and further escalation where improvement is not achieved. At present, due to the lack of capacity within the PPE team to undertake additional audits, the PDP process is not actively practiced. However, we were advised that local management will engage with ECNS users on wider performance issues. The limitations in coverage and number of clinicians receiving regular audits (see key finding 4) also impacts the effectiveness of the PDP process in identifying those who require additional support.	Lack of mechanisms to address continued noncompliance.	**Agreed Action:** As per the agreed action for Key Finding 2 the Trust will have the uplifted number of ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case. This will enable the required levels of audits. **Expected Evidence of Implementation:** The uplifted levels will be evidenced through establishment reports.
		Medium Priority	**Officer:** Jonathan Edwards, Assistant Director of Operations **Target Implementation Date:** 30th September 2025

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Performance Monitoring	Control Operation	

Objective 3: Benefits not realised at the close of the programme continue to be subsequently monitored to completion.	**Limited**

As per *objective two*, in December 2022 the implementation of ECNS was included within the transfer of the outstanding actions from the CCC Clinical Review project to the G2C Programme. G2C highlight reports reviewed listed remaining areas of focus as the use of ECNS functionalities such as video consultations, directory of services and email/text function.

Review of CSD performance dashboards confirms that the use of video consultation within triages has increased in the time since implementation, with the number of such calls rising from under 100 per month at the end of 2022, to between 400-500 video consultations per month between October 2024 – March 2025.

Discussion with key contacts noted that there is continuing progress in utilising other parts of the system, although alternative functionality will be used to communicate call summaries to patients. End of consultation summaries are produced and transferred to the Welsh Clinical Portal for access by wider health services, such as GP Practices or health board urgent care services. We note that fuller integration of ECNS with the clinical portal is a deliverable within the Remote Integrated Care Project; as is continuing to make improvements to the directory of services.

As per *objective one*, the ECNS investment case included forecasts for productivity and financial gains resulting from reductions in call times, however CSD performance reports indicate that these forecast reductions have not materialised. The achievement of such will have been directly impacted by continuing unscheduled care pressures.

We could not identify any subsequent periodic review or reporting on system benefits since the project closed. As such, this, combined with the lack of defined benefits, would mean the Trust is not fully sighted in relation to initial or subsequent achievement. (See **Key Finding 6**)

	Key Findings	Risk & Impact	Agreed Management Action
6	**Periodic Benefit Assessment** We could not identify any post implementation review, or subsequent assessment of the system benefits since the closure of the project. As such the Trust will not be sighted on the system impacts, outcomes and progress towards benefit realisation.	The effectiveness and confidence could be impacted where benefits are not periodically assessed.	**Agreed Action:** The Trust accepts this finding and agrees with the necessity for clearer benefits assessment milestones at the beginning of such programmes. The majority of benefits were, however, fully realised upon implementation. Consequently, ongoing periodic benefits assessments were not planned. The later rapid addition of 28 full-time clinicians, while helpful, shifted focus and changed baseline operational benefits of other metrics, due to new and rotating CSD staff and demand-capacity adjustments. Operational measures are now monitored through existing mechanisms. The Trust will develop a clear table of evidence outlining which benefits have been achieved on implementation (how and why) and which outstanding benefits require more work or are now being monitored through existing mechanisms or link to existing agreed actions within this audit.

			Expected Evidence of Implementation: Development of a table of ECNS benefits with outline of evidence or monitoring.
		Medium Priority	**Officer:** Mike Brady, Assistant Clinical Director for Remote Care
	Theme: Performance Monitoring	Control Operation	**Target Implementation Date:** 30th September 2025

Objective 4: Lessons learnt have been identified from the programme, including feedback gained through patient and staff experience, to inform immediate and future service changes.	**Reasonable**

Prior to implementation, representatives of the Trust had published within the *Annals of Emergency Dispatch & Response* journal (an official international peer-reviewed journal published by the IAED) the justification for its use of a paramedic and nurse staffing mix: '*Proposed use of the emergency communication nurse system in Welsh ambulance service 999 secondary triage with paramedic and nurse users'* (2021). This noted that paramedics experience in dealing with a wide range of patient presentation, increasing scope of practice and the Trust's evolving approach to telephone triage which supported this.

The paper included the intention to undertake further research in the period following implementation to explore themes, trends, outcomes and efficiencies; and two further publications have followed – '*Emergency Communication Nurse System Outcomes of Advanced Medical Priority Dispatch Codes in a UK ambulance service*' (2024) and '*999 triage. A comparison of UK ambulance nurse and paramedic case mix, outcomes and audit compliance'* (2024). Both papers were based upon the review of patient data and audits of calls across the period May 2022 – November 2022. The former noted the '*positive range of outcomes reached through secondary consultation'*, whilst the latter noted that having assessed patients with the same 'symptomology' there '*was little difference in the clinical outcomes nurses and paramedics reached for their patients and little difference in the overall compliance of their call audits, which were overwhelmingly safe.'*.

As per *objective 3*, no post implementation review has been undertaken following programme closure, the need to ensure adequate capacity for reflection following significant changes was noted in discussion with key contacts. (See **Key Findings 1 & 6**)

At present we note there is no mechanism to allow for patient feedback to be directly collected for ECNS calls, outside of established Trust feedback routes generally available. We are informed the Trust is investigating how it can develop capturing user feedback within the wider Integrated Care service, and feedback received features within monthly Quality Management Group meetings. Staff feedback is captured within the established Integrated Care Quality and Support days, this recently included gathering responses on staff wellbeing, workload and pressures.

Objective 5: Appropriate governance and reporting arrangements have been established post-implementation and operate as intended.	**Reasonable**

Following the implementation of ECNS, a Quality Group was established to identify and review themes and trends, however we could only source documentation for one meeting held in August 2022. We note that, the existing 111 Quality Group was expanded (November 2024) to include CSD under a revised Integrated Care Quality Group (ICQG) remit, with refreshed terms of reference in place to reflect this change, and. discussions with management highlighted awareness that the operation and reporting from the group will need time to mature. The case for investment (see objective one) listed a number of ways in which ECNS data may inform planning and assist in analysis of outcomes, but we were not able to identify that level of analysis within the current reporting arrangements. (See **Key Finding 7).** The CSD ECNS Audit and Quality report provided to the ICQG included an outline of actions to address areas of non-compliance, such as development of supporting guidance to be shared with clinicians, and links to be established with Duty Operations Managers to ensure audit feedback is addressed. However, these actions are not formalised into a plan to address non-compliance rates (See **Key Finding 8**).

The ICQG produces a highlight report following each meeting which is shared with the Operations Directorate Senior Operations Team. There is also a monthly presentation to the Trust Quality Management Group (QMG). Whilst we did not identify either document highlighting the recent issues in completing audits and the increasing non-compliance rate, we were informed that both groups had awareness of the identified issues.

The Operations Senior Leadership Team (SLT) received a report in January 2025 referencing concerns that the prior approach to ECNS audits had obscured the Trust's compliance rate, and this was included within the SLT highlight report to the Trust's Executive Leadership Team. The same SLT meeting endorsed the transfer of audit responsibility to the Operations Quality team within the EMS Co-Ordination, however, further discussion at the March 2025 meeting noted this was still in train (see **Key Finding 2**).

Board-level committees (Finance and Performance, Quality Safety and Patient Experience, and People and Culture committees) regularly receive the Operations Directorate Quarterly Reports (ODQR) which highlight key issues and service developments. Review of the Q2 and Q3 reports (Q4 not reported at completion of fieldwork) did not identify any reference to ECNS non-compliance levels or the possible impact to the Trust's ACE accreditation (see **Key Finding 9**). The Q2 ODQR included that the recent completion of an action plan to address non-compliance within the MPDS has led to the Trust no longer being in remediation status for its accreditation under that discipline.

Within the Trust, the Clinical Prioritisation Assessment Software Group (CPAS) provides oversight for the development of 'clinical guidance and pathways' for both 999 and integrated care. CPAS terms of reference were amended in 2023 to include ECNS and reflect the retirement of the Trust Medical Director who had provided direct oversight during system implementation. Review of CPAS agenda papers noted discussion of ECNS including system issues and updates where applicable.

Key Findings		Risk & Impact	Agreed Management Action
7	**ECNS Quality Reporting** Whilst we could identify inclusion of activity, compliance rates, and themes included within service quality reports, discussion with officers indicated that these were limited by the relatively small number of audits undertaken per month. Further, we did not identify reporting in line with areas referenced within the investment case which included analysis of: • patient presentation through analysis of previous health interactions • sensitivity of referrals • efficacy of supporting algorithms.	Full functionality and benefits from the system may not be realised within current reports.	**Agreed Action:** Scheduled to be routinely shared with QMG with the SBAR going to CQGG in May 2025. **Expected Evidence of Implementation:** SLT minutes, IC Audit and ELT to ELT triple A Report, CQGG SBAR
		Medium Priority	**Officer:** N/a **Target Implementation Date:** Closed post fieldwork
	Theme: Information, Data Quality & Data Accuracy	Control Design	
8	**Actions to address non-compliance rates** The ICQG receives a regular Audit and Quality report in relation to ECNS use within CSD. Noting the reported increase in number of non-compliant calls, the report includes a summary of actions in place to address these. However, whilst status updates were provided for some listed actions, these are not captured formally with associated timescales and leads.	Lack of clarity of action ownership and deadlines may result in improvements not being realised.	**Agreed Action:** A revised action plan with agreed action owners and timelines will be presented to the June Integrated Care Quality Group with monthly monitoring through that mechanism and reporting through Senior Operations Governance Structure through the AAA mechanism. **Expected Evidence of Implementation:** ICQG Papers will demonstrate the required detail.
		Medium Priority	**Officer:** Peter Brown, Assistant Director of Operations **Target Implementation Date:** 30th June 2025
	Theme: Planning, Delivery & Deadline Management	Control Operation	

Key Findings		Risk & Impact	Agreed Management Action
9	**Reporting to Committee** Trust Committees receive regular reporting from the Operations Directorate on key issues and service changes. We note committee reporting has not included the issues currently faced in addressing ACE accreditation compliance rates in respect of ECNS, and the potential risk that this accreditation may be lost.	Lack of escalation may leave the Trust unsighted on a reputational risk.	**Agreed Action:** Committee reporting for Q4 2024/25 includes the issues currently faced in addressing ACE accreditation compliance rates in respect of ECNS. **Expected Evidence of Implementation:** Operations Quarterly Report (Q4 provided to QUEST 9th May 2025)
		Medium Priority	**Officer:** N/a
	Theme: Reporting	Control Operation	**Target Implementation Date:** Closed post fieldwork.

Appendix A Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Service University NHS Trust, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Service University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

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

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

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

AGENDA ITEM No	**19**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

INTERNAL AUDIT: SEASONAL FORECASTING AND MODELLING – FEEDBACK FROM ARAC

MEETING	Finance and Performance Committee
DATE	21 July 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Steve Owen, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Audit, Risk and Assurance Committee (the ARAC) received and discussed the **Seasonal Forecasting and Modelling audit report** at its meeting on 24 June 2025. This report summarises the discussion from this meeting in reference to this report.

2. **Seasonal Forecasting and Modelling – Reasonable Assurance**. The purpose was to assess the Trust's approach to forecasting and modelling, including a focus on winter resilience planning.

3. A forecasting and modelling group, established during the COVID-19 pandemic, has become a permanent fixture, coordinating activities across the trust. Management acknowledged the findings and noted that while the structures and culture are strong, the processes need improvement. The desire to have a written framework and SOPs was discussed to ensure the quality and reliability of forecasting and modelling outputs, as well as the need to formalise the analysis of actual performance against forecasted models, which is currently done informally. Further clarity was sought by members as to whether further managerial capacity is required to address the recommendations fully and this will be revisited in September.

4. Two objectives in the audit were rated reasonable assurance and one limited. Seven medium priority recommendations were raised. The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.

5. Members cautioned against discussing resourcing in this forum and emphasised managing within existing budgets. Hugh Bennett agreed and

proposed further discussion outside the meeting. The Committee noted that the need for formal evaluation was a recurring audit theme and asked the Finance and Performance Committee, who will receive the report in July, to consider its role in overseeing such evaluations. Further clarity on capacity will be revisited in September.

RECOMMENDATION: The Finance and Performance Committee is asked to note the discussion at the meeting of the ARAC on 24 June 2025, and the assurance that was received following receipt of the Seasonal Forecasting and Modelling audit report and agreed management actions.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Seasonal Forecasting and Modelling audit report

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

Forecasting & Modelling

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAS-2425-06
Fieldwork	March - April 2025
Executive Sign Off	27 May 2025
Audit Committee	26 June 2025
Executive Lead	Rachel Marsh, 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

To assess the Welsh Ambulance Services University NHS Trust's (the Trust) approach to forecasting and modelling, including focus on winter resilience planning.

Overview

The Trust set up a Forecasting & Modelling Group as part of their response to the Covid-19 pandemic. This became a permanent group co-ordinating forecasting and modelling activities across the Trust, in collaboration with the NHS Executive and the NHS Wales Joint Commissioning Committee (JCC). Arrangements have become business as usual for the Trust in undertaking strategic, tactical and operational forecasting and modelling to assist with service delivery, including on a seasonal basis such as winter resilience, and across NHS 111 Wales, Emergency Medical Services and Ambulance Care. An independent strategic Emergency Medical Services Demand and Capacity review is conducted every five years to identify the most efficient and effective way of meeting patient demand.

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

- To enhance the effectiveness of the forecasting and modelling process, there needs to be documentation to encompass key elements such as ownership, evaluation, approvals and quality assurance. There has been no comprehensive assessment to identify any gaps in forecasting and modelling activity in relation to the Trust's IMTP priorities.
- Roles and responsibilities for forecasting and modelling activities, and the key processes for undertaking such have not been documented. Staff business continuity arrangements would benefit from a review to ensure they are robust and enhance resilience.
- The content of the terms of reference for the Forecast and Modelling Group needs to be reviewed along with strengthening the administration of meetings.
- Whilst extensive analysis was undertaken as part of the last winter resilience planning, the effectiveness of the process could be strengthened by analysing actual performance against forecasted and modelled output. However, we note that actual performance is impacted by factors outside the Trust's control e.g. handover delays associated with wider system pressures.
- Review of the governance structure to ensure there is sufficient oversight of forecasting and modelling arrangements and appropriate escalation of key issues.
- Establishment of a robust mechanism to capture organisational learning arising from forecasting and modelling activities.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- There is no mechanism in place to confirm that the agreed actions contained within the winter plan have been addressed. We recognise that the plan was broadly representative of the Clinical Model Transformation plan and there is a clearer link to the Trust's IMTP priorities so performance can be tracked. However, there needs to be an appropriate level of oversight to ensure that any issues are addressed, e.g. enhancement to the accuracy of predicted performance for the next winter period.

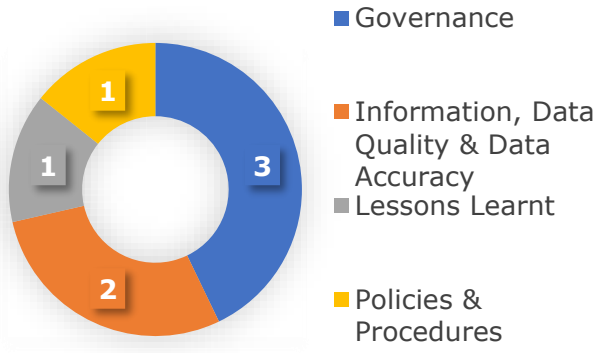
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Trust has appropriate arrangements and frameworks in place to coordinate forecasting and modelling activities that support strategic, tactical and operational decisions.	1,2,3	**Limited**
2	The forecasting and modelling process, tools and techniques have been applied appropriately for the winter resilience planning.	1,2,4,5,6,7	**Reasonable**
3	An appropriate governance framework is in place to provide effective oversight, monitoring and scrutiny of forecasting and modelling arrangements, and there are opportunities for continuous improvement and learning.	5,6,7	**Reasonable**

Management Actions

0	7
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Quality or Safety Issues

Public Perception & Reputational Risk

Choose an item.

Winter Resilience Planning - At a Glance

The table below details the output results for the Most Likely Scenario (MLS) and Reasonable Worst-Case Scenario (RWC) for the winter period, which has been extracted from the Trust's Quarterly Forecast for Winter 2024/25:

Winter Period	Scenario	RED (%) <8mins	AMBER 1 Median	AMBER 2 Median	Abandoned Demand (%)
Feb-23	*BASELINE*	*51%*	*55min*	*1hr 16min*	*0%*
OctNov	MLS	47%	2hr 10min	4hr 0min	1%
OctNov	RWC	40%	5hr 35min	8hr 23min	5%
DecJan1	MLS	42%	4hr 3min	6hr 15min	3%
DecJan1	RWC	36%	8hr 36min	10hr 31min	8%
Jan234Feb	MLS	53%	1hr 13min	1hr 56min	0%
Jan234Feb	RWC	44%	3hr 11min	5hr 25min	2%
Mar	MLS	49%	1hr 58min	3hr 27min	1%
Mar	RWC	41%	5hr 11min	8hr 0min	4%

The table below categorises the Quarterly Forecast for Winter 2024/25 report's outcomes:

Scenario	Good	Not so good	Poor	Very Poor
RED Performance (%)	>= 65%	60% - 65%	55% - 60%	< 55%
AMBER 1 Median Response Time (mm:ss)	< 30min	30 - 45 min	45 - 60 min	>= 60 min
AMBER 2 Median Response Time (mm:ss)	< 60min	60 - 90 min	90 - 120 min	>= 120 min
Abandoned Calls	< 0.5%	0.5% - 1%	1% - 5%	> 5%

Findings & Agreed Action Plan

Objective 1: The Trust's arrangements and frameworks in place to coordinate forecasting and modelling activities.	**Limited**

Forecasting and modelling activities are embedded within the Trust in informing strategic decision-making across various services, including 111, Emergency Medical Services (EMS) and Ambulance Care, through the Demand and Capacity reviews being conducted every five years to ascertain the most efficient and effective way for meeting patient demand. Seasonal modelling is employed at a tactical level to prepare for the winter plan, while operational forecasting and modelling is carried out for key dates such as Easter. Forecasting is an integral part of the weekly review of REAP (Resource Escalation Action Plan). However, there is no mechanism in place to record the business-critical models or forecasts utilised by the Trust, or that plots key elements of the process (see **Key Finding 1**).

There is a small team responsible for carrying out forecasting and modelling activity consisting of two employees. One of the key responsibilities of the Forecasting and Modelling Group (as outlined in their terms of reference) was to develop and maintain a Framework, but this has been de-prioritised due to limited staff capacity and other priorities. However, there is no documented guidance, procedure or templates to establish consistency within the process, clarify roles and responsibilities, and provide robust business continuity arrangements (see **Key Finding 2**). The HM Treasury's '*Aqua Book: guidance on producing quality analysis for government'* could be used in the interim.

A Forecasting and Modelling Group was established as part of the Trust's response to the Covid-19 pandemic, which includes representation from the NHS Wales Joint Commissioning Committee (JCC), NHS Executive and Omda (external consultants - formerly known as Optima). While the Group's terms of reference provided key details relating to its purpose, quorum, meeting frequency, and reporting arrangements, the content could be enhanced to confirm its current membership and role as well as escalation arrangements (see **Key Finding 3**).

The Trust works with the NHS Wales Modelling Collaborative on a national basis, facilitating the exchange of good practice. We note that forecasting and modelling work has also been undertaken as part of service transformation (Omda Readiness software was utilised to assist with improving shift overruns).

Although risks associated with forecasting and modelling activities are not routinely documented, there is a risk recorded on the Strategy, Planning & Performance Directorate's risk register that has been recently reviewed, "*Failure to undertake forecasting and modelling, which means that the Trust fails to forward plan and mitigate demand & capacity changes at a strategic, tactical and operational level across 111, 999 and Ambulance Care, which impacts on patient safety and staff well-being*". Mitigations include the use of external experts for undertaking this work as part of contingency arrangements, but note that a formal Standard Operating Procedure (SOP) is required (see **Key Finding 2**).

Key Findings		Risk & Impact	Agreed Management Action
1	**Modelling and Forecasting Process** Through discussion, it is evident that while forecasting and modelling activity is clearly embedded within the Trust, the process lacks sufficient documentation and clarity of the arrangements. The following weaknesses were identified: • There is no mechanism that captures the business-critical models or forecasts that the Trust applies, to clarify ownership and track key stages of the process, e.g. approvals, evaluation undertaken, version control, etc. We note that the winter plan was discussed at Operations Directorate Senior Leadership Team meeting, but there is no record of its approval. • The work of the external consultants engaged for forecasting and modelling activities is subject to their own internal checks. The quality assurance reviews of the work performed within the Trust have only recently been initiated but cannot be consistently evidenced (we saw evidence within the EMS Operational Transformation Closure report). • One of the key responsibilities of the Forecasting and Modelling Group (as detailed in its terms of reference) is to obtain user feedback, but this is not clearly recorded within the process (although evidence was supplied of this for the Easter 2025 111 rostering). • There has been no comprehensive assessment or evaluation of the Trust's forecasting and modelling activities, including its alignment to key priorities. This would be beneficial for effectively managing staff resource and ensuring alignment with organisational goals.	Ineffective arrangements resulting in wasted resources and a failure to plan effectively resulting in poorly designed services.	**Agreed Action:** Complete the draft Standard Operating Procedure for Forecasting & Modelling. This would include approvals, version control and evaluations. Develop a forecasting & modelling report tracker, which would enable the Forecasting & Modelling Group to track where reports go, who uses them, user feedback, lessons learnt and benefits; and evidence of quality assurance (where appropriate). The Forecasting & Modelling Group will undertake a formal review of the draft IMTP from a forecasting and modelling perspective to ensure that its work programme reflects the IMTP priorities. **Expected Evidence of Implementation:** Standard Operating Procedure and Forecasting & Modelling Report Tracker included in AAA (Alert, Advise, Assure) report to Strategy, Planning & Performance Directorate Business Leadership Team meeting; formal review of IMTP from a forecasting and modelling perspective to go to Integrated Technical Planning Group and noted in AAA reporting up to Strategic Transformation Board.
		Medium Priority	**Officer:** Assistant Director Commissioning & Performance **Date:** 31 March 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
2	**Documented Procedures** There is a small team responsible for carrying out forecasting and modelling activity within the Trust, consisting of a Senior Commissioning & Performance Analyst (within the Strategy, Planning & Performance Directorate) who is principally involved in modelling processes; and a Principal Analyst (Operations Directorate) who carries out forecasting work. However, there are no documented procedures to provide clarity and ensure consistency of approach. An initial version of a Standard Operating Procedure (SOP) has been developed to outline the Trust's structures and processes for the management of Omda Optima Predict (an externally provided software designed for testing hypotheses and scenarios). However, there is no documented guidance or templates to clearly detail roles and responsibilities (both internal and external) and clarifies the process for strategic, operational and tactical forecasting and modelling. Although forecasting processes are predominantly automated, not all the key staff that carry out forecasting and modelling activity have the same level of access to data, e.g. to a 'warehouse' to source key data independently. Capacity also needs to be considered for the management of the process including carrying out quality assurance checks and the development of supporting procedures. While we were advised that the Digital Service Directorate and external consultants could provide forecasting and modelling resource in the absence of key staff, business continuity arrangements would benefit from a review to ensure the processes in place are robust to enhance resilience.	Inconsistent processes leading to a lack of accountability and oversight.	**Agreed Action:** Complete the draft Standard Operating Procedure for Forecasting & Modelling. This would include approvals, version control, access to data and evaluations. The Executive Director of Strategy, Planning & Performance and Assistant Director Commissioning & Performance are currently reviewing the capacity of the Commissioning & Performance Team, of which forecasting and modelling is a part. As part of this review, we will consider business continuity for forecasting and modelling in the Trust.
			Expected Evidence of Implementation: Standard Operating Procedure shown in AAA report to Strategy, Planning & Performance Directorate Business Leadership Team meeting; review of Commissioning & Performance Team's capacity/structure confirmed via Director.
		Medium Priority	**Officer:** Assistant Director Commissioning & Performance **Date:** 1 November 2025
	Theme: Policies & Procedures	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
3	**Terms of Reference** The latest version of the Forecasting and Modelling Group's terms of reference (ToR) was provided, but the following weaknesses were identified: • Frequency of review: The ToR was approved by the Executive Director of Strategy, Planning & Performance in April 2024, but the document does not record how frequently it should be reviewed noting that good practice is that such documents should undergo a review at least annually. • Responsibilities: The content of the ToR needs to be updated to reflect the current position as it details that one of the Group's responsibilities is to develop and maintain the Trust's Forecasting and Modelling Framework. This has been de-prioritised due to limited staff capacity and other priorities. • Membership: Similarly, we were advised that the current membership of the Group is not reflective of that detailed in the ToR. • Escalation arrangements: The ToR does not detail escalation arrangements. Reporting arrangements are noted as the Group will report to the Executive Director of Strategy, Planning & Performance, who is the Executive Sponsor and that she will attend the Group once a year. Due to other priorities, she has been unable to attend as required.	Unclear roles and responsibilities leading to a lack of accountability and failure to deliver key priorities.	**Agreed Action:** Undertake annual review of terms of reference.
			Expected Evidence of Implementation: Updated ToR, approved in Strategy, Planning & Performance Directorate Business Leadership Team meeting.
		Medium Priority	**Officer:** Executive Director (Strategy, Planning & Performance Directorate) & Assistant Director Commissioning & Performance
	Theme: Governance	Control Design	**Date:** 30 September 2025

Objective 2: Winter Resilience Planning — **Reasonable**

As per *objective 1,* since 2020, the Trust has been employing forecasting and modelling techniques to enhance winter resilience planning. This was initially in response to the challenges posed by the Covid-19 pandemic, and has since been included in the annual winter plan submissions to Welsh Government. There are considerable pressures during the winter period, many of which are outside of the Trust's control such as prolonged hospital handover delays. During December 2024, the Trust declared a critical incident escalating the REAP to its highest level (Level 4) signifying the state of extreme pressure on services.

Historically, the Trust has procured modelling activities from external consultants, Omda, but the last exercise (2024/25) was carried out in-house with access to Omda's methodology and software; and support from a consultant where required. As per **Key Finding 2**, roles and responsibilities are not documented and templates are not utilised; but the methodology and data sources for the winter planning modelling exercise are well defined. We note that two scenarios are created for each of the four winter periods (1 October - 30 November; 1 December – 4 January; 5 January – 28 February; and 1 March – 31 March): MLS (Most Likely Scenario) and RWC (Reasonable Worst-Case Scenario).

Five predictor variables are used to forecast performance using the Omda Optima Predict software based on demand; time at scene; time at hospital; unit hour profile (UHP) (ratio of actual hours to planned hours of Emergency Ambulance (EA), Advanced Paramedic Practitioner (APP), Cymru High Acuity Response Unit (CHARU), and Urgent Care Service (UCS) vehicles); and implemented operational change (the changes to the Trust's operation that are expected to be implemented by the time of the corresponding winter periods).

The outcomes of the latest winter modelling exercise are clearly detailed (see **page 3**) noting that the '% Red <8 minutes' performance target has not been met in scenario planning (which was the same position as the previous winter). Data limitations are recorded in the wider winter modelling report, but the content needs to be more explicit on data assumptions used (see **Key Finding 4**).

We were advised that the Omda consultant reviewed the outputs as this was the first time the Trust had undertaken the winter modelling exercise in-house, but this cannot be evidenced (see **Key Finding 1**). Furthermore, there is no documentation confirming the discussion and approval of the report presented to the Forecasting and Modelling Group (26 September 2024) (see **Key Findings 1** and **5**). Noting the Trust's intention to continue this work in-house, it would be beneficial to incorporate Welsh Government's winter modelling scenario planning in future exercises and to validate how the model outputs align with actual performance (see **Key Finding 4**).

The winter plan, which is linked to the Trust's IMTP priorities, was discussed at the Operations Directorate Senior Leadership Team's meeting (26 November 2024) where some minor amendments were incorporated, but there is no record of its approval (see **Key Finding 1**). The document details an action plan for each of its key objectives, including ensuring "*capacity planning is connected to forecasting and modelling for winter is undertaken*". Currently, there is one action for this objective that has not been recorded as completed (forecast and model 111 performance through the winter period). The Assistant Director (Commissioning and Performance) confirmed that this task had been undertaken, but there was a recognised need for further improvement to enhance the accuracy of predicted performance for the next winter period. Forecasting on 111's capacity is in place, and it is anticipated that the external review of 111 rosters will include predictions of performance.

For the 2023/24 winter planning exercise, there was reporting to both the Finance and Performance Committee and the Trust Board on forecasting and modelling activities, but there was no similar reporting for the 2024/25 period (see **Key Finding 6**). While the planning process is considered as 'business as usual', there needs to be an appropriate balance to ensure there is sufficient oversight and scrutiny of current arrangements. Similarly, while there have been reflections of risks and lessons learnt from the last winter planning exercise, e.g. to Welsh Government, there is not a robust mechanism for recording and sharing organisational learning (see **Key Finding 7**).

Key Findings		Risk & Impact	Agreed Management Action
4	**Winter Resilience Planning** The following weaknesses were identified in the winter planning process: • While the Winter Modelling (2024/25) provides a comprehensive overview of data limitations, the data assumptions are not recorded, e.g. average time in hospital. • Consideration was not given to the Welsh Government's (WG) 2024/25 Winter Modelling scenario planning (September 2024) when developing the Trust's exercise. The WG's report provides retrospective analysis, comparing actual performance against the winter modelling scenarios for 2023/24. The Trust has not got a robust tool to undertake similar analysis (assessing actual outputs to those forecasted and modelled) to identify good practice and determine whether any enhancements are necessary for future modelling and forecasting.	Winter resilience forecasting and modelling is ineffective with a failure to mitigate demand and capacity changes potentially impacting patient safety and staff wellbeing.	**Agreed Action:** As part of the Forecasting & Modelling SOP, confirm the template(s) to be used for in-house reports. Build WG winter modelling scenario work into the SOP.
			Expected Evidence of Implementation: Forecasting & Modelling SOP approved in SP&P BLT meeting. Forecasting and modelling reports incorporating WG analysis and data assumptions
		Medium Priority	**Officer:** Assistant Director Commissioning & Performance **Date:** 1 November 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 3: Governance framework and opportunities for continuous improvement and learning	**Reasonable**

The dedicated Forecasting and Modelling Group convenes informally on a weekly basis while also holding more formal monthly meetings that adhere to a set agenda and an action log. However, the absence of dedicated administrative support has resulted in a lack of documented evidence regarding the quoracy and key outcomes of these meetings. Consequently, updates are primarily communicated verbally, rather than through written reports. Although a work plan has been established, it has not been consistently maintained due to limitations in staff capacity (see **Key Finding 5**).

Recognising the need for enhanced governance arrangements within the Trust, particularly with operational governance, an integrated governance map has been developed. This map outlines principles designed to ensure effective oversight and accountability across its meetings; provide clarity over roles and responsibilities; and improve the administration of meetings. The Forecasting and Modelling Group is included under the Strategy, Planning & Performance Directorate within this governance framework, but the extent of oversight regarding forecasting and modelling activity within the Trust could not be easily demonstrated despite some recent reports encompassing this content (see **Key Finding 6**).

The Trust has yet to establish a systematic approach to reflect on the successes or lessons learned from forecasting and modelling activities (see **Key Finding 7**). While individual instances exist, such as with the 111 service Christmas forecasting, there is currently no routine mechanism in place to capture and analyse them and record the action taken for any improvement identified.

Key Findings		Risk & Impact	Agreed Management Action
5	**Forecasting and Modelling Group Meeting Administration** The existence of a multi-disciplinary Forecasting and Modelling Group is a positive step in collaborative working, but it was difficult to evidence the level of discussion and scrutiny of modelling and forecasting activity as key decisions are not recorded, e.g. within a decision log. Predominantly, verbal updates were provided due to staff pressures. We were advised that written reports are provided where there is a particular forecasting or modelling output to be discussed, e.g. Omda report, but that some of the written reports may have gone to the informal weekly meetings rather than the monthly meetings that have a structured agenda. Similarly, while the Group's terms of reference detail the quorum arrangements, e.g. Chair or Vice Chair to be present along with a JCC representative, nothing is recorded to confirm the meeting attendance (also refer to Key Finding 3). A workplan and project tracker has been recently implemented however, its effectiveness is currently limited by staffing constraints, noting a lack of dedicated administrative support	Meetings may not be effective if they are not planned appropriately, and there may be a lack of accountability of issues escalated.	**Agreed Action:** Introduce a AAA report for the Forecasting & Modelling Group and confirm governance route. Continue to strengthen focus on work plan through the F&M Group, as it was only recently introduced before the audit. **Expected Evidence of Implementation:** AAA reports (taken to SP&P BLT meeting).

	Key Findings	Risk & Impact	Agreed Management Action
	within the team. The workplan has nine actions recorded, but four do not record a timescale. Similarly, the project tracker has 16 actions, but timescales were unclear for seven actions and nine actions were overdue.		Use an up to date work plan – articulated through the AAA.
		Medium Priority	**Officer:** Executive Director (Strategy, Planning & Performance Directorate) & Assistant Director Commissioning & Performance **Date:** 1 November 2025
	Theme: Governance	Control Operation	
6	**Oversight of Forecasting and Modelling activity** The Forecasting and Modelling Group's (FMG) terms of reference note that the "*Group will report to the Executive Director of Strategy, Planning & Performance who will determine the subsequent flow of information into the relevant setting*." While verbal updates are provided to the Executive Director, who serves as the Executive Sponsor for the Group, there is a lack of clear onward reporting from the Group and the extent of oversight within the broader Trust governance framework could not be easily demonstrated. There was evidence of recent engagement that incorporates reporting of forecasting and modelling activity. For example, reporting to the Operations Directorate's weekly performance review meeting and Senior Leadership Team (SLT) meetings. However, wider reporting to Trust Board and its committees has been restricted to a closed session of Finance and Performance Committee (FPC) (16 July 2024) on the outcomes of the Emergency Medical Services (EMS) Demand and Capacity Review; and to both the FPC (17 September 2024) and the Trust Board (26 September 2024) concerning the closure of the EMS Operational Transformation Programme Board. As highlighted in *objective 2*, there was no reporting to the Trust Board or its committees on the recent winter planning exercise.	Ineffective reporting could result in poor decision making and a lack of accountability and oversight.	**Agreed Action:** Introduce AAA reports at FMG and SP&P BLT. Winter modelling to be reported formally into Operations SLT.
			Expected Evidence of Implementation: AAA reports (FMG and SP&P BLT), Operations SLT AAA report into ELT to show evidence of the winter modelling discussion.
		Medium Priority	**Officer:** Assistant Director Commissioning & Performance **Date:** 31 October 2025
	Theme: Governance	Control Operation	

Key Findings		Risk & Impact	Agreed Management Action
7	**Organisational Learning** There is no formal mechanism in place to capture good practice and lessons learnt arising from modelling and forecasting activity. As noted in *objective 2*, there have been no reflections from the 2024/25 winter planning exercise, but wider consideration is required to prompt if elements of the forecasting and modelling process needs to be corrected for future planning. We noted evidence of continuous improvement within Trust Board reporting (March 2025 - Actions to mitigate avoidable patient harm in the context of extreme and sustained pressure across urgent and emergency care); operational performance meetings in relation to the 111 Christmas forecasting (as noted in *objective 2*); and the EMS Operational Transformation Board Closure Report incorporated some lessons learnt in relation to the forecasting and modelling for the roster review. However, there is no structured process to prompt for these to be shared and to ensure that delivery of any actions arising from lessons learnt are effectively monitored.	Ineffective organisational learning could lead to missed opportunities for improvements and poor decision making.	**Agreed Action:** The Forecasting & Modelling Report Tracker will record lessons learnt.
			Expected Evidence of Implementation: Forecasting & Modelling Report tracker; and identified as part of the AAA reporting up to SP&P BLT.
		Medium Priority	**Officer:** Assistant Director Commissioning & Performance **Date:** 1 November 2025
	Theme: Lessons Learnt	Control Design	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

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

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

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

AGENDA ITEM No	**20**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Updates to NHS Wales No PO No Pay Policy

MEETING	Finance and Performance Committee
DATE	21st July 2025
EXECUTIVE Sponsor	Chris Turley, Executive Director of Finance & Corporate Resources
AUTHOR	Edward Roberts, Interim Assistant Director of Finance
CONTACT	Edward.Roberts@wales.nhs.uk

EXECUTIVE SUMMARY

The all Wales No PO No Pay policy governs invoices which arrive in the system without an order number (unless on the approved exception list – see Appendix 1 in attached policy). These are then placed on hold and a weekly communication is emailed to the supplier who is instructed to seek an order number from the relevant department and manager before payment is made.

The aim is to drive up compliance with the Standing Financial Instructions as well as ensuring a more standard order management process.

The continued implementation of a national policy of 'No Purchase Order No Pay' is to be an essential and fundamental building block from which the efficiency and effectiveness of the Procure to Pay (P2P) process can be further developed.

This policy, which has been in place since September 2018, reviewed in September 2023 is now subject to a small number of proposed amendments. First drafted in June 2024, these have been through several national groups to be officially signed off and now is at the final stage being brought to this committee for WAST adoption and approval.

Summary of changes to the previously adopted policy:

- List of objectives increased to include reference to late payment fees and service disruption.
- Inclusion of references made to the 'exception list' throughout the document.
- Clarity of % compliance required for Public Sector Payment Policy.
- Removal of letter issued to supplier from appendices.
- Removal of escalation process tables to allow for this being determined locally.
- Updates to exceptions list in appendix 1.

The committee is requested to receive and accept the changes to the National Policy, and adopt and **APPROVE** this policy.

KEY ISSUES/IMPLICATIONS
None

REPORT APPROVAL ROUTE

ARAC 24 June 2025

REPORT APPENDICES
NHS Wales No PO No Pay Policy

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

NHS Wales Shared Services Partnership

NHS Wales No PO No Pay (No Purchase Order No Payment) Policy

To be adopted by Each Health Board, Special Health Authority and Trust in NHS Wales

Contents:

1 Introduction/Overview

The P2P - the Procure to Pay process – encompasses the end-to-end process from sourcing goods and services through to delivery and receipt of goods and payment to the supplier. A No PO No Pay policy is where invoices arriving in the system without an order number (unless on the approved exception list – see Appendix 1) are placed on hold and a weekly communication is emailed to the supplier who is instructed to seek an order number from the relevant department and manager that was supplied before payment is made. The aim is to drive up compliance with the Standing Financial Instructions as well as the standard order management process.

2 Policy Statement

The implementation of a national policy of 'No Purchase Order No Pay' is to be an essential and fundamental building block from which the efficiency and effectiveness of the P2P process can be developed.

3 Aims/Purpose

To ensure:

- That all goods and services are ordered appropriately and are supported by official Purchase Orders in line with LHB, Trust and Special Health Authority Standing Financial Instructions.
- Efficient processes are put in place so that goods are delivered when required.
- Costs are controlled by:
    - Ensuring all non-pay expenditure incurred by the organisation is valid and appropriately authorised in advance of the goods/services being received.
    - Minimising transactional costs associated with payment for goods.
    - Paying supplier invoices within deadlines set by Welsh Government.
    - Maximising financial incentives for early payment offered by suppliers.
    - Reducing the risk of late payment interest and fees being charged by suppliers.

4 Objectives

This policy seeks to ensure that NHS Wales only pays for goods, services and works which have been properly ordered and authorised in accordance with the NHS Wales Procurement rules and Standing Financial Instructions. It also ensures invoices received by the NWSSP Accounts Payable teams can be processed efficiently to minimise delay in payments to suppliers and contractors. Invoices received by the NWSSP Accounts Payable Team without a valid PO number will severely delay payment to the suppliers. Successful adoption of this policy will lead to the following benefits:

- Better control environment – the correct level of authorisation of purchase orders, in advance of expenditure being incurred.
- Catalogue compliance will be improved leading to less off catalogue purchasing and lead to revenue savings.
- More comprehensive procurement intelligence being captured through the system about what and where goods and services are purchased allowing for better sourcing decisions.
- Costs will be more accurately accrued by the system reducing management accounting and Accounts Payable (AP) team workload.
- Public Sector Payment Policy compliance will improve because processing times reduce.
- Early payment discounts can be maximised.
- Overall processing costs in NWSSP P2P will reduce, releasing resources for NHS Wales.
- Suppliers will be paid on time thus supporting the wider economy.
- Less late payment interest and fees will be charged.
- Supplies of goods / services will not be disrupted or stopped due to late payment of invoices.

5 Scope

This policy is relevant to the following groups of staff within NHS Wales Health Boards, Special Health Authorities, Trusts and NHS Wales Shared Services Partnership:

- ***Requistioners***
  Those staff that process requisitions for goods and services in departments and directorates within NHS Wales.

- ***Approvers/Budget Holders***
  Those staff that approve requisitions for goods and services in departments and directorates within NHS Wales.

- ***Staff that Receive Goods/Services***
  Those staff that indicate within the Oracle or other ordering systems that the goods/services ordered have been received.

- ***Procurement Staff***
  All NWSSP Procurement staff in the Procurement Directorate.

- ***Accounts Payable Staff***
  All NWSSP Accounts Payable staff involved in the invoice payment process.

- ***Finance Departments***
  All staff involved in financial management.

6 Roles and Responsibilities

6.1 All Staff with Responsibility for Ordering

It is the responsibility of all staff, designated under the local scheme of delegation, that order goods and services to ensure that a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. If the goods/services being ordered are on the Exception list, then all staff must ensure they are aware of the correct payment authorisation process for those goods/services.

6.2 Requistioners

All staff that raise requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. If the goods/services being ordered are on the Exception list, then all staff must ensure they are aware of the correct payment authorisation process for those goods/services.

6.3 Requisition Approvers/Budget Holders

All managers and budget holders designated to approve requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. It is their responsibility to ensure the person raising the order has sufficient information to be able to do so, and knowledge of when the goods / services are received to be able to update the system accordingly. If the goods/services being ordered are on the Exception list, then all managers and budget holders must ensure their staff are

aware of the correct payment authorisation process for those goods/services. These invoices will come in requiring Authorisation and be put on an Awaiting Authorisation hold. Any invoice not classed as an exception and does not quote a valid PO number will be subject to a non-compliance escalation procedure.

6.4 Staff who 'Receipt' Goods and Services

All staff that work in central stores, receipt and distribution points and local departments where goods are delivered, or services are received have responsibility for recording the goods/services as being received. They must ensure that the Purchase Order is marked as 'received' as soon as possible within the Oracle system within 2 working days following delivery of goods or provision of the service.

6.5 Procurement Services Staff

All staff working within NWSSP Procurement Services will engage with Health Board/Trust/SHA accountable Budget Holders to ensure that this policy is adopted and adhered to by all HB/Trust/SHA staff and that local operational procedures for supporting the No PO No Pay Policy are observed at all times. Procurement Services will ensure training and awareness of the Policy with Key HB/Trust/SHA stakeholders.

6.6 Accounts Payable Staff

All staff that process the payment of invoices within NWSSP Accounts payable must ensure that no invoice is paid (unless it is identified as an exception in Appendix 1) if a Purchase Order number is not quoted on the invoice. All invoices received with no Purchase Order number must be recorded within the Oracle system and the supplier notified in accordance with the communications shown in Section 8. The invoice will be placed on a No PO No Pay hold and marked as disputed.

6.7 Finance Staff

The Finance P2P Lead in each Organisation must promote this policy to finance staff, requisitioners, approvers, budget holders & receipters within their Organisations.

Finance staff must ensure there are processes in place to capture data on invoices received but unpaid, that have no Purchase Order, so that expenditure can be accrued if necessary.

7 Operation of the Policy

7.1 How does No PO No Pay Work?

No PO No Pay policy operates by requiring all invoices submitted by suppliers to contain an official PO number. In all but agreed exceptional circumstances the PO number will be:

- Generated from NHS Wales Oracle Ordering system or
- Generated from other local ordering systems e.g. pharmacy; and
- Given to the supplier or contractor BEFORE making any commitment to spend NHS Wales's monies.

There are a number of categories of expenditure that are excluded from the policy which are shown in Appendix 1.

Any invoice received by the Accounts Payable Team that is not on the exception list and does not quote a valid PO number will incur processing and approval delays which could result in severe delays to supplier payment. Exceptions will be reviewed and amended from time to time and users notified of the amendments accordingly.

7.2 What constitutes a Valid PO?

An exercise will be undertaken to remind suppliers of the NHS Wales No PO No Pay Policy and reinforce that they must not, under any circumstances, accept any verbal or written order from NHS staff unless a valid PO number is given or there is an agreed exception as set out in Appendix 1.

Any invoice received that does not quote a valid PO number will be placed on hold until a valid PO number is provided.

7.3 What is a Valid PO number?

Valid PO numbers are generated from NHS Wales ordering systems as follows:-

- Oracle Financial and Procurement System
  - Oracle is the standard financial system used by NHS LHBs/ Trusts/SHAs in Wales.
- Oracle via Basware

    - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
- Oracle EBS via GHX
    - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
- The Pharmacy system used for generating pharmaceutical orders.

7.4 Submission of invoice

The Purchase Order will confirm which address invoices need to be submitted for payment. Some invoices will be submitted through the electronic exchanges or via the OCR process.

7.5 Public Sector Payment Policy

Provided a supplier has quoted a valid Purchase Order number which has been obtained in advance of supply, NHS Wales commits to paying invoices in line with the Public Sector Payment Policy i.e. within 30 days from the later of the receipt of goods or services or receipt of a valid invoice [not the invoice date].

All NHS Wales organisations are required by Welsh Government to be at least 95% compliant with this policy. Compliance is reported quarterly to Welsh Government, and annually in the Organisation's annual financial accounts.

7.6 Notification to Supplier of No PO on Invoice

If a supplier sends an Invoice without a Purchase Order number quoted and it does not sit within the agreed exception list, Accounts Payable will email the supplier weekly to inform them that their invoice has been placed on hold and that the supplier must contact the Health Organisation and request a Purchase Order number to be given to them. The supplier will be reminded of outstanding invoices awaiting confirmation of a Purchase Order every time the No PO No Pay report is run.

8 Non-Compliance

Non-compliance with this policy results in non-compliance with the Organisation's Standing Financial Instructions. The method of dealing with non-compliance will be for each organisation to determine but may include:

- Retraining of member of staff
- Escalation to senior management
- Escalation to Audit Committee (or equivalent)
- Escalation to Board

- Removal of access rights to the Oracle system

9 Training

Training resources aimed at the key staff affected by this policy have been developed and iProcurement training can be provided upon request from the NWSSP e-Enablement team.

10 Implementation

The No PO No Pay policy was implemented across NHS Wales on the 1st September 2018. In accordance with clause 12 below, the latest formal review of the Policy has been undertaken in June 2024 and the proposed changes/amendments to it will be adopted by all NHS Wales Organisations

11 Audit

The application of this policy will be subject to internal audit review as part of the NWSSP Accounts Payable audits.

12 Review

This policy was implemented in September 2018, reviewed in September 2023 with further amendments in June 2024 and is due for further review in June 2027.

APPENDIX 1

All Wales Exceptions to the No PO No Pay Policy

The following items are exceptions and do not require a valid PO number. This includes a number of areas where local ordering systems are in place with appropriate authorisation control processes that do not require an Oracle PO to be raised.

	ALL WALES EXCEPTIONS
Barrister Fees	Yes
Blue Badges	Yes
Bunkered Fuel & Fuel Cards	Yes
Capital Construction contracts (where approval outside of Oracle)	SBU only
CHC - FNC	Yes
CHC/Nursing Home Payments	Yes
Collaborative Fees (GPs)	Yes
Estates (Grammes/Studio 3 Feed)	BCU & WAST only
Eye Tests	Yes
Fleet vehicles (Chevin Feed)	WAST only
GP Loads (Drugs)	Yes
Grants	Yes
HMRC	Yes
Hospital Car service	Yes
Lease Car repairs	Yes
Local Government/Authorities including Business Rates	Yes
Losses & Compensation including Redress	Yes
NHS Organisations excluding NHS Supply Chain	Yes
Nurse agency	Yes
Orthotics	Yes
Patient reimbursements including patients travelling	Yes
Petty Cash	Yes
Pharmacy (including home deliveries ordered through pharmacy system)	Yes
Primary Care contracts OOHRs	Yes
Primary care Low vision - HESP forms	Yes
Public Finance initiative	Yes
Purchase/Procurement Card	Yes
Telephone Landline - Line Rental, Call Charges & Maintenance	Yes
Telephone - Mobile Phone Charges	Yes
Salary deductions	Yes
Salary Sacrifice Schemes	Yes

Same day couriers	Yes
Tax, NI & Superannuation	Yes
Taxi Patient transport	WAST & NWSSP only
TV & Music Licences	Yes
Utilities (Gas, Electricity, Water and Oil heating)	Yes
Work Permits/Certificate of Sponsorship	Yes

Archwilio Cymru
Audit Wales

Urgent and Emergency Care – Arrangements for Managing Demand Welsh Ambulance Services University NHS Trust

Date issued: April 2025

Document reference: 4820A2025

This document has been prepared for the internal use of the Welsh Ambulance Services University NHS Trust as part of work performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2024 review of the arrangements for managing demand for urgent and emergency care at the Welsh Ambulance Services University NHS Trust (the Trust). The work is the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase, which examined discharge planning and the impact of patient flow on urgent and emergency care, has been reported separately in regional reports covering the health board and local authorities for each of the seven health and social care regions[1].

2 Our approach recognises that the urgent and emergency care system is complex, with many different organisations needing to work together to provide urgent and emergency care and to ensure the wider system works effectively and efficiently. The Welsh Government's Six Goals for Urgent and Emergency Care Programme (Six Goals Programme) launched in 2021, provides the context for our work. At the time of our review, the urgent and emergency care system in Wales continues to be under significant pressure.

3 Our work has examined how the Trust is managing demand for urgent and emergency care services. Specifically, we looked at how it is working to reduce conveyance to Emergency Departments and how it supports the treatment of patients in the right place, first time for their needs, where better alternatives to attendance at Emergency Departments exist. The work has been undertaken to help discharge the Auditor General's statutory duties under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Trust has proper arrangements in place to ensure the efficient, effective, and economic use of its resources.

4 We undertook our work between May 2024 and January 2025. The audit methods and criteria we used to deliver our work are summarised in **Appendix 1 and 2**.

[1] The seven health and social care regions align with the seven regional partnership boards.

Key facts and figures

Calls to 111 and 999	
2,427	Average number of calls to the 111 service every day in February 2024[2] (101 calls an hour).
14%	Calls to 999 that were ended following a WAST telephone assessment (providing advice or signposting to alternative services) in February 2024[3], compared to 8.2% in February 2019
178%	Increase in Category A (red) ambulance calls between February 2019 and February 2025.
15%	999 callers who cancelled their ambulance or were told that the Trust could not send an ambulance to them during February 2025, compared to 24% in November 2024.

Ambulance response	
51%	Category A (red) ambulance calls responded to within eight minutes in February 2025, compared to 72% in February 2019. The national target is 65%.[4]
02:03hrs	Average response time to amber calls in February 2025, an increase of 1 hour 37 minutes compared to the average in February 2019.
63%	Patients conveyed to hospital following a 999 call in February 2025, compared to 68% in February 2019.

[2] Due to the Trust implementing a new 111 system for call handling and clinical assessment there has been disruption to the reporting of this data since February 2024.

[3] This verified data is currently only available up to April 2024, however February 2024 data used for comparative purposes.

[4] As described in paragraph 55 the level of demand and the number of patients the Trust is reaching within eight minutes is growing.

Handover delays	
16%	Patients handed over from ambulance crews to an emergency department within 15 minutes of arrival in February 2025, compared to 53% in February 2019 and against a national target of 100%.
1,601	Number of patient handovers which took longer than 4 hours in February 2025.
18,812	Lost hours due to handover delays in February 2025, compared to 5,610 lost hours in February 2019. This is an increase of 235%.
463	Patients estimated to be coming to severe harm because of long handover delays in February 2025[5]. This equates to 3.5% of total handovers.

Funding	
£0	Direct allocation of Six Goals Programme funding.

[5] Based on modelling developed by the Association of Ambulance Chief Executives, 2021

Key messages

Overall conclusion

5 Overall, we found that **changes to service delivery are leading to improvements in managing urgent and emergency care demand, supported by clear and regularly monitored plans. However, their impact is hindered by limitations in joined up data and access to alternative pathways in health boards as well as by continually high levels of handover delays at Emergency Departments.**

Key findings

Planning arrangements

6 The Trust has robust and clear plans for managing urgent and emergency care demand, with changes aimed to better manage demand by treating patients in the community rather than taking them to hospital, where possible.

7 Plans are informed by data and seek to address the risks associated with urgent and emergency care with actions that are aligned to the Six Goals Programme. The Trust does not have direct access to national six goals funding in the same way as health boards. As a result, the Trust is largely reliant on identifying sources of, and bidding for, national allocations to enact service changes it believes could improve patient safety and experience, which has caused plans to be deferred or delayed in recent years. However, the Trust has prioritised the uplift in allocation to progress plans to transform its clinical model in an attempt to mitigate avoidable harm within its control.

Accessing services

8 The Trust employs a range of methods to provide members of the public with information on its urgent and emergency care services. Although there is no communication plan, the Trust has recently updated its engagement plan to support its Clinical Model Transformation Programme. The Trust uses methods including social media posts and public engagement events to engage with and inform the public about using urgent and emergency care services. However, there are no mechanisms in place to assess and monitor the public's understanding of its services and when these should be accessed.

9 The Trust is aware of ongoing issues with the 111 Wales website, including the symptom checker. While small improvements are being progressed to address immediate functionality concerns, a draft business case has been developed to support more substantial improvements. The symptom checker tool is currently signposting users to out-of-date information which the Trust recognises as a priority issue. The Trust has agreed to use discretionary capital funding to begin

work on updating the symptom checkers, with further funding to support comprehensive improvements included in the drafted business case currently under discussion with commissioners.

10 Over recent years, the Trust has expanded the range of services it offers, including expanding its clinical desk, developing additional specialist practitioners and increasing its use of advanced paramedic practitioners. These are having a positive impact on managing urgent and emergency care demand. Rates of providing remote advice to patients have risen since pre-pandemic levels, with early data indicating that there are further improvements since the Trust changed its clinical model in November 2024. As a result, more patients are being treated over the phone and less are being conveyed to hospital.

11 However, the Trust's ability to redirect patients is also reliant on the availability of alternative services in health boards. While referrals to the GP out of hours services are increasing, referrals to alternative services remain low. The Trust holds a directory of services for each health board area, but these are not always accurate and up to date. Issues accessing alternative pathways by Trust staff, including Urgent Primary Care Centres and Same Day Emergency Centres also means that conveyance to an Emergency Department often remains the default destination when remote or face-to-face clinical assessment have identified an ongoing healthcare need for the patient.

12 The benefits of the service changes made by the Trust also continue to be outweighed by the continuing problems with long handover delays across Wales. Only 16% of patients were handed over from ambulance crews to an Emergency Department within 15 minutes of arrival over the last twelve months, compared to a national target of 100%. Response times for both red and amber calls continue to be challenged, with risks that both delays in response times and handover delays are resulting in patients coming to harm. Lack of available ambulances is likely also leading to higher attendance rates at emergency departments across Wales, as patients make their own way to hospital. Some of these patients may not have needed to go to the emergency department, but opportunities for paramedics to treat patients remotely (See and Treat) earlier in their patient journey are being missed due to handover delays.

Scrutiny and monitoring arrangements

13 The Board and operational groups regularly monitor and scrutinise the progress of plans and their impact on mitigating avoidable patient harm and operational risks.

14 There is a range of data to monitor and scrutinise how the Trust’s service changes are working. However, this data is not joined up with health board data, which limits the Trust’s understanding of how its services impact on the entire patient journey, though the Trust is currently working to find solutions to this issue. The Trust is capturing staff and patient feedback, which it feeds into its future strategic plans, but response rates are low.

Recommendations

15 **Exhibit 1** details the recommendations arising from our work. The Trust's management response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Accuracy of 111 Wales website R1 To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number **(Paragraph 27)**.
Directories of Service R2 To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories **(Paragraph 45)**.

Detailed report

Planning arrangements

16 This section considers whether the Trust has robust plans in place to manage the demand on urgent and emergency care services. We were specifically looking for evidence of plans:

- being informed by relevant and up to date information;
- identifying and seeking to address key risks associated with urgent and emergency care services;
- aligning with requirements of the Six Goals Programme, and clearly setting out how alternative clinical pathways will work; and
- identifying the current and required levels of resource and staffing to achieve the intended ambitions.

17 We reviewed the Trust's Integrated Medium-Term Plan (IMTP) along with its longer-term strategic framework, its plans relating to its Clinical Model Transformation Programme[6] developed during 2024, and its winter plan for 2024-25.

18 We found that **plans for managing urgent and emergency demand are robust and clear and clearly align to the national Six Goals Programme.**

19 The findings from our review of the plans are summarised in **Exhibit 2**.

Exhibit 2: approach to planning urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Plans are informed by relevant and up to date information?	**Yes**	The Trust's plans contain relevant and up-to-date information, including operational performance, demographic predictions and demand and capacity data. They also include modelled scenarios for the Trust's performance, based on actual and potentially improved levels of handover

[6] The Clinical Model Transformation Programme is a programme of work the Trust is leading, with the support of commissioners and partners. The programme seeks to increase clinical input within the patient call cycle and to provide a greater range of response options for patients who need a face-to-face assessment. These changes should enable more patients to access treatment appropriate to their needs without the need for a hospital conveyance.

Audit question	Yes/ No/ Partially	Findings
		delays experienced within the broader health system.
Plans identify and seek to address key risks associated with urgent and emergency care services?	**Yes**	The Trust's plans clearly identify key risks and mitigating actions. Risks align with those identified through the Trust's corporate risk register. These risks focus on the impact of operational pressures on the Trust's ability to provide a safe service for patients. These risks have been at the highest score of 25 since December 2019 due to ongoing and increasing pressures. The Trust is currently engaged in a programme of work which includes a review of these risks to delineate between what can be managed and mitigated by the Trust and what external factors the Trust can monitor and seek to influence. Risks in relation to specific service changes and projects are also identified and regularly overseen by operational groups, with concerns escalated to the Trust's Strategic Transformation Board.
Plans align with requirements of the Six Goals for Urgent and Emergency Care Programme, and clearly setting out how the alternative clinical pathways will work?	**Yes**	The IMTP is explicit about its alignment to the Six Goals Programme and demonstrates how the Trust can make a meaningful contribution across each individual goal. Appendix 1 of the IMTP clearly articulates each goal, the relevant quality statement, the actions the Trust intends to take to achieve each goal and what it anticipates being the measurable benefits of its actions. Relevant sections throughout the body of the IMTP detail how alternative pathways or service improvements will work. The IMTP, along with the documents on the clinical model transformation programme outline changes aimed to better manage demand by treating patients in the community rather than taking them to hospital, where possible. These include introducing rapid

Audit question	Yes/ No/ Partially	Findings
		clinical screening for 999 calls to identify potential opportunities to signpost them to alternative services, expansion of Advanced Paramedic Practitioner roles and enhancing falls services.
Plans identify the current and required levels of staffing and resource to achieve the intended ambitions?	**Partially**	The IMTP has clear implications for increasing the workforce in specific service areas. Plans to support these implications are further detailed within the Trust's strategic workforce plan. The IMTP does not clearly identify the costs required to pursue additional schemes, and whether they require additional funding. However, this detailed information is available within the Trust's more detailed financial plans. The Trust does not receive a direct allocation of Six Goals funding in the same way as health boards, though it can access funding via the health boards to contribute to specific health-board schemes. The limited availability of additional funding has led to the Trust needing to slow the pace or defer planned changes to some of its services in recent years. However, in line with other NHS bodies, the Trust received an uplift in its core allocation during 2024-25, which enabled it to progress its clinical model transformation programme.

Source: Audit Wales

Accessing services

20 This section considers whether the Trust has appropriate arrangements in place to encourage and enable people to access urgent and emergency care services that best meet their needs, and whether these arrangements are working. We were specifically looking for evidence of:

- effective signposting of patients to the most appropriate urgent and emergency care services;
- staff having access to good information on the range of services available to patients, and the extent to which there is good engagement between Trust and health board staff involved in urgent and emergency care;
- a range of services that help manage urgency and emergency demand; and
- whether the above arrangements are helping to positively manage demand for urgent and emergency care services.

21 We found that **the Trust's approach to managing demand is improving, but handover delays limit the operational efficiencies gained from improvements, and information on the entire patient journey is not joined up.**

Signposting of services to the public

22 We found that **activity to signpost information to the public is not evaluated to ensure it is effective, and there are ongoing issues with the 111 Wales website.**

Communication plans

23 The Trust does not have a communication plan which sets out how it engages with the public to improve and support their understanding of how to access urgent and emergency care services. However, the Trust has recently updated its Engagement Plan, originally developed in 2023, to support its Clinical Model Transformation Programme which includes information on public messaging. However, the engagement plan is very high-level and does not outline the details of its approach to public engagement.

24 The Trust employs a range of methods to provide members of the public with information on its urgent and emergency care services. These methods include social media posts, news coverage in times of significant pressure, and information contained on the Trust and 111 Wales websites. Through its Public Engagement and Community Involvement Team, the Trust also holds events to engage with the public. According to an internal audit report in February 2025, this team held 147 events between January 2023 and October 2024 where it met with a variety of community groups. As part of these events the Trust will inform patients which services they should access and when.

111 Wales website

25 The 111 Wales website describes itself as 'the home of health advice and information for people living in Wales' and is a key tool to signpost the public to healthcare options. It includes symptom checkers, information on what to do out of hours, a directory of nearby services and advice on planned care and living well. The number of website hits on the 111 Wales website increased significantly during 2023. Currently an average of 400,000 – 550,000 people access the 111 website each month across Wales.

26 Available data does not show the main reasons people visit the 111 Wales website, but there is data on the main reasons for people calling the 111 phoneline. The top five reasons for calls are set out in **Exhibit 3**.

Exhibit 3: top five reasons for calling 111 (February 2024)

All-Wales position	% of all calls
Dental problems	4.1
Abdominal pain	2.4
Chest pain	1.6
Cough	1.4
Rash	1.0

Source: Ambulance Services Indicators

27 We reviewed the 111 Wales website symptom checker to understand what advice is available to patients searching for help on the most common conditions. We found that the website can be unreliable, with the symptom checker sometimes failing and displaying an error message. Our tests of the symptom checker showed that it can also refer the user to out-of-date information, including the old NHS Direct Wales number (**Recommendation 1**). Furthermore, our review found that the skin rashes tool has limited functionality, consisting of a slideshow of images. The Trust routinely seeks feedback from the public via an online survey to understand their experiences of the 111 Wales website. Past feedback from the public has raised similar issues with the functionality of the symptom checker and the website more generally.

28 The Trust is aware of ongoing issues with the symptom checker and recognises the need for increased investment in the website. While small changes are being made to improve its functionality and user experience, the Trust has also invested in the development of virtual assistant technology during 2024-25, which was ongoing at the time of our fieldwork. To address wider challenges, the Trust has drafted a business case to support more substantial changes to the website,

including updated symptom checker functionality and enhanced governance of the digital front door. The business case will be submitted to commissioners and the national Six Goals Programme Board following discussions with Welsh Government regarding financial envelopes and commissioner expectations. The business case will also cover 111 communications activity, and as this work progresses, the Trust should ensure it includes mechanisms to evaluate the effectiveness of its public engagement and adapt its approach where needed.

Staff awareness and ability to refer

29 We found that **referral pathways and processes between the Trust and health boards do not work seamlessly which is impacting access to alternative services.**

Assessment and treatment

30 During the last ten years, the Trust has introduced many initiatives and service changes to enhance its clinical offering with the aim of increasing the treatment of patients within the community and reducing conveyances to hospital. This has included expanding its clinical desk to provide advice to patients over the phone to 999 callers as well as introducing a referral process for patients seeking mental health support to have fast and direct access to relevant health board services (referred to as '111 press 2'). The Trust has also invested in its ability to treat patients face-to-face within the community, enabling them to stay at home, including increased its advanced paramedic practitioner workforce.

31 The ability of the Trust to treat, provide advice or signpost information to patients to avoid conveyance to hospital is referred to as 'consult and close'[7] and 'see and treat.' **Exhibit 4** sets out the extent to which the ambulance call centre can manage patients after assessment (consult and close), and ambulance crews can manage patients at the scene (see and treat).

[7] Previously referred to as 'hear and treat'.

Exhibit 4: percentage of ambulance calls and responses ended after telephone assessment (May 2023 – April 2024) or at scene (May 2023– April 2024) [8]

Indicator	All-Wales position	Trend
% of ambulance 999 calls ended after telephone assessment (consult and close)	13.9	
% of ambulance responses treated at scene (see and treat)	12.1	

Source: Ambulance Service Indicators

32 The rate of consult and close has increased substantially in recent years, from 8.2% in February 2019 to 14% in February 2024. This increase is mainly due to an increasing investment in recruiting clinicians to operate its Clinical Support Desk, particularly as part of plans to mitigate annual winter pressures.

33 Recent unverified data shows that the number of patients treated or referred to alternative services over the phone is further increasing after the Trust introduced rapid clinical assessments. In 2023 WAST commissioned a clinical model design of the Trust's EMS service by ORH.[9] The work ecommended that 999 calls should be reviewed and either referred for a fuller remote clinical assessment or returned to the queue to receive an ambulance dispatch. After receiving an increased core allocation to its base budget in 2024-25 due to inflation, the Trust decided to progress this recommendation and recruited 28 clinical navigators to launch the first phase of its Clinical Model Transformation Programme in November 2024. Unverified data for December 2024 showed the rate increasing from under 15% to over 20%.

34 When a call is ended through consult and close, a patient may have received a range of advice which can include self-care, contacting their GP within normal working hours, or signposting to other available services, (as set out in **Exhibit 5**). Within the Trust, there has been an increase in the range of available services to directly refer to. These include the mental health '111 press 2' service which directs patients to mental health support, as well as the urgent dental service to book urgent appointments. The urgent dental service is available via 111 for five of the seven health boards (excluding Aneurin Bevan and Cardiff and Vale who have their own services).

35 In 2023, the Trust also developed its capability to remotely monitor and manage patients within the community through the Connected Support Cymru service. This

[8] Data not available beyond April 2024.

[9] ORH, also known as Operational Research in Health Ltd, is a company which conducts research and analysis of emergency services aimed at optimising resource use and response.

service uses the support of volunteer responders, clinical support desk clinicians and remote monitoring technology to manage patients remotely and keep them at home, where appropriate. This service is currently in its early stages, with plans for it to be scaled up over the next few years as outlined within the Trust's IMTP 2024-27. However, this service currently utilises short-term funding from NHS charities together which is due to conclude in March 2025. The future of this service depends on the level of additional investment available.

36 Whilst the rate of patients treated at scene increased during the 12 months between March 2024 and February 2025, the rate has decreased slightly over a longer period. Between March 2019 and February 2020, the rate stood at an average of 2,770 patients treated at scene per month, compared to an average of 2,321 between March 2024 and February 2025.

37 The Trust has been expanding its advanced paramedic practitioner service to avoid hospital conveyance and improve patient outcomes. Advanced paramedic practitioners provide enhanced treatments to patients within their homes or communities. Since the introduction of the advanced paramedic practitioner role in 2017, the number of these roles within the Trust has increased to 119 as of February 2025, with recruitment of a further 11 currently underway. The Trust's IMTP sets out plans to further increase this workforce by 40 per year up to 2027, dependent on availability of funding. Case studies, local evaluations and interviews show that the advanced paramedic practitioner role is making a significant impact in treating patients closer to home. However, this is not currently being demonstrated clearly within 'see and treat' data that is available. The Trust is undertaking work to understand the reasons for this.

38 In addition to advanced paramedic practitioners, the Trust has developed a Cymru High Acuity Response Unit (CHARU) which provides advanced care to the most critically ill patients, including those experiencing cardiac arrest or major trauma. Data presented to the Trust's Finance and Performance Committee in September 2024 shows the service supporting better outcomes for 'red' calls such as cardiac arrests.

39 For urgent needs that are not immediately life-threatening, the Trust is also seeking to develop its own services, including falls responders. The Trust provides two levels of falls response services, with level one focused on lifting patients from the floor. Level two works with health boards to provide greater support to patients following a fall that are experiencing worsening frailty, by undertaking a full medical and social assessment at the point of need.

Referral to other services

40 As well as the availability of its own alternative services, the Trust's ability to refer patients to alternative services depends on the availability of those services within the health board regions. We found each health board has a range of services in place to manage and treat urgent and emergency care needs.

41 **Exhibit 5** sets out the extent to which 111 has been able to refer patients to other urgent and emergency services.

Exhibit 5: referral to other services (March 2023 - February 2024)

Indicator	All-Wales position	Trend
% of 111 calls referred to GP out of hours	41.5	
% of 111 calls advised to attend Emergency Department / Minor Injuries Unit	10.6	
% of 111 calls referred to urgent dental service	9.7	
% of 111 calls referred to 999	6.7	
% of 111 calls advised to contact their GP (in-hours)	4.6	
% of 111 calls referred to another health professional	2.0	

Source: DHCW Urgent and Emergency Care Dashboard, GP Out of Hours Data, Ambulance Services Indicators

42 The data shows that the most common service 111 callers are referred to is the GP out of hours service, with this rate increasing between March 2023 and February 2024. This rate aligns to public messaging which signposts patients with urgent out of hours needs to contact 111 to access GP out of hours services and suggests that public messaging is generally working effectively in this regard. The rate with which 111 call handlers refer patients to contact their own GP in hours (4.6%), indicates that patients could be better informed about which service to access, however it is also likely to reflect how the public are increasingly struggling to gain appropriate access to in-hours GP appointments due to capacity issues within primary care. The low rate of referrals to other health professionals (2%) also suggests that there are limited alternative services in place for 111 call staff to refer patients with specific conditions to access.

43 Between February 2022 and February 2024, 5.2% of 999 calls were transferred to the 111 service, on the basis that the calls were deemed non-urgent and therefore could be dealt with through alternative services. However, 27.7% of these calls were transferred back to 999 with an outcome of ‘ambulance required’ This comparatively high rate suggests that while these cases are not sufficiently urgent to warrant a 999 response, options for alternative services were either not in place or not accessible.

44 To facilitate effective referral between the Trust and health boards, there needs to be a sufficient range of appropriate pathways that the Trust staff are aware of and can access. One of the key ambitions of the Clinical Model Transformation Programme is to increase collaboration between the Trust and health boards to

identify potential pathways for patients, and to ensure that Trust clinicians have appropriate access to those pathways, either by streaming patients to health board clinical hubs, or directly to a care pathway via the directory of service.

45 The Trust holds a directory of service for each health board area. Directories of service have been set up to hold accurate and up-to-date information on available alternative pathways that patients can be signposted to by remote clinicians and paramedics. However, our fieldwork found that arrangements for maintaining the directories of service need to be strengthened between the Trust and health boards to ensure they are accurate and up to date, including containing the right opening hours for services (**Recommendation 2**).

46 Where pathways are established, our fieldwork also found that there are issues with ensuring Trust staff can access them. This can be because:

- referral criteria is unclear or too limited;
- pathways do not allow for referrals from Trust staff; or
- the extent of variation in the way in which services operate make them more challenging for Trust staff to access consistently or efficiently.

47 Interviews with a range of staff groups suggested that the inconsistencies in the availability of, and access to, alternative services serve to reinforce Emergency Departments as the default destination for ambulance conveyances.

48 In line with the ambitions of the Six Goals Programme, some health boards have established Urgent Primary Care Centres (UPCCs). The principle of UPCCs is to provide diagnosis and treatment to patients with urgent but non-life-threatening injuries or illnesses. However, the UPCC models developed in response to the Six Goals Programme vary within and between health boards. The Trust has been piloting booking patients directly into UPCCs from the 111 service, but this is limited to a small number of appointments and for very specific conditions. This stops Trust staff from using UPCCs to their full potential to manage urgent demand in the way they are intended.

49 Another key ambition of the Six Goals Programme was for health boards to establish Same Day Emergency Centre(s) (SDECs) to provide same day assessments and treatment without the patient needing to be admitted into hospital overnight. We have found that the SDEC models developed in response to the Six Goals Programme also vary across health boards. This variation results in a lack of clarity for Trust staff as to the referral criteria in place and the pathways they should use to access SDECs.

50 In response to this issue, Welsh Government issued an all-Wales policy on direct paramedic referral to same day emergency care in April 2022. The policy clarifies the different expectations of Trust and health board staff to support effective referrals into SDECs. However, despite the policy stating that it is ‘essential for the Welsh urgent and emergency care system that direct paramedic referral into SDEC/Ambulatory services is implemented’, Trust data shows that, between May

2023 and February 2025, on average only 0.13% of patients conveyed were taken to a health board SDEC each month.

51 We heard varying reasons for this low rate of referral during our fieldwork. This included technical issues but more prominently because SDEC units tend to become full within minutes of opening due to broader pressures on Emergency Departments. They then remain full until it becomes too late to accept any new referrals before the units close.

Impact of services to help manage demand

52 We found that **recent work to reduce conveyance to Emergency Departments is outweighed by unacceptably long handover delays across Wales**

Ambulance response times

53 Data shows that demand on the Trust's services, particularly in relation to red calls, has increased, placing additional strain on its ability to provide a timely service. Red calls across Wales increased by 178% between February 2019 and February 2025, with an average of 5,367 red calls per month between March 2024 and February 2025 (an average of 179 calls per day). This is in part due to the need to increase the number of conditions within the red categorisation to ensure they receive a timelier response. Whilst the number of amber calls has declined slightly since the pandemic, they continue to account for most of the 999 calls, with an average of 24,412 calls per month between March 2024 and February 2025 (an average of 814 calls per day).

54 The average percentage of red calls responded to within eight minutes between March 2024 and February 2025 was 48.6% and significantly below the target of 65%. However, during those 12 months, performance has improved with the Trust reaching a greater number of patients within eight minutes. For example, in December 2024 and January 2025 the Trust reached 33% and 22% more patients than its average two-year rate. Following the recent announcement by the Cabinet Secretary for Health and Social Care there will be changes to monitoring performance, with the creation of two separate metrics: one for cardiac and respiratory arrest; and another for other red emergency calls. These changes will take effect from 1 July 2025[10].

55 In contrast to red calls, responses to amber calls have become significantly poorer in recent years. On average, the response time to amber calls between March 2024 and February 2025 was 1 hour 50 minutes, rising to 9 hours 58 minutes for the patients who waited the longest (95th percentile). This performance fluctuated during those 12 months, with significant deterioration during December 2024 and

[10] On 11 March 2025 the Cabinet Secretary for Health and Social Care announced changes to the performance framework for ambulance services effective from 1 July 2025.

January 2025 due to winter pressures. Average response times for those months were 3 hours, 1 minute and 2 hours, 29 minutes respectively.

56 Call handlers provide patients with their estimated response time during their call. As a result, since 2022 a significant proportion of 999 callers have called back to cancel their place in the queue for an ambulance response ('cancelled calls'). There have also been circumstances where call handlers have been required to inform patients that they were unable to dispatch an ambulance response to them due to operational pressures at that time ('no send/can't send'). Concerningly, there is no method to capture what happens to these patients to find out if they decided to make their own way to the Emergency Department, found alternative services for their needs or simply decided not to receive treatment.

57 The Trust routinely captures and reports data on the number of cancelled calls or calls that received a 'no send/can't send' response. In September 2024, this cohort accounted for 9,440 calls or 21% of patients who dialled 999 that month. Further work by the Trust has established that up to 20% of all cancellations come from patients presenting with chest pain or falls, conditions that can result in significant patient harm. The Trust Board has heard directly about the impact this can have on patients, including a patient story during 2023 where a patient suffered a cardiac arrest within the hospital car park after being driven to hospital by a family member due to lack of ambulance availability.

58 As part of the Clinical Model Transformation Programme, the Trust took the decision in November 2024 to stop providing a 'no send/can't send' response, relying on the impact of its new changes such as rapid clinical screening to better manage demand. This means that the Trust takes greater responsibility for the patient and patient risk. This appears to be starting to have a positive impact, as data from February 2025 shows that the numbers of cancelled ambulances had reduced to 5,815, accounting for 15% of the total calls for that month.

Conveyance to hospital

59 After the ambulance has been dispatched and it is decided that the patient needs hospital assessment and treatment, they will be conveyed. Whilst the conveyance rate to hospital by the ambulance service was substantially impacted during the pandemic, data since 2023 shows a steadily decreasing conveyance rate when compared with pre-pandemic levels, with rates dropping from 68% (19,022 patients) in February 2019 to 63% (11,705 patients) in February 2025.

60 Data that shows where patients are conveyed to indicates further opportunities to increase conveyance to destinations other than the Emergency Department. **Exhibit 6** sets out the destination for all conveyances.

Exhibit 6: conveyance destination as a proportion of total conveyance (March 2024 – February 2025)

Indicator	All-Wales position	Trend
% of patients conveyed to major emergency departments	88.7	
% of patients conveyed to minor injuries units	6.4	
% of patients conveyed to major acute medical admissions unit	3.1	
% of patients conveyed to other unit e.g. mental health or maternity unit	1.8	

Source: Ambulance Services Indicators

61 The overwhelming majority of conveyance continues to be to Emergency Departments. This is likely to be the most appropriate destination for many calls, which, are by their nature, urgent and/or life-threatening. However, our interviews with ambulance and health board staff suggest that barriers exist which inhibit ambulance crews from conveying patients to settings which may be more appropriate for their needs.

62 For example, conveyance rates to minor injuries units are consistently low. Part of the reason for this is that there is significant variation in opening hours and criteria for accepting referrals to the minor injuries units operating within and between health boards. As a result, those we interviewed stated that paramedics will tend to rely on Emergency Department conveyance. This reduces the risk that the patient will not be accepted by the minor injuries unit, which results in poor patient experience and inefficiencies in having to undertake additional transportation to the Emergency Department.

63 We also heard that some alternatives to the Emergency Department, such as direct referral to units within specialties can be reluctant to accept referrals from paramedics. This is due to the types of observations and tests paramedics can complete. These services would prefer for patients to be routed through the Emergency Department first.

64 However, data on conveyance to hospital following 999 calls from a care home is showing some signs of improvement. This rate decreased from a high of 64.8% in November 2023 to a low of 58.7% in September 2024. This suggests that some of the work the Trust is doing to support care homes, including by supplying lifting equipment or providing enhanced falls response services, is resulting in lower rates of conveyance to hospital.

Ambulance handovers

65 Data shows that ambulance handover delays continue to be at unacceptable levels. Only 16% of patients were handed over from ambulance crews to an Emergency Department within 15 minutes of arrival between March 2024 and February 2025, against a national target of 100%. This compares to 56% between March 2018 and February 2019. Under half (43.9%) of the patients conveyed to an Emergency Department were handed over within an hour during February 2025. The average time for patient handover in December 2024 was 2 hours, 12 minutes. In England, the average handover delay for December 2024 was 39 minutes.

66 These high levels of handover delay result in extremely high numbers of 'lost hours' where a paramedic crew is unable to respond to other calls within the community, with lost hours routinely over 20,000 a month during 2024. This roughly equates to between one quarter or one third of the available capacity of the ambulance service each month. Comparing lost hours for February 2025 with those in February 2019 shows a 235% increase. The lost hours in February 2025 equate to 1,597 12-hour paramedic shifts.

67 Research commissioned by the Association of Ambulance Chief Executives (AACE) states that patients experiencing delays of over one hour are much more likely to experience avoidable harm because of the delay they face. Using the modelling developed as part of that research, the Trust has estimated that 463 patients (3.5% of conveyed patients) came to severe harm because of long handover delays in February 2025.

68 Despite the Trust's increasing activity to avoid hospital conveyance by remote treatment, either over the phone or in person, data shows that there remains a significant amount of work to do to improve handover performance. Lack of available ambulances will also lead to higher attendance rates at emergency departments across Wales, as patients make their own way to hospital. Some of these patients may not have needed to go to the emergency department, but opportunities for paramedics to treat patients remotely (See and Treat) earlier in their patient journey are being missed due to handover delays.

69 Problems associated with handover delays are widely recognised. In March 2025, the Cabinet Secretary for Health and Social Services announced the establishment of a patient handover improvement delivery group. This group is intended to identify and oversee action aimed at improving ambulance patient handover performance, learning from UK-wide and international best practice. An update on the progress of this group's work is anticipated in July 2025.

Scrutiny and monitoring arrangements

70 This section considers whether the Trust is doing enough to monitor the performance of its urgent and emergency care services, and applying lessons learnt to improve services further. We were specifically looking for evidence of:

- arrangements for monitoring the impact of alternative clinical pathways; and
- effective oversight and scrutiny of the delivery of plans for urgent and emergency care.

71 We found that **there is good oversight of performance and plan progress relating to urgent and emergency care demand which is informed by staff and patient feedback but is limited by lack of joined up data**

Monitoring impact

72 We found that **monitoring of plans is informed by regular staff and patient feedback, but without joined up data the Trust cannot monitor the effectiveness of referral pathways with certainty.**

73 The findings that have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: approach to monitoring the impact of alternative pathways on urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is the Trust tracking and reporting data to show whether patients are accessing urgent and emergency care services appropriately?	**Partially**	The Trust routinely tracks relevant data on demand, rates of signposting and referral to alternative services (consult and close) and rates of conveyance to hospital units, including Emergency Departments. However, Trust and health board information systems are not currently linked up to enable the tracking of an entire patient journey i.e. to confirm whether patients followed advice they have received.
Is regular patient feedback is being	**Yes**	The Trust captures patient feedback through regular CIVICA experience surveys[11]. There are

[11] Civica Experience is a software which helps healthcare professionals collect and analyse data to turn patient feedback comments into insights.

Audit question	Yes/ No/ Partially	Findings
sought and used to inform and improve plans?		surveys in place for 999, 111 and the Trust's falls service. These surveys capture patient responses to questions including their overall rating of the experience for the service they received, as well as more specific questions, such as whether patients intend to follow the advice they found on the 111 Wales website. The Trust recognises that response rates to these surveys are low, with 371 responses across each of those listed above between April and September 2024, and it continues to explore options to increase participation. Supporting appendices of the Trust's IMTP summarise patient feedback and concerns relating to services, including 111 and 999 services and links them to specific actions within the plan which aim to address those concerns and improve patient experience.
Is there regular staff feedback on the impact of changes to services and pilots to identify and apply lessons?	**Yes**	The Trust shows a commitment to hearing from staff, including via monthly WAST Live virtual staff meetings, surveys and bi-annual Chief Executive Officer roadshows held in ambulance stations and offices across Wales. Furthermore, the Trust involves trade union representatives in key working groups and each board committee, as well as through the Welsh Ambulance Service Partnership Team. These mechanisms provide a staff perspective during decision making. In January 2025, the Trust surveyed staff involved in delivering the Clinical Model Transformation Programme and the associated new initiatives. The survey asked staff for their views on the way in which changes have been implemented. The response rate was low at 17% (30 responses) and whilst overall scores were mostly positive, comments included concerns about the pressure caused by the pace and scale of the programme, as well as a need for more regular and meaningful staff engagement. The Trust is currently developing actions to respond to these concerns.

Audit question	Yes/ No/ Partially	Findings
		Staff feedback and related actions to address areas of concern are also included within an appendix of the Trust's IMTP.

Source: Audit Wales

Oversight and scrutiny

74 We found that **there is regular operational and strategic oversight and scrutiny of the performance and the delivery of plans**

75 The findings that have led us to this conclusion are summarised in **Exhibit 8**.

Exhibit 8: approach to oversight and scrutiny of urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is there effective oversight of urgent and emergency care performance operationally, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	**Yes**	The Trust provides operational oversight and scrutiny of its actions to improve demand management through its Clinical Transformation Board, and supporting workstreams, as well as its Integrated Strategic Planning and Development Group. These groups are supported by strong arrangements, including appropriate membership and regular frequency. The Trust continues to oversee and manage performance in line with its Quality and Performance Management Framework 2022-25. Operational performance is scrutinised at detailed levels by various operational, quality and planning subgroups before being collated and submitted for oversight and challenge by the Executive Leadership Team.
Is there effective oversight of urgent	**Yes**	Performance information on the Trust's urgent and emergency care services is regularly

Audit question	Yes/ No/ Partially	Findings
and emergency care performance at the committee and board level, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?		reported to the Performance and Finance Committee; the Quality, Experience and Patient Safety Committee; and the Board. In 2024, the Trust developed a patient harm mitigation scorecard. This provides a collective set of metrics to indicate the levels of harm that may be occurring as a result of system pressures. However, again this information is limited due to the absence of joined up information between the Trust and its commissioning health boards. As a result, the scorecard only indicates estimated levels of harm based on the AACE model. The Finance and Performance Committee and the Board are also responsible for overseeing the progress of the Trust's Integrated Medium-Term Plan.

Source: Audit Wales

Appendix 1

Audit methods

Exhibit 9 sets out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 9: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Integrated Medium Term Plan and appendices; • Corporate Risk Register and Board Assurance Framework; • Internal Audits; • Winter Plan; and • Clinical Model Transformation Stakeholder briefing document, September 2024.
Interviews	We interviewed the following: • Executive Director of Operations; • Executive Director of Paramedicine; • Executive Director of Strategic Planning and Performance; • Director of Partnerships and Engagement; and • Assistant Director, Commissioning and Performance.
Group discussions	We held group discussions with the following: • Advanced Paramedic Practitioners.
Observations	We observed the following meeting(s): • Finance and Performance Committee; and • Board.
Data analysis	We analysed data relating to urgent and emergency care services, using the following sources: • Ambulance Services Indicators; • Data provided from the Trust, including rates of consult and close and SDEC referrals;

Element of audit approach	Description
	• DHCW Urgent and Emergency Care Dashboard; • StatsWales; and • Data provided by Welsh Government in relation to GP out of hours services.
Website and practice reviews	We reviewed the Trust's website and social media accounts relating to the provision of information to the public on accessing urgent and emergency care services.

All audit work has been delivered in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) audit standards.

Appendix 2

Audit criteria

Exhibit 10 sets out the audit criteria that we used to deliver this work.

Exhibit 10: audit criteria

Audit questions	Audit criteria
Does the Trust have robust plans in place to manage the demand for urgent and emergency care services?	
Do plans seek to improve the management of demand through changes to service delivery in line with the six goals for Urgent and Emergency care?	• Strategies and/or plans relating to urgent and emergency care: – are based and grounded in rich and up-to-date information, informed by urgent and emergency care demand data (past and future), including peaks in activity at certain times/days and months, demographics, and conditions of patients. – identify and seek to address key risks associated with demand for urgent and emergency care services. – align with the plans of partner Health Boards. – align with the requirements of the Welsh Government Six goals for Urgent and Emergency Care for better managing demand. – include documented information on alternative clinical pathways, including how and when they should be accessed.
Do plans identify the current and required	• Strategies and/or plans detail the:

Audit questions	Audit criteria
levels of resource and staffing to achieve the ambitions?	– resource requirements and identified funding to support any changes to service delivery included within the strategy/plan. – workforce and skills required to meet demand, including for changes in models of delivery such as winter peaks. The plan is clear about the required resources of clinical and non-clinical skills/staff.
Are arrangements in place to encourage and enable people to access the right care, in the right place, at the first time, and are these working?	
Is the Trust effectively signposting urgent and emergency care services to the public, so they know how to access services appropriately?	• The Trust provides clear information on available services and alternatives to emergency departments to the public through various avenues – websites, call handlers, posters/leaflets, advertisements, social media, videos etc. • Strategies and/or plans on public communication align to requirements of goals 2 and 3 of the WG Six goals for Urgent and Emergency Care (Right care, right place, first time) • There is evidence to suggest patients have a good understanding of how to access urgent and emergency care services that are appropriate to their needs
Do staff have good knowledge of, and access to, information regarding the range of other services available to their patients and at what times they are available?	• There is engagement between the Trust and health boards about alternative pathways in place and the future of urgent and emergency care services. Information on these pathways and services are accessible for staff. • Staff can refer directly / divert patients to more appropriate settings for their needs, including Minor Injury Departments, Urgent Primary Care Centres (UPCC) and Same Day Emergency Centres (SDEC).
Is there evidence that changes to service delivery are resulting in	• Referrals into new service models are in line with the ambitions of the six goals for urgent and emergency care policy handbook. • WAST can refer at least 4% of cases to SDEC.

Audit questions	Audit criteria
better demand management?	• Data indicates that there are increasing rates of See and Treat and Hear and Treat. • Calls to 111 are answered quickly and abandonment rates are low. • Emergency ambulance response times, ambulance handover delays and waits within Emergency Departments and Minor Injury Units are improving. • Data indicates that there are fewer amber calls requiring an upgrade to red due to lengthy response times. • Data shows decreasing volumes of patients with low acuity / minor complaints presenting at Emergency Departments. • Data indicates that calls diverted between 999 and 111/NHS Direct Wales are appropriate with low levels of calls diverted back and low numbers of re-contact rates.
Is the Trust doing enough to monitor the performance of its urgent and emergency care services and apply lessons learnt to improve the services further?	
Is the Trust monitoring the effectiveness of alternative clinical pathways, including by seeking feedback from staff and service users?	• The Trust tracks and reports data to show whether patients are accessing urgent and emergency care services appropriately. • The Trust can evidence that it seeks patient feedback regularly and uses it to inform and improve plans. • Regular feedback is sought from various staff on the impact of changes to services and pilots to identify and apply lessons
Is there effective scrutiny and assurance in relation to delivering plans for urgent and emergency care and alternative clinical pathways?	• There is effective oversight of urgent and emergency care performance operationally and at the committee and board level. This includes scrutiny and assurance on the effectiveness of the plans and actions being taken to better meet demand. Oversight and scrutiny are informed by comparative benchmarking and learning from other bodies where appropriate. • There are arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government. This includes establishing value for money and what difference the project has made.

Appendix 3

Management response to audit recommendations

Exhibit 11 sets out the Trust's management response to the recommendations made because of this audit.

Exhibit 11: management response

Recommendation	Management response	Completion date	Responsible officer
Accuracy of 111 Wales website R1 To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number **(Paragraph 28)**.	The Trust accepts this recommendation. While WAST is not directly commissioned to manage the 111 Wales website, we fully support the need for accurate content to signpost patients safely. We routinely raise concerns, such as outdated references to NHS Direct Wales and will strengthen this by formally escalating issues through an agreed assurance route with Digital Health and Care Wales. A business case has been drafted to propose a new governance model with dedicated resources for oversight and content management to improve accuracy and ownership. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission.	May 2026	Director of Digital Services

Recommendation	Management response	Completion date	Responsible officer
	Website content accuracy will be a standing item at the monthly 111 Wales digital governance group. Over the next 12 months, issues will be actively monitored, and formal escalations logged to demonstrate progress and provide evidence of action taken.		
Directories of Service R2 To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories **(Paragraph 46)**.	The Trust accepts this recommendation. We agree on the need for accurate and up-to-date service information. While WAST does not control the content provided by health boards, we maintain mechanisms to receive and manage this data. The recommendation is therefore best addressed through strengthened collaboration with health boards, who remain responsible for the accuracy of their service information. A business case has been drafted to improve Directory of Services (DoS) governance and support. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission. WAST will continue to update any content we own/publish into to the DOS and will escalate outdated information to relevant health boards. This will be monitored over 12 months, with escalations logged as evidence of action.	May 2026	Director of Digital Services

Source: Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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

AGENDA ITEM No	**22**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

Committee Priorities and Cycle Monitoring Report

MEETING	Finance and Performance Committee
DATE	21 July 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Steve Owen, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

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.

2. The Committee is to note that the Value Based Healthcare Report, scheduled for receipt on the Cycle of Business, and based on a recommendation from the Executive Director of Quality and Nursing, has been agreed to be received for discussion at a suitable Board Development Day.

RECOMMENDATION: The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – FPC Cycle of Business Monitoring Report

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

COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING FOR 2025/26

SITUATION

3. 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.

BACKGROUND

4. 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.

5. 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.

6. 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.

7. 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.

ASSESSMENT

8. The Committee 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).

	• An update on the Financial Sustainability Programme is scheduled for receipt at the Committee meeting on the 21 July 2025.
A focus on Clinical Model Transformation performance	• Updates on the progress will be included as part of the Integrated Medium Term Plan (IMTP) Progress Report which is received at every meeting of the Committee. An update regarding progress of the Clinical Model Transformation will be included in the report received on the 21 July 2025.
A focus on resilience including information security and progress on any Manchester Arena Inquiry recommendations	<u>Resilience and Information Security</u> • The Information Governance (IG) Report (received 20 May 2025) highlighted 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. <u>Manchester Arena Inquiry</u> • The Committee will continue to receive progress updates against the Manchester Arena Inquiry with regards to the recommendations required via the Operations Directorate report received at each meeting. • The following suite of reports are programmed for receipt at the 21 July meeting: Annual HART KPI Report, Business Continuity Annual Report and the Welsh Government Annual Emergency Planning Report. Furthermore, in the closed session, the Incident response Plan is programmed for receipt.

9. In terms of the Value Based Healthcare Report which is scheduled for receipt on the Cycle of Business, based on a recommendation from the Executive Director of Quality and Nursing, it has been agreed that this matter will be received for discussion at a suitable Board Development Day.

RECOMMENDATION: The Committee is asked to note the update.

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, Bangor Workshop at July meeting.
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	TBC	Annually							EDO	Assurance	HART Internal Audit Nov 22 recommended annual reporting of HART KPIs which was accepted. See July FPC on HART KPIs
Metrics for digital systems infrastructure	TBC	Three times a year							DD	Assurance	
Commissioning arrangements	ELT	Consider annually							EDSPP	Endorsement	Consider potential annual report to be developed
Demand and capacity reviews	ELT	Ad Hoc							EDSPP	Endorsement	
Estates Condition and Backlog Maintenance Update [EFPMS Data/Re	TBC	Annually							EDOF	Assurance	This was added in as a future requirement (following initial receipt in September 2024) by CorGov.
Decarbonisation Update	Decarb Programme Board	Every other meeting							EDOF		Progress also against WG action plan and Trust Plan; metrics in development. Annually to include update on waste management.
Waste Management Update	Decarb Programme Board	Annually							EDOF	Assurance	Annual update aligned with Internal Audit recommendations. First report in September 2023.
Sustainability Report	Decarb Programme Board	Annually							EDOF	Assurance/Endorse	Annual update - as per Manual for Accounts.
Fire safety annual report	ELT/Board	Annually							EDOF	Assurance	Timing of annual report TBC (annual compliance report was presented in Jan 24). By exception reporting outside cycle.
Fire safety exception report	TBC	Periodically as required							EDOF	Assurance	By exception outside of annual report
WG Annual Emergency Planning Report	ELT/Board	Annually							EDO	Assurance	Report provides for compliance with Civil Contingencies Act 2004; exercises carried out; learning from incidents/exercises/debriefs.
Incident Response Plan Report [closed session]	ELT	Annually							EDO	Assurance	Externally reported - See Note 2
Business Continuity Annual Report	ELT	Annually							EDO	Assurance	See Note 2
Cyber Resilience and Cyber Security Reporting	TBC	TBC							DD	Assurance	Reporting developing in 23/24 - start off at 3 times a year reporting; intention to bring to every meeting if possible.
Information Governance Toolkit	IGSC	Annually							DD	Assurance	
Information Governance Report	IGSC	Each meeting							DD	Assurance	
Policies for review and approval	Policy Group	Ad Hoc							BS	Approval	
Board Assurance Framework	Board	Each meeting							BS	Assurance	
Corporate Risk Register	Board	Each meeting							BS	Assurance	
Audit Recommendation Tracker	ADLT	Each meeting							BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc							Relevant Director	Assurance	
STANDARD ITEMS											
Quarterly operations update	TBC	Each meeting							EDO	Information/Discussion	Only received in quarter, not at every FPC meeting (if it would otherwise be a duplicate from previous meeting)
GOVERNANCE											
Committee effectiveness review and annual report	Audit/Board	Annually							Board Sec.	Approval	
Review of Terms of Reference	Audit/Board	Annually							Board Sec.	Approval	
Committee cycle of business refresh	N/A	Annually							Board Sec.	Approval	
Committee Cycle of Business review	Audit/Board	Each meeting							Board Sec.	Approval	
Committee Review of Annual Priorities	None	Every other meeting							Chair	Review	
SUB-GROUPS											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
PROMPTS											
External Reports	N/A	Ad Hoc							TBC	TBC	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.