Bundle Finance and Performance PUBLIC 15 September 2026

Agenda attachments

Finance and Performance Committee Public Agenda 15 September 2026

0 09:30 - OPENING ITEMS

1 Chair's welcome, apologies and quorum

2 Declarations of interest

Item 02 Board Member Register of Interests - Updated 04082026

3 Minutes of the last meeting held on 21 July 2026

Item 03 2026-07-21 PUBLIC FPC Minutes draft

4 Action log and matters arising

Item 04 Action Log and Decisions (Public) FPC

4.1 Committee AAA report: 21 July 2026

Item 04.1 Finance and Performance Committee Highlight Report 21 July 2026

4.2 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - Financial Performance at Month 4 - 2026/27 / Financial Position for Month 5 - 2026/27

Please note: there are documents in the Reading Room for this item

Item 05 Finance Report Month 4 2026-27

Item 05 Annex 3 Financial Grip and Control

6 09:50 - Integrated Medium Term Plan (IMTP) Update [Verbal]

7 10:00 - Manchester Arena Inquiry Progress Update: Commissioner Response and Residual Risk Position

Please note: there are documents in the Reading Room for this item

Item 07 Manchester Arena Inquiry Progress Update: Commissioner Response and Residual Risk Position

8 10:10 - Monthly Integrated Quality Performance Report (MIQPR) June July 2026

Item 08 MIQPR June July 2026

Item 08 Annex 1 MIQPR

9 10:25 - Non Emergency Patient Transport (NEPTS) including the Audit Wales report

Item 09 NEPTS including Audit Wales report

Item 09 Annex 1 Audit Wales Review of NEPTS & Management Responses

9.1 10:45 - COMFORT BREAK

10 11:00 - Audit Wales Digital Transformation Review

Item 10 Feedback Report from ARAC to FPC Audit Wales Digital Transformation

Item 10 Annex 1 WAST Digital Transformation Review

Item 10 Annex 2 WAST Digital Transformation Review - mgmt responses

11 11:15 - Digital Reporting September 2026

Item 11 Digital Reporting September 2026

Item 11 Annex 1 Digital Reporting September 2026 Metrics

12 11:25 - Information Governance Report

Item 12 Information Governance Reporting September 2026

13 11:35 - Annual Estates Infrastructure report to include: Estates condition and backlog maintenance, Decarbonisation, Waste management

Item 13 Annual Estates Infrastructure Report

14 11:50 - Risk Management Report

Please note: Annex 2 for this item can be found in the Reading Room

Item 14 Risk Management Report

Item 14 Annex 3 Trending Data August 2026

15 12:00 - Audit Tracker Q1 2026/27

Item 15 Audit Tracker 26-27 Q1 (Apr-Jun26) Updates

15.1 CONSENT ITEMS

16 Audit Wales Urgent and Emergency Care review part 3
Audit Wales Urgent and Emergency Care review part 3

17 Committee Cycle of Business Monitoring Report

Item 17 Finance and Performance Committee Cycle of Business Monitoring Report 2026-27

Item 17 Annex 1 Cycle of Business 2026-27 Monitoring Report

17.1 12:10 - CLOSING ITEMS

18 Reflections

19 Any other business

20 Date and time of the next meeting: 17 November 2026

Length of Meeting:	02:45	Agenda Status: AGREED	[PUBLIC] FINANCE AND PERFORMANCE COMMITTEE - 15 September 2026					Deadline for Papers: 4 September 2026	
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**
			OPENING ITEMS						
		1	Chair's welcome, apologies and quorum	Verbal	Information	Standing	n/a	Chair	n/a
		2	Declarations of interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a
09:30	00:05	3	Minutes of the last meeting held on 21 July 2026 (Confirmation of recording/transcript deletion of previous meeting)	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action log and matters arising	Paper	Discussion	Standing	n/a	Chair	n/a
		4.1	Committee AAA report: 21 July 2026	Paper	Discussion	Standing	n/a	Chair	Trish Mills
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:35	00:15	5	Financial Performance at Month 4 - 2026/27 Financial Position for Month 5 - 2026/27	Paper Presentation	Assurance	CoB	FinCor	Chris Turley	Ed Roberts
09:50	00:10	6	Integrated Medium Term Plan (IMTP) Update	Verbal	Assurance	CoB	SPP	Rachel Marsh	James Houston
10:00	00:10	7	Manchester Arena Inquiry Progress Update: Commissioner Response and Residual Risk Position	Paper	Assurance	Forward Planner	Ops	Lee Brooks	Judith Bryce
10:10	00:15	8	Monthly Integrated Quality Performance Report (MIQPR) June July 2026	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Melanie O'Connor
10:25	00:20	9	Non Emergency Patient Transport (NEPTS) including the Audit Wales report	Paper	Assurance	adhoc	Ops	Lee Brooks	Mark Harris
10:45	00:15		COMFORT BREAK						
11:00	00:15	10	Audit Wales Digital Transformation Review	Paper	Assurance	Forward Planner	Digital	Jonny Sammut	Leanne Smith
11:15	00:10	11	Digital Reporting September 2026	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
11:25	00:10	12	Information Governance Report	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
11:35	00:15	13	Annual Estates Infrastructure report to include: - Estates condition and backlog maintenance - Decarbonisation - Waste management	Paper	Assurance	CoB	FinCor	Chris Turley	Ed Roberts
11:50	00:10	14	Risk Management Report	Paper	Assurance	CoB	Gov	Trish Mills	Julie Boalch
12:00	00:10	15	Audit Tracker Q1 2026/27	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce
			CONSENT ITEMS						
12:10	00:00	16	Audit Wales Urgent and Emergency Care review part 3	Paper	Information	CoB	Ops	Lee Brooks	Mark Harris
12:10	00:00	17	Committee Cycle of Business Monitoring Report	Paper	Information	CoB	Gov	Trish Mills	AnnaMaria Williams
			CLOSING ITEMS						
		18	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a
12:10	00:05	19	Any other business	Verbal	Discussion	Standing	n/a	Chair	n/a
		20	Date and time of the next meeting: 17 November 2026	Verbal	Information	Standing	n/a	Chair	n/a
12:15	**02:45**		**CLOSE**						

LEAD PRESENTERS

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

Welsh Ambulance Services University NHS Trust
Board Member Register of Interests (Updated 04/08/2026]

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
AHMAD, Umar Afthab DR	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	GP Partner at Plains View Surgery, Nottingham	Financial Interest	2014	
		Primary Care Network Clinical Director for Arrow Health, Nottingham	Financial Interest	2019	
		Non-executive Director (appointed company director) for Primary Integrated Community Services Ltd, Nottingham and small shareholder [Company number 08763136]	Financial Interest	2023 and 2016	
		Owner and company director of Travel Jab Guru Ltd – online medical travel advice [Company number 14685908]	Financial Interest	2023	
		Local Medical Committee Member	Financial Interest	2019	
		Nottingham Integrated Care Board Cardiovascular Disease and Stroke Prevention Clinical Design Authority Lead	Financial Interest	2025	
		Associate Non-executive Director Nottinghamshire University Hospital Trust (non-voting member of the board)	Financial Interest	2024	
BEESLEE, Jayne	**Non-Executive Director** * Chair of Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment fro interim assignments via Public Sector Resourcing (an agency) regarding the rev iew of major UK Government programmes (remunerated nex of tax via an umberella company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023	
		Governor on the Finance and General Purposes Committee of Cardiff and Cale Further Education College	Non-Financial Personal	01 February 2024	
		Fellow Chartered Institute of Persennel and Development	Non-Financial Personal	01 April 2006	
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019	
		Member of the Order of St John	Any Other Interest	01 March 2023	
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021	
		Trustee of Action for Children Pension Board	Position in Charity or Voluntary Organisation	22 May 2023	
		Company Director - Action for Children [04764232]	Directorships	01 February 2021	
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022	
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021	
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Non-Financial Professional	01 March 2024	
		Independent Member - Kaplan Open Learning (including member of the Audit & Risk Committee)	Directorships	21 March 2024	
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Group Chair of South Central Ambulance Service NHS Foundation Trust and South East Coast Ambulance Service NHS Foundation Trust	Directorships	27 March 2026	
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024	
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024	
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024	
DURRANT, Penny	**Deputy Director of Nursing, Quality and Governance**	Nil Declaration		30 May 2026	
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019	
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019	
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020	
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019	
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022	

Welsh Ambulance Services University NHS Trust
Board Member Register of Interests (Updated 04/08/2026]

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
EVANS, Bethan [continued]	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020	
		Companty 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	
		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	
		Longhope Property Ltd	Directorships	12 February 2026	
		My Choice Healthcare England Ltd	Directorships	26 August 2025	
		My Choice Healthcare Ltd	Directorships	26 August 2025	
		Glyncornel Care Ltd	Directorships	16 August 2022	
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024	
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025	
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025	
		Consultant Advisor to the FASAR Trial, Nottingham Trent University	Financial Interest	25 March 2026	
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * 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	

Welsh Ambulance Services University NHS Trust
Board Member Register of Interests (Updated 04/08/2026]

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020	
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020	
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018	
LEWIS, Angela	**Director of Culture Change**	Chartered Fellow of the CIPD		2005	
MARSH, Rachel	**Deputy Chief Executive/Executive Director of Strategy, Planning and Performance**	Nil Declaration			
MILLS, Patricia (Trish)	**Director of Corporate Governance / Board Secretary**	Nil Declaration			
PARRY, Hugh	**Trade Union Partner**	Nil Declaration			
ROBERTS, Edward	**Deputy Director of Finance (from 09 September 2025)**	Nil Declaration			
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022	
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021	
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [from 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024	
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025	
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 2026
		CHIME (College of Healthcare Information Management Executives) Digital Health Fellowship - UK Cohort 2026	Non-Financial Professional	07 May 2026	
		Author of the book: '*Working With AI, Not Against It*' ~ commerically published and generates royalty income from sales.	Financial Interest	24 February 2026	
		Family member appointed to a post within Digital Directorate but will not be line managed by Director [appointment accepted 24/07/2026]	Any Other Interest	24 July 2026	
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020	
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Nil Declaration			
TURNER, Damon	**Trade Union Partner**	Nil Declaration			
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019	
		Member Royal College Nursing	Any Other Interest	01 August 2022	
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022	
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025	
WOOD, Emma	**Chief Executive (from 01 October 2025)**	Chartered Fellow of CIPD (Chartered Institute of Personnel and Development)	Non-Financial Professional	2000	
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025	
		Part-time Yoga Teacher at Burnham Swim and Sports Academy Leisure Centre	Financial Interest	July 2025	
		Sub/Relief Yoga Teacher at Omni Studio, Worle, North Somerset	Financial Interest	04 April 2026	

MINUTES OF THE MEETING OF THE PUBLIC FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 JULY 2026 IN THE CARDIFF MRD AND VIA TEAMS

The meeting started at 09:30

ATTENDEES:

Jayne Beeslee	Non-Executive Director and Chair
Peter Curran	Non-Executive Director *(to 10.25 at the end of item 7)*
Colin Dennis	Non-Executive Director
Penny Durrant	Interim Director of Nursing
Bethan Evans	Non-Executive Director
Trish Mills	Director of Corporate Governance/Board Secretary
Hugh Parry	Trade Union Partner *(not present between 11.13 and 12.05 for items 10 to 14)*
Chris Turley	Executive Director of Finance and Corporate Resources

APOLOGIES:

Lee Brooks	Executive Director of Operations
Matthew Dugdale	Assistant Director of Commercial Development
Rachel Marsh	Deputy Chief Executive
Liz Rogers	Deputy Director of People and Culture
Jonny Sammut	Director of Digital

OPENING ITEMS

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

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

2. DECLARATIONS OF INTEREST

2.1 There were no other declarations recorded.

3. MINUTES OF PREVIOUS MEETING 19 MAY 2026

3.1 The minutes of the public meeting of the Finance and Performance Committee held on 19 May 2026 were received and approved subject to one minor amendment.

4. ACTION LOG AND MATTERS ARISING

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

4.1 AAA HIGHLIGHT REPORT 19 MAY 2026

4.1.2 The AAA Highlight Report from the meeting held on 19 May 2026 was noted.

ITEMS FOR ASSURANCE, DISCUSSION OR APPROVAL

5. QUARTERLY OPERATIONS REPORT Q1 2026/27

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

5.1 The committee received an update through the Operations Quarterly report on the Trust's response to recent extreme heat events, including a period of unprecedented demand that resulted in the declaration of a critical incident. Demand significantly exceeded forecasts, particularly for life-threatening calls and falls among older people, placing considerable pressure on services. Assurance was provided that operational teams responded effectively under challenging circumstances, supported by strong organisational coordination and staff wellbeing measures. Early learning from the subsequent debrief is informing future planning, including improved demand forecasting, a better understanding of the impact of extreme heat on clinical demand, and strengthening organisational preparedness for what are expected to become more frequent climate-related events.

5.2 Following members' discussion of the report, an action was taken for more information to be provided at the next meeting on:

- Long-term funding arrangements for the Falls Desk
- When the Trust is expected to receive a decision or outcome on the HART uplift business case submission
- The meaning of 'high level costs' on page 9 of the report, clarification of the assumptions underpinning the cost estimates and an indication of the likely future funding ask to commissioning bodies

5.3 Members asked for information on the difference between the Enhanced Community First Responder (ECFR) role and the Community First Responder (CFR) role to be provided at the Trust Board meeting on 30 July 2026. Members also requested that TOIL is referenced in all subsequent Operations reports so that the committee is aware of any updates on this.

5.4 Members asked about confidence in delivery of the Welsh Language Clinical Consultation Plan. They were assured that the plan has been developed with substantial oversight and thoroughly developed and scrutinised before implementation.

5.5 Members discussed the great work that has taken place on volunteering, how to keep up momentum on this and whether to consider using volunteer surveys to help better understand what is working well and where further improvements may be needed. Assurance was provided that volunteering remains a key organisational priority and that volunteering strategy now has strengthened governance, resourcing and organisational focus. Regular engagement events and established volunteer representative forums ensure that volunteer feedback is heard and that the volunteer voice remains central to future developments.

6. FINANCIAL REPORT MONTH 2, 2025/26 FINANCIAL POSITION FOR MONTH 3, 2026/27

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

6.1 Jason Collins, Head of Financial Management, attended this meeting and presented the financial report for month 2 2026/27 and the presentation of the financial position at month 3 2026/27. Members were assured that the Trust remains on a break-even trajectory and is performing well against its savings programme. Key assumptions within the forecast for the year included the updated treatment of additional Welsh Risk Pool (WRP) costs being covered by Welsh Government, the need to continue to monitor and manage the volatility in fuel prices, and successful delivery of the required savings programme.

6.2 Assurance was provided that the Trust does not rely on non-recurrent savings to balance its position, has no underlying deficit and has consistently delivered balanced financial positions without any financial support, for more than 10 years.. Members heard that the approach to savings delivery has further evolved this year, including the application of recurrent budget reductions and a stronger focus on sustainable savings that support future financial resilience. Members noted the month 2 revenue financial position and were assured by the performance of the Trust as at 31 May 2026.

6.3 Members discussed the potential impact of changes to the Welsh Risk Pool position. While the financial plan had assumed the Trust would have to

absorb these costs, Welsh Government has indicated that some elements may be funded directly, which could reduce the in-year savings requirement. Notwithstanding this, the Trust remains focused on delivering the full recurrent savings target to strengthen its position for future years.

6.4 Looking ahead, members noted the significant financial challenges anticipated in 2027/28, including the prospect of a potential flat cash settlement and the potential for further savings requirements through commissioning arrangements. It was recognised that future financial sustainability is likely to require more transformational approaches and difficult choices, with early planning already underway to prepare for an increasingly constrained financial landscape.

6.5 Key financial risks for the year continue to include fuel costs, operational demand pressures and wider NHS Wales financial challenges. Members were assured that the Trust has strong financial grip and control arrangements in place and that budget holders remain accountable for delivering agreed savings.

6.6 The committee noted the delivery of the 2026/27 savings plan, and the context of this within the overall financial position of the Trust, the initial capital programme for 2026/27, and the month 2 Welsh Government (WG) monitoring return submission (as required by WG).

7. FINANCIAL SUSTAINABILITY REPORT

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

7.1 The committee received the report and were assured on the financial sustainability programme, welcoming the increased clarity around its strengthened governance arrangements, workstreams and reporting structure.

7.2 Discussions highlighted that the programme is evolving into a structured portfolio of work encompassing targeted cost reduction, productivity, commercial development and future financial planning, with a strong focus on securing recurrent savings and longer-term financial resilience.

7.3 Members heard that there is ongoing consideration of the NHS Wales Grip and Control framework and were advised that a task and finish group is reviewing travel, subsistence and accommodation expenditure to identify further opportunities for control and recurrent savings.

7.4 Members noted the month 2 savings position, with £1.423m achieved against a planned £1.342m. They recognised that assurance on full-year recurrent savings delivery remains partial, due to £1.2m of the recurrent savings requirement having not yet been identified and currently assumed not to be delivered in the year-end forecast. It was noted that this needs to be considered with the Trust's continued reporting of a forecast balanced year-end overall financial position for 2026/27, due to the removal of some cost pressures, most notably relating to the WRP as above, that were assumed in the opening financial plan for the year.

7.5 Members sought clarification on the governance and reporting arrangements for the Financial Sustainability Group and an action was taken for the next report to committee to include a schematic setting out workstreams, oversight groups and reporting lines to support committee understanding. Members were assured that robust governance arrangements are in place for the financial sustainability programme through the Strategic Transformation Board, including oversight of programme reporting, detailed scrutiny and assurance.

7.6 Chris Turley advised that he is interim Senior Responsible Officer for the financial sustainability programme, following the departure of the Chief People Officer; this role will transfer to the new postholder once appointed. Members were also advised that interviews for the programme director role will take place within the next few weeks.

8. INTEGRATED MEDIUM-TERM PLAN (IMTP) PROGRESS REPORT

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

8.1 The committee received the IMTP report, welcoming the new reporting approach structured around the Trust's strategic objectives and the emerging governance arrangements. It was noted that the report provides greater clarity, intelligence and strategic focus, while strengthening committee oversight and grip on delivery. The report provides a consolidated view which the board will receive, and a focus for the committees on objectives within their remit, enabling them to seek out deep dives where deliverability confidence is low or outcomes not being realised, and to report and escalate to the board via their AAA report. The new reporting framework was recognised as a significant step forward in supporting assurance and enabling future integration with performance and risk reporting.

8.2 Members noted the strong Q1 position and progress made, with the majority of deliverables reported as on track, while recognising that organisational

capacity constraints will require careful prioritisation to maintain delivery momentum. Members sought clarification on the interpretation of the confidence ratings within the report, specifically whether they related to individual deliverables, priority areas or the overall strategic objective. Additionally, it was agreed that future reports will include definitions for RAG ratings and delivery confidence levels, so that committee members can interpret these consistently.

8.3 Members discussed several deliverables reported as an Amber (Monitor) status with lower delivery confidence, particularly the concerns management improvement programme and whether it would deliver the required improvements and move the organisation to a more sustainable position. Challenges highlighted included the volume and increasing complexity of concerns being received. Assurance was provided that governance arrangements are being streamlined and priorities refocused, to demonstrate organisational grip and control, and deliver tangible improvements in a more manageable and coordinated way. Further scrutiny on this will be undertaken through the QuEST Committee.

8.4 Members highlighted the Advanced Paramedic Practitioner (APP) productivity improvement deliverable as an area requiring ongoing scrutiny and suggested the committee maintains oversight of this area as implementation progresses.

8.5 Members were advised that, in light of organisational capacity pressures and the need to maintain focus on current performance, productivity and transformation priorities, formal engagement on the strategy refresh is now expected to commence in 2027. Assurance was provided that this will not have a material impact, as the current strategy remains in place until 2030, with preparatory stakeholder engagement continuing in the interim.

9. MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR) MAY/JUNE 2026

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

9.1 The committee received and considered the first iteration of the revised MIQPR reporting framework, for May/June 2026, welcoming the move towards a more streamlined, committee-focused approach aligned to the agreed board performance framework.

9.2 Members acknowledged that the revised format provides improved visibility and grip of performance issues, while recognising that further refinement is

planned, including the introduction of additional Statistical Process Control (SPC) charts to support trend analysis and assurance, and enhanced trajectory reporting to support more effective scrutiny and interpretation of performance trends.

9.3 Members' discussion focused on continued challenges in emergency response performance, including:

- Cardiac arrest and Return of Spontaneous Circulation (ROSC)
- Consultant close rates, with work underway to understand the reasons for the recent reduction in rates compared to improved performance over the prior 18 months
- 111 call abandonment, with improvement actions underway including rostering changes and improvements to the Clinical Advice Line processes
- Non-emergency patient transport performance (NEPTS), with improvement work continuing to address performance concerns.

9.4 Members noted the additional metrics included in the report and the ongoing work that will continue to refine these for the committee. It was agreed that the wording used in the report will be reviewed, specifically where the wording 'not capable' does not accurately reflect the position and could be misinterpreted.

10. INTERNAL AUDIT REPORT: FIRE SAFETY

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

10.1 The committee received the reasonable assurance report on fire safety arrangements, which also emphasised the need to maintain focus on this area, given the inherent risks.

10.2 Members reviewed the report, noting the agreed management actions and mitigations of risk as well as the discussion and feedback from Audit and Risk Committee (ARAC). Members were advised that they will have an opportunity to scrutinise the impact and monitor the closure of these in response to audit recommendations via tracker reports and future assurance reporting on this issue.

10.3 The unique fire safety challenges associated with the Trust's diverse estate were acknowledged, with 130 sites held across the country. Strengthened governance reporting and board-level oversight was noted as contributing to the positive progress in fire safety observed. Members supported exploring

more integrated reporting across estates and infrastructure matters to strengthen oversight and assurance.

11. INTERNAL AUDIT REPORT: VEHICLE (AMBULANCE) REPLACEMENT PROGRAMME

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

11.1 The committee welcomed the report on this core area of the Trust's work and the reasonable assurance rating given. It was noted that the audit provided confidence in the effectiveness of arrangements for planning, funding and delivering the programme, despite the increased scale resulting from increased investment received in recent years.

11.2 Members reviewed the report, noted the limited improvement actions identified and mitigations of risk. The positive findings regarding the integration of decarbonisation and wider strategic priorities were welcomed, noting particularly that the findings demonstrated a strong strategic approach and evidenced that decarbonisation considerations are embedded throughout fleet and capital planning activity.

11.3 Members noted the discussion and feedback on the report from ARAC, and that there will be opportunity to scrutinise the impact and monitor the closure of the actions in response to audit recommendations via tracker reports and future assurance reporting on this issue.

11.4 Members were assured that governance arrangements were working effectively, the increased capital investment was being managed appropriately, and the vehicle replacement programme was operating well, despite significant growth in activity.

12. INTERNAL AUDIT REPORTS

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

12.1 DIGITAL BUSINESS CONTINUITY

12.1.1 The committee received this reasonable assurance report, acknowledging that the Trust has effective arrangements in place to respond to major digital disruption and an established framework comprising business continuity policies, ICT continuity arrangements, departmental plans, impact assessments and tested incident response processes.

12.1.2 Members discussed two themes emerging from the report; the need to strengthen the integration and accessibility of existing business continuity documentation through a centralised resource and the need to further formalise the testing, tracking and learning processes associated with continuity plans. Members were advised that the Continuity2 platform has already been procured and is being implemented to support these improvements, with the audit recommendations being incorporated into the implementation programme.

12.1.3 Members noted that opportunities to further strengthen resilience through enhanced oversight, testing and organisational learning, are consistently embedded within future arrangements, and took assurance from the actions already underway to address the audit recommendations and improve continuity management.

12.2 DATA MANAGEMENT PRACTICES / DEVOLVED DATA

12.2.1 The committee received and reviewed the reasonable assurance report on arrangements for managing devolved data activity that takes place outside the digital team, noting the agreed management actions and mitigations of risk in place.

12.2.2 The audit examined whether reporting arrangements were sufficiently standardised across the organisation. Members heard that work was underway to establish a Community of Practice model across the Trust, with the aim of improving consistency, governance, collaboration and professional standards across analytical and reporting functions.

12.2.3 Members noted the importance of strengthening data governance as analytical capability continues to grow across the Trust and took assurance from progress to establish a data and analytics community of practice to improve consistency, oversight and reporting standards.

12.2.4 The committee noted the discussion and feedback from ARAC and that there will be opportunity to scrutinise the impact and monitor the closure of these actions in response to audit recommendations via tracker reports and future assurance reporting on this issue.

12.3 EMERGING TECHNOLOGY ADOPTION

12.3.1 The committee received this reasonable assurance report and took assurance from progress in strengthening AI and automation governance arrangements, including the establishment of enhanced oversight, approval processes and supporting policies.

12.3.2 Members noted that the audit recommendations on the report were focused on formalising governance arrangements as adoption of emerging technologies (such as AI) increases, rather than addressing any significant weaknesses in current controls.

12.3.3 Members discussed the need to ensure that controls, governance and oversight arrangements scale alongside technology adoption and sought assurance that sufficient capacity exists within digital services to implement the recommendations arising from the audit. Members were assured that many of the audit actions will be supported by the new Digital Oversight Group, which will provide robust governance structures and visibility over digital initiatives. The Trust will also continue to consider whether automation capability can be delivered internally or whether external support may be required where capacity is insufficient.

12.3.4 Members requested clarification on how the Trust intends to demonstrate and evidence the benefits realised from AI and automation initiatives as adoption increases across the organisation. Members were assured that the AI Steering Group is actively addressing complex issues in developing approval processes and ethical and responsible AI arrangements, as well as ensuring that AI adoption is supported by broad organisational involvement.

13. DIGITAL REPORTING JULY 2026

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

13.1 The committee received the Digital report for July 2026 and acknowledged the contents, which provided assurance on the progress of Digital Plan activities, IMTP commitments and Clinical Model Transformation (CMT) involvement of the Digital Directorate teams.

13.2 Members noted the progress in strengthening digital governance arrangements through the Digital Oversight Group and the development of a clinical digital safety work programme.

13.3 Members were assured that digital capacity and prioritisation are being actively managed in response to significant demand pressures, particularly

within data and analytics. The need to clearly articulate the impact of dependencies on national digital and data-sharing programmes, where these may affect delivery of local priorities and benefits realisation, was highlighted.

13.4 Members discussed recent staff resignations, some in highly specialised roles, which could create significant operational challenges. While acknowledging that capacity and specialist skills remain a live issue, members were assured that recruitment processes to fill these positions were underway and accelerated where possible.

13.5 Members sought clarification regarding the development of the Single Directory of Services on a Once for Wales basis, asking whether wider system arrangements, including the role of national digital bodies, were impacting progress. Members were advised that the Trust had been engaged in the development stages for this and that Digital Healthcare Wales (DHCW) would play an important role in delivery. The main area requiring further clarity was the long-term operating model, including future governance, ownership and service management arrangements once implementation is complete.

14. INFORMATION GOVERNANCE REPORT

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

14.1 The committee received the report and were assured on the Trust's information governance arrangements, noting continued progress in addressing records management pressures, reducing data protection impact assessment (DPIA) backlogs and strengthening management of information governance risks.

14.2 Members discussed a recent third-party data breach and were assured that appropriate investigation, mitigation and supplier assurance activities were underway, with broader work continuing to strengthen oversight of cyber, data protection and supplier-related risks across the Trust. Digital and Fleet teams were undertaking further assurance work through DPIA and other impact assessments to better understand data flows and associated risks. Members heard that consideration is also being given to the longer-term future of the system, including potential upgrade or re-procurement options.

14.3 Members sought clarity on how the Trust is assured that suppliers maintain appropriate cyber security standards and were advised that supplier cyber assurance has become a key focus for the Cyber Team and forms part of a wider programme of assurance activity. There is an ongoing review of digital systems against clinical safety standards, with DPIA and impact assessment

activity helping to strengthen understanding of data flows, system risks and third-party assurance arrangements.

14.4 The committee were assured on the progress of the Trust's information governance arrangements and related specialist activities for data quality, records management, freedom of information requests and information security.

15. INTERNAL AUDIT REPORT: HIGH RISK RECORDS POLICY

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

15.1 The committee received and reviewed this reasonable assurance report, which acknowledged an established framework and controls for managing high-risk records, with the key challenge being consistent implementation and maintenance.

15.2 Members noted that the process is currently managed by a small central team and is heavily reliant on manual administration, contributing to review backlogs and compliance pressures. Members discussed progress to modernise the process through a new digital application, which is expected to improve resilience, oversight and the timely management of high-risk records.

15.3 Members noted the agreed management actions and mitigations of risk, noting that the audit findings primarily reflected capacity and compliance challenges rather than weaknesses in the underlying policy framework.

15.4 The committee noted the discussion and feedback from ARAC and that there will be opportunity to scrutinise the impact and monitor the closure of these actions in response to audit recommendations via tracker reports and future assurance reporting on this issue.

16. RISK MANAGEMENT REPORT

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

16.1 The committee received the Risk Management and Board Assurance Framework report and considered the controls in place against the risks, as well as the actions described to further mitigate the risks.

16.2 Members were assured that all risks had undergone quarterly review and been previously considered by ARAC, with no changes in scores. The activity undertaken during this period was due to be considered by the Executive Leadership Team on 12 August 2026.

16.3 Ongoing work to refine the corporate risk profile was noted, including a foreshadowed reduction to the score for Risk 690 *(SAR and Disclosure of Records Compliance)* and the reframing of 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)* into two separate risks, to improve clarity

16.4 Regarding Risk 542 *(Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan),* members noted that whilst further work to reframe the risk remains outstanding, assurance continues to be received through capital planning, infrastructure programmes and related internal audit activity, where decarbonisation considerations are routinely embedded in decision-making and programme delivery. It was also confirmed that the risk had been discussed at Executive Leadership Team (ELT) on 27 May 2026 and continues to be monitored through usual governance processes.

16.5 On this basis, members agreed that consideration of the proposed reframing of Risk 542 could be deferred until later in the financial year, without compromising oversight or assurance. Members were assured that the risk remains a priority and the delay is due to the operational consequences of reduced resources, capacity constraints and competing priorities.

16.6 Members noted a broader review of how risks are scored relative to one another across the Corporate Risk Register has also been discussed at ELT, which is expected to be progressed later in the year as part of ongoing risk management development.

CONSENT ITEMS

There were no consent items

CLOSING ITEMS

17. REFLECTIONS

17.1 Members noted that receiving six internal audit reports within a single meeting was unusual, however this emphasised the value of the reports in supporting risk triangulation and assurance.

17.2 The committee's continuing transition towards more strategic oversight was reflected upon, noting that emerging digital, data and technology governance structures would provide opportunities to review and streamline the flow of digital and information governance assurance, ensuring that committee reporting remains focused on key strategic risks and metrics.

18. ANY OTHER BUSINESS

18.1 There was no other business.

19. DATE AND TIME OF THE NEXT MEETING

19.1 The next meeting will be held on 15 September 2026 at 9:30am

The meeting closed at 12.22

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

Action Number	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
TB Action 9.7 - 28/05	28 May 2026	**Monthly Integrated Quality and Performance Report**	**ACTION FROM TRUST BOARD TO FINANCE AND PERFORMANCE COMMITTEE** Patient feedback outcomes form Albot interaction wil be reported going forward to Finance and Performance Committee; this item to be added to the forward planner for the next meeting.	Jonny Sammut/Trish Mills	15 September 2026	Update for FPC 150926: This was omitted from the commissioning of this paper and will be added to the commissioning for the November meeting	Open
5/1/210726	21 July 2026	**Operations Quarterly Report Q1 2026/27**	Following members' discussion of the Operations report, an action was taken for more information to be provided at the next meeting on: • Long-term funding arrangements for the Falls Desk • When the Trust is expected to receive a decision or outcome on the HART uplift business case submission • The meaning of 'high level costs' on page 9 of the report, clarification of the assumptions underpinning the cost estimates and an indication of the likely future funding ask to commissioning bodies Members also requested that TOIL is referenced in all subsequent Operations reports so that the committee is aware of any updates on this.	Lee Brooks	17 November 2026	To be updated in the next Operations report to the committee, which will be at the November meeting. Action sent to LB 27 July 2026. **Action proposed for closure as added to forward planner for November meeting**	Complete
5/2/210726	21 July 2026	**Operations Quarterly Report Q1 2026/27**	An action was taken for more information to be provided at the July Trust Board meeting on the difference in the role of the Enhanced Community First Responders as compared to the standard Community First Responders.	Lee Brooks	30 July 2026	Action sent to LB 27 July 2026. AW **Action proposed for closure as added to forward planner for November meeting**	Complete
7/210726	21 July 2026	**Financial Sustainability Report**	An action was taken for the next report to include a schematic setting out workstreams, oversight groups and reporting lines to support committee understanding.	Chris Turley	17 November 2026	This has been added to the forward planner and closure is proposed	Complete
8/210726	21 July 2026	**Integrated Medium Term Plan (IMTP) Progress Report**	It was agreed that future reports will include definitions for RAG ratings and delivery confidence levels, so that committee members can interpret these consistently.	James Houston	17 November 2026	**Update from ASM 27 July 2026** The next progress report will be in November 2026 and the changes to be reflected in that report. **Action proposed for closure as added to forward planner for November meeting**	Complete
9/210726	21 July 2026	**Monthly Integrated Quality Performance Report (MIQPR) May/June 2026**	It was agreed that the wording used in the report will be reviewed, specifically where the wording 'not capable' does not accurately reflect the position and could be misinterpreted.	James Houston	15 September 2026	Amendments made to the report	Complete
12/210726	21 July 2026	**Internal Audit Reports**	An action was taken to provide SBAR cover sheets for all future internal audit reports, regardless of whether feedback has been provided by ARAC, to provide clarity on what is being asked of the committee.	Trish Mills	15 September 2026	**Update 24 July 2026** Corporate Governance team will ensure this is in place for future reporting.	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	30 July 2026
Committee Meeting Date	21 July 2026
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No alerts arose from this meeting for the board.

ADVISE

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

2. The committee received an update through the **Operations Quarterly report** on the Trust's response to recent extreme heat events, including a period of unprecedented demand that resulted in the declaration of a critical incident. Demand significantly exceeded forecasts, particularly for life-threatening calls and falls among older people, placing considerable pressure on services. Assurance was provided that operational teams responded effectively under challenging circumstances, supported by strong organisational coordination and staff wellbeing measures. Early learning from the subsequent debrief is informing future planning, including improved demand forecasting, a better understanding of the impact of extreme heat on clinical demand, and strengthening organisational preparedness for what are expected to become more frequent climate-related events.

3. **Members reflected** positively on the committee's continued development towards a more strategic and assurance-focused role, recognising the value of Internal Audit in strengthening assurance through alignment of risks, controls and mitigations. The committee also welcomed the new IMTP reporting approach and emerging governance arrangements, noting their potential to support more streamlined, strategically focused reporting and oversight.

ASSURE

(Detail here assurance items the Committee receives)

The following items will also be presented to board at their next meeting however members may benefit

from the following points of discussion from the committee:

Financial Position and Financial Sustainability

4. Financial performance **month 2 and month 3 2026/27** was reviewed and that detail will be in the board meeting on 30 July. Of note from the committee:
   - The committee received assurance that the Trust remains on a break-even trajectory and is performing well against its savings programme. Assurance was provided that the Trust does not rely on non-recurrent savings to balance its position and has no underlying deficit. Members heard that the approach to savings delivery has evolved this year, including the application of recurrent budget reductions and a stronger focus on sustainable savings that support future financial resilience.
   - The committee also discussed the potential impact of changes to the Welsh Risk Pool position. While the financial plan had assumed the Trust would absorb these costs, Welsh Government has indicated that some elements may be funded directly, which could reduce the in-year savings requirement. Notwithstanding this, the organisation remains focused on delivering the full recurrent savings target to strengthen its position for future years.
   - Looking ahead, members noted the significant financial challenges anticipated in 2027/28, including the prospect of a flat cash settlement and the potential for further savings requirements through commissioning arrangements. It was recognised that future financial sustainability is likely to require more transformational approaches and difficult choices, with early planning already underway to prepare for an increasingly constrained financial landscape.

5. Members received assurance on the **financial sustainability programme** and welcomed the increased clarity around its governance arrangements, workstreams and reporting structure. Discussion highlighted that the programme is evolving into a structured portfolio of work encompassing targeted cost reduction, productivity, commercial development and future financial planning, with a strong focus on securing recurrent savings and longer-term financial resilience.

Integrated Medium Term Plan 2026/27 Delivery Assurance

6. The committee warmly welcomed the revised IMTP reporting approach, noting that it provides greater clarity, intelligence and strategic focus, while strengthening committee oversight and grip on delivery. The new reporting framework, aligned to strategic objectives, was recognised as a significant step forward in supporting assurance and enabling future integration with performance and risk reporting. Members also noted the strong quarter one position, with the majority of deliverables reported as on track, while recognising that organisational capacity constraints will require careful prioritisation to maintain delivery momentum.

7. Discussion focused on several deliverables reported as an Amber (Monitor) status with lower delivery confidence, particularly the concerns management improvement programme. Assurance was provided that governance arrangements are being streamlined and priorities refocused, with further scrutiny to be undertaken through QUEST.

8. In light of organisational capacity pressures and the need to maintain focus on current performance,

productivity and transformation priorities, formal engagement on the strategy refresh is now expected to commence in 2027. Assurance was provided that this will not have a material impact, as the current strategy remains in place until 2030, with preparatory stakeholder engagement continuing in the interim.

MIQPR Performance Metrics

9. The committee received the first iteration of the revised MIQPR reporting framework and welcomed the move towards a more streamlined, committee-focused approach aligned to the agreed board performance framework. Members acknowledged that the revised format provides improved visibility and grip of performance issues, while recognising that further refinement is planned, including the introduction of additional SPC charts and enhanced trajectory reporting to support more effective scrutiny and interpretation of performance trends.

10. Discussion focused on continued challenges in emergency response performance, consultant close rates, 111 call abandonment and non-emergency patient transport performance. Members noted the actions underway to address these areas, including improvements to rostering, clinical capacity and service transformation initiatives.

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

11. A number of internal audit reports were received, the details of which are in the agenda section below. Most of these reports had been reviewed by the Audit, Risk and Assurance Committee at their June meeting and their feedback was included. Of note:

    - *Fire Safety Internal Audit*: The committee received reasonable assurance on fire safety arrangements, whilst emphasising the need to maintain focus given the inherent risks. Members also supported exploring more integrated reporting across estates and infrastructure matters to strengthen oversight and assurance.

    - *Vehicle Procurement and Replacement Programme Internal Audit*: The committee welcomed the reasonable assurance rating, noting that the audit provided confidence in the effectiveness of arrangements for planning, funding and delivering the programme despite increased investment. Members noted the limited improvement actions identified and welcomed the positive findings regarding the integration of decarbonisation and wider strategic priorities.

    - *Digital Business Continuity Internal Audit***:** The committee received reasonable assurance that the Trust has effective arrangements in place to respond to major digital disruption. Members noted opportunities to further strengthen resilience through enhanced oversight, testing and organisational learning, and took assurance from the actions already underway to address the audit recommendations and improve continuity management.

    - *Data Management for Devolved Data Activity Internal Audit:* The committee received reasonable assurance on arrangements for managing devolved data activity. Members noted the importance of strengthening data governance as analytical capability continues to grow across the Trust and took assurance from progress to establish a data and analytics community of practice to improve

consistency, oversight and reporting standards.

- *Emerging Technology Governance:* The committee took assurance from progress to strengthen AI and automation governance arrangements, including the establishment of enhanced oversight, approval processes and supporting policies. Members noted that the audit recommendations on this reasonable assurance report were focused on formalising governance arrangements as adoption of emerging technologies (such as AI) increases, rather than addressing any significant weaknesses in current controls.

- *High Risk Records Management:* Members welcomed this reasonable assurance report and progress to modernise the process through a new digital application, which is expected to improve resilience, oversight and the timely management of high-risk records. The committee noted that the audit findings primarily reflected capacity and compliance challenges rather than weaknesses in the underlying policy framework.

12. The **Digital Report** highlighted progress in strengthening digital governance arrangements through the Digital Oversight Group and the development of a clinical digital safety work programme. Members were assured that digital capacity and prioritisation are being actively managed in response to significant demand pressures, particularly within data and analytics. The need to clearly articulate the impact of dependencies on national digital and data-sharing programmes where these may affect delivery of local priorities and benefits realisation was highlighted.

13. Members received assurance on the Trust's **Information Governance** arrangements, noting continued progress in addressing records management pressures, reducing DPIA backlogs and strengthening management of information governance risks. Members discussed a recent third-party data breach and were assured that appropriate investigation, mitigation and supplier assurance activities were underway, with broader work continuing to strengthen oversight of cyber, data protection and supplier-related risks across the Trust.

14. In **private session** members endorsed the business case and contract award for the Rhyl Ambulance Station, details of which were taken in private session due to commercial sensitivity. Members also received an update on progress on the Manchester Arena Inquiry recommendations and agreed that future updates will be taken in public session.

RISKS

The Risk and Board Assurance Framework report was noted. Members were assured that all risks had undergone quarterly review, with no changes in scores. The activity undertaken during this period is due to be considered by the Executive Leadership Team on 12 August 2026.

Ongoing work to refine the corporate risk profile was noted, including a foreshadowed reduction to the score for Risk 690 (SAR and Disclosure of Records Compliance) and the reframing of Risk 100 (Commissioning) into two separate risks.

Risk 542 Decarbonisation

Members noted that, whilst further work to reframe the risk remains outstanding, assurance continues to

be received through capital planning, infrastructure programmes and related internal audit activity, where decarbonisation considerations are routinely embedded in decision-making and programme delivery. On this basis, members agreed that consideration of the proposed reframing of the risk could be deferred until later in the financial year without compromising oversight or assurance.

COMMITTEE AGENDA FOR MEETING		
Operations Q1 2026/27 report	Financial position M2 and M3 2026/27	Financial sustainability
IMTP progress report	MIQPR May/June 2026	Fire safety internal audit report
Vehicle (ambulance) replacement programme internal audit	Digital business continuity internal audit	Data management practices/devolved data internal audit
Emerging technology adoption internal audit	Digital reporting July 2026	Information governance report
High risk records policy internal audit	Risk management report	

COMMITTEE ATTENDANCE						
Name	**19 May 2026**	**21 Jul 2026**	**15 Sep 2026**	**17 Nov 2026**	**19 Jan 2027**	**16 Mar 2027**
Jayne Beeslee (Chair)						
Bethan Evans						
Peter Curran		Until item 8[1]				
Chris Turley		[2]				
Rachel Marsh		James Houston				
Lee Brooks		Mark Harris				
Liam Williams						
Director of People		Liz Rogers				
Jonny Sammut		Leanne Smith				
Trish Mills	Julie Boalch					
Hugh Parry	Until 12:40					
Damon Turner						
Matt Dugdale						
Penny Durrant						

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Colin Dennis and Emma Wood were in attendance for this meeting also
[2] Jason Collins was also present

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

Agenda Item No.	5

REPORT TITLE

Financial Performance as at Month 4 – 2026/27

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This paper presents to the Committee the latest Financial Performance Report of the 2026/27 financial year, the reported position as at Month 4 (July 2026). An update on the Month 5 position will also be provided to the Committee by way of a presentation on the day.

2. The Committee is asked to review, comment, note and receive assurance on the financial position and 2026/27 outlook and forecast of the Trust, noting the risks to in year delivery in doing so.

3. Key highlights from the report for the Committee to note are:
   - The Trust is reporting a breakeven position for month 4 2026/27, but the assumptions made in doing so need to be noted;
   - Capital expenditure plans are being finalised with plans to fully achieve in year;
   - In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust continues to forecast a breakeven position by the 2026/27 financial year end;
   - In line with the financial plans that support the IMTP, gross savings of £2.979m have been achieved in month 4 against a target of £2.699m;
   - Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.0% for the number, whilst slightly off track in terms of value at 91.6% of non-NHS invoices paid within 30 days.
4. The Committee is also asked to note the work undertaken across multiple directorates on the Welsh Government requested Financial Grip and Control exercise.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

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

ADDITIONAL PAPER(S)

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

The Committee is requested to receive the following:

Annex 1 Monitoring return submitted to Welsh Government for month 4 – as required by WG *****
Annex 2 Monitoring return letter submitted to Welsh Government for month 4 as required by WG *****
Annex 3 Grip and Control document
*****Both papers available to view in the Reading Room

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

SITUATION

1. This report provides the Committee with a summary of the revenue financial performance of the Trust as at 31 July 2026 (Month 4 2026/27), along with a brief update on the 2026/27 capital programme.

2. The report also provides a final update and the brief output following the review of the Trust's Financial Grip and Control measures, as requested by Welsh Government (WG) and NHS Wales Performance & Improvement (NHS P&I) .

BACKGROUND

3. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2025/26** (1 April 2026 – 31 July 2026) are that:

   - The revenue financial position reported is **breakeven,** based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2026/27. The underlying year-end forecast for 2026/27 is currently a balanced position;

   - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of **£2.979m** have been achieved against a target of **£2.699m**;

   - Public Sector Payment Policy is on track with performance**, against a target of 95%, of 98.0% for the number,** whilst slightly off track in terms of value at **91.6% of the value** of non-NHS invoices paid within 30 days.

4. At the planning stage of the 2026/27 financial year the Trust assumed it would need to cover in full, the emerging cost pressure of the increase in the Welsh Risk Pool (WRP) costs, as such the Trust strove to identify savings to cover the whole £2.355m estimated cost increase, as part of the original £9.000m total savings requirement. However, following the submission of the plan, Welsh Government (WG) confirmed that if organisations could deliver a balanced position other than for the WRP element then WG would fund this pressure. As such, the Trust is now assuming cover for this. This therefore is the basis of both the year to date and forecast financial position, and the residual in year savings delivery required, which now aligns to that which was identified as deliverable at the outset of the financial year (£7.8m).
   In terms of the current reported position, this is further compounded by the cost pressure and volatility that has emerged following the completion of the plan in relation to fuel price increases, primarily due to the impact of the conflict

in the Middle East. Should prices remain as high as they have been throughout the financial year, this would translate into a c.£1.500m additional cost pressure not recognised in the original financial plan.

5. Whilst reporting and forecasting balanced position therefore, which is clearly encouraging, it is key to also note the following assumptions that have been made in reporting this current and forecast position:

   - The ability to deliver a minimum of at present £7.800m in savings in year.
   - Assumed financial cover from WG for the increased WRP costs – at a value of £2.355m.
   - No other developments, enhancements or cost increases not currently funded within budgets will be able to be progressed until a confirmed funding source for them is found, or an agreed equivalent value of cost is stopped or reduced elsewhere.
   - The ability to manage any other in year cost pressures as they arrive, within the small contingency the Trust continues to hold, as per the IMTP / 2026/27 financial plan.
   - Income assumptions in opening financial plan are fully funded via commissioners and Welsh Government (i.e. pay awards / Employers National Insurance increases)

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

7. However, the above key updates from the Trust Board approved financial plan and budget set needs to be understood in reviewing the detail of this Month 4 position, and in particular the additional cost coverage now assumed and the emerging impact on the costs and forecast spend of current fuel pump prices. Without making some of these assumptions the Trust would have been in deficit.

8. Finally, at the outset of the financial year, given the significant issues and challenges being faced across the NHS in Wales and many organisations being unable to deliver a balanced financial plan for 2026/27, WG asked all of NHS Wales

organisations to reexamine their Financial Grip and Control Measures previously developed to identify any gaps in its processes or procedures. Following detailed scrutiny and self-assessment against that provided, an updated brief overview of the outcome of this work is provided to Committee later in this report.

ASSESSMENT

REVENUE FINANCIAL PERFORMANCE – MONTH 4 2026/27

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

Revenue Financial Position for the period 1st April - 31st July				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-343,138	-114,655	-114,918	-263
Expenditure				
Pay	252,795	83,412	82,901	-511
Non-pay	64,820	20,309	21,083	774
Total pay & non-pay expenditure	317,615	103,721	103,984	263
Depreciation & Impairments / interest payable & receivable	25,523	10,934	10,934	0
Total	**0**	**0**	**0**	**0**

Income

10. Reported Income against the initial budget set to Month 4 shows an overachievement of **£0.263m**.

Pay Costs

11. Overall, the total pay variance at Month 4 is an underspend of **£0.511m**.

Non-pay Costs

12. The non-pay position at Month 4 is an overspend of **£0.774m**. In addition, for reporting purposes Depreciation, Impairment and Interest is excluded from the above figure, however in month the budget aligned to the actual.

Savings

13. As above, the original 2026/27 financial plan identified that a minimum of **£9.000m** of planned savings (including income generation) were likely to be required to achieve financial balance in 2026/27. However as detailed above following the cover for the WRP being provided by WG, the initially unidentified savings of £1.2m are now assumed not to be delivered in the current financial year, with work progressing to ensure this can be further delivered recurringly.

14. Month 4 in month performance was, plan of £0.680m and £0.837m achieved, therefore an overachievement of £0.157m (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
BX01-Chief Executive Directorate	107	5	6	1	22	17	-4	107	107	0
BX02-Corporate Governance	39	1	1	0	4	4	0	39	39	0
CX01-Partnerships & Engagement Directorate	40	3	3	0	13	13	-1	40	39	-1
DX01-Operations Directorate	4,337	380	402	21	1,587	1,608	21	4,337	4,390	53
FX01-Finance and Corporate Resources Directorate	1,064	94	143	49	338	362	24	1,064	1,092	28
HX01-Planning and Performance Directorate	267	26	37	10	56	144	88	267	375	108
JX01-Quality, Safety and Patient Experience Directorate	420	35	52	17	140	142	2	420	432	12
KX01-Digital Directorate	720	60	75	15	240	328	88	720	720	0
PX01-People and Culture Directorate	402	41	86	45	165	272	107	402	551	149
RR01-Trust Reserves	20	2	2	0	7	7	0	20	20	0
UX01-Medical & Clinical Services Directorate	384	32	32	0	128	83	-45	384	339	-45
Totals	**7,800**	**680**	**837**	**157**	**2,699**	**2,979**	**280**	**7,800**	**8,105**	**305**

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

15. ***Appendix 1*** provides the overall detail for Month 4 by theme.

Financial Performance by Directorate

16. Whilst there is a breakeven position at Month 4, there are some small variances between Directorates, as shown in the table below, when compared to the budgets set at the outset of the financial year. These are fairly minor in nature,, but they will be continued to be closely monitored.

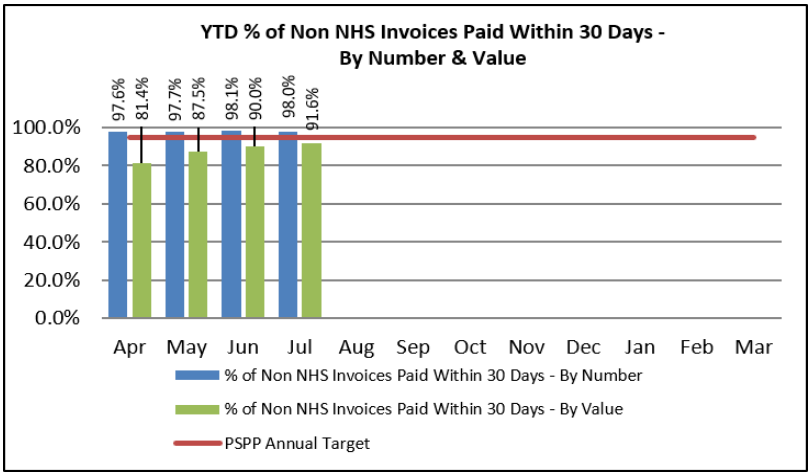
Financial position by Directorate @ 31st July	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	226,734	75,187	75,250	64	0.1%
Chief Executive Directorate	2,189	756	748	-8	-1.1%
Board Secretary	781	259	258	-1	-0.4%
Partnerships & Engagement Directorate	716	219	196	-23	-10.4%
Finance and Corporate Resources Directorate	38,594	13,036	13,204	168	1.3%
Planning and Performance Directorate	3,242	1,131	1,037	-94	-8.3%
Quality, Safety and Patient Experience Directorate	8,368	2,760	2,664	-96	-3.5%
Digital Directorate	17,304	4,973	4,832	-141	-2.8%
People and Culture	6,993	2,062	2,029	-34	-1.6%
Medical & Clinical Services Directorate	6,782	2,178	2,186	8	0.4%
Trust Reserves	4,007	-312	-156	156	-50.1%
Trust Income (mainly JCC)	-315,710	-102,249	-102,249	0	0.0%
Overall Trust Position	**0**	**0**	**-0**	**-0**	

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

17. Public Sector Payment Policy (PSPP) compliance to Month 4 was **98.0%** against the **95%** WG target set for non-NHS invoices by number and **91.6%** by value.

18. Whilst the number is in line with the target, due to a payments processing issue, one large value invoice failed to process correctly in month 1, resulting in the 30 day target for value being missed. Due to the cumulative nature of this, it is

expected that this delivery will recover as we progress through the rest of the financial year.



2026-27 CAPITAL PROGRAMME

19. The discretionary capital programme and resulting budgets have only recently been finalised, and work is ongoing to go through the required tendering processes to commence work on these schemes. A number of these will now be presented to F&PC and Trust Board, where required, this month.

20. At Month 4, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2026/27 is **£30.928m**. This includes **£24.133m** of All Wales Approved schemes and **£6.795m** for Discretionary schemes.

RISKS AND ASSUMPTIONS

21. At present, it is considered that there are no medium or high likelihood risks as reported to WG. However, as the financial year progresses, the Trust will continue to review both the likelihood and financial value of risks. Depending on the outcome of issues highlighted, higher risks may need to be reported in due course. This will also inform a further review of risk 139 in the BAF.

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

23. The low risk of £2.000m previously included in relation to the JCC additional savings request has now been removed on the basis that the Trust has agreement around the funding for 2026/27. The Trust continues to work with the JCC to demonstrate non-cash-releasing productivity gains.

24. Given the pressures the Trust is already experiencing in relation to the conflict in the Middle East, a risk has been included around further increases in energy prices. While the Shared Services forecast indicated a reduction for WAST, this was based on energy baskets already secured, which have increased again since Month 3. In addition, the Trust has a number of sites outside this supply arrangement, including one high-usage site where costs are recharged by the landlord and are therefore more heavily impacted by rate increases. In light of the additional baskets secured by Shared Services, the risk has again been reduced by £0.100m to **£0.300m**. The Trust will continue to monitor this area as it moves into the higher-usage months.

25. At this stage it is prudent to include a risk of the WRP funding not being provided by Welsh Government, as such a risk has been included for the full amount of **£2.355m**. However, given the assurance from WG that if we achieve our forecast, it will be covered in full, this is a low risk.

26. In addition to the current forecast around the Risk Pool, given the additional work being undertaken and the change in methodologies being applied by the courts, an unquantified low risk has been included.

27. As noted above, there are currently no individually assessed high financial risks. However, when this is considered alongside continuing significant service pressures and the likely need to balance financial risk against patient safety, quality and experience, it remains clear, as set out in the IMTP, that 2026/27 is likely to be another challenging financial year. This remains the case despite the initially reported Month 04 financial performance and the assumptions underpinning it.

28. Full consideration and management of all these risks will clearly be high on the agenda for the Trust Board and its relevant Committees.

Grip and Control

29. Just ahead of the start of the current financial year, WG wrote to all Chairs and CEOs of NHS Wales organisations drawing attention to work undertaken by NHS P&I on financial grip and control, including sharing updated best practice guidances alongside a consolidated schedule setting out the expected core financial, workforce and procurement measures all are expected to have in place. It was noted that this was particularly prevalent to ensure and safeguard financial stability during periods of significant financial pressure, and needed to focus as much on compliance as to the existence of policies and procedures in the first place.

30. Committee members will be aware of the receipt of this and the very high-level initial assessment made at the time, with the detailed work now having been fully undertaken across the Trust. The outcomes of this is a very detailed document providing both the Trust's controls and processes in place and assurances that the processes are operational. The full document is available in the ibabs reading room, with a summary of the outcome and assurances on the findings, including any areas of ongoing work or improvement now summarised below. This has also been received and further reviewed via the Financial Sustainability Programme Governance Group.

31. The review of the Grip and Control measures were undertaken across multiple directorates and the exercise confirmed that WAST already had strong and robust processes and procedures in place in most areas, as has been confirmed and evidenced alongside a range of existing assurance mechanisms, including governance effectiveness reviews, Audit Wales Structured Assessments and bespoke reviews, NAO self-assessments, and Internal Audit findings.

32. However, as would be expected, the exercise did highlight some areas where work is either already in progress, or which could benefit from a further review of current practice and likely further improvements could be made. These are highlighted within the detailed document provided and include:
    - Recording of training for budget holders, to ensure inductions and regular refreshers training are managed, the team are looking at exploring options around capitalising on existing systems to monitor and record this training.
    - The review also highlighted a gap around evaluation of benefits realisation on revenue schemes; work is progressing via the Financial Sustainability Programme to develop this to ensure the Trust can evaluate and review schemes to ensure they are delivering on the elements identified at business case stage.
    - Developments around Travel & Subsistence, especially hotel bookings, work is progressing with a Task and Finish group to build on existing technologies and ensure value for money.
    - As Committee members may recall, following a fairly recent IA review, further enhancements in relation to Trust wide contract management.

33. It was initially suggested and understood that this would be more of an internal self-assessment exercise with areas of improvement identified for internal delivery. More recently NHS Wales P&I colleagues have however requested that all organisations submit their completed assessments to them for review. The Trust will therefore now look to do so, following the noting of the completion of this exercise by F&PC. It is also to be noted that IA plan to cover some of this off as part of their upcoming audit on financial savings later this financial year.

RECOMMENDATION (S)

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

NEXT STEPS

35. Monitor the ongoing revenue and capital position as we move through 2026/27, linking in with key stakeholders, to ensure delivery to plan.

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

37. Provide the completed Grip and Control assessment to NHS P&I

Appendix 1

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

Savings Performance by Theme 26-27

Reporting Month 4

	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
Income Commercialisation Opportunities	150	17	0	-17	17	0	-17	150	150	0
Non Pay Estates Efficiencies - Corporate	135	11	11	0	46	41	-5	135	135	0
Non Pay Fleet Efficiencies - Corporate	250	21	23	2	83	33	-51	250	181	-69
Non Pay Local Schemes - Corporate	471	39	36	-3	157	113	-44	471	324	-147
Non Pay Local Schemes - Operations	915	69	88	19	236	271	35	915	934	19
Non Pay Local Schemes - Operations Contract Reviews	415	30	18	-12	169	121	-48	415	415	0
Non Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Agency Reduction	89	7	7	0	30	30	0	89	89	0
Pay Cost Management (Variable Cost reductions) - Operations	1,100	96	96	0	334	334	0	1,100	1,100	0
Pay End of Shift Overrun - Operations	110	9	23	14	38	72	34	110	144	34
Pay Skill Mix Modernisation - Operations	500	42	42	0	168	168	0	500	500	0
Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,368	204	358	154	780	1,155	376	2,368	2,836	469
Pay Vacancy Management - Operations	1,297	134	134	0	642	642	0	1,297	1,297	0
Totals	**7,800**	**680**	**837**	**157**	**2,699**	**2,979**	**280**	**7,800**	**8,105**	**305**

Savings Performance by Theme 26-27 - Recurrent

Reporting Month 4

	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
Income Commercialisation Opportunities	150	17	0	-17	17	0	-17	150	150	0
Non Pay Estates Efficiencies - Corporate	135	11	11	0	46	41	-5	135	135	0
Non Pay Fleet Efficiencies - Corporate	250	21	23	2	83	33	-51	250	181	-69
Non Pay Local Schemes - Corporate	471	39	36	-3	157	113	-44	471	324	-147
Non Pay Local Schemes - Operations	915	69	88	19	236	271	35	915	934	19
Non Pay Local Schemes - Operations Contract Reviews	415	30	18	-12	169	121	-48	415	415	0
Non Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Agency Reduction	89	7	7	0	30	30	0	89	89	0
Pay Cost Management (Variable Cost reductions) - Operations	1,100	96	96	0	334	334	0	1,100	1,100	0
Pay End of Shift Overrun - Operations	110	9	23	14	38	72	34	110	144	34
Pay Skill Mix Modernisation - Operations	500	42	42	0	168	168	0	500	500	0
Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,368	204	358	154	780	1,155	376	2,368	2,836	469
Pay Vacancy Management - Operations	1,297	134	134	0	642	642	0	1,297	1,297	0
Totals	**7,800**	**680**	**837**	**157**	**2,699**	**2,979**	**280**	**7,800**	**8,105**	**305**

Savings Performance by Theme 26-27 - Non Recurrent

Reporting Month 4

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

Please note figures are rounded to the nearest whole number

Financial Grip and Control measures across NHS Wales

Financial Planning and Delivery Directorate

Objective:

To provide organisations with a consolidated schedule setting out the core financial, workforce and procurement grip and control measures to safeguard financial stability during periods of significant financial pressure.

Background:

At M09 2025/26 six health boards in Wales report deficits totalling £206m, (1.9% of the reported Revenue Resource Limit).

Given the scale of the pressure, it is essential that the NHS Wales Finance Function can demonstrate that the financial governance and financial control environment mechanisms are robust and sufficient assurance is received on their effectiveness.

Scope:

The tool is designed to help organisations assess their financial grip and control. It is not an exhaustive list but is predicated on common themes and areas of risk identified through NHS Wales.

The key focus for the grip and control schedule is the practical controls, processes and actions that should be in place in year to avoid excessive or inappropriately approved financial commitments; reduce waste; and improve in year expenditure run-rates. The tool will help organisations to strengthen the underpinning financial governance and control measures that support improved financial performance.

As a first step, the focus has been placed on core financial, workforce and procurement processes and systems. There is more limited literature available on best practice grip and control within specific expenditure areas such as commissioning, CHC and prescribing systems and processes.

Preparation approach:

The schedule has been prepared by Financial Planning and Delivery by examining and consolidating examples from various sources including:-

- Grip and Control presentation report (Financial Planning and Delivery May 2022)
- Financial Grip and Control Checklist (NHS England December 2022)
- Establishment Control (HFMA May 2025)
- Budgetary Framework and Grip and Control Discussions (Directors of Finance Forum July 2024)

Structure of the document:

The schedule includes both **financial controls (in black)** that organisations should have in place and **grip actions (in blue)** that will support the reduction of expenditure run rates.

The financial grip and control measures are categorised across eight themes:- Framework and Guidance, Vacancies, Sickness and Leave, Rostering and Rotas, Bank and Agency, Other Staff Payments, Procurement and Other items.

The document includes both a summary schedule and a detailed schedule. The summary schedule identifies key thematics and the highest impact actions from the detailed schedule.

Other financial governance reference documents:

The checklist may be used in conjunction with:

- HFMA's "Improving NHS financial sustainability: are you getting the basics right?" checklist tool Improving NHS financial sustainability: are you getting the basics right? (hfma.org.uk) – focus on key overarching financial processes such as planning, budget setting, reporting, financial governance, training and development
- Financial Management Maturity Model (NAO January 2010)
- Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions – NHS Wales (issued by Welsh Government)
- The Finance Academy's 'Financial Control Procedures Governance Best Practice Principles Guide' - available on the learning and development platform

All are valuable tools to support organisations to consider if they have the controls and processes in place to achieve best value for money.

Completion and next steps:-

Complete the checklist to consider whether the relevant policy or process exists and secondly to consider operational delivery and compliance. This may require input from representatives from several areas workforce, procurement, efficiency, finance and audit.

Agree priority issues and how proposed actions to address the issues identified will be taken forward. This may require assembling a working group including representatives from workforce, procurement, efficiency, finance.

Key findings from the exercise to be shared through the Director of Finance forum to identify any national areas of focus.

1. Summary Schedule

Framework and Guidance	Establishment and Vacancies	Sickness and Leave Management	Rostering, Rotas and Job Planning
• Clear and Up to Date Standing Financial Instructions and guidance. • Clear procedures & process notes. • Budget holders and all financial administrators have received up to date training on their roles & responsibilities • Clear governance process for new investment. • Delegation letters issued and signed. • Internal Escalation process in place.	• Ensure robust budgeted establishments are in place and regularly reviewed and reconciled. • Regular vacancy control panel (VCP). • Automated weekly head count tracker. • Ensure managers notify HR of leaving dates. • Review all current vacancies with a view to remove or freeze posts.	• Enforce compliance with the All Wales Sickness policy. • Adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels. • Monitor absence and sickness on individual, service line, divisional and organisation level. • Monitor medical annual leave. • Policies to limit carry forward of significant leave balances	• E-rostering fully deployed. • Rosters approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework). • Contracted hours to be fully rostered. • Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times; and alignment of rota to job capacity plans.

Temporary Staffing	Other Staff Payments	Procurement	Other items
• Temporary Staffing Policy in place. • Clear process for booking, and compliance with process. • Review bank and agency authorisation levels – seniority and consistency across sites. • No off-contract agency & locum. • Auto enrolment for new starters onto the bank. • Review pay rates and consider weekly pay for bank as an incentive. • Ensure appropriate deduction for agency staff breaks.	• Implement prior approval for overtime and enhanced payments. • A monthly 'audit' of the highest overtime earners and expenses claimants. • Non-clinical overtime controls in place. • Enhanced authorisation process for WLIs with clear demonstration that existing Programmed Activities (PAs) have been utilised before WLIs awarded. • Review process in place for additional sessions allocated.	• Monitor use of Single Tender Waivers. • Consolidate a list of supplier discounts. • Robust contract management processes in place. • Enforce the 'No PO No Pay' policy. • Review and reduce those able to requisition and order. • Targeted approach for clinical preference variation (as identified by V&S procurement group).	• Review and ensure all eligible VAT is being reclaimed. • Income management policies to minimise bad debt costs. • Stock management policies to minimise wastage. • Review all credit balances on the Balance sheet for potential over accrual. • Journals are based on latest relevant data and assumptions.

2. Detailed Schedule

1. Framework and Guidance	Controls / Processes in place	Assurance that processes are operational
Clear and Up to Date Standing Financial Instructions • SFIs are up to date and readily accessible to all relevant officers.	Maintained through periodic review and Board approval of Standing Financial Instructions (SFIs); accessible via intranet and embedded within finance governance framework.	Version-controlled SFIs, Board approval records and internal audit reviews confirming compliance.
Clear Process Notes • All Financial Control Procedures are up to date, accessible and minimum provision aligns with the Finance Academy best practice guide. (e.g. month end close down processes, financial reforecasts). • All Financial Control Procedures are widely available to all relevant team members. • Adequate training is provided to all relevant staff members to ensure awareness and understanding of relevant financial control procedures.	• Financial Control Procedures are maintained, covering all core processes along with detailed month end timetables • All procedures are subject to formal version control, with ownership assigned and scheduled periodic review (at least annually or following material process change). • Procedures are centrally stored within a controlled repository (e.g. intranet / SharePoint Finance Hub) ensuring a single source of truth. • Access rights are structured to ensure all relevant staff have visibility, with clear navigation and indexing of key processes. • A defined process ownership framework exists, with named leads accountable for maintaining accuracy and consistency of documentation. • Developments - A structured training programme is being put in place (induction + refresher training), covering key financial control processes and updates to procedures, this is one of the Finance Teams key objectives for 2026/27 to strengthen the work already done.	• Procedures are reviewed at least annually to ensure they are up to date • Completion of key control activities (e.g. month-end timetables, forecast submissions) is monitored and tracked, with exceptions escalated. • Internal audit reviews confirm alignment to best practice standards. • Developments - Training records for financial control training across relevant staff groups are going to be developed as part of the work underway, with development of the Learn 365 platform. • Feedback loops (e.g. team meetings, lessons learned from close-down cycles) are used to refine and improve procedures continuously. • No recurring or material control failures identified through audit, ARAC reporting, or financial

Colour Key:- **financial controls** are black **grip actions** are blue

	• Change management arrangements ensure that updates to processes are communicated proactively to all impacted staff.	reporting processes linked to unclear or unavailable procedures • A matured role of Finance Business Partnering across the Trust including monthly meetings, good support, oversight and relationships between BPs and Directorate budget holders.
Roles and Responsibilities • Roles and responsibilities of budget holders clearly defined and clearly communicated, including responsibilities with respect to core budgets, cost reduction element of their budgets and procurement. • Delegation letters have been issued and have been signed. • All budget holders have objectives supporting the delivery of financial objectives in Performance appraisal process. • Budget holders receive training on their roles responsibilities and objectives at reasonable intervals and monitoring of this can be demonstrated. • Consider whether the number of budget holders is appropriate - reduced budget holders can improve control over expenditure.	Documented budget holder roles and responsibilities within Standing Financial Instructions (SFIs) and Budget Manual. Clear linkage between: • Core budget management • Cost reduction targets • Procurement responsibilities (aligned to NWSSP / procurement frameworks). Formal communication via: • Budget setting packs • Delegation letters • Finance briefings / guidance documents Defined escalation routes for financial underperformance (financial recovery / grip actions). Training content covering: • Budget management fundamentals • Procurement rules • Reporting and forecasting requirements	Signed acknowledgment of roles (via delegation letters and budget acceptance process) mainly to Directors with some cascading to other assistant directors. Evidence of circulation of guidance (email cascades / intranet publication). Internal audit review of budgetary control framework (e.g. audit findings and action plans) Documented review of budget holder structure (evidence in finance papers / approvals)

Colour Key:- **financial controls** are black **grip actions** are blue

	Periodic review of **budget holder structures** as part of: • Annual budget setting process • Organisational design reviews Clear mapping of budgets to accountable officers	
Investments and Business Cases • Clear Business Case review procedures for reviewing and approving any new projects across the organisation. • The above includes a relevant committee structure where robust review and challenge takes place. • Post implementation benefit realisation reviews process in place. • Review previous 12 months of business cases to ensure savings/benefits realisation. • Establish list of ongoing and planned projects and determine what can be ceased or delayed.	Standardised Business Case Template used across the organisation, aligned to strategic, economic, financial and management case requirements Clearly defined business case development and submission process, including: • Initial proposal and strategic alignment assessment • Formal options appraisal and economic case development • Financial review and affordability assessment Structured committee governance framework (e.g. Capital Management Board, IMTP Groups, Financial Sustainability Programme Governance Group) providing: • Independent review and challenge • Formal approval thresholds and escalation routes	Evidence of regular committee meetings reviewing and approving business cases (e.g. Capital Management Board, Financial Sustainability Programme Governance Group, IMTP group leads on IMTP development also EFG stood up as and when required) Scrutiny and approval of relevant cases at Finance & Performance Committee and Trust Board, where required Documented approval records and minutes demonstrating scrutiny and challenge at each stage Audit trail showing finance verification and prioritisation scoring for submitted cases (e.g. capital prioritisation process in business case documentation) Internal audit confirming governance arrangements are in place and effective

Colour Key:- **financial controls** are black **grip actions** are blue

	Requirement for clear benefits definition, including ownership, targets, and measurement methodology Mandatory inclusion of risks, dependencies and constraints within each case Use of change control and governance processes for scope or cost variations post-approval Formal Benefits Realisation Framework and Plan required for all significant investments: • Defined benefits with baseline, trajectory and measurement approach • Named Benefit Owners and SRO accountability • Agreed review frequency (e.g. quarterly, 6-monthly, annual depending on benefit timing) Requirement for benefits tracking and reporting throughout project lifecycle and post-implementation Annual or periodic retrospective review programme covering all approved business cases within last 12 months Defined methodology comparing: • Planned vs actual financial savings	Sample testing of business cases shows consistent application of template, financial scrutiny, and approval processes Developments – The benefits realisation process for revenue-based schemes is being reviewed, with the FSP taking the lead on developing the approach. Evidence of named benefit owners actively reporting performance and variances Documented project closure reports confirming achievement (or non-achievement) of planned benefits Demonstrable data collection and performance tracking against agreed benefit measures Internal or external review confirming that: • Benefits are being measured • Variances are identified and corrective action taken Published review outputs / reports summarising findings across business cases Evidence of benchmarking or evaluation exercises to assess effectiveness of past investments Clear documentation demonstrating: • Where benefits have not been delivered

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	• Planned vs actual service / quality outcomes Use of standard evaluation framework aligned to original business case objectives Incorporation of findings into future business case development guidance and learning loops Maintenance of a centralised programme / capital investment pipeline: • Includes all ongoing and planned projects • Categorised by priority, affordability and strategic alignment	• Actions taken to address underperformance Reporting of findings to senior governance groups / committees Evidence that lessons learned are embedded into revised business case templates or approval criteria
Internal Escalation • Clear internal escalation processes in place for service areas that are not delivering their financial plans with appropriate financial or non-financial controls or remedial actions applied.	• Monthly finance reports shared (written and or delivered via QS systems) stating in month and YTD positions • Summary directorate positions included in governance finance papers • Directorates meetings attended by finance staff	• Via e-mails / system access etc • Included in monthly finance reports internal to Finance but also in core finance paper to FP&C and TB • Minutes of directorate meetings Finance feedback to senior meetings like SLT/Ops with key budget holders present

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2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational

Colour Key:- **financial controls** are black **grip actions** are blue

Policy and Procedure • Criteria in place for annual and other leave (e.g. study and parental leave) to be notified to the organisation and signed off (where applicable) with sufficient notice to minimise impact on rotas. • Processes in place to ensure compliance with the AllWales Sickness policy - Rigorous sickness policy and procedure is in place and communicated to minimise absences (inc. return to work meeting). • Consider increasing sign off levels for sick leave to ensure transparency.	Formal leave management process embedded within ESR / e-rostering (GRS), requiring: • Advance submission of all planned leave (annual, study, parental) in line with defined minimum notice periods. • Line manager approval prior to leave being confirmed, based on service capacity and rota requirements. Standardised local principles in place to manage competing leave requests fairly (e.g. first-come basis or agreed team rules). Agreed abstraction levels for Operational areas to maintain UHP Integration with rota planning processes to ensure: • Leave aligns with safe staffing levels. • Limits applied to the number of staff on leave at any given time (service-specific thresholds). Clear accountability: • Line managers responsible for approval. • Staff responsible for timely submission and compliance with process. Alignment with All-Wales policies (e.g. Special Leave Policy) for specific leave types, with	ESR / roster system reporting: • Audit trails demonstrating leave requests, approvals, and lead times. • Exception reporting for late or retrospective approvals. Routine monitoring: • Monthly workforce reports highlighting % of staff on leave vs thresholds. • Identification of outliers (e.g. high leave concentration, year-end spikes). Operational assurance: • Evidence of rotas being approved in advance. • Spot checks by HR / workforce teams on compliance with approval processes. Performance monitoring: • Absence rates tracked at individual, service, divisional, and organisational level. • Publication of monthly glide paths on sickness absence trends • Comparison against defined organisational targets for sickness levels.

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	defined approval routes and documentation requirements Full adherence to the All-Wales Sickness / Managing Attendance at Work Policy, including: • Mandatory day 1 notification and recording processes. • Completion of sickness absence notification forms and welfare contact. • Requirement for GP certification from day 8 onwards (where applicable). Structured absence management framework: • Trigger points for formal review and escalation. • Mandatory return-to-work interviews following every absence episode. • Reduction in manager discretion on cases. Occupational Health engagement: • Defined referral criteria and service level expectations. • Integration with attendance management processes. Line manager responsibilities clearly defined and supported through guidance and training.	• Monthly report to ELT on sick absence data • Reporting to P&C Committee Compliance monitoring: • Audit of return-to-work interviews completed vs required. • Tracking of trigger breaches and management action taken. Reporting and oversight: • Regular reporting to Board / Finance & Performance Committee, with deep dives into hotspot areas. Internal audit / HR assurance: • Periodic reviews of policy compliance and documentation quality. Workforce data validation: • Reconciliation between ESR data and local records to ensure completeness and accuracy. Reporting and exception handling: • Monitoring of long-term sickness cases and management interventions. • Tracking of cases requiring higher-level approval and evidence of compliance.

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2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
	People Services team coaching and check and challenge on sickness absence with managers. Consistent recording within ESR to ensure accurate reporting and payroll alignment. Defined approval thresholds for sickness absence: • Line manager approval for initial absence recording. • Escalation requirements for longer-term or repeated absence (e.g. senior manager / HR review). Consideration of strengthened controls: • Sickness absence management is covered in 121s in Operations. Clear documentation requirements: • All decisions (extensions, phased return, adjustments) formally recorded in ESR and case files. Integration with HR case management processes to ensure consistency and transparency. Cases are managed consistently through the policy. Evidence of a number of dismissals for both long term and frequent short term sickness absence.	Governance structures: • Review of sickness cases through workforce review meetings / panels. Audit and assurance: • Sample testing of sickness cases to ensure correct approval levels are applied. Transparency: • Clear audit trail demonstrating escalation and decision-making. Board visibility: • Inclusion of long-term sickness in workforce dashboards.

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Establishment (Establishment control | HFMA) • Workforce plans are in place, are of a sufficiently granular level of detail (for example, by service, workforce type and substantive/ temporary); and align to approved establishment levels and budget. • Workforce plans are regularly reviewed by service and divisional leads to ensure compliance with or action to move to compliance against both establishment and budget. • Reconciliation process in place to ensure that WTEs per financial and HR systems reconcile.	**Annual and in-year workforce planning framework** • Directorate/service-level workforce plans developed as part of IMTP and annual budget-setting cycle • Plans include **WTE, staff group, pay band, and contract type (substantive vs temporary)** **Integration between Finance and Workforce teams** • Joint sign-off of workforce plans to ensure alignment with approved budget envelopes • Standard templates used to ensure consistency and comparability across services **Establishment control baseline** • Approved establishment held centrally (e.g. ESR/Finance ledger baseline) • Any changes to establishment require formal approval through delegated governance (e.g. business case or change control process) **System alignment** • Workforce plans reflected within ESR (or equivalent HR system), financial ledger, and planning models	Approved workforce plans documented and signed off as part of annual plan / IMTP submission Evidence of **Finance–Workforce triangulation** (e.g. agreed baseline establishment and pay budgets) Audit trail of establishment changes via business cases / approvals Availability of detailed workforce reports by service, staff group, and contract type Regular reporting to Finance & Performance Committee / Board demonstrating alignment between actual and budget Good assurance on workforce planning approaches highlighted by recent Audit Wales review. Regular (e.g. monthly) workforce and finance reports presented to governance forums Documented minutes/action logs from performance review meetings showing challenge and follow-up Evidence of corrective actions taken where variances are identified (e.g. recruitment decisions, vacancy freezes, redesign) KPI dashboards showing trends in workforce metrics and compliance with plan, the Trust utilises an approved Strategic Workforce Plan and also has developed BI dashboards on staff

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	Scenario modelling capability
	• Ability to model demand, vacancies, and cost pressures to support affordability and operational decision-making
	• Well established Integrated Technical Planning Group made up of colleagues from Planning and Strategy, Clinical, Workforce Planning, Education and Development, Finance and Operations hold the ring on end to end workforce planning from service demand and capacity through to operational delivery.
	Monthly workforce performance reporting
	• Reporting of WTE, vacancies, agency usage, and pay expenditure against plan
	Budget holder accountability
	• Service and divisional leads held accountable for workforce position through monthly budget meetings
	Variance analysis
	• Systematic comparison of:
	  ○ Actual WTE vs funded establishment
	  ○ Pay spend vs budget
		/ vacancy data, turnover, exit surveys etc – also shared with P&C Committee 6 monthly
		Clear visibility of overspends/underspends and mitigating actions, via budget meetings

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	○ Substantive vs temporary workforce mix **Escalation and corrective action** • Defined thresholds for variance with required actions (e.g. recruitment controls, vacancy management, cost improvement actions) • Recruitment Control Panel with representatives from People and Culture, Finance and Planning and Strategy at Director level scrutinise all requests to recruit. **Governance oversight** • Workforce and finance performance reviewed through: ○ Divisional performance reviews ○ Finance & Performance Committee **Link to operational planning** • Workforce changes linked to demand, rostering, and service delivery requirements **Defined reconciliation process** • Regular (typically monthly) reconciliation of: ○ ESR (or HR system) WTE	

	○ Finance system (ledger/payroll) WTE and pay costs **Standard reconciliation outputs** • Agreed reconciliation template highlighting differences: ○ Funded vs in-post WTE ○ Substantive vs temporary staff ○ Payroll vs ledger variances **Ownership and accountability** • Clear ownership between Finance and Workforce teams for completing and reviewing reconciliations **Investigation and resolution** • Defined process to investigate discrepancies (e.g. timing differences, coding errors, unapproved posts) **Data integrity controls** • Controls over establishment changes, recruitment, and payroll changes to minimise mismatches **System synchronisation** • Alignment of: ○ Cost centres ○ Assignment numbers	

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2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
	○ Pay budgets and establishment structures	
Vacancy Review (Establishment control | HFMA) • Establish a regular vacancy control panel (VCP) or equivalent to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits. • Ensure the VCP terms of reference enable flexibility to avoid operationally delaying opportunities for savings and considering clinical need. • Implement an automated weekly head count tracker (temporary and substantive). • Assess the recruitment process and remove blockers/ bottle necks that may lead to higher agency & locum costs. • Review all current vacancies with a view to remove or freeze posts. • Focus on long term/ 6-month vacant posts – can these be removed or re-engineered? • Review the establishment to remove partial posts not required and identify unfunded posts. • Implement non-clinical recruitment freeze unless it can be evidenced that role is business critical or key for financial/ quality and safety improvement.	- Regular Vacancy Recruitment Control Panel established to review recruitment against budget limits. - Terms of Reference allow flexibility to balance savings and clinical need. - All vacancies reviewed to assess removal or freeze. - Establishment reviewed to remove partial or unfunded posts, as part of savings requirement	- Evidence of regular RCP meetings and recorded decisions. - Headcount reports produced monthly and reviewed by finance/workforce leads. - Audit trail of recruitment approvals aligned to ToR. - Monitoring of vacancy numbers and reductions over time. - Reporting of agency/locum usage trends linked to recruitment actions via Monitoring return

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2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
Leavers • Processes in place to ensure line managers notify HR of leaving dates and any other pay-impacting staff changes in a timely manner to reduce risk of overpayments.	- Line managers notify HR of leaving dates and pay-impacting changes via the SMA app Payroll issues automated reminders to line managers regarding the monthly payroll cut-off dates, which highlights the importance of new starters, leavers and changes being processed in a timely manner. An example is given in the email of a mid-month leave and the importance of submission before the cut of date for that month.	ESR payroll reconciliation reports highlight overpayments and leaver adjustments. Internal audit/payroll reviews provide assurance on timely processing. Exception reports on overpayments reviewed through Finance and People Services
Workforce management monitoring (Establishment control | HFMA) • Process in place to review levels of poorly performing staff and consider options for more rapid improvement and/ or staff exit. • Periodical review of actual temporary staff rates against rates charged to identify and address issues (specific and themes).	- Processes to identify poorly performing staff and consider improvement or exit options. - Periodic review of temporary staff rates vs charged rates. Crucial Conversations training rolled out to managers to address issues at the first opportunity and before they escalate.	- Documentation of performance reviews and outcomes. - Reports comparing actual vs charged rates reviewed periodically. - Evidence of actions taken on rate discrepancies. Managing performance policy used for improvement requirements

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3. People Costs – Sickness and Leave Management	Controls / Processes in place	Assurance that processes are operational
Monitoring and Reporting • Monitor adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels. • Monitor absence and sickness on individual, service line, divisional and organisation level. • Sickness is regularly reviewed at the board level, and problem areas identified and examined. • There is a set % target for staff off sick at any time and performance is measured against this target. • There is a set % target for staff on leave at any time and performance is measured against this target. • Monitor staff compliance with core organisational HR policies (e.g. annual leave requests, sickness absence) and ensure outliers are identified and addressed through appropriate routes. • Monitor medical annual leave. • Limits to the amount of annual leave, training and other influenceable absences that can be taken at any time. • Global policies for the management of leave to prevent excessive use of annual leave at the end of the year or carry forward of significant balances.	Routine reporting framework in place to monitor compliance with attendance at work policies and Occupational Health standards. Regular reporting mechanisms exist to track sickness absence across individual, service, divisional and organisational levels. Committee / Board-level reporting cycle established with escalation of problem areas. Defined organisational targets for sickness absence in place and embedded in performance reporting. Monitoring of sickness absence against wider ambulance sector (inappropriate to measure against other HBs and Trusts in Wales) Defined organisational leave thresholds in place and monitored. Systems in place to monitor compliance with HR policies and identify outliers for management action. Monitoring arrangements in place for operational annual leave. Controls implemented to limit the amount of leave, training and other influenceable absences at any point in time.	Evidence of regular reports demonstrating compliance monitoring against attendance policies. Documented reports showing sickness trends at all organisational levels. Board papers/minutes evidencing regular review of sickness and escalation of issues. Performance reports demonstrating tracking against sickness targets. Reports confirming monitoring against leave thresholds. Audit or exception reporting demonstrating identification and management of policy non-compliance. Reports evidencing tracking of operational leave utilisation. Evidence of controls being applied through rota or leave systems limiting absences. Monitoring reports demonstrating management of leave balances and reduction in carry forward.

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	Global policy framework in place to manage leave balances and reduce end-year spikes or excessive carry forward.	

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
General rostering and rotas • E-rostering is fully deployed • Rosters are approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework), and minimal changes to rosters once approved, for all staff grades. • Processes to ensure contracted hours are fully rostered. • Clear timeline for submission of rotas.	E-rostering system (GRS in house system) implemented across operational workforce. WAST operate a predominate fixed rosters/relief/self roster model, Rosters are published a minimum of 6 weeks in advance for relief, with 7-12 weeks is the self rostering window for 111 rostering Contractual Compliance for all rostered staff is monitored and the new Resourcing Policy and subsequent functional SOPs, will detail the process for audit and monitoring purposes.	We have fixed roster keys (Demand & Capacity) the actual is subject to establishment, abstractions, overtime etc

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational

Robust Nursing Rota Management
• Staff levels are matched to patient demand patterns to avoid waits and avoidable admissions.
• Weekly monitoring for shift requests vs. shift fill rate and any associated care and safety issues.
• Review staffing levels against patient ratios vs current guidelines (inc. safer staffing tools) and provide constructive challenge to clinical leads on achieving efficiency while maintaining quality.
• Review specialing policy, approvals, and tracking process to ensure standardised approach linked to patient need/acuity.
• Review nursing agency & locum use before, during and after school holiday periods (tests the strength of rota planning).
• Review options for:
  ○ reduced handover periods;
  ○ back-to the ward for nursing management staff for a number of shifts per week; and
  ○ specialist nurses to provide a number of clinical shifts on wards to reduce agency & locum bill, cover vacancies, and improve staff rotation.
	N/A	N/A

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational

Robust Medical Job Planning Management
• Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times.
• Process in place to ensure alignment of rota to job plans.
• Monitoring in place to support Medical Director leadership track medical productivity for example:-
  ○ job plan delivery (individual and then team job plans);
  ○ PAs over 12;
  ○ % Direct Clinical Care; and
  ○ theatre/clinic throughput.
• Review consultant job planning compliance (assess current level of rollout) to identify opportunities for greater productivity (review of low and high Professional Activity "PA" staff).
• Improve transparency of medical workforce holiday planning to core planning teams, linking to theatre and clinic planning.
• Review on-call run rate for utilisation trends.
	N/A	N/A

Other Clinical Staff • Review compliance with / introduce Clinical Nurse Specialist and Allied Health Professional job planning process to identify opportunities for greater productivity.	N/A	N/A

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Policy, procedures, roles and responsibilities • An organisation wide temporary Staffing Policy in place and up to date. • There is a clearly communicated process in place for bank / agency & locum booking. • Monitoring controls in place to monitor compliance with the process for bank / agency & locum booking. • Governance process exists to oversee temporary staffing with clear ToR (either at overall level or by key staffing group e.g. nursing, medical, corporate). • Limit who can authorise bank and agency & locum staff to increase transparency; follow up on all short notice use. • Review consistency of authorisation levels and approach across sites.	Agency and locum work is extremely low for WAST and normally in areas such as ICT or Fleet where the Trust needs temporary worker to cover peaks in activity in relation to rolling out new vehicles, or in the case of ICT providing specialist work that internal staff are unable to provide We do have recently updated guidance on agency workers. Updated in the context of counter fraud. Agency is between 0 and 0.5% of the payroll budget in WAST.	Financial reporting in MMRs. RCP reporting includes requests for agency workers.
Bank utilisation • All relevant staff groups are auto enrolled on the bank. • Review actual temporary staff rates against rates charged periodically to identify and address issues. • Implemented and promoted a medical bank; and an Administration and Clerical bank. • Promote bank staff as an alternative to agency & locum. • Review pay rates and consider financial incentives for bank staff to increase bank usage, for example consider weekly pay as an incentive.	N/A … no separate bank operated in WAST	N/A … no separate bank operated in WAST

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational

Agency and Locum controls
• Robust controls over agency & locum usage for example:-
  ○ self-imposed cap on agency & locum expenditure;
  ○ senior sign off of agency & locum expenditure;
  ○ senior sign off of off-framework expenditure;
  ○ clear Board accountability defined and communicated across organisation;
  ○ improved communication of planned clinic cancellations to agency/bank teams; and
  ○ no direct approach for agency.
• Process in place to ensure non-framework or off-contract agency staff are not engaged.
• An organisation process in place for long term agency & locum use.
• Seek local agreement of agency & locum pay rates with surrounding trusts / explore use of a collaborative bank.
• Evaluate opportunities for moving from use of agency & locum to internal organisation resource and / or bank.
	Agency drawn off frameworks and hence via POs.
	
	Initial request via RCP
		SFI / SOs determine agency delegation limit etc

Timesheet and expenses management • Ensure breaks and hours claimed are accounted for correctly in timesheets (i.e. agency workers are only paid for time worked, in accordance with HB policies). • Ensure appropriate deduction for agency & locum staff breaks (lunch). • Ensure mileage claims are only for required intra-site travel.	Contracted hours (inc patten) determined in agency ToR. Timesheets / expenses approved by line manager	Via Framework draw offs. Invoices paid via POs so check against order values
Restrictions on non-clinical temporary staff • Review and implement exit strategies for all non-clinical temporary workers. • Temporary ban on usage of non-clinical agency staff, with exceptions authorised by executive director.	Request scrutinised via RCP on a case-by-case basis.	RCP KPIs reported

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Effective monitoring • Senior leads monitor weekly dashboard summaries of temporary staff usage, cost and trends to provide early warning signs and demonstrate progress with issues arising. • Track number of interims, termination dates, delivery of objectives, and daily rates. Focus on reducing number and costs. Consider options for contract terms that enables the organisation to offer substantive role after x months use:- e.g. offer locums a suitable package to convert from locum to substantive contracts. • Identify medical rotas with the highest use of temporary and bank staff and set out a plan to address • Hold weekly agency & locum meetings across all staffing groups with agency & locum overspends, attended by finance and key stakeholders, to review and control agency & locum expenditure.	N/A – due to low volume of agency usage	N/A – due to low volume of agency usage

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6. People Costs – Other Staff Payments	Controls / Processes in place	Assurance that processes are operational
Overtime and enhanced payments controls • Ensure breaks and hours claimed are accounted for correctly in timesheets. • Perform a monthly 'audit' of the top 10 highest overtime earners by division. • Implement prior approval for overtime and enhanced payments - monitor and reduce. • For non-clinical staff - implement non-clinical overtime controls to limit expenditure in this area (e.g. Exec director authorisation required).	Overtime controls in place in Operations based on hours available (linked to savings programme).	Payroll data provided to Budget Managers as part of Month End reporting packs. Access to QS to allow drill down to Budget Managers Overtime hours reported in key directorate reports
Expenses Monitoring • Monthly monitoring of the highest mileage and expenses claimants.	Development - Work is on going to improve the Travel and Subsistence with expenditure controls being developed around Hotels to ensure value for money, also looking at a travel hub to manage transport Directorate reductions in T&S spend as part of FSP.	Payroll data provided to Budget Managers as part of Month End reporting packs. Hotel invoices signed off by a director Development - Work around the Hotel booking system will produce KPI against value for money and cheaper alternatives with justification needing to be provided if the cheapest hotel wasn't selected.

Waiting List Initiatives (WLIs) controls
• Ensure consistent process across organisation including compliance with the WLI rate across the organisation.
• Appropriate review process in place for additional sessions allocated.
• Enhanced authorisation process for WLIs, with checks are undertaken before WLIs are awarded to ensure that :-
  ○ WLIs offer financial benefit or are operationally critical before approving, and
  ○ existing Programmed Activities (PAs) have been utilised.
	n/a	n/a

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• Benchmark WLI rate against other Health Boards.		

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Clarity of Roles • Clear documentation and communication of roles between local managers, the procurement function and Shared Services.	These are part of the SLA between the Trust and Shared Services	SLA and internal audits
Procurement - Tender process • Approval limits are periodically and regularly reviewed where appropriate. • All new contracts awarded in compliance with Statutory Regulations and SFIs. • All new contracts (including agency & locum staff) are procured via appropriate tendering procedures to ensure best value for money is attained. • Single Tender Waivers controlled to minimise use. • Whole Life Costings are applied to evaluate tenders. • Appropriate SLAs and T&Cs are applied to ALL contracts to enable appropriate and effective contract management. • Breaches are reported to the relevant Executive Director and included in financial performance monitoring arrangements.	• All procurements are run in accordance with Public Procurement Regulations, Standing Financial Instructions, and internal governance. • The Shared Services Procurement team review compliance. • All awards go through the relevant internal governance dependant on value • Whole-Life Costing (WLC) is applied where appropriate. • Contract award packs with standard T&Cs are issued to named Contract Managers. • Single Tender Waivers (STWs) are tightly controlled, with numbers reported via ARAC • Breaches are escalated to the Deputy Head of Procurement and reported through ARAC.	• Procurement agenda item on Local p2p meetings •Contract award pack samples with named Contract Manager acknowledgements. •ARAC papers noting any breaches and actions closed. •Internal audit outcomes on procurement compliance.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Call Off • Contract pricing is reviewed annually to attain any further increased banding cost advantages through life of contract. • Product catalogues reviewed (both NHS Supply Chain and Local Catalogues) to remove duplicate items on catalogue (e.g. pens) to ensure value for money. • Consolidate a list of supplier discounts and penalties for early / late payments (in alignment with contract register) - set out plans to recover / avoid these and share with accounts payable team to enact.	•Contract pricing is reviewed in line with contract mechanisms to secure banding advantages and value for money. •Catalogue content is actively cleansed to remove duplicates and guide buyers to preferred lines. •Procurement partners with Finance to ensure negotiated discounts are applied and to mitigate late-payment risks.	•Enablement reports showing duplicate item removals and catalogue compliance rate •Evidence of discounts applied on invoices •AP on-time payment KPI trend where relevant to discount realization.
Procurement - Contract management • Robust contract management processes are in place, including a complete and up to date contract register. • Regular contract reviews to ensure SLAs are being met - with specific focus on PFI contracts where relevant. • When contracts expire, these are retendered in accordance with the statutory regulations rather than rolled over, and explore options for efficiencies/price reduction. • Contract terms are relative and proportionate to the contract matter and that there is a clear understanding of the risks transferred. • Service specifications are reviewed and ensure SLAs are being achieved or amend where suitable and do not directly affect patient care (e.g. reduce frequency of window cleaning etc.)	• A Trust wide contract register is being developed and will be maintained centrally. • Local registers maintained for higher volume / value contracting areas, e.g. estates and digital • Contract management packs categorize contracts (e.g., critical/strategic/transactional) and set monitoring expectations. • Expiring contracts are proactively recommissioned; rollover is avoided unless justified.	• Contract registers (development in this space for a new system) • Internal Audit Reviews • Contract delivery

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Purchase to Pay • Establish a robust purchase ordering (PO) system to enable the implementation of a 'no PO no payment' rule and no retrospective POs , in collaboration with Accounts Payable, to help control expenditure. • Invoices that fail three way match (PO, goods receipt, invoice) are rejected and returned. Source of error are identified and contract managed appropriately. • Payments are only processed following sign off from the appropriate level. • Sample audit batches for any possible out of policy expenditure. • Continuous review of all open purchase orders that feed the monthly goods received not invoiced (GRNI) accrual for accuracy and appropriateness, ensuring any no longer valid items are removed/closed. • Consider limiting and refining approval limits of requisitioners where appropriate.	• Robust P2P governance is in place via joint AP & Procurement working groups and All-Wales P2P forums. • Three-way match is enforced; invoices failing match are returned per policy. • 'No PO, No Pay' is embedded; retrospective POs are discouraged and tracked. • Breaches are flagged by buyers and reported via ARAC. • Requisitioner numbers and approval limits are being refined, with mandatory training for requesters and approvers.	•P2P dashboards •Retrospective PO logged within ARAC report. •Attendance/ competency records for requisitioner/approver training to be introduced •ARAC reports including policy breaches and closures

Colour Key:- **financial controls** are black **grip actions** are blue

7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement - Other • Process in place to identify any "off contract" and consultancy expenditure. A strategy in place to review and market test costs to ensure best value. • Contract pipeline clearly identified (and shared with NWSSP) to enable economies of scale. • Ensure the number of purchasing cards in the organisation is right-fitted and balances the process efficiencies against the risk that the use of these bypasses procurement processes. • Targeted approach for clinical preference variation (as identified by V&S procurement group).	• Procurement activity is managed through NWSSP arrangements, SFIs, contract registers and PO controls, with structured tender governance and monitoring of expenditure including off-contract and consultancy spend. • Contract pipeline identified through forward planning exercises and contract registers, with active collaboration with NWSSP to confirm and maintain the Trust's contractual position and pipeline visibility. • Purchasing card usage is governed by financial control procedures, including restrictions on usage, requirement for approvals, limits on transactions, and alignment with standard procurement processes (e.g. requirement for purchase orders and adherence to contract arrangements).	• Assurance provided through procurement audit reports, contract monitoring documentation, PO compliance reports and NWSSP assurance frameworks evidencing adherence to procurement processes and value testing. • Committee reporting and contract portfolio reviews provide visibility of pipeline (including renewal timelines and risks), supporting governance oversight and enabling economies of scale. • Assurance through compliance with financial control procedures, including audit and governance oversight, and evidence from finance reporting and compliance monitoring aligned to SFIs and procurement controls.
Procurement – Signalling • Organisation has considered placing a hold on certain items (e.g. external venue hire). Although the savings will be low, can act as a signalling mechanism.	n/a	n/a

Colour Key:- **financial controls** are black **grip actions** are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
VAT recovery management • Review latest contracted out services guidance to ensure all eligible VAT is being reclaimed.	Contract in place with EY	Quarterly reviews take place along with ad hoc Capital reviews
Income and Debt management • A NHS visitor and migrant cost recovery programme in place. • Bad debt cost management process in place e.g.:- ○ Ensure debtors categorised logically (e.g. NHS, Non-NHS, Private Patients, Overseas, Salary Sacrifice, Prescriptions, Salary Overpayments, etc.) with agreed risk based, proportionate approach to collection for each category. ○ Identify strategy for key debtors, and set collection targets for team members. ○ Review processes in place to ensure invoices are issued in real time or as soon as possible. ○ Consider payment in advance/on delivery where appropriate or the use of pro forma invoices in areas such as private patients backed with settlement facilities available at point of delivery. ○ Identify and address internal issues that are preventing timely collections i.e. unresponsive / untimely resolution of queries by divisions. ○ Scrutinise requests to write-off salary overpayments (if historic practice shows these are material). ○ Ensure prompt referral to external debt recovery agencies where necessary.	Bad debt policy in place, Trust actively chases overdue invoices and utilises CCI to recover debts Activity in the space is relatively low, bulk of WAST income with SLA's, contracts or ad-hoc work for the HB's	Weekly reviews of bad debt and requests to DDOF for approval to take to CCI

Colour Key:- **financial controls** are black **grip actions** are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
Stock Management • Ensure appropriate stock rotation processes are in place and being followed to minimise wastage. Agree process with suppliers to swap out short shelf life items or use consignment. • Review stock level minimum and maximum thresholds in line with current usage to minimise wastage. • Review delivery charges, triggers and schedules and implement changes to reduce any carriage charges where possible (e.g. standing orders, minimum order values, 3 day delivery rather than next day). • Review controls on consignment stock.	Minimum / Maximum levels of stock held at operational stations and vehicles. Waste audits undertaken by QSPE / Operations via site visits Rolled out Supply X to key stations In House Logistics service that also holds central stock for distribution	Annual stock values held in annual accounts where high stock level stations are counted and reported 5 MRD sites in WAST add extra resilience Rolled out Supply X to key stations

Colour Key:- **financial controls** are black **grip actions** are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
Estates • Review outliers identified from benchmarking overall running costs for facilities and estates (inc. estates footprint use) (see the VAULT). • Ensure appropriate maintenance schedules in place to ensure asset kept in good working order. • Ensure an estates strategy is in place and regularly reviewed, to include estate rationalisation consideration to determine where savings might be delivered. • Establish list of ongoing and planned estates and maintenance projects and ensure it has been prioritised and has Board approval.	WAST outside/outlier benchmarking process Regular estate maintenance programs are in place Estates strategy is still live	Both internal and external audit reviews. • Data collection is undertaken in-house and reported annually via NWSSP Specialist Estate Services. • Day to day operational Maintenance & Engineering teams utilise estates systems for PPM schedules daily and report into governance groups for check and challenge as mentioned. • Good recent Audit Wales review of estates • Significant improvement in overall estates condition and backlog maintenance values over recent years. • Range of estates disposals over recent years and significant increase in estates utilisation, post pandemic impacts

Colour Key:- **financial controls** are black **grip actions** are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
Journal Approvals • Internal journal review process in place and regular accruals and prepayments have been reviewed to ensure they remain current and the method of calculation is based on up to date assumptions. • Controls over journals are appropriate including posting authorisation levels, review and sign off process.	Business as Usual – • Oracle E-Business Suite – System Access and Ledger Security FCP – includes General Ledger Input Procedures covering Journal processing, postings and approval. • Oracle keeps an automated record of all journals posted which can be linked back to source. • Feeders Control Sheet completed by Core Accounting Team for all external feed journals from outside the Oracle system. • Prepayments reconciled monthly	All journals are either posted/signed off by a separate member of the team or via the overnight process. Internal audit review on financial process and systems File provided for approval prior to posting prepayments Accrual reviewed as part of month end process by Business Partners
Fixed Assets and Capital • Fixed asset register is in place and regularly updated including a fixed asset verification exercise. • Review capital programme for subsequent revenue affordability, deferring, reducing or stopping schemes as appropriate. • Asset lives regularly reviewed to ensure appropriate and that depreciation is consistent with consumption. • Consider reprioritising the capital programme to prioritise spend-to-save projects. • Review assets held on SoFP (buildings, equipment etc) and dispose of any no longer in use or needed. • Consider VfM of ownership options such as lease v purchase.	Business as usual – Business case process to ensure affordability Assets are verified as and when required, lives are reviewed against manual for accounts and local intelligence Analysis where possible is considered for lease vs purchase, however due to buying power leasing is highly unlikely to be the best VFM option for long term solutions	Annual audit, internal audits. Local reviews of accounting treatment Assessment undertaken where not undertaken previously or market exists for leasing, lessons learn from previously lease options have proved the initial costs are rarely the final costs and the total costs are hard to estimate

Colour Key:- **financial controls** are black **grip actions** are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
Balance Sheet Review • Ensure all balance sheets are reconciled at appropriate intervals and action is taken to address historical balances. • Monthly assessment of existing provisions to determine whether these can be released during year as opposed to later in the year/year end. • Review all credit balances on the Balance sheet for potential over accrual (e.g. Annual Leave Accrual or GRNI balances).	Reconciliation processed monthly. Check to ensure balances are in alignment to latest intelligence	Monthly balance sheet review packs. Annual audit

Colour Key:- **financial controls** are black **grip actions** are blue

Agenda Item No.	7

REPORT TITLE

Manchester Arena Inquiry Progress Update: Commissioner Response and Residual Risk Position

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a as the meeting is in public

REPORT SPONSOR

Executive sponsor	Lee Brooks, Chief Operating Officer
Author(s) of report	Lee Brooks, Chief Operating Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This paper provides the Finance & Performance Committee with an update following receipt of the Joint Commissioning Committee's formal response to the Trust's Manchester Arena Inquiry Recommendation 106 submission and the Trust's subsequent reply. It sets out the current position, areas of agreement and continuing difference, residual risks and the work underway with commissioners, Welsh Government and NHS Performance & Improvement.

2. The Joint Commissioning Committee has concluded that the majority of the Trust's proposals represent proportionate and targeted enhancements and supports these proceeding through the Trust's internal prioritisation arrangements. It has also identified proposals requiring further development through the IMTP process and future planning cycles. The Trust welcomes this recognition and the commitment to continued engagement.

3. The principal area of disagreement concerns the proposed increase in emergency ambulance capacity, which commissioners did not support at this time. The Trust respects that conclusion but has confirmed that it does not change the Trust's assessment of the capability and resources required to implement the outstanding recommendations in full.

4. The Trust has continued to progress recommendations where reasonably possible using existing resources, including the Incident Response Desk, an additional Operational Commander post in North Wales, Multi-Casualty Triage Bags, EPRR restructuring and the Welsh Government funded SORT enhancement. Further material proposals remain wholly or partially unfunded, including training and exercising, control room EPRR capability, Tactical Incident Command, body-worn video and wider HART developments.

5. Further internal absorption is increasingly difficult in the context of financial constraint and recurrent savings requirements. Reprioritisation also reduces the Trust's ability to invest elsewhere. Residual capability, affordability, preparedness and risk ownership issues therefore remain and will continue to be managed through Corporate Risk 641 and engagement with commissioners and Welsh Government.

6. The Trust is engaged with NHS Performance & Improvement on options relating specifically to specialist assets for North Wales. The case for HART expansion in South Wales has also been submitted to Welsh Government and is endorsed by NHS Performance & Improvement. The case was not brought back for submission approval because it was included within the Trust Board approved submission to commissioners and Welsh Government. If the proposal is supported, spending approval will be sought through the Trust's normal governance arrangements before any commitment is made.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. Receive assurance on progress since the Committee's previous update;
2. Note the commissioner response and the Trust's subsequent reply;
3. Note the areas of agreement and continuing difference, including the Trust's unchanged assessment of the emergency ambulance capacity requirement;
4. Note the residual operational, strategic and financial risks and the actions underway to manage them; and
5. Note the position on specialist assets for North Wales and the submission of the HART South Wales expansion case to Welsh Government.

ADDITIONAL PAPER(S)

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

The Committee is requested to receive the following in the Reading Room:

Annex 1 Joint Commissioning Committee correspondence dated 10 August 2026

Annex 2 Trust response dated 24 August 2026

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
Corporate Risk 641: The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry recommendations impacting its response to a major incident/mass casualty incident.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
8 September 2026	Operations Senior Leadership Team
Circulation	Executive Leadership Team

SITUATION

1. The Trust submitted its Manchester Arena Inquiry Recommendation 106 assessment to commissioners and Welsh Government in August 2024. Following an extended period of scrutiny, review and discussion, the Joint Commissioning Committee formally responded to the Trust on 10 August 2026.

2. The commissioner response recognises that the majority of proposals represent proportionate and targeted enhancements and supports these progressing through the Trust's internal prioritisation arrangements. It also identifies proposals requiring further development through the IMTP process and future planning cycles.

3. The response does not support the proposed increase in emergency ambulance capacity at the current time. The Trust replied on 24 August 2026, acknowledging the areas of agreement while setting out those matters where its assessment remains unchanged.

4. This report updates the Committee on the implications of the commissioner response, the unresolved risks and the actions being taken.

BACKGROUND

5. Recommendations 105, 106 and 107 of the Inquiry concern ambulance service assessment of mass casualty capacity, recommendations to commissioners on additional or different resources, and urgent consideration of those recommendations by the responsible government and commissioning bodies.

6. Since the Trust's submission, commissioners have undertaken structured stakeholder workshops, collaborative assessment sessions with Health Boards, independent legal advice and an external review. The Trust has participated in the scrutiny process and provided supporting evidence and clarification.

7. The external review broadly validated the seriousness and credibility of the Trust's assessment, while identifying some differences regarding scale, sequencing and the balance between additional resources and alternative delivery models.

8. The Trust has not stood still while awaiting the formal commissioner position. Progress has included the Incident Response Desk and work to create the National Operations Coordination Centre, Multi-Casualty Triage Bags, one additional Operational Commander post in North Wales, elements of EPRR restructuring and Welsh Government funded SORT enhancement.

9. The Committee's previous report noted that a number of material proposals remained dependent on external funding and system decisions. The commissioner response now provides some clarity on the areas supported, requiring further development or not supported at present.

ASSESSMENT

10. The formal response is helpful in confirming material areas of agreement, though specificity is being encouraged. The Trust welcomes commissioner recognition that the majority of proposals are proportionate and targeted, together with the commitment to continued work through the IMTP and future planning cycles.

11. The central difference concerns emergency ambulance capacity. Commissioners have not supported this proposal at the present time. The Trust has confirmed that this remains the commissioner position and does not alter the Trust's evidence-based assessment of the resources required to address the identified capability gap.

12. The Trust also differs from any implication that the remaining requirements can be met in full through internal prioritisation or the existing resource envelope. Investment already made internally has required the redirection of financial allocations and management capacity from other priorities. This has opportunity costs and is becoming more difficult in a highly constrained financial environment with recurrent savings requirements.

13. Material proposals that remain wholly or partially unfunded include (but not limited to) the Training and Exercising function, control room EPRR capability, Tactical Incident Command capability, body-worn video and wider HART developments. Several require recurring capability growth rather than one-off expenditure.

14. Mutual aid remains an important resilience mechanism but is not a direct substitute for Welsh capability where operational modelling identifies a material gap. This is particularly relevant in North Wales, where access to specialist cross-border support may be affected by availability, competing incidents, threat levels and mobilisation times. Independent and voluntary sector capability also complements, rather than replaces, appropriate core provision.

15. The principal emerging risks are: funding and affordability risk where recurrent proposals remain unfunded; residual capability risk where gaps are only partly mitigated; preparedness risk because recruitment, training, equipment and exercising require lead time; and risk ownership where responsibilities for unfunded residual risk require continued system discussion.

16. These risks are more significant in the context of major events planned in Wales, including the Tour de France stage in 2027 and UEFA EURO 2028 activity; now described as a 31-day festival with a footprint extending way beyond the Principality Stadium in Cardiff. The Trust has not identified these events as the basis for its Recommendation 106 assessment, but they reinforce the need for timely decisions on preparedness and resilience.

17. The Trust will continue to manage its organisational exposure through Corporate Risk 641. It will also seek clearer commissioner and Welsh Government positions on supported proposals, funding, national responsibilities and ownership of residual risk.

18. The Trust is engaged in discussion with NHS Performance & Improvement regarding options specifically relating to specialist assets for North Wales. This work will consider the appropriate operational construct options before any further proposal is brought forward. We are seeking some guidance on direction of what options are worthwhile including in any business case creation.

19. The case for expansion of HART in South Wales has now been submitted to Welsh Government and is endorsed by NHS Performance & Improvement. It was not returned for separate submission approval because it formed part of the Trust Board approved submission to commissioners and Welsh Government. This does not constitute approval to spend. If Welsh Government confirms support, the associated expenditure and implementation proposal will be brought through the Trust's normal governance and spending approval arrangements.

20. Overall, partial assurance can be taken from the commissioner support for the majority of proposals and the progress already made. Assurance remains qualified because material capability gaps and recurrent funding requirements remain unresolved and are dependent on further system decisions.

RECOMMENDATION (S)

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

NEXT STEPS

22. The Trust will continue to engage with commissioners to secure detailed confirmation of the treatment of each proposal and the route for matters requiring further development through the IMTP and future planning cycles.

23. Discussion will continue with Welsh Government and NHS Performance & Improvement on specialist assets for North Wales and the HART South Wales expansion case.

24. Residual risk will remain under review through Corporate Risk 641, with the risk description, controls, actions and assessment updated to reflect the formal commissioner response and subsequent developments.

25. Any proposal receiving external support that requires expenditure or implementation approval will be brought through the Trust's established governance arrangements before commitments are made.

26. Further high-level updates will be reported to the Finance & Performance Committee in public where this can be done without disclosing sensitive operational vulnerabilities.

Agenda Item No.	8

REPORT TITLE

Monthly Integrated Quality Performance Report – June/July 2026

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a as the meeting is in public

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. The purpose of this report is to provide the committee with the Monthly Integrated Quality and Performance Report for **June and July 2026**, bringing together the Trust's key indicators across Our Patients, Our People, Finance and Value, and Partnerships and System Contribution, in the top scorecard that goes to every committee and Trust Board, and then more committee specific indicators.

2. The report has been further refined this month to strengthen specific committee oversight, including a clearer focus on specific measures, greater use of trajectories, and more explicit interpretation of SPC charts. This remains an evolving product and further refinement will continue as the new format beds in.

3. For ambulance response, the new Purple (Arrest), Red (Emergency), Orange (Now), Yellow (Soon) and Green (Planned) categories are now established. Arrest performance remains within the expected target range, while Emergency and Orange (Now) performance continue to indicate that the current system is not yet able to consistently achieve the required standards. Stroke and STEMI call-to-door times also remain significantly above the Trust's ambition, reflecting the wider pressures across ambulance response and hospital handover.

4. Hospital handover performance has improved materially compared with the same period last year, with 9,929 hours lost in July 2026 compared with 12,565 in July 2025. This is welcome progress, although performance remains significantly above the level the Trust's operating model is designed to cope with i.e. three quarters of this number of lost hours.

5. 111 call handling performance has deteriorated in recent months. July's 2026 abandonment rate was 15%, and SPC indicates the service is not currently able to reliably achieve the 10–15% ambition consistently within the existing resource envelope.

6. Ambulance Care performance remains mixed. While cancellation performance overall remains a concern and is now a key area of focus within the wider NEPTS Improvement Programme.

7. Finance and Value indicators show a mixed position: the Trust remains on plan financially, EA productivity (jobs per shift) is above the independently modelled ambition. At one level this is good – an EA is undertaking more jobs – but at another level it means that the EA is not free to respond and deliver lower response times, particularly for Orange. APP productivity is different, the Trust wants APPs to be busier, as they are aimed at lower acuity incidents, where being free to respond is less of an issue. NEPTS cancellations continue to indicate areas where the current system is not yet delivering the required level of value and efficiency consistently. Work is currently being undertaken, in conjunction with the JCC, to assess, and better understand. productivity metrics across the Trust.

8. Partnerships and System Contribution indicators show encouraging progress in some areas, particularly the consult and close rate (although this has dipped in recent months), reduced patient cancellations and 111 outcomes, but system indicators such as conveyance to ED and hospital handover require further transformation.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is requested to:

Consider the June/July 2026 Integrated Quality and Performance Report and actions being taken and determine whether:

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

ADDITIONAL PAPER(S)

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

Annex 1 Monthly Integrated Quality and Performance Dashboard

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
223 The Trust's inability to reach patients in the community causing patient harm and death **224** Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients **100** Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience **139** Failure to deliver our Statutory Financial Duties in accordance with Legislation

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

SITUATION

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

BACKGROUND

2. The F&P Committee specific MIQPR continues to evolve. This is the second committee specific iteration of the F&P MIQPR. The scorecard is the Trust Board approved one, but the graph pack includes additional specific F&P metrics, based on discussions with the lead executives for this committee and the Director of Corporate Governance/Board Secretary. These metrics focus on time, capacity, resource and value.

3. Trajectories are not yet included for the operational time-based response metrics e.g. Red and Orange. These measures are more complex to model and require a longer period of stable data from the new clinical model before reliable modelling can be presented to the committees and Trust Board. The Trust is taking active steps to update its simulation models and is aiming to model the planned changes it is making to patient flow optimisation through the new model, in time for winter and the associated winter plan.

4. Previous iterations of the MIQPR have included Statistical Process Control (SPC) charts.

> Statistical Process Control (SPC) charts help distinguish between the normal variation expected within a stable process and signals that performance has changed. The centre line shows average performance, while the upper and lower process limits show the range within which results would usually be expected to fall.
>
> Patterns within the limits indicate common cause variation. Patterns such as a sustained shift above or below the average, a trend, or a single point outside the limits indicate special cause variation and should prompt further consideration.
>
> SPC helps decision makers assess not only whether performance is above or below target, but whether the current system is able to achieve that target consistently.

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

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

ASSESSMENT

Our Patients

6. **Ambulance Response** (safety / patient experience): on 1 July 2025, phase one of the Trust's New Ambulance Performance Framework was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. In July 2026, there were 975 purple calls to the ambulance service, around 2.64% of all calls, and 5,089 (Emerg) red calls, around 13.72% of all calls. The main measure for Purple Arrest calls is the Return to Spontaneous Circulation (ROSC) rate which was 23.4% in July 2026 compared to 20.3% in June 2026, with an underlying upward trend.

7. The July 2026 median response times for Purple and Red calls were 7 minutes 39 seconds and 9 minutes 13 seconds respectively, against the required range of 6–8 minutes. Purple performance remains within range; however, Red performance remains above the required range caused by the RCS0 deflection rate to RICS not being high enough (RCS0 incidents timing out after 60 seconds), ambulance unit hours produced and handover lost hours. Improvement work is being progressed through the Clinical Model Transformation Programme, with a specific Task and Finish Group focused on call categorisation and flow optimisation. This includes work on breathing difficulties and RCS/Clinical Navigator capacity, with the aim of increasing the proportion of RCS0 incidents clinically screened and appropriately directed into RICS before timing out into the Emergency dispatch queue. The Trust is currently reviewing how it might boost ambulance production in advance of winter. The pan-Wales application of W45 is also key.

8. This work is being supported by continued operational grip through the weekly Operations Performance Meeting, winter planning, the Productivity Improvements Tracker, and ongoing focus on workforce planning, recruitment and unit-hours production. Delivery of the W45 ambition remains a key dependency for sustained improvement in response performance.

9. On 2nd December 2025, the second phase of the New Ambulance Performance Framework went live. Amber and Green categories were removed, and new Orange (Now), Yellow (Soon) and Green (Planned) categories were introduced for those patients needing a face-to-face response. The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand. The July 2026 median response times for Now (Orange) was 1 hour 5 minutes, just higher than the ambition of one hour, noting that July demand was unusually high – winter in summer – linked to the heatwaves.

10. **RICS 90th Percentile** reporting metric under development and should be available for formal reporting within the next two to four weeks. Internally, operational managers do have access to RICS metrics, but further work is required to assure the changes and data definitions before public reporting can commence.

11. **Can't Send and Cancelled** by Patient Volume In July 2026, 5,456 ambulances were cancelled by patients, a slight decrease from the 5,882 cancelled in June 2026.

12. **111 call answering** performance has minimally improved over recent weeks, with the call abandonment rate for July 2026 being 15%, and therefore just achieving the 10% to 15% ambition. The SPC chart in the slide deck suggests that the current system, capacity and processes will not deliver the required level of performance consistently. 111 demand in July 2026 did see an 24% increase compared to July 2025. The ELT have recently received a detailed paper setting out a performance improvement plan focusing on areas of efficiency.

13. **111 Welsh Call Answering**, in July 43.2% of Welsh calls offered were answered. This remains below the 70% ambition and has remained below target since November 2024. The improvements set out in paragraph 12 above apply here also. Further work is being undertaken on how realistic the attainment of the 70% ambition is.

14. **999** call answering times during July 2026 saw the 95th percentile decrease minimally to 35 seconds. However, the 65th percentile and median performance times remained consistently good. Work has been undertaken on demand and capacity analysis of 999 call demand, but further work is required, due to a disparity between internal modelling and external modelling.

15. **Advanced discharge and transfer journey** performance increased to 72.2% (95% target), with this primarily being an issue with capacity. Same day discharge and transfer journey performance achieved 94%, just dropping below the 95% target. The same day discharge and transfer performance is a positive metric, but discussions through the IMTP development process have identified that

cancellations (whether by the Trust, by patients or by health boards) are too high, accounting for 18% of demand (serviced demand + cancellations). The Trust is already undertaking a complex and difficult re-roster of NEPTS transport and has a range of improvement actions underway, with a particular focus around digital solutions e.g. two way texting, apps for patients.

Finance & Value

16. **NEPTS Activity Total Cancellations** reached 18.4% in July 2026. Ambulance Care cancellations, although above target, have been within normal process limits over the past 12 months. The NEPTS Improvement Programme is the main transformational response to this metric.

17. **Financial Balance**: at Month 4 the Trust achieved both its External Financing Limit and its Capital Resource Limit.

18. **Average Jobs per Shift**: overall, EAs averaged 3.16 jobs per shift during July 2026. The ambition for this metric has been independently modelled at 2.3. This may seem low but is based on EAs being free to respond to achieve an Amber 1 median (the modelling was undertaken prior to the new APF) of 30 minutes. APPs attended an average of 2.43 jobs per shift during July 2026, with planned improvements to achieve the ambition of 4.75 jobs per shift before winter.

19. **Fleet reporting** metric under development.

Our People

20. **EMS Production**: the Trust produced 116,549 Ambulance Response unit hours during July 2026 and delivered an emergency ambulance unit hours production (UHP) of 89%, not achieving the 95% target. Reduced overtime (linked to the financial plan), abstractions (IMTP productivity measure) and UCS recruitment (under review) are the underlying causes.

Partnerships & System Contribution

21. **Albot and Webchats**. In July 2026, the website had 323,162 visits and Albot hosted 5,328 conversations, reaching 1.65% achieving the 1.35% ambition (this has been consistently the case for the past four months). The Trust is planning further improvements to its 111 digital front end in advance of winter.

22. **111 Outcomes** from February 2025 to June 2025, a concern was noted as outcomes were increasing; however, recently there has been an improvement (reduction) in 111, 999 & ED outcomes over the past few months. In July 2026 outcomes to 999 and EDs reached 16.4%.

23. **The consult & close rate** was 15.8% in July 2026, a decrease from the previous month (17.1%) and not achieving the IMTP ambition of 22%; however, there has been a material uplift in the consult & close rate as a result of the CMT Programme, with a possible cause in is reduction being a definitional issue caused by the move to the RICS single queue. There will be a series of meetings in September to get underneath what is happening and resolve this. Reduced taxi budget may also be a contributory factor.

24. **See and Treat**: the number of incidents treated at scene and referred to alternative pathways have both remained relatively stable over the past year. There are different definitions available for see & treat in different parts of the UK and this needs to be reviewed further.

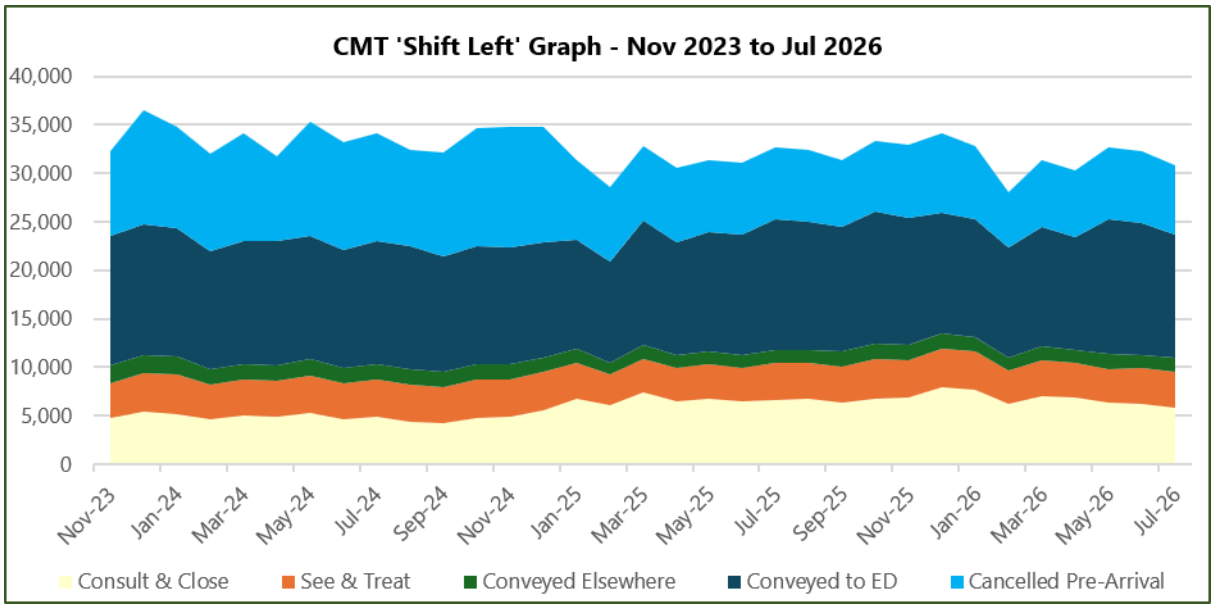
25. Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS demand has increased over the past few months within past seasonal trends but also due to the heatwave currently being experienced. EMS production has minimally reduced to 86% in July 2026. Whilst there has been a reduction in handover lost hours, the Trust lost 9,929 hours in July 2026, with W45 equating to less than 7,000 hours per month, so the lost hours remain a significant drain on the Trust's ability to respond in a timely manner. The Trust's main focus is to continue to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme. Areas of focus for 2025/26 include:

    - Further investment and improvement into remote clinical capacity and process (additional 10 w.t.e in place from Oct / Nov);
    - Further improvement to productivity of APPs, in particular, scheduling and re-rostering;
    - Further development of the remote integrated care service (111 clinicians and CSD clinicians);
    - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: use of volunteers, Falls Desk, Falls response, Respiratory Desk etc.; and
    - The transformation of the various clinical model categories as per the previous paragraph.

26. For the **W45 target**, the chart shows there was a sustained improvement in performance between April 2025 and December 2025, with variation remaining below the mean for seven consecutive months. Recently, the Trust has supported three workshops with ABUHB, BCUHB and SBUHB, as requested by NHS Wales Performance & Improvement. The main outputs from these meetings are performance plans with performance trajectories to achieve the W45 target. The Trust will start monitoring these internally.

27. **Number of Conveyances to ED** these conveyance rates remain above the 30% target, meaning the system is not currently able to deliver the ambition. It is likely that the deteriorating conveyance rates were due to a reduction in the number of lost hours to handover.

28. Finally, the following graph aims to provide a composite picture of the impact of the Trust's CMT Programme through a longer period of time. The time series analysis clearly shows the uplift in the consult & close rate, a reduction in patient cancellations, with conveyance to ED remaining stable (the Trust has actually seen increased conveyance of high acuity patients resulting from reduced cancellations and increased ambulance availability), but with see & treat not really demonstrating any movement. This is an area of focus into 2026/27.



RECOMMENDATION (S)

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

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

Monthly Integrated Quality & Performance Report

June/ July 2026
Annex 1 – Top Indicator Dashboard

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

Version 1.0
September 2026

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Ambition 2026/27	May-26	Jun-26	Jul-26	2 Year Average	RAG
Our Patients (SO1&5)						
Return of Spontaneous Circulation (ROSC)	25-30%*	22.1%	20.3%	23.4%	21.6%	A
Stroke Call to Hospital Door Times	01:30	02:32	02:43	02:14	02:28	R
STEMI Call to Hospital Door Times	01:30	02:46	02:35	02:27	02:34	R
NOF Call to Hospital Door Times						
Arrest (Purple) Median	6-8 Minutes*	07:45	07:42	07:39	N/A	G
Arrest (Purple) 90th	<20 Minutes	18:00	18:20	18:27	N/A	G
Emerg. (Red) Median	6-8 Minutes*	09:12	09:32	09:13	N/A	R
Emerg. (Red) 90th	<20 Minutes	22:39	23:14	22:07	N/A	R
Now (Orange) Median	<60 Minutes	01:22	01:29	01:05	N/A	A
Time to Integrated Care RICS 1 90th Percentile	<60 Minutes					
Can't Send & Cancelled by Patient Volumes	<5,770	6,109	6,288	5,905	6,837	A
NHS111 Call Handling Abandonment Rates	<10-15%	19.7%	16.1%	15.0%	12.4%	G
Renal Repeat Cancellation +	Zero	N/A	N/A	N/A	N/A	
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	>70%	72.8%	74.2%	75.3%	76.6%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	>95%	72.7%	67.6%	72.7%	77.6%	R
% of 111 call presented in Welsh, Answered in Welsh	>70%	51.3%	58.0%	43.2%	58.7%	R
National Patient Reported Experience Measure (average overall experience score)	85%					
Concerns Response within 30 Days	>40%					
Enactment of the Duty of Candour Total	100%	100%	100%	0%	N/A	R
National Reportable Incidents reports (NRI)	MOA	12	2	5	5	MOA
Joint Investigation Framework Referrals to HBs	<7	10	15	N/A	13	R

Top Monthly Indicators	Ambition 2026/27	May-26	Jun-26	Jul-26	2 Year Average	RAG
Our People (SO2)						
% of Under-represented Groups Offered	>7%	34.4%	26.7%	12.5%	N/A	G
EMS Hours Produced (Against Planned)	95%	87%	87%	86%	86%	A
Sickness Absence *(all staff)*	<6%*	7.62%	7.70%	8.17%	7.91%	R
Staff Turnover Rate	<10%*	8.36%	8.32%	8.42%	8.11%	G
PADR/Medical Appraisal	>85%	74.63%	73.67%	73.47%	73.83%	R
Statutory & Mandatory Training	>85%	89.52%	89.31%	89.08%	86.97%	G
Finance & Value (SO6)						
Average Jobs per Shift (EA)	>2.3	3.06	3.02	3.16	2.79	G
Average Jobs per Shift (APP)	4.75	2.59	2.59	2.43	2.93	R
NEPTS Activity Cancelled (by CMP, Patients & HBs)	<10%	18.3%	19.3%	18%	17.7%	R
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	100%	G
Partnerships / System Contribution (SO3&4)						
Number of Patients using Albot	MOA	5,263	5,286	5,328	N/A	MOA
Webchats as a % of Web Site Hits	>1.35%	1.51%	1.51%	1.65%	N/A	G
111 Outcomes (999 & ED)	MOA	15.4%	17.0%	16.4%	18.9%	MOA
Successful Consult & Close Outcome	>22%	17.2%	17.1%	15.8%	18.1%	R
% See & Treat & Alternative pathways (of verified activity)	>20%	9.59%	10.03%	10.30%	10.56%	R
Number of Handover Lost Hours	<6000	14,057	13,874	9,929	17,109	R
Number of Handovers over 45 mins	Zero*	4,597	4,612	3,681	5,444	R

RAG Indicates -

TBD: Status cannot be calculated (To Be Determined)

MOA – Measure of Activity

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

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

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

*NHS Wales Performance Framework Measures 26/27 (Feb-26)

+ 4 weekly data

Delivering on our Strategic objectives

Overall strategic objective profile

STRATEGIC OBJECTIVE	DESCRIPTOR	RED	AMBER	GREEN	TBD	MOA
SO1 – Our Patients	Significant performance challenges	6	3	4	3	0
SO2 – Our People	Mixed performance	2	1	3	0	0
SO3 – Innovation & Digital Transformation	Strong performance	0	0	1	0	1
SO4 – Partnerships & System Contribution	Significant performance challenges	4	0	0	0	1
SO5 – Quality, Safety & Patient Experience	Mixed performance	2	0	0	2	1
SO6 – Finance, Resources & Value	Mixed performance	2	0	2	0	0

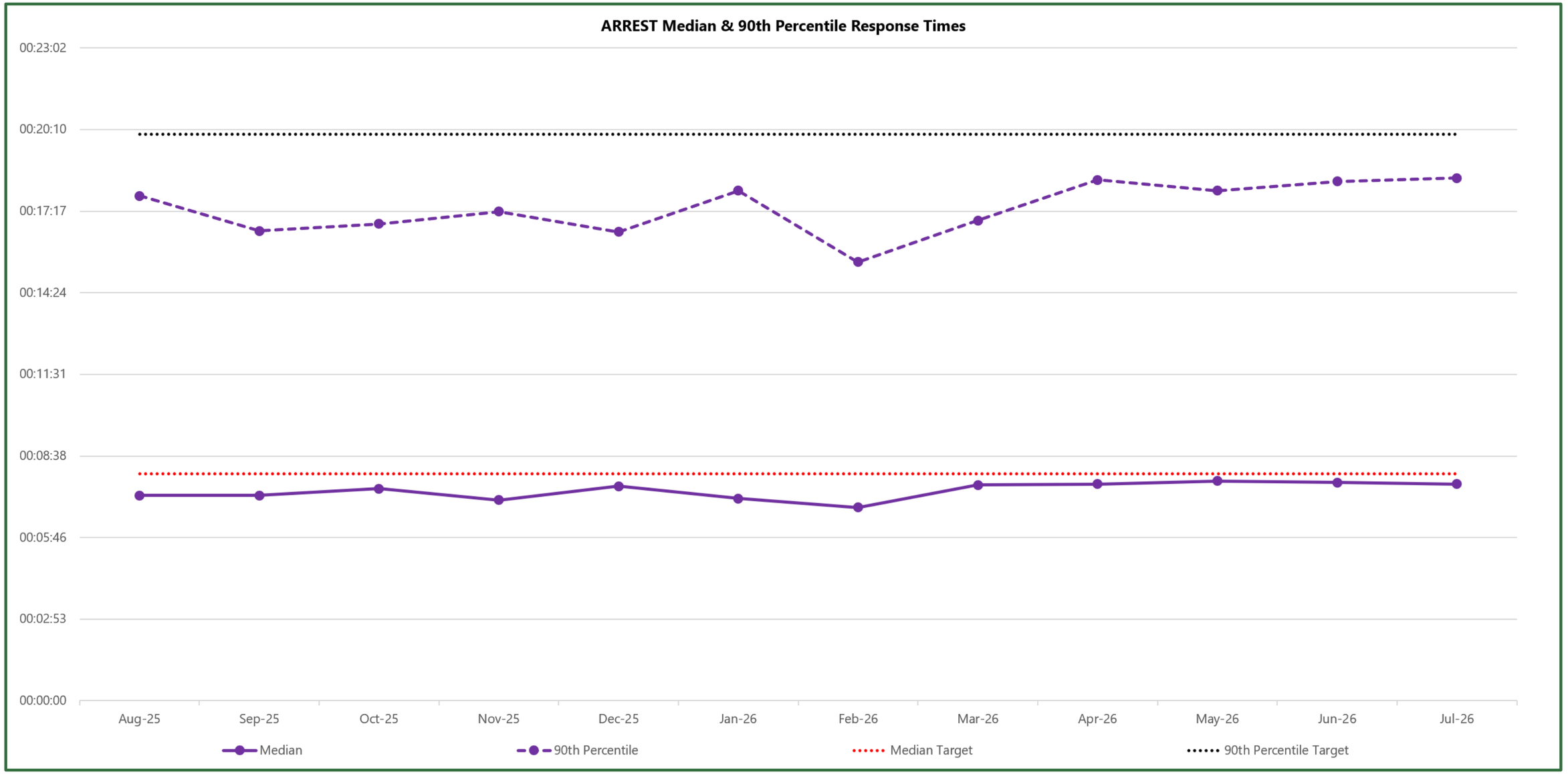
The dashboard shows significant performance challenges across Strategic Objectives 1 and 4, with mixed performance across Strategic Objectives 2, 5 and 6, and strong performance in Strategic Objective 3. The most significant challenges currently facing the organisation relate to patient access, operational responsiveness, workforce capacity and wider system flow.

Our Patients

Arrest (Purple) Indicators

Strategic Objective 1

Arrest Median	Arrest 90th
G	G

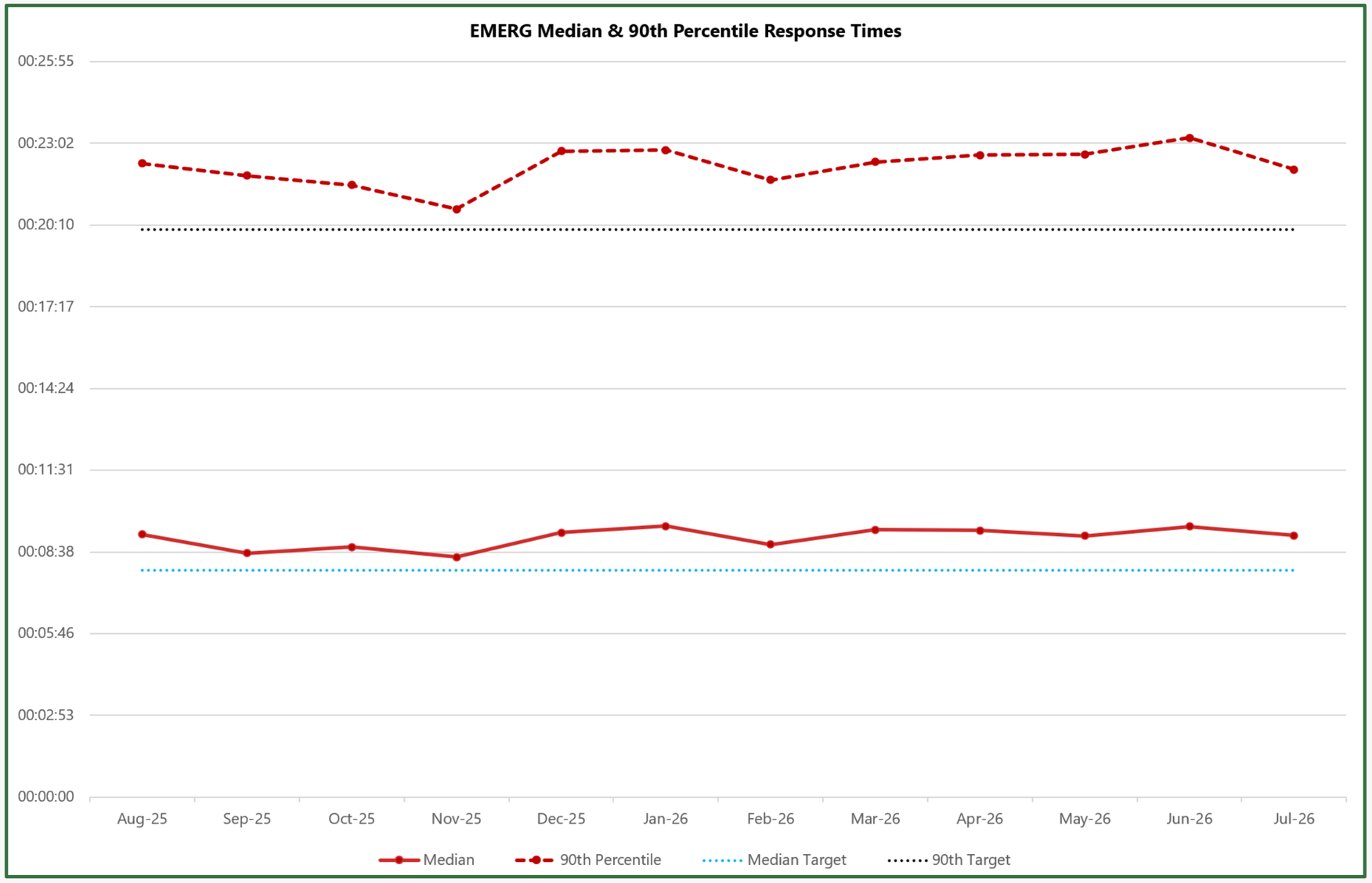


Our Patients

Emerg (Red) Performance Indicators

Strategic Objective 1

Emerg Median	Emerg 90th
R	R



Analysis

In July 2026 there were 5,069 Emerg (Red) incidents, which accounted for 13.7% of all verified incidents.
For Emerg calls the median and 90th percentile response time targets are 6-8 minutes and 20 minutes, respectively. Response times are not achieving performance targets.

The median response time in July 2026 for Emerg incidents was 9 minutes 13 seconds. Cardiff and Vale health board had the lowest median time of 8 minutes and 16 seconds, and Powys had the highest at 11 minutes and 33 seconds. For Emerg calls, the 90th percentile response time was 22 minutes 7 seconds. Cardiff and Vale had the lowest time of 17 minutes and 32 seconds, and Powys had the highest at 31 minutes and 58 seconds.

Remedial Plans & Actions

Two of the Call Categorisation (3) Flow Optimisation Task & Finish Group are relevant to this indicator 1) breathing difficulties and 6) RCS/Clinical Navigators. The aim is to increase the number of RCSO incidents which are sent for further clinical assessment in RICS, thereby reducing the Emerg demand. Solutions lie both in improving and streamlining processes, but also about reviewing clinical navigator capacity. Delivery of W45 will also be a key contributory factor.

Expected Performance Trajectory

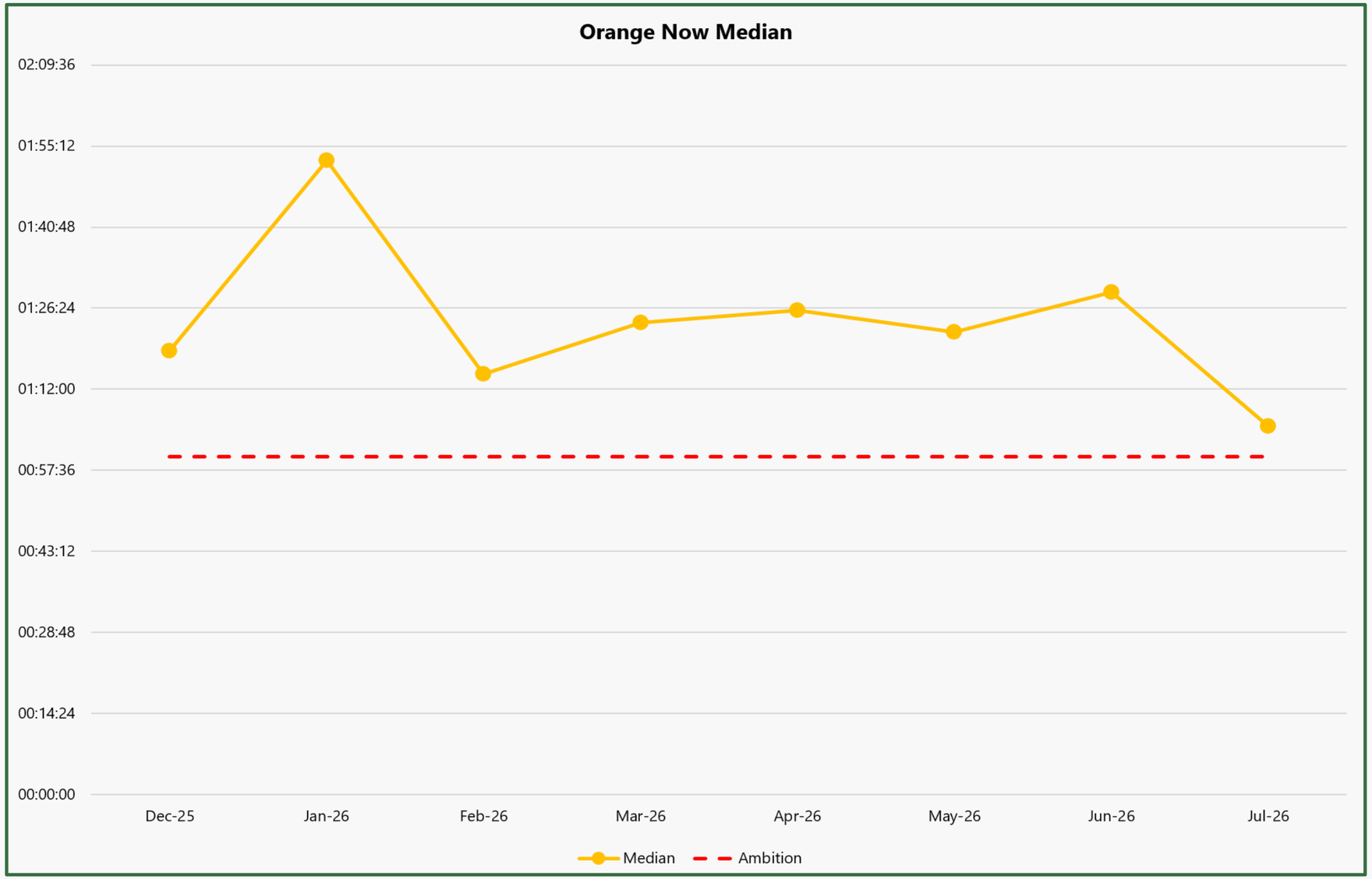
An expected trajectory will be included once the simulation software has been retuned to the new model. This is due in the Autumn and in advance of winter.

Our Patients

Orange (Now) Performance Indicator

Strategic Objective 1

Now Median
A



Analysis

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

The median response time in July 2026 for Orange (Now) incidents was 1 hour 5 minutes 29 seconds. Betsi Cadwaladr health board had the lowest median time of 46 minutes and 28 seconds, and Swansea Bay had the highest at 1 hours 28 minutes and 6 seconds.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Modelling (based on forecast December demand) recently undertaken suggested that if total time at hospital was reduced to 42 minutes (which matches the average handover time in England of 27 minutes plus the 15 minutes currently allowed), the Orange median response time would reduce to under 50 minutes and therefore achieve the WAST ambition of under 1-hour.

The modelling was also carried out based on W45, which indicated that Orange median response times would remain at just above the 1-hour threshold.

Our Patients

Time to Integrated Care – RICS1

Strategic Objective 1

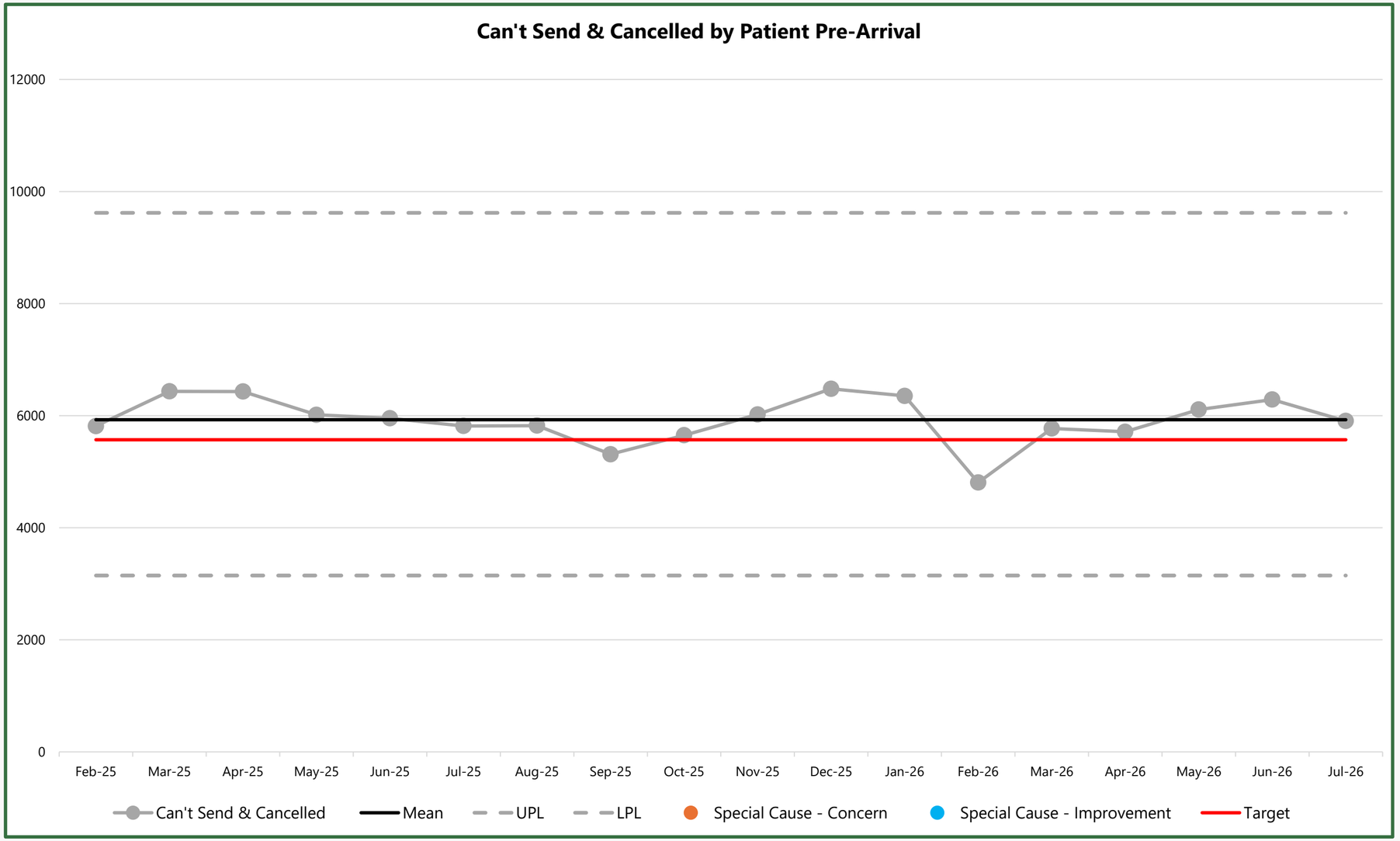
Under Development

Our Patients

No Send or Patient Cancellations

Strategic Objective 1

Can't Send
A



Analysis

5,456 ambulances were cancelled by patients in July 2026, a slight decrease from the 5,882 cancelled in June 2026. Patient cancellations have remained relatively static since early 2025, following a significant reduction from figures seen during 2024, which the Trust believes is due to the implementation of Rapid Clinical Screening during the winter of 24/25. As a result, the SPC has been reset to February 2025, when this change took effect to show the true variation within the new system. It does show that we are still not routinely delivering on the target number of cancellations.

Expected Performance Trajectory

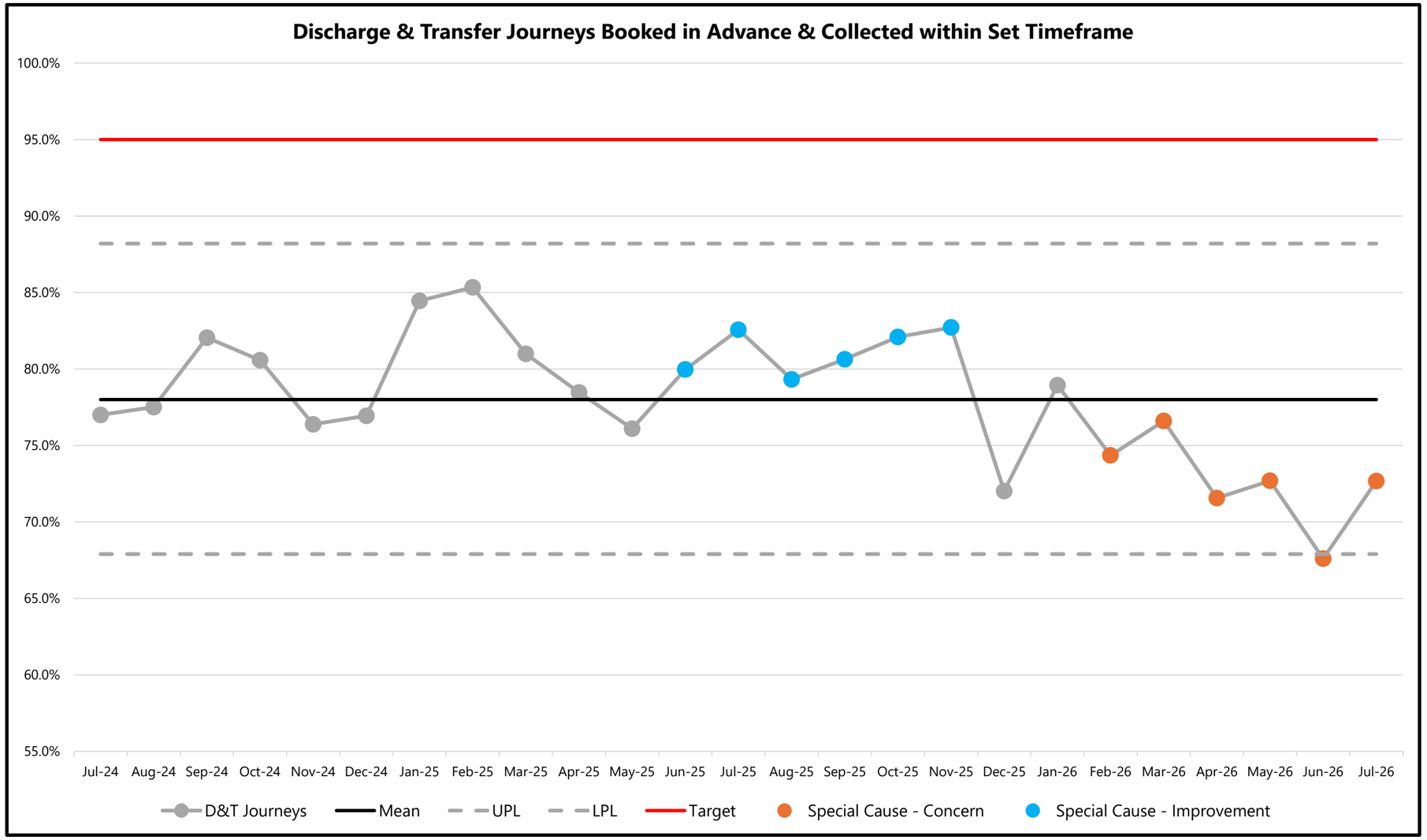
The Trust Board ambition is to reduce cancellations to <5,770, linked to the further transformation work on-going through the CMT Programme and the delivery of W45 by all health boards. It is difficult to put a trajectory on this, but the winter plan is predicated on delivery of both of these, so by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

Our Patients

Ambulance Care Indicators – Discharge & Transfers

Strategic Objective 1

Advanced D&T
R



Analysis

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment time increased slightly in July 2026 to 72.7% but remains below the 95% target. The SPC shows there has been a clear deterioration in performance over the past 6 months, with the data point for June 2026 falling below the lower process limit and showing variation which is special cause for concern.

Part of this dip in performance has been due to an increase in early bookings in certain parts of Wales that have required us to have local discussions with Health Boards about resource re-profiling. To date, no consensus has been reached on these, as resources available are still required. However, the team have adapted their planning approach to address this issue and early signs of recovery are evident.

Remedial Plans and Actions

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

Expected Performance Trajectory

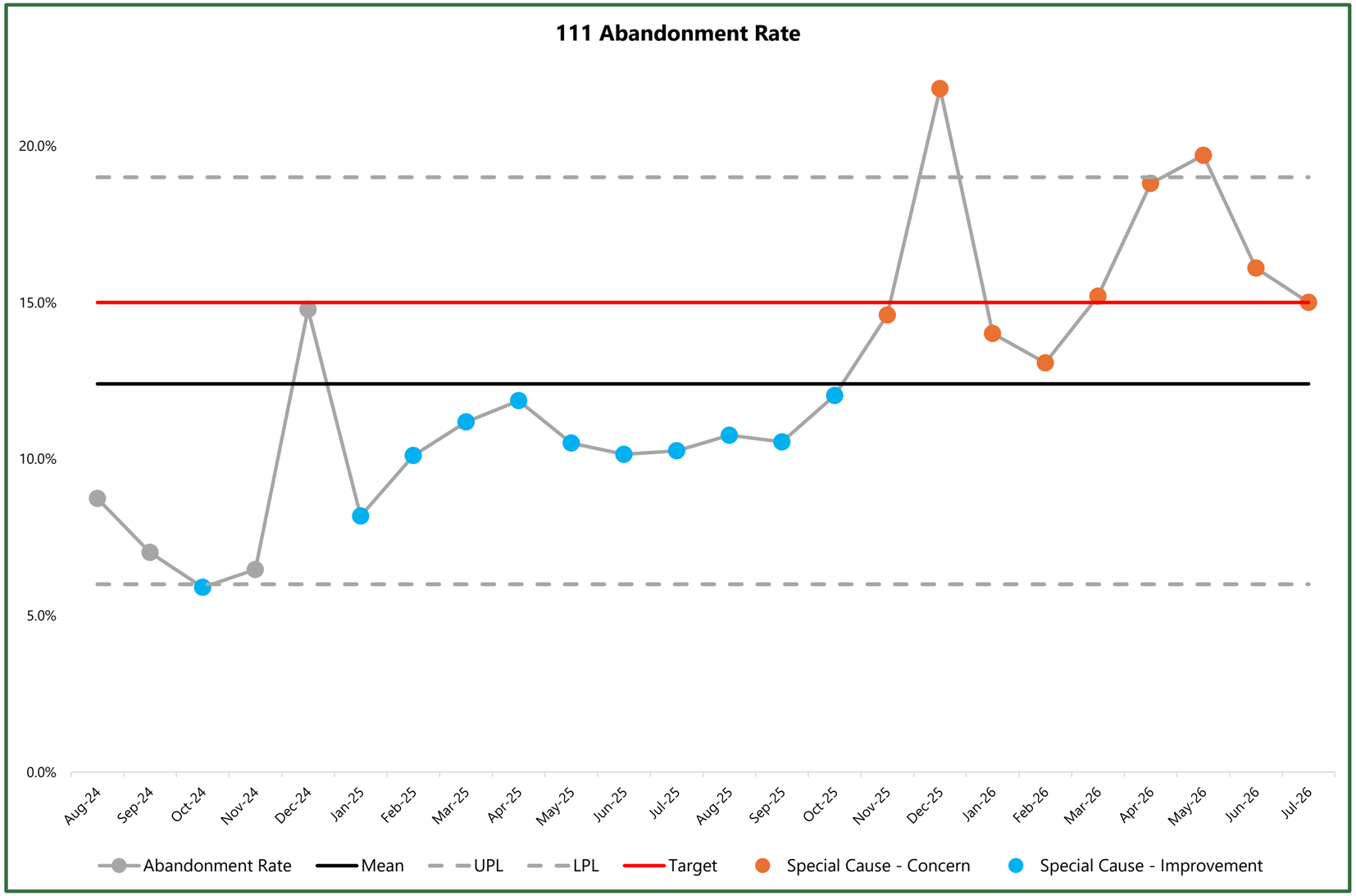
Dependent on options paper.

Our Patients

111 Call Abandonment Performance Indicators

Strategic Objective 1

Abandonment Rate
G



Analysis

The 111-call abandonment rate decreased to 15% in July 2026. Based on the SPC chart, the service is not currently able to meet the target consistently. Performance has seen a decline since October 2025, which has seen the metric consistently above the mean and in two months, above the upper process limit. This would indicate a process that is not in control.

111 call demand increased to 97,253 in July 2026. Previous analysis has shown that current capacity can sustainably handle around 85,000 calls a month, however, once this figure increases over 90,000 there is a much stronger likelihood of increased abandonment rates. Average Handling Times (AHT) have also increased in recent months. During 2024/25 AHT was below 9.5 minutes, but in early 2026 it has risen to around 10 minutes. This means a reduction in the number of calls handled per hour. Finally, changes to some of the activity required within the Clinical Advice Line (CAL) has also reduced call handling hours, with 6% of capacity reduced due to CAL in June 2026. All these factors combined with increased abstraction rates has seen a clear deterioration in 111 performance during 2026.

Remedial Plans and Actions

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

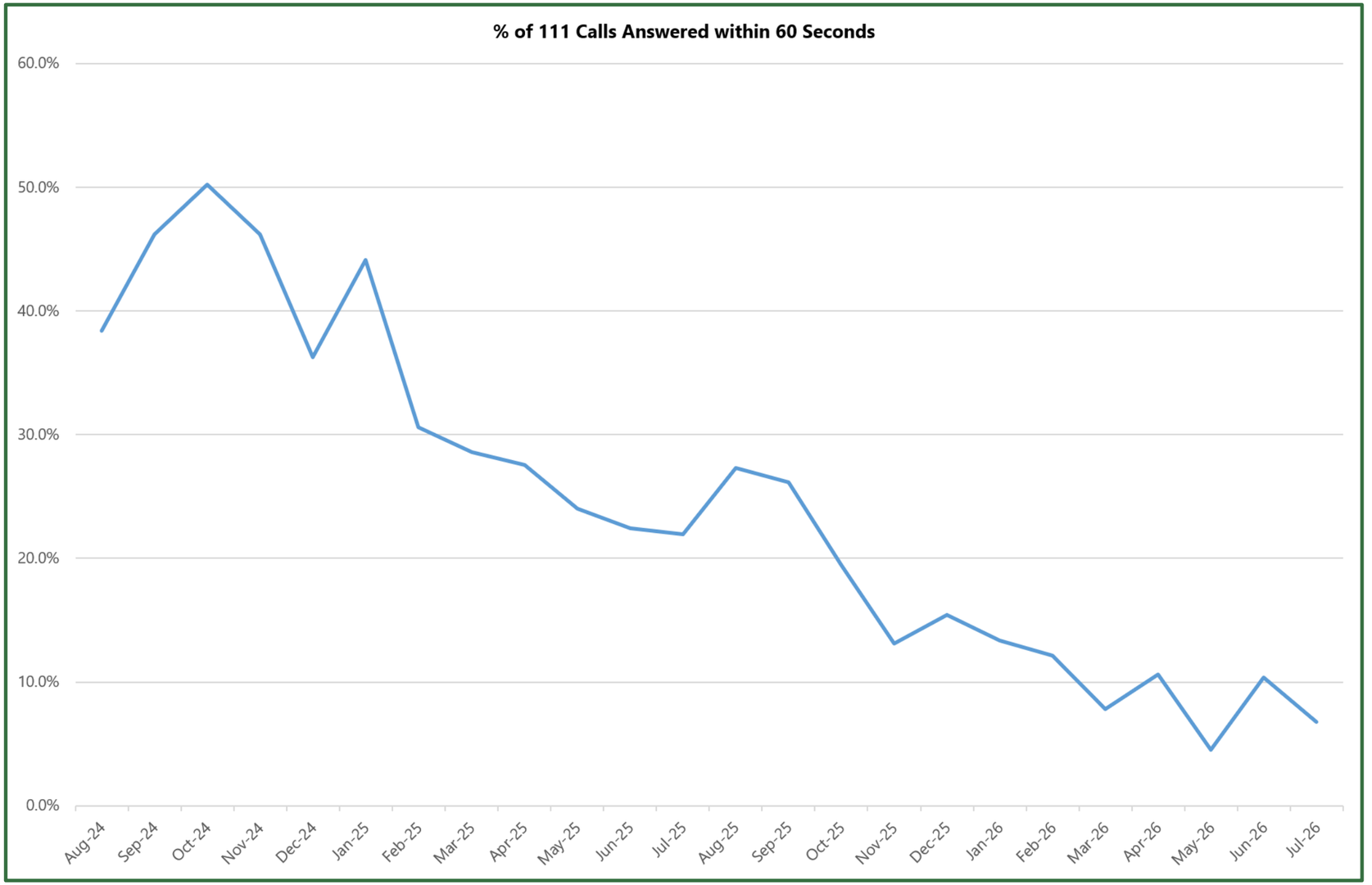
Expected Performance Trajectory

The independent modelling indicates that the Trust should expect to see a performance range of 10%-15% based on the current commissioned establishment.

Our Patients

111 Call Answering

Strategic Objective 1



Analysis

The call answer rate within 60 seconds in July 2026 was 6.8%, which, is a decrease from the 10.4% in June 2026, and is significantly below performance levels seen during 2024. This is at a time when UHP capacity for call handlers has increased slightly.

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

Remedial Plans and Actions

Key actions include:

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

A 111-re-roster review, is currently being implemented. The review has identified that the alignment between the Trust's available resource and demand is good, so re-rostering will not lead to a performance improvement as such, but moving to more fixed rosters will make the rostering process more efficient and better for staff. The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.

Expected Performance Trajectory

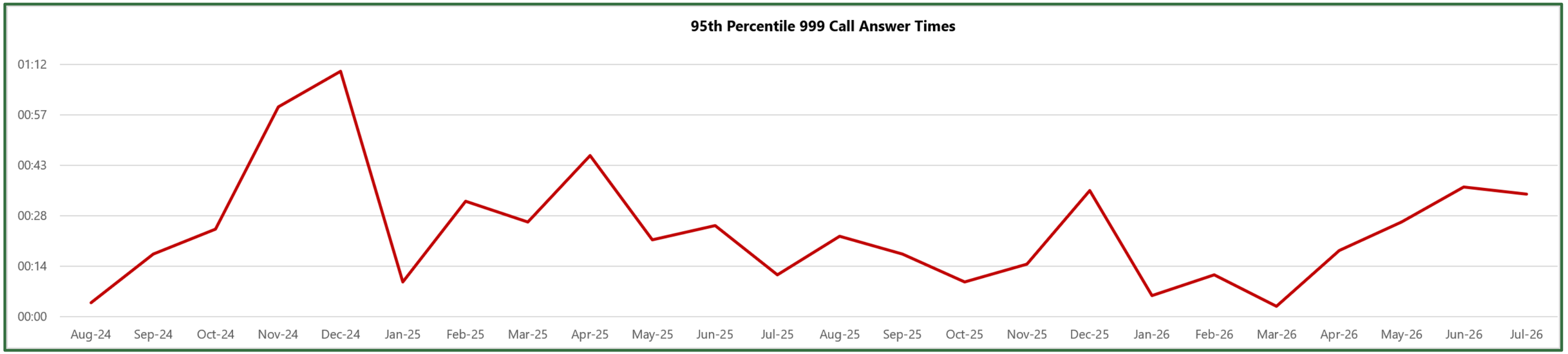
We would expect to see performance levels remain low during the summer as abstraction levels historically rise slightly.

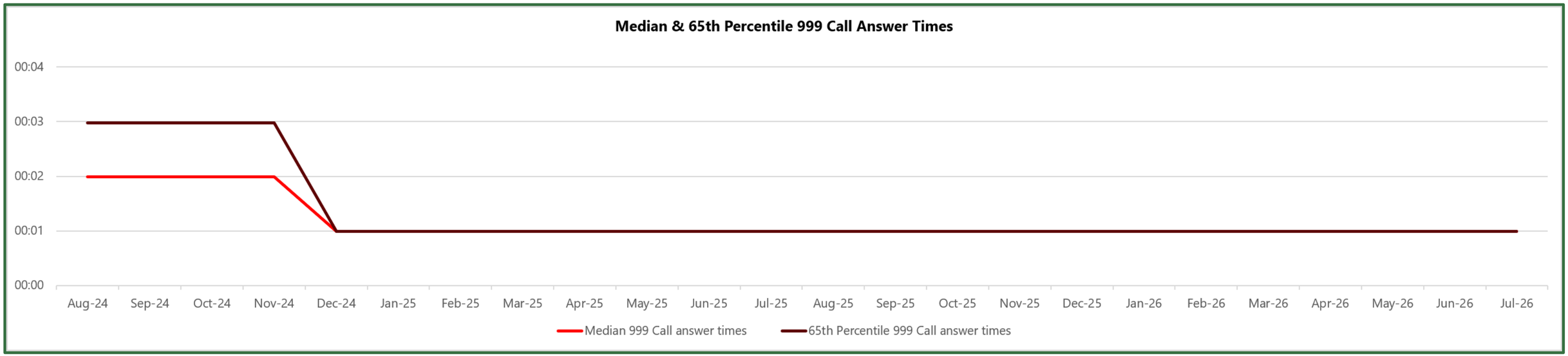
The Trust has developed a 111-performance predictor, reverse engineering erlang C. The accuracy of the predictor is currently being tested.

Our Patients

999 Call Answering

Strategic Objective 1

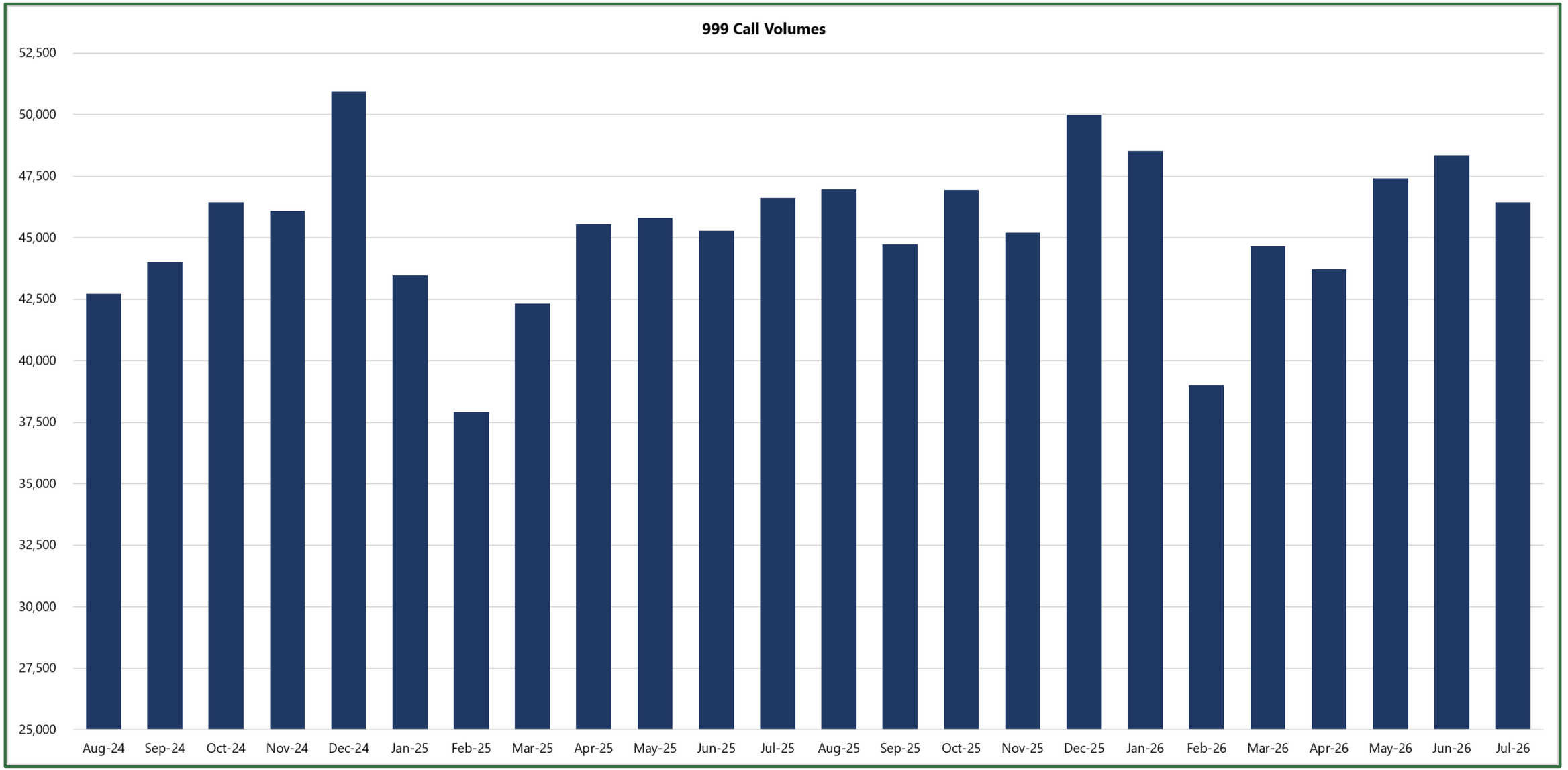




Our Patients

999 Call Demand

Strategic Objective 1



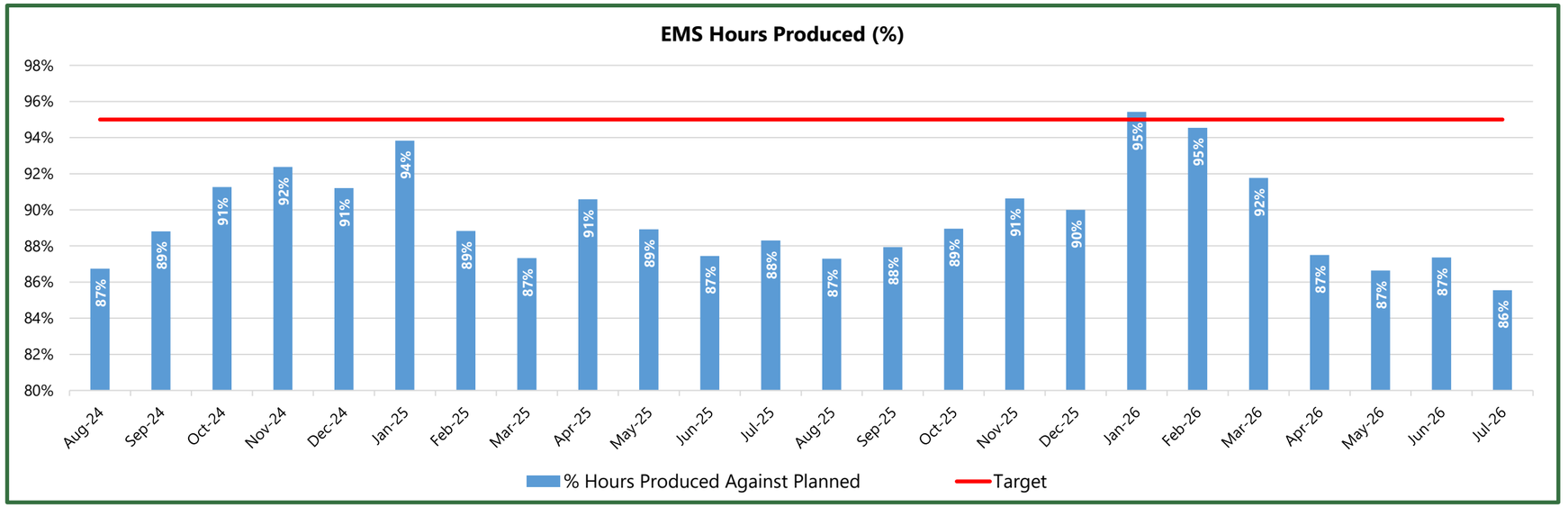
Our People

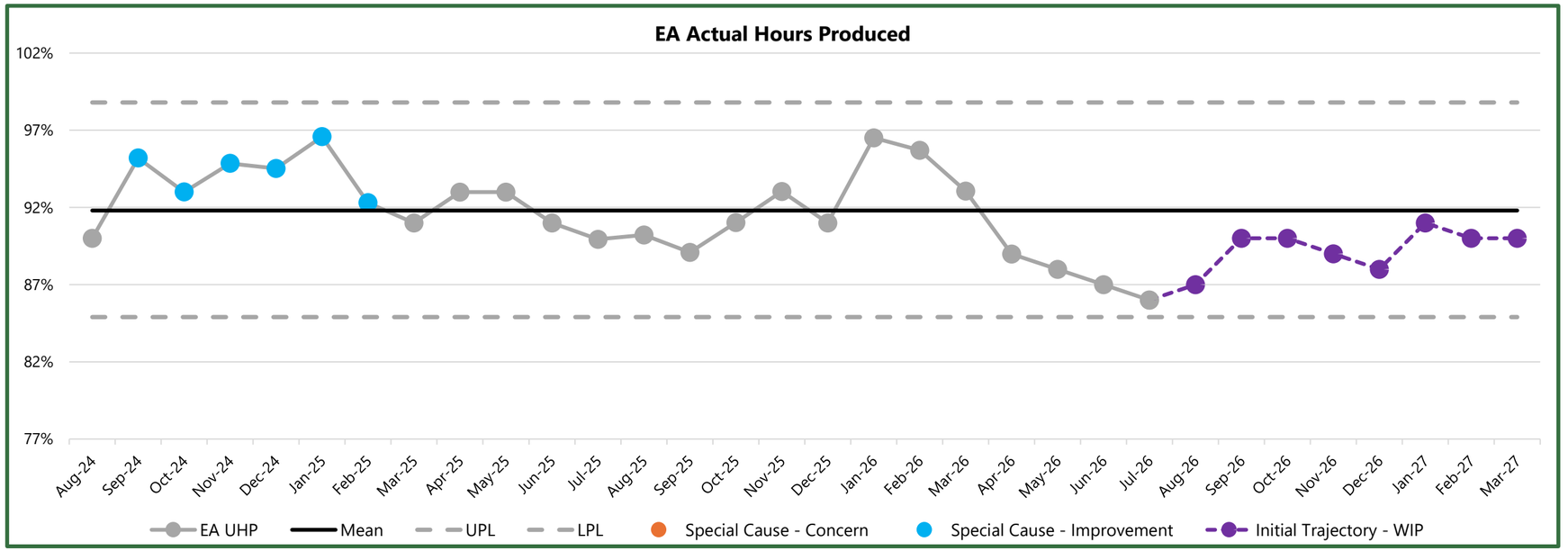
EMS Hours Production Indicators

EMS Production

A

Strategic Objective 2





Analysis

The total EMS hours produced is a key metric for patient safety. The SPC chart highlights that over the past two years this metric has stayed within normal process limits, although the past four months have seen a steady decline.

EMS Hours Produced achieved 86% in July 2026 which equated to 116,549 Actual Hours, against a planned total of 136,229, and remained below the 95% target, with reduced overtime availability linked to financial constraints a factor.

Remedial Plans and Actions

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

Expected Performance Trajectory

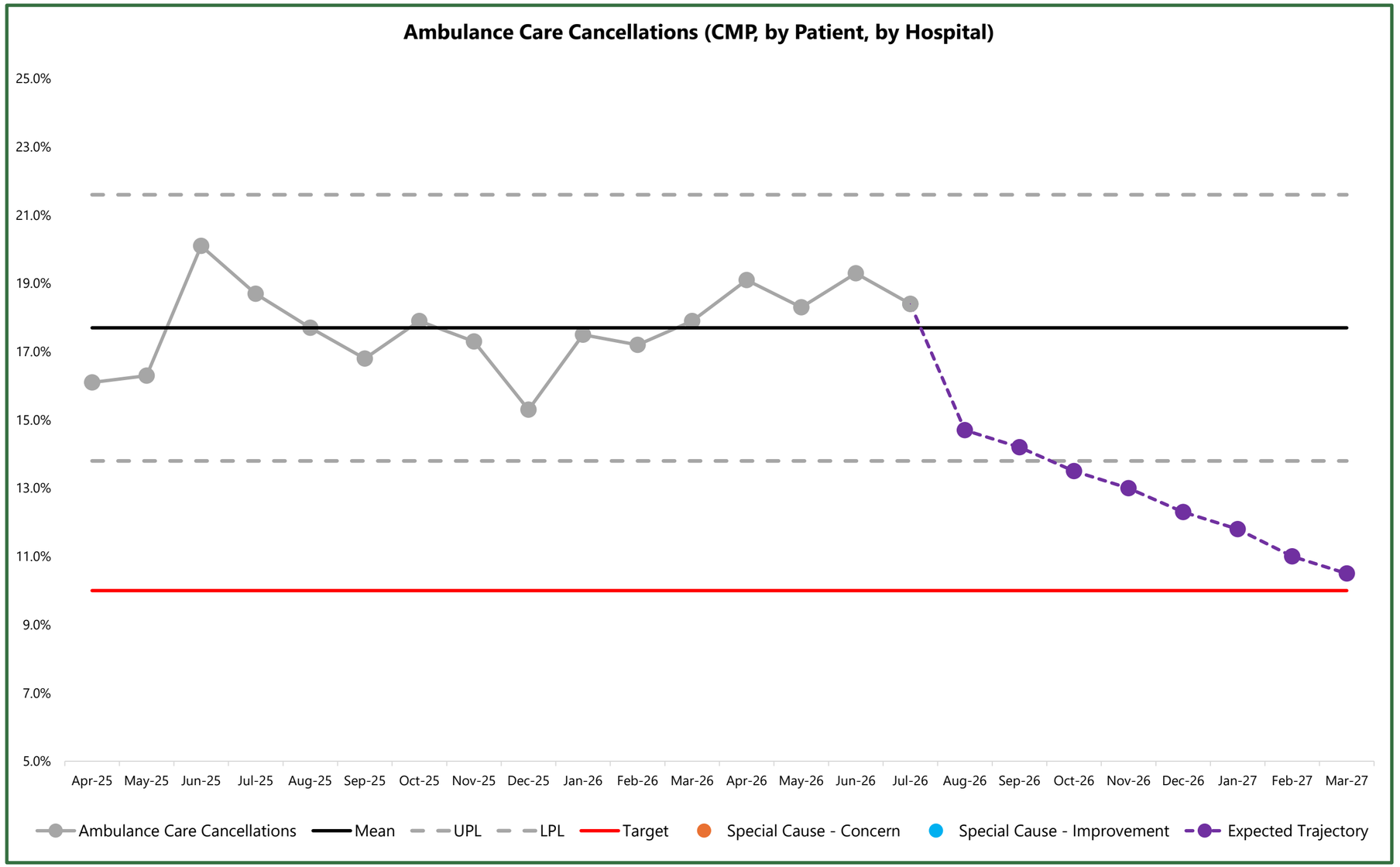
The purple trajectory is the initial trajectory modelled. This is currently review by Operations SLT. The abstractions benchmark is currently under review; however, initial findings do not indicator a lower level of abstractions. Operations are also in discussion with FinCor on the overtime budget, and related actions, and whether the Trust can boost production for winter. Once these discussions have concluded (this month), the trajectory will be revised.

Finance, Resources and Value

Ambulance Care Indicators

Strategic Objective 6

NEPTS Activity Cancelled
R



Analysis

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

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

Remedial Plans and Actions

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

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

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

Expected Performance Improvement

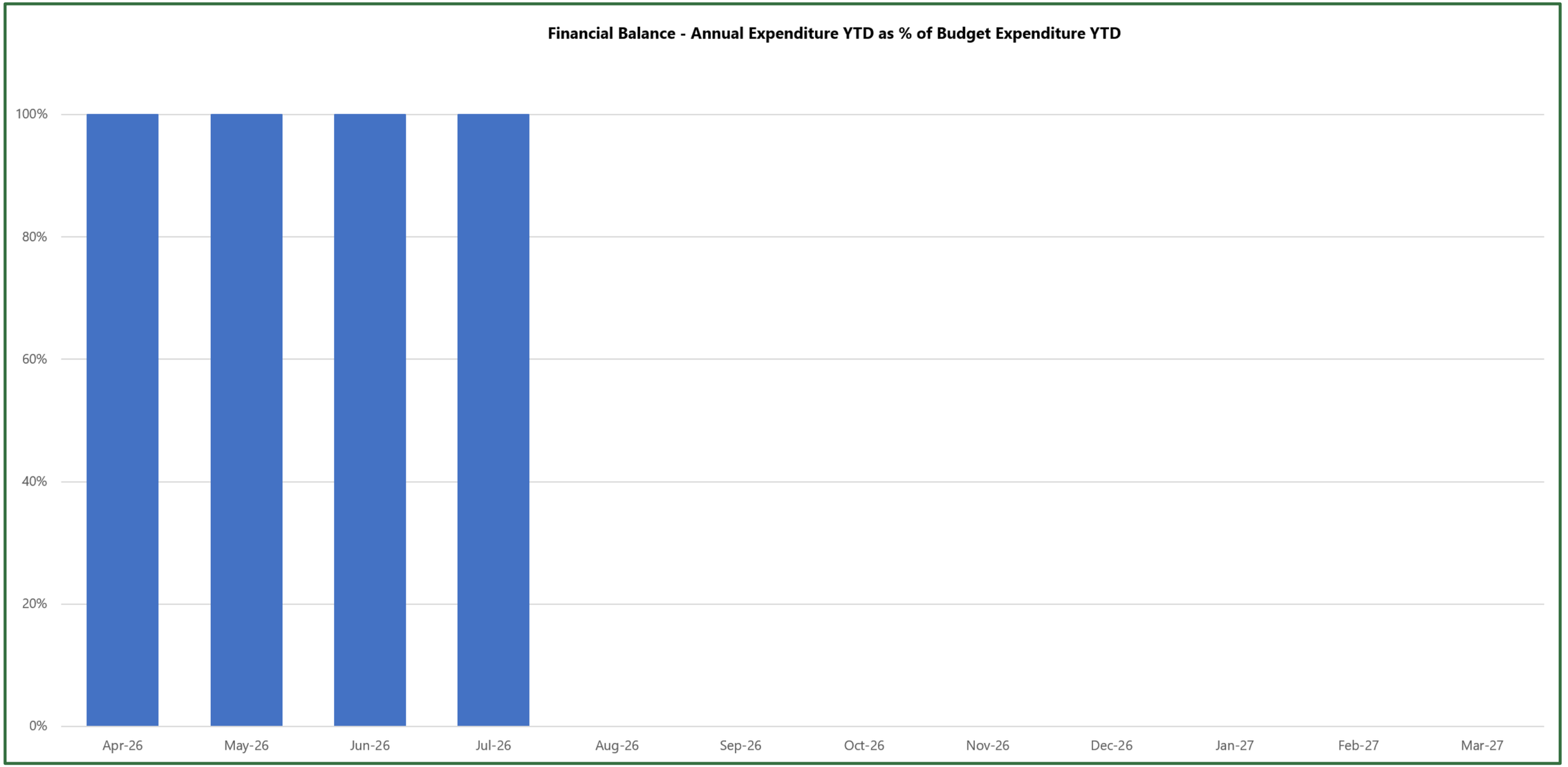
The chart illustrates the expected performance improvement, but the ambition of moving from 19% to less than 10%, needs to be reconsidered, in the light of a revised metric for this indicator.

Finance, Resources and Value

Financial Balance

Strategic Objective 6

Balance
G

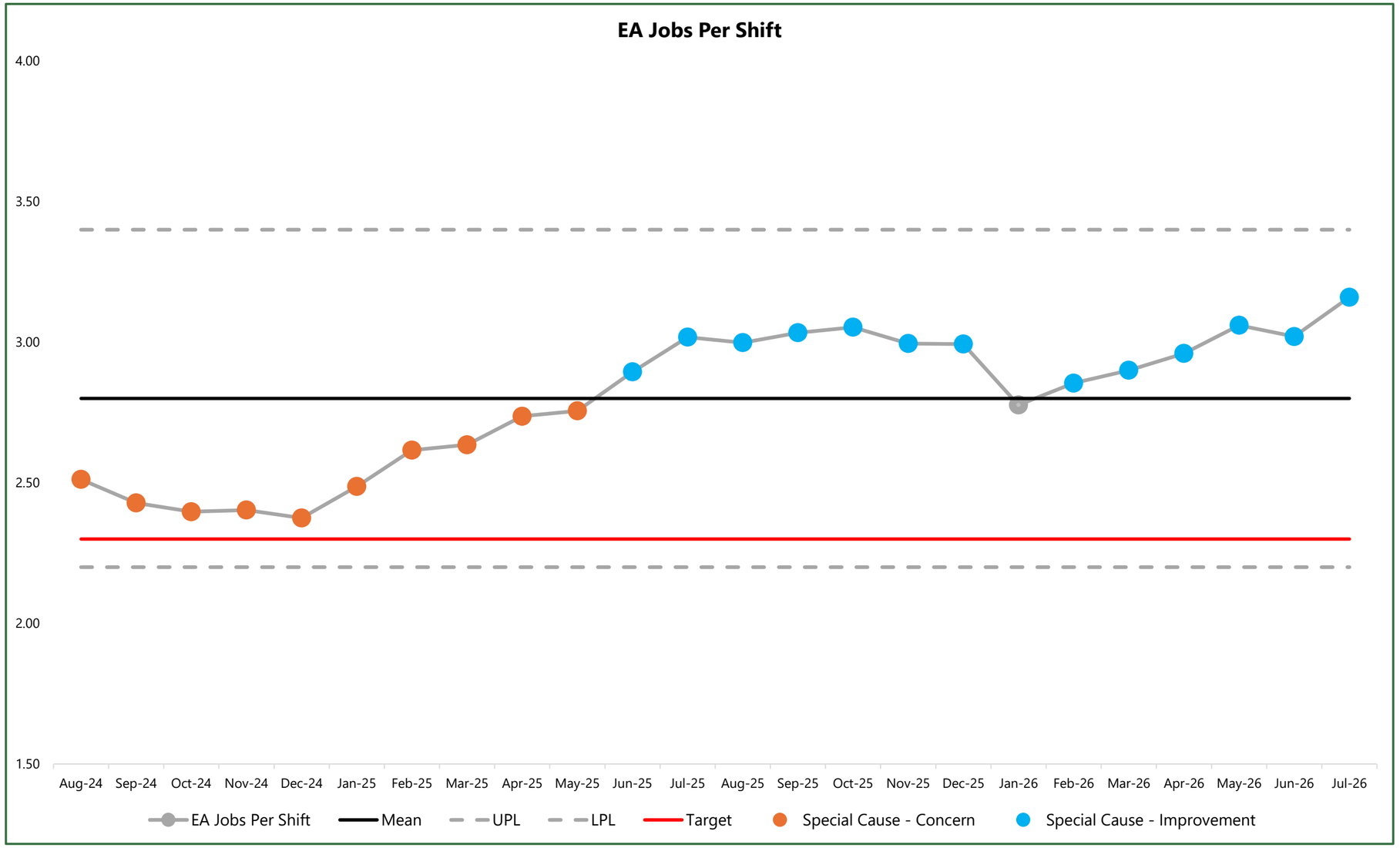


Finance, Resources and Value

EA Average Jobs Per Shift

Strategic Objective 6

EA Jobs Per Shift
G



Analysis
Overall, EAs averaged 3.16 jobs per shift during July 2026. The independently modelled ambition for this metric has been set at 2.3 jobs per shift or above.

The SPC chart shows that there has been a sustained increase in the number of jobs per shift being carried out by EAs linked to reduced hospital handover times.

Remedial Plans and Actions
Further consideration needs to be given to this metric as performance is actually better than target here. See below.

Expected Performance
The ambition for this metric is based on the 2023 EMS Demand & Capacity Review, which produced a rate of 2.3 jobs per shift or above, based on reduced handover lost hours of 7,000. A lower rate actually means more ambulances are available to respond.

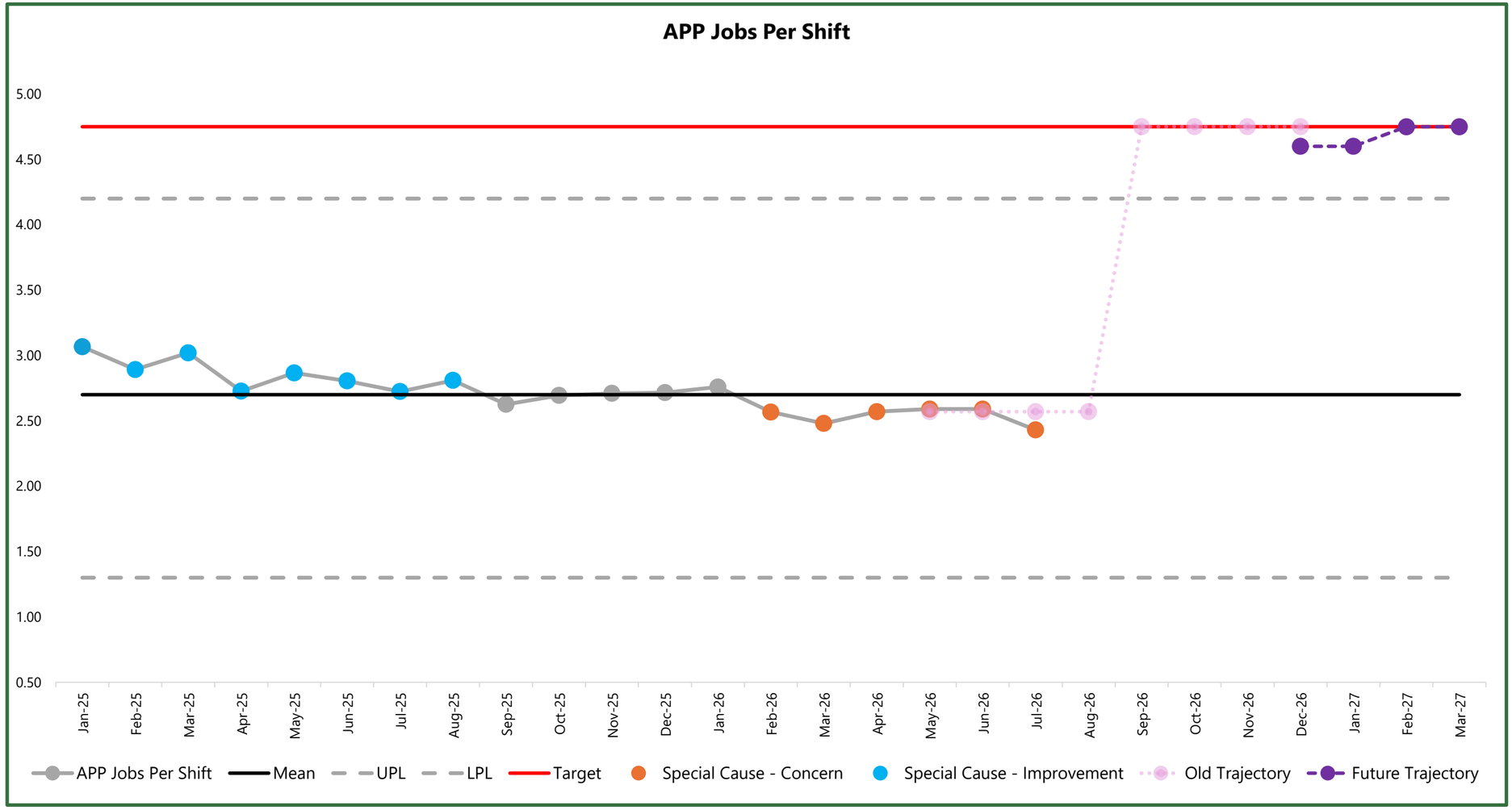
The Trust has already exceeded this ambition and if health boards can deliver further reductions on handover lost hours and the Trust works on improved job cycle productivity on the aspects it controls, further improvement should be possible. For this metric, further consideration needs to be given to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

Finance, Resources and Value

APP Average Jobs Per Shift

Strategic Objective 6

APP Jobs Per Shift
R



Analysis

APPs attended an average of 2.43 jobs per shift during July 2026. The SPC chart shows a there has been a deterioration in this metric from early 2025, with a sustained run of points below the mean from February 2026. Performance is currently well below the target (4.75) — indicating the current system is not capable of meeting this target.

Remedial Plans and Actions

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

Expected Performance Improvement

Both a) + b) above are expected to be in place by 01 December, in line with the Winter Plan. Advanced simulation software has been used to develop the new APP rosters. The lilac future trajectory line, was the original improvement trajectory, with the purple trajectory line, representing a revised one, based on a delay in a planned change to the CAD to facilitate the scheduling. The modelling indicates a step change in jobs per shift as a result of the new rosters and scheduling.

Finance, Resources and Value

Fleet

Strategic Objective 6

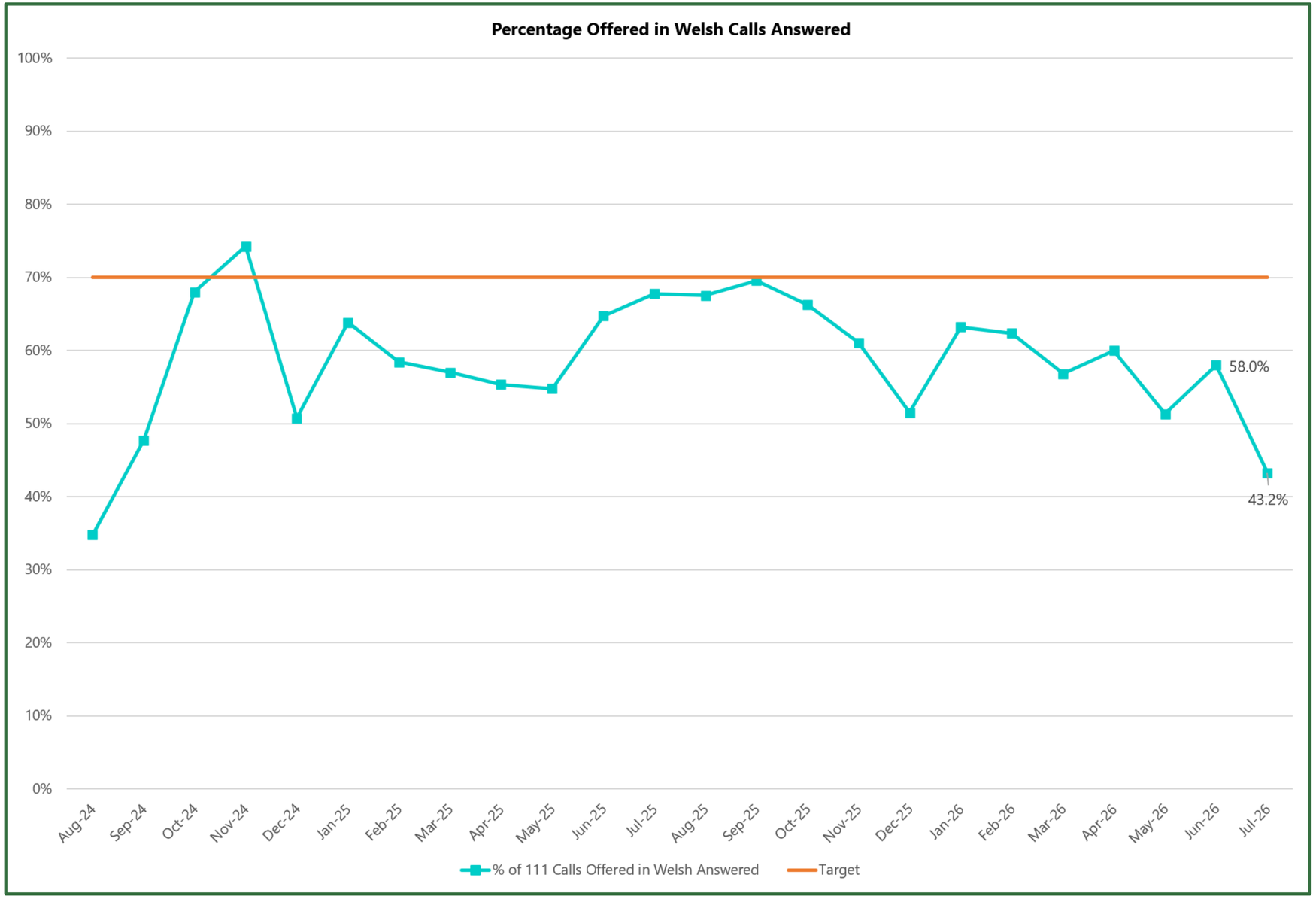
Under Development

Partnerships / System Contribution

NHS111 Outcomes and Welsh Calls

Strategic Objective 1

R



Analysis

In July 2026, the total number of Welsh calls offered was 1,984 calls, 858 of these were answered, equating to 43.2%. This remains below the 70% ambition and has remained below target since November 2024.

Remedial Plans and Actions

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

Expected Performance Trajectory

The independent modelling was based on 1470 calls to the Welsh line. The figure for July was 1,984, so has increased, but the key point is that this is a very small part of the overall demand, which was 97,253 calls in July. It would be very inefficient to ring fence Welsh speakers to answer this demand and the independent modellers have not advised that, instead Welsh speaking call handlers are interspersed through the new rosters, when they go live. Being interspersed through the rosters and not ring fenced, means that even if in work, they may be answer an English call at the time a Welsh call comes in. The demand actually needs to be further segmented by regional dialect

Performance should improve as a result of the new rosters. The advice of the independent modellers was to wait and see what performance looks like post go live of the new rosters and consider the IMTP ambition around this indicator.

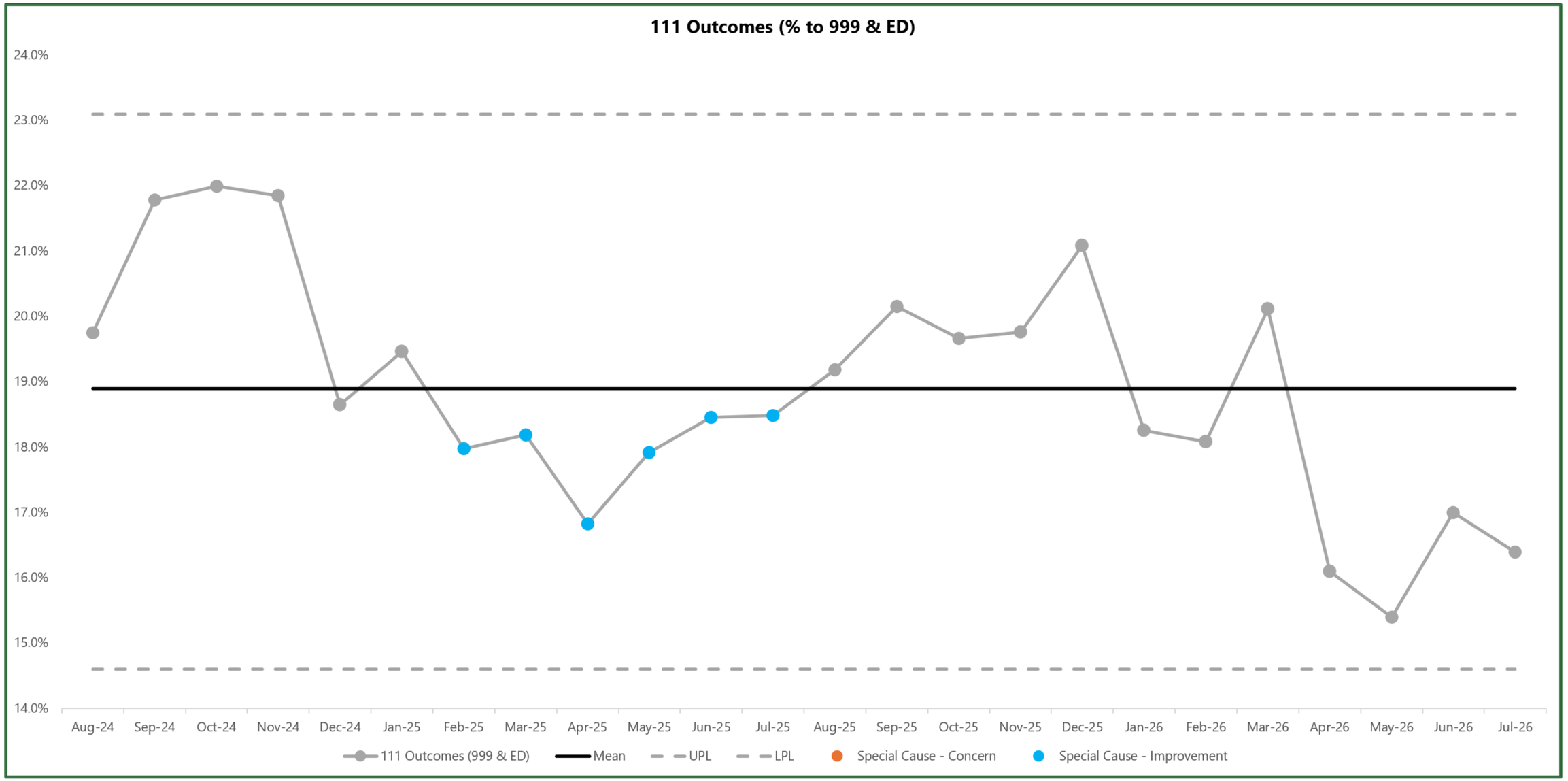
Partnerships / System Contribution

NHS111 Outcomes

Strategic Objective 4

111 Outcomes

MOA

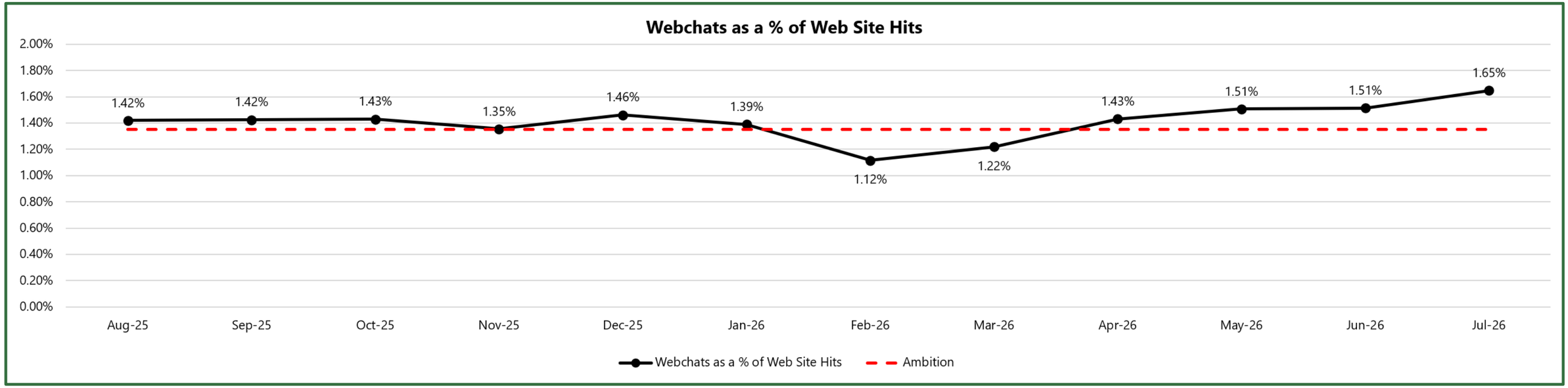


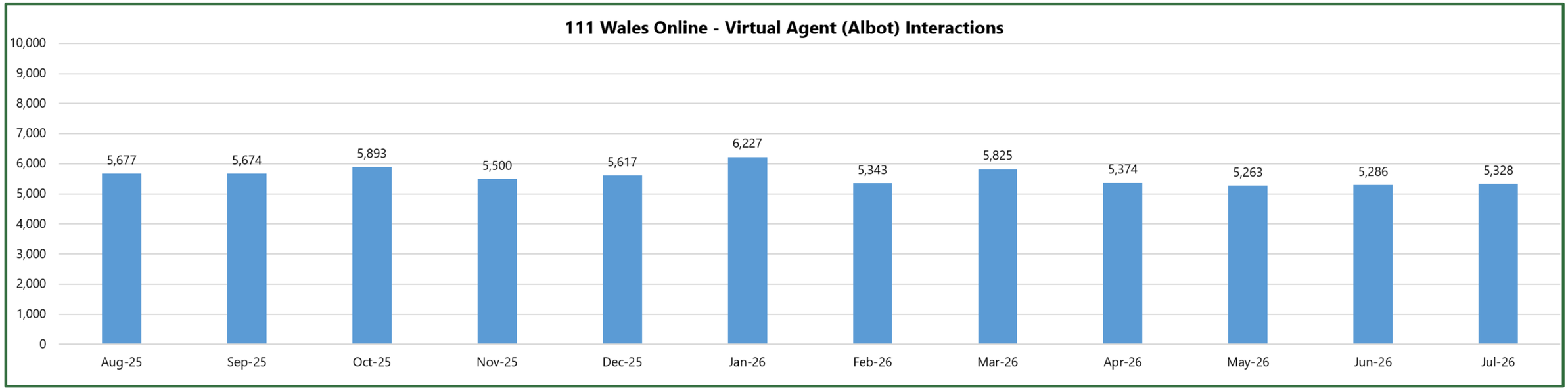
Partnerships / System Contribution

Albot and Web Chats

Strategic Objective 3

Web Chats	Albot
G	MOA



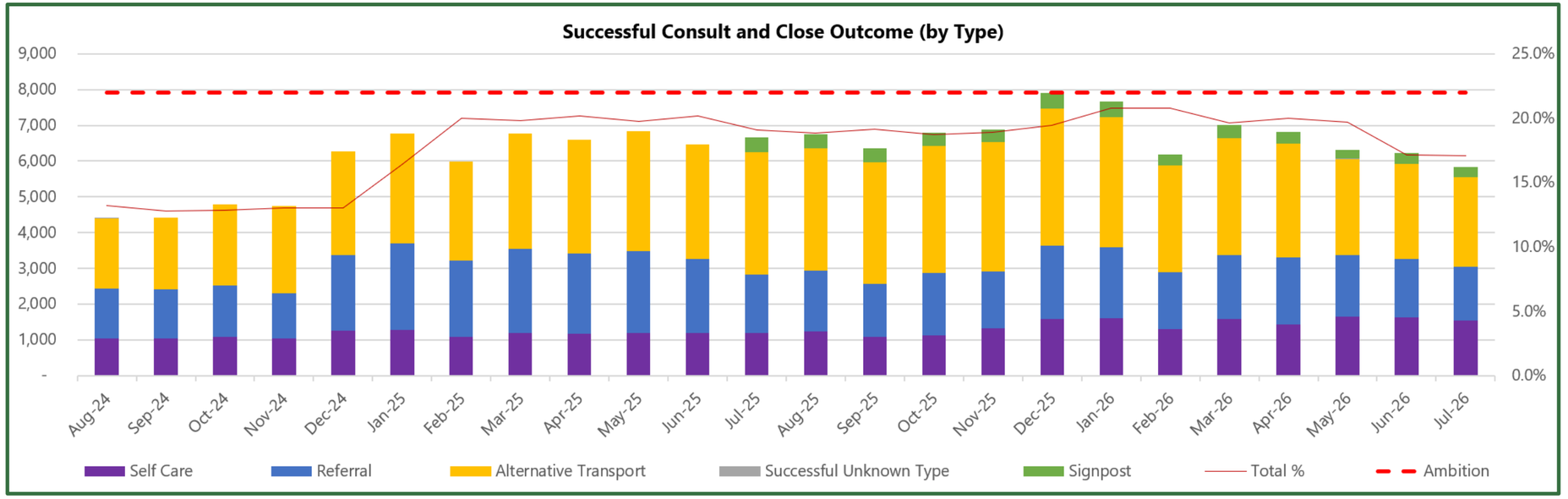


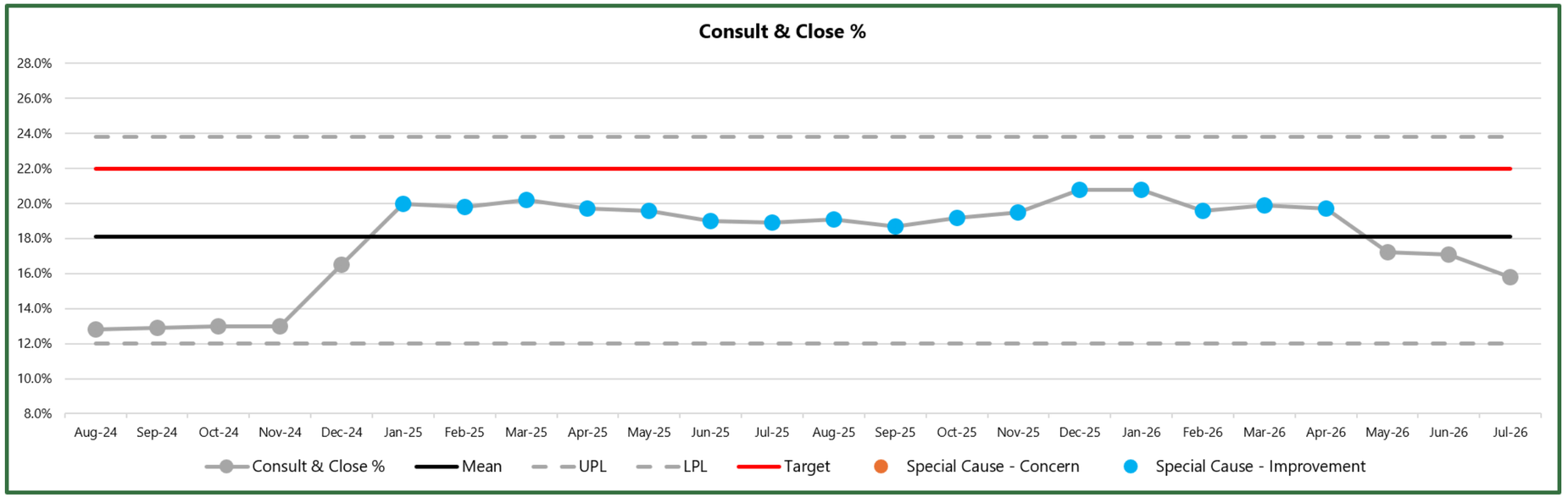
Partnerships / System Contribution

Consult & Close Indicators

Strategic Objective 4

C&C Outcomes: R





Analysis

A new **Consult and Close** definition was agreed with the JCC Director of Commissioning in May 2025 with reporting recommencing in June 2025 after backdating data collation to May 2024.

The SPC chart highlights a system improvement over the last year, with 16 consecutive data points exceeding the mean, indicating a sustained pattern of improvement in this metric, although performance has dropped below the mean the past three months, falling to 15.8% in July 2026.

Remedial Plans and Actions

The likely cause of the fall in the consult & close rate is the move to the RICS single queue and also taxi use recording/taxi use, connected to available budget. The AD Commissioning & Performance will undertake a series of meetings with expert staff during September, with the aim of resolving these issues in advance of winter.

Expected Performance Trajectory

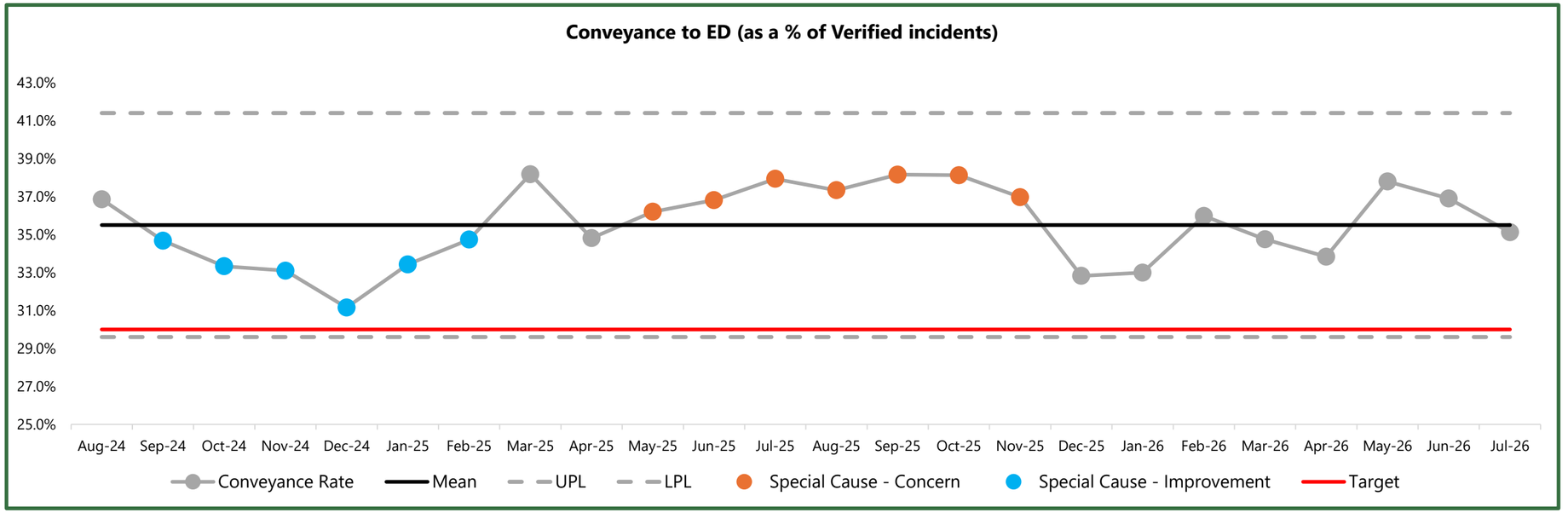
The independently modelled ambition is 22%. A trajectory is now dependent on the work to be undertaken in September as above.

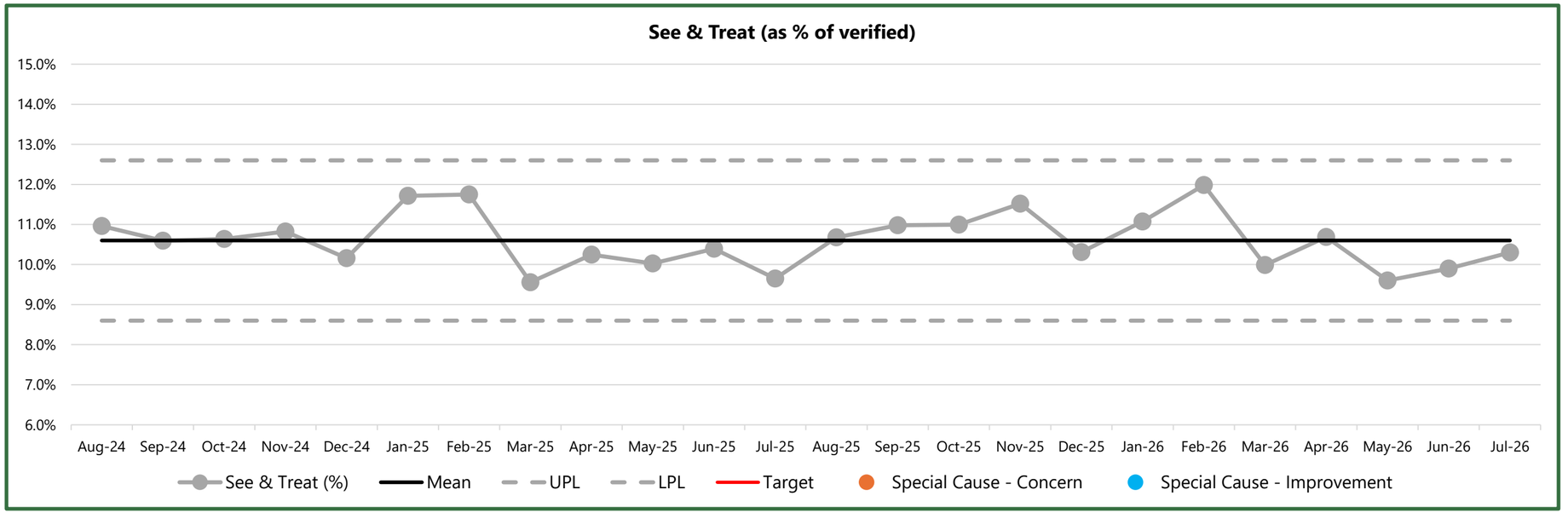
Partnerships / System Contribution

Conveyance to ED/See & Treat Indicators

Strategic Objective 4

Conveyed to ED	% See & Treat
R	R





Analysis

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

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

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

Remedial Plans and Actions

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

Expected Performance Improvement

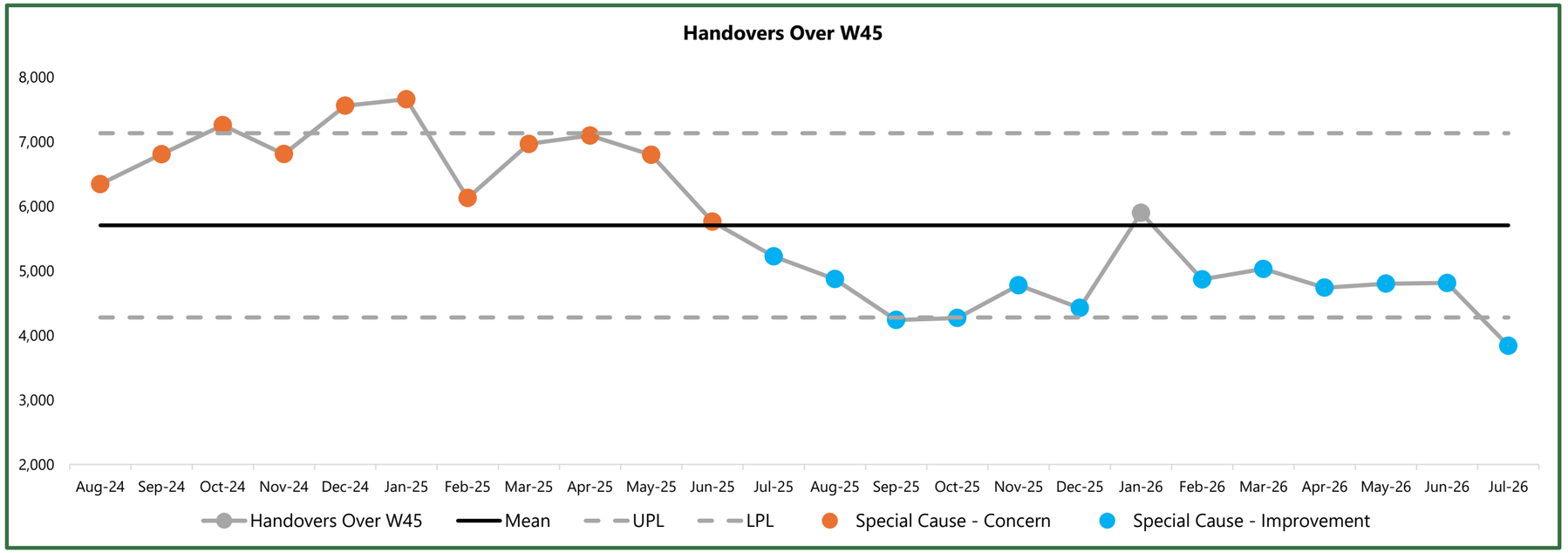
The 2023 Demand & Capacity Review, modelled a position of 30%, if all transformation changes are successfully implemented and W45 delivered.

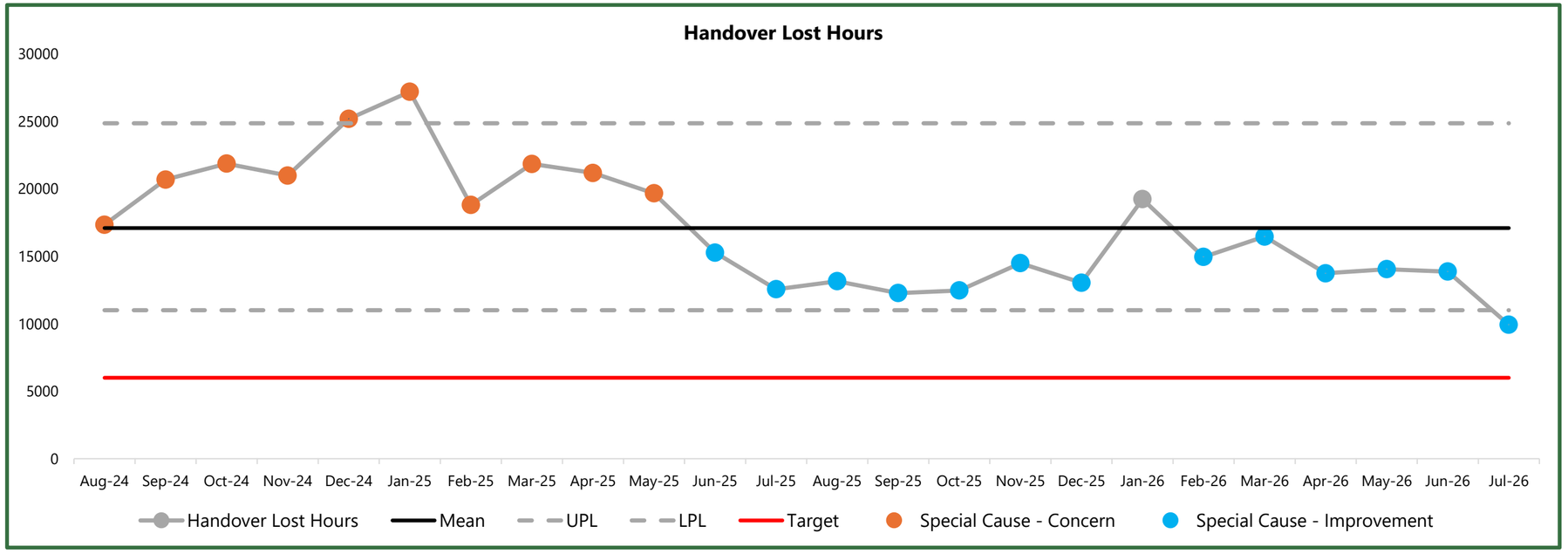
Partnerships / System Contribution

Handover Indicators

Strategic Objective 4

W45	Lost Hours
R	R





Analysis

167,743 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Aug-25 to Jul-26), compared to 242,880 hours over the same timeframe the previous year. There were 9,929 hours lost in July 2026, which is the lowest figure recorded since June 2021.

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

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

In July 2026, the Trust could have responded to approximately 3,132 more patients if handovers were reduced to the target level, which highlights the impact these numbers are still having on the service.

Remedial Plans and Actions

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

Expected Performance Trajectory

The expected ambition from Welsh Government is no waits over 45 minutes. Improvement plans have been developed by health boards, including trajectories. The Trust has been supplied with these, and these will now be monitored going forward.

Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	CTM / CTMHB	Cwm Taf Morgannwg Health Board	HIW	Health Inspectorate Wales	NHSDW	National Health Service Direct Wales	ROSC	Return Of Spontaneous Circulation
AOM	Area Operations Manager	C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	HI	Health Informatics	NPUC	National Programme for Unscheduled Care	RRV	Rapid Response Vehicle
APP	Advanced Paramedic Practitioner	DAG	Delivery & Assurance Group	H&W	Health & Wellbeing	NQPs	Newly Qualified Paramedic	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
AQI	Ambulance Quality Indicator	D&T	Discharge & Transfer	HR	Human resources	NRI	Nationally Reportable Incident	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	DU	Delivery Unit	HSE	Health and Safety Executive	OBC	Outline Business Case	STEMI	ST segment Evaluation Myocardial Infarction
CASC	Chief Ambulance Services Commissioner	EAP	Emergency Ambulance Practitioner	IG	Information Governance	OD	Organisational Development	TPT	Tactical Pandemic Team
CCC	Clinical Contact Centre	ED	Emergency Department	IMTP	Integrated Medium Term Plan	ODU	Operational Delivery Unit	TU	Trade Union
CCP	Complex Case Panel	ELT	Executive Leadership Team	IPR	Integrated Performance Report	OH	Occupational Health	UCA	Unscheduled Care Assistant
CEO	Chief Executive Officer	EMD	Emergency Medical Department	JCC	Joint Commissioning Committee	P / PHB	Powys / Powys Health Board	UCS	Unscheduled Care System
CFR	Community First Responder	EMS	Emergency Medical services	KPI	Key Performance Indicator	PCR / 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		

Agenda Item No.	9

REPORT TITLE

Audit Wales Review of Non-Emergency Patient Transport Services

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale:	n/a

REPORT SPONSOR

Executive sponsor	Lee Brooks, Executive Director of Operations
Author(s) of report	Mark Harris, Assistant Director of Operations (Ambulance Care)

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This paper presents the findings of the independent Audit Wales Review of Non-Emergency Patient Transport Services (NEPTS), attached at Appendix 1. The review examined how effectively the Trust is positioned to deliver the ambitions set out within the Future Vision for Non-Emergency Patient Transport in Wales 2030. Audit Wales concluded that the Trust has ambitious and appropriate plans for improvement that align with the Future Vision and are informed by service performance data. However, further work is required to strengthen programme management, benefits realisation, risk management and system-wide accountability arrangements.

2. The Trust has previously reported extensively on NEPTS performance, capacity and improvement activity through Board and Committee governance arrangements. This has included the following updates:

   - 2026 – 2029 Integrated Medium Term Plan (IMTP);
   - 4 November 2025 QUEST committee patient experience;
   - 20 January 2026 Finance and Performance Committee - Item 06 NEPTS Capacity Management;
   - Board performance reporting; and
   - Discussion at the 2026 Trust Annual General Meeting.

3. These reports have set out the operational challenges facing the service, the increasing demand for patient transport, capacity constraints, cancellation levels and the actions being undertaken to address these issues.

4. In response to ongoing NEPTS pressures and the publication of the Future Vision, the Trust has maintained regular dialogue with commissioners through the Joint Commissioning Committee (JCC) structures. This has included correspondence regarding the Trust's approach to service improvement, demand management and capacity challenges, together with discussions on the inclusion of key NEPTS improvement priorities within the Trust's IMTP 2026-29. The report recognises the importance of partnership working with commissioners, health boards and system partners in delivering sustainable service improvements.

5. The review acknowledges the establishment of the Trust's NEPTS Improvement Programme, which has been created to coordinate delivery of improvement actions in response the current challenges faced and arising from the Future Vision. Governance and oversight of the programme have been established through the Strategic Transformation Board, with executive leadership arrangements in place to support delivery, benefits realisation, programme assurance and risk management. Audit Wales notes that this programme provides an important mechanism to progress improvement activity and address the recommendations contained within the report.

6. Audit Wales has made four recommendations focused on strengthening planning and shared delivery arrangements; establishing programme and risk management arrangements; accelerating delivery and system coordination; and strengthening performance reporting and oversight. The recommendations align closely with work already underway through the NEPTS Improvement Programme and Future Vision implementation activity.

7. The Audit Wales review provides an important independent third line of defence assessment of the Trust's arrangements for improving NEPTS. All recommendations and agreed management actions will be incorporated into the governance arrangements of the NEPTS Improvement Programme and monitored through the Strategic Transformation Board.

8. Progress against recommendations will continue to be reported through routine IMTP monitoring arrangements, providing assurance to Board and Committees regarding delivery and improvement outcomes.

9. The Audit Risk and Assurance Committee received the Audit Wales review of NEPTS at the public meeting on 3 September 2026. The notes from that meeting are set out here for the benefit of this committee's review of the report:

    - Emma Wood welcomed the findings and advised that the report accurately reflected the challenges facing the service, whilst also recognising the significant progress made through the NEPTS improvement programme. Emma noted that several developments have already progressed since the review was undertaken and highlighted the strengthened programme structure now supporting improvement activity.
    - Judith Bryce emphasised that many of the challenges and solutions identified by Audit Wales extended beyond WAST and required a coordinated approach with the Joint Commissioning Committee (JCC), health boards and Welsh Government. Judith noted that work was underway with system partners to improve patient pathways and develop a more sustainable future operating model for the service.
    - Chris Turley highlighted that many of the planned improvements would be achieved through service redesign and operational efficiencies rather than relying solely on additional investment. Chris outlined ongoing work to improve rostering, optimise vehicle utilisation, reduce late cancellations and strengthen demand management processes.
    - Members explored the affordability of future service developments, the interdependencies with external partners and the realism of the proposed implementation timescales. Questions were raised regarding patient eligibility criteria and how changes to service models could improve efficiency whilst maintaining patient experience.
    - Assurance was provided that the recommendations were already being progressed through the established improvement programme and that the proposed actions and timescales had been developed to be achievable and sustainable.
    - It was noted that the actions will be overseen by the Finance and Performance Committee.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance and Performance Committee is requested to:

1. Receive and discuss the audit report and findings;
2. Confirm that the committee is assured by the findings and that the appropriate management responses are in place; and
3. Note that management actions arising from the report will be incorporated into the NEPTS Improvement Programme and monitored through existing governance and IMTP reporting arrangements.

ADDITIONAL PAPER(S)

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

The Finance and Performance Committee is requested to receive:

Annex 1 Audit Wales Review of NEPTS & Management Responses

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
Board Assurance Framework risks relating to NEPTS service sustainability, patient experience, capacity management, workforce availability and delivery of strategic transformation priorities.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
18 August 2026	Senior Leadership Team
August 2026	Executive Leadership Team

Archwilio Cymru
Audit Wales

Review of Non-Emergency Patient Transport Services

Welsh Ambulance Services University NHS Trust

July 2026

We have prepared and published this report under section 61(3)(b) of the Public Audit (Wales) Act 2004.

If you need any help with this document

If you would like more information, or you need any of our publications in an alternative format or language, please:

- call us on 029 2032 0500
- email us at info@audit.wales

You can use English or Welsh when you get in touch with us – we will respond to you in the language you use.

Corresponding in Welsh will not lead to a delay.

Mae’r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

Contents

Audit snapshot

What we looked at

1 We looked at how well the Welsh Ambulance Services University NHS Trust (the Trust) is set up to improve the Non-Emergency Patient Transport Service (NEPTS).

2 We have not looked at the NEPTS eligibility criteria, which are set by the Welsh Government, the role of the Joint Commissioning Committee (JCC), or the actions taken by the seven health boards.[1]

Why this is important

3 The Trust is responsible for running NEPTS, which is commissioned by the JCC, on behalf of the seven health boards in Wales.

4 NEPTS provides transport for people who are unable to make their own way to and from their medical appointments. It is an important service that ensures patients across Wales can access vital NHS treatment.

5 In recent years, the service has struggled with rising demand, limited resources, and a high number of on-the-day and last-minute cancelled journey appointments.[2] This has affected how efficiently the service runs.

6 In March 2025, the JCC approved The Future Vision for Non-Emergency Patient Transport in Wales 2030 (the Future Vision). This sets out five key priority areas to transform and improve NEPTS so it can meet future demand and provide good patient care.

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[1] The Joint Commissioning Committee (JCC) was established in April 2024 as a joint committee of the seven health boards in Wales. The JCC plans and commissions a range of specialised services and other healthcare services, including emergency medical services, on behalf of the seven health boards.

[2] Cancelled journeys are caused by a range of factors, including cancellations by patients, hospitals and due to lack of capacity within the Trust.

What we have found

7 The Trust has ambitious plans to improve NEPTS. These plans are aligned to the Future Vision and informed by performance data. However, expected benefits and outcomes are not yet defined, roles and responsibilities across partners are not fully agreed, and plans are not fully costed or prioritised.

8 The Trust is developing programme management arrangements for NEPTS improvements, but these are not yet fully established. The Trust and the JCC monitor actions and performance, but the Trust does not yet have clear sight of progress against the expected outcomes of the Future Vision across the system as a whole. Achieving those outcomes will require faster delivery, a clearer focus on benefits, and closer working with key partners.

9 Delivery of key improvement actions has been slower than planned in some areas. While performance has improved for some journey types, pressures such as rising demand, more complex patient needs, cancellations, delays, and communication issues continue to affect patient experience. Reporting does not consistently link improvement actions to milestones, benefits, or measurable impact. This makes it hard to assess whether changes are delivering the intended outcomes.

What we recommend

10 We have made four recommendations as part of this report. They are focussed on the following areas:

- making plans clearer by better defining outcomes and resources;
- setting up clearer programme, risk, and oversight arrangements;
- delivering improvements more quickly and working better with partners; and
- improving reports so they more clearly demonstrate the impact of actions.

Key facts and figures

570,000	The average number of NEPTS journeys each year in Wales.
640	Number of staff that work for NEPTS.
161	Number of volunteer car drivers.
42%	Percentage of journeys completed by private providers, taxis, and the voluntary and community sector (VCS) on behalf of WAST.
63,000	The number of short-notice cancellations (within four hours) in 2025.
14%	The number of on-the-day journey appointments cancelled during March 2025.
18,000	Number of additional journeys per year the Trust anticipates will be created by digital and rostering changes, once fully implemented.

Our findings

Planning for NEPTS improvements

Improvement plans are ambitious and align to the Future Vision, but benefits and shared responsibilities are not yet fully defined

11 The Trust has set out ambitious plans to modernise NEPTS in line with the Future Vision, mainly through its Integrated Medium Term Plan (IMTP) 2026-29. This plan identifies NEPTS as a key priority. This reflects ongoing concerns about cancellations, delays and overall patient experience.

12 The Trust's plans for NEPTS are based on a wide range of performance data and show a good understanding of current service pressures.

13 We reviewed the Trust's plans and supporting documents for delivering the five priority areas set out in the Future Vision. A summary of our assessment is set out in **Exhibit 1**. Taken together, these findings show that the Trust has identified the right improvement actions, but further work is needed to turn them into a deliverable programme.

Exhibit 1: Trust plans to deliver key aims of NEPTS Future Vision

Key strategic priority	Findings
Modernising for change: Adapting resources and approach to service delivery, to respond to the changing needs of the population and healthcare system.	Plans show a strong strategic intention to improve NEPTS, with clear actions on patient eligibility, staff rostering, fleet, and estates. Specific actions in the IMTP include: • using staff and transport more effectively through better rostering and planning so more patients can be transported; • agreeing the future shape of the ambulance care fleet to ensure it continues to minimise carbon emissions; and • using technology and equipment to improve safety and working standards. The Future Vision also highlights the need to review the patient transport eligibility criteria to ensure it better meets the need of NHS Wales. This review is the responsibility of the Welsh Government, the JCC, and health boards, but it is not yet clear when it will take place. In the meantime, the Trust has started to apply the existing eligibility criteria more strictly to help manage demand.
Digital transformation: Leveraging technology to improve co-ordination, efficiency and patient experience.	Plans include many digital changes to how bookings and patient communication are managed, such as linking the NEPTS booking system with health boards. But some actions do not have clear timelines or measures of success. Also, the Trust's plans to link its booking system with health boards' systems are not included in its digital plans or reported to the relevant committees.

Key strategic priority	Findings
Strategic integration: Ensuring non-emergency patient transport services are integrated within the wider healthcare system.	The Trust can point to examples of integration activity with system partners, including pilot work with Hywel Dda University Health Board to coordinate data, improve booking efficiency, and reduce short notice cancellations. But at the time of our work, the Trust had not set out a clear approach to learning from the system-integration pilots or how this would be applied more widely if successful.
Patient focused: Prioritising patient needs and feedback to enhance service delivery.	Although the Trust does not have a dedicated workstream for this pillar, it is taking action through other NEPTS improvement work. This includes improving access to booking systems and changing staff rosters to increase capacity. The Trust gathers feedback from patients through surveys, complaints, and patient stories. This feedback consistently highlights concerns about cancellations, which are affecting patient confidence in the service. The Trust expects its wider improvement programme to help reduce these concerns and improve the patient experience over time.
Working in partnership: Building strong collaborative relationships with partnership organisations to improve service outcomes.	The Trust's digital transformation actions aim to improve co-ordination and joint planning for NEPTS. By using new technology and offering more ways to book journeys, the Trust aims to simplify processes and strengthen how it works together with transport providers, patients, and health boards. This should help deliver a more efficient and responsive service.

Source: Audit Wales

14 While the Trust’s plans for NEPTS are set out in its IMTP 2026-29, there is no jointly owned implementation plan that clearly allocates responsibilities, milestones, and accountability across system partners. This means it is not always clear which actions the Trust will take on its own and which are the responsibility of health boards.

15 The Trust has mapped the Future Vision’s actions against its plans to show where actions align and where there are gaps. The gaps mainly relate to actions that need joint working with the JCC and partners. These include applying eligibility rules, providing alternative transport, and sharing data. Without a shared plan, it is difficult to set clear milestones and ensure accountability for delivery of the Future Vision across partners.

16 The Trust's plans recognise the need for changes to staffing, rostering, and service delivery to support improvements to NEPTS. But actions to improve NEPTS are largely non-cash releasing and have not been fully costed. This makes it hard to know if all planned improvements can be delivered within available resources (see **paragraph 21**).

Programme management and leadership

Programme and risk management arrangements for NEPTS are not yet fully developed or joined up, limiting assurance over delivery

Programme management

17 At the time of our work, the Trust was setting up a NEPTS Improvement Programme. The draft Project Initiation Document notes that governance and oversight will be through the Trust's existing Strategic Transformation Board. Key project management roles are clear and include the Executive Director of Operations as the Executive Sponsor and the Assistant Director of Operations (Ambulance Care) as the Senior Responsible Officer.

18 However, the NEPTS Improvement Programme is not yet fully operational. Key elements were still being developed at the time of our work. These include confirming workstream leads, agreeing formal reporting arrangements, completing the risk register, and agreeing SMART benefit measures.[3] These gaps make it hard to be fully assured that improvement activity is being prioritised, co-ordinated, monitored, and delivered in a way that will achieve the intended outcomes. Addressing these gaps is important given the financial pressures the Trust expects in 2026-27 (see **paragraph 21**).

Risk management

19 The Trust's Board Assurance Framework highlights strategic risks that could affect improvements to NEPTS. These include workforce capacity, financial pressures, and reliance on system partners. However, these risks are spread across a number of corporate risks and have not been brought together in one place. This makes it hard to see how NEPTS risks, improvement plans, actions, and assurances fit together.

[3] Specific, Measurable, Achievable, Relevant, and Time-Bound

20 The IMTP 2026-29 recognises that delivering improvement priorities alongside day-to-day services is a key risk. To mitigate this risk, the Trust states that it is prioritising improvement activity and strengthening programme management arrangements. However, it is not yet clear whether these actions will provide sufficient capacity to deliver all planned improvements within the timescales set out in the Future Vision.

21 The Trust faces significant financial pressures in 2026-27. These include delivering a £9 million savings requirement, rising non-pay costs, and limited funding for investment. While the Board Assurance Framework recognises financial pressure as a strategic risk, it is not clearly linked to NEPTS delivery. As a result, there is a risk that not all planned improvements to NEPTS can be funded and delivered.

22 These pressures mean the Trust needs to prioritise its improvement actions and make clear decisions about how it uses resources to support delivery. Without a stronger link between priorities, actions, resources, and risks, the Trust may take longer to deliver the improvements and intended outcomes. Effective risk management arrangements are important in supporting these decisions.

23 The draft Project Initiation Document includes a process for identifying, escalating, and monitoring NEPTS Improvement Programme risks. However, many risks were not fully developed at the time of our work. This limits assurance that programme risks are being managed in a consistent way.

Monitoring and oversight

Current reporting provides good visibility of operational performance, but limited assurance that improvement activity is delivering measurable benefits

Monitoring of improvement actions

24 NEPTS improvement work is monitored through actions set out in the IMTP 2026-29, with updates set out in quarterly performance reports to the Board and the Finance and Performance Committee. The Trust also reports to these fora on key work, such as re-rostering and service pressures affecting NEPTS.

25 At the time of our work, progress in delivering many of the Trust's NEPTS Future Vision actions was slower than planned. Many actions were described as being in development or at an early stage of delivery. For example, the need to re-roster, identified in 2019, was delayed due to the COVID-19 pandemic and the need to prioritise Emergency Medical Services. The project was then delayed further by more complex demand patterns, concerns about proposed shift patterns, discussions with trade unions, and the challenges of redesigning the service model. As a result, implementation is now planned for the first quarter of 2026-27. This suggests the Board needs to strengthen its oversight of improvement action delivery.

26 Performance is monitored by both the Trust and the JCC through its Commissioning Assurance Group (CAG). However, the Trust does not yet have an agreed way of tracking the cross-organisation changes that its NEPTS improvement plans depend on. This makes it hard for it to assess if those plans are on track. A Task and Finish Group, previously suggested by the JCC, could give the Trust clearer sight of delivery and a route to escalate delays that affect its actions.

Performance monitoring

27 The Trust routinely monitors NEPTS performance through dashboards, structured reports, and committee oversight. Performance data is shared regularly with the JCC, the CAG, and health boards, giving a clear view of trends and risks across the system.

28 Performance data shows that demand for renal transport is increasing and that patients' needs are becoming more complex. Together, these factors lead to greater use of ambulances. This can reduce ambulance capacity for outpatient appointments and patient discharges. Performance data shows improvement across key journey types, but pressures on the service remain.

29 Patient feedback for NEPTS consistently highlights concerns about cancellations and delays, which are affecting patient confidence in the service and the Trust. The Trust's performance reports also show that short-notice cancellations, delays, and poor communication remain key challenges.

30 Cancellations are caused by a mix of patient, hospital, system, and WAST capacity issues. There were 42,827 cancellations from January to March 2026. Over half were due to hospital and patient cancellations, showing that the Trust cannot address this issue on its own. However, capacity remains a key constraint for the Trust, with around one in six cancellations linked to no resources being available at the time of planning.

31 Around 37% of journeys were cancelled within four hours of travel between January and March 2026, leaving little time to reuse capacity or arrange alternatives. This shows the Trust needs to improve capacity planning, booking accuracy, and communication with patients, while also working with hospitals and health boards to reduce avoidable and late cancellations. The Trust is taking some action, including changes to rostering and digital systems, but these are not yet leading to consistent improvement in the areas of concern patients highlight most.

32 At the time of our work, reporting did not consistently link improvement initiatives to delivery milestones and expected benefits. This makes it hard to show the impact of specific actions on performance and patient experience. The Trust has set up a team within its Digital Services to focus on service improvement. However, senior managers recognise that the Trust's approach to change management needs to improve.

33 Taken together, the current monitoring arrangements provide good visibility of performance trends and areas of operational pressure. However, to support delivery of the Future Vision, routine reporting should more clearly show how priority improvement actions (including digital, rostering, and joint working with partners) are expected to reduce cancellations and improve communication. It should also set out delivery timescales and show progress against agreed benefits. This would strengthen accountability and improve assurance that improvement activity is delivering the intended benefits for patients and partners.

Recommendations

34 The following table details the recommendations arising from our work.

Strengthening planning and shared delivery

R1 The Trust should strengthen planning for NEPTS to support delivery of the Future Vision by clearly defining outcomes, responsibilities, and resource requirement. It should:

- **R1.1** Define measurable outcomes and benefits for key improvement actions (**paragraphs 13 and 33**).
- **R1.2** Agree a shared delivery plan with the JCC and health boards, setting out roles, responsibilities, and joint actions (**paragraphs 14 and 15**).
- **R1.3** Set out resource requirements and what can be delivered within available resources, including where trade-offs or prioritisation are needed (**paragraphs 16, 21, and 22**).

Strengthening programme and risk management

R2 The Trust should fully establish its NEPTS Improvement Programme and ensure risks and oversight arrangements support delivery. It should:

- **R2.1** Put in place core programme arrangements, including workstream leads, reporting, a full risk register, and measures of success (**paragraphs 17 and 18**).
- **R2.2** Ensure NEPTS risks are clearly aligned across programme and corporate risk frameworks (**paragraphs 19 and 23**).
- **R2.3** Strengthen links between priorities, risks, resources, and delivery plans (**paragraphs 20 to 22**).
- **R2.4** Agree system-level oversight arrangements with the JCC and health boards to support delivery of the Future Vision across organisations (**paragraph 26**).

Improving delivery and system coordination

R3 The Trust should accelerate delivery of improvement actions and strengthen coordination with partners. It should:

R3.1 Set out and deliver against a clear timeline for the actions to reduce cancellations and improve patient experience, including communication with patients (**paragraphs 25 and 29 to 31**).

R3.2 Evaluate and apply learning from system-integration pilots (**paragraph 13**).

Strengthening performance reporting, oversight, and impact

R4 The Trust should strengthen reporting and Board oversight to clearly show the impact of improvement actions on performance and patient experience. It should:

R4.1 Link improvement actions to milestones, expected benefits, and outcomes in routine reporting, enabling the Board to track delivery (**paragraphs 32 and 33**).

R4.2 Track and report progress against key measures, including cancellations, timeliness, and patient experience, so the Board can assess whether performance is improving (**paragraphs 27 to 31**).

R4.3 Use performance and patient feedback to assess whether improvements are delivering the intended impact and support the Board in challenging and refining the approach where progress is limited (**paragraphs 29 to 33**).

1 About our work

Scope of the audit

We looked at how well the Trust is set up to deliver improvements to NEPTS. In particular, we considered how well the Trust's plans align to the ambitions of the Future Vision. We also considered how the Trust was managing, monitoring, and overseeing progress against its plans and their impact on NEPTS performance.

Audit questions and criteria

Questions

Our audit addressed the following questions

- Does the Trust have clear and realistic plans to deliver the aims set out in the NEPTS Future Vision 2030 around modernising for change?
- Has the Trust reviewed and costed the resources needed to ensure the effective delivery of the NEPTS Future Vision 2030?
- Are there clear leadership and oversight arrangements to ensure the successful delivery of the NEPTS Future Vision by 2030?
- Is the Trust effectively monitoring NEPTS performance and delivery of its improvement plans?

Criteria

We assessed the Trust's approach against audit criteria shaped by key strategic plans, including The Future Vision for Non-Emergency Patient Transport in Wales – 2030.

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes, including the Monthly Integrated Quality and Performance Report and Integrated Medium Term Quarterly Monitoring Report.
- Key strategies and plans, including the Trust's Integrated Medium-Term Plan (2026-29), and the draft Project Initiation Document for the NEPTS Improvement Programme;
- Key risk management documents, including the Trust's board assurance framework and operational risk registers.
- Relevant Internal Audit reports, including Capacity Management Plan (2026).

We interviewed the following key stakeholders:

- Executive Director of Operations;
- Executive Director of Strategy, Planning and Performance;
- Assistant Director of Operations (Ambulance Care);
- Assistant Director of Digital;
- Head of Financial Management;
- Director of Commissioning for Ambulance Services and 111 (JCC).

We also reviewed data available from the Trust's regular performance reports. We have not audited the validity of the data from this source.

2 Management Response

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R1 The Trust should strengthen planning for NEPTS to support delivery of the Future Vision by clearly defining outcomes, responsibilities, and resource requirement. It should: **R1.1** Define measurable outcomes and benefits for key improvement actions.	The Trust accepts this recommendation and has already established a NEPTS Improvement Programme, supported by appropriate governance, reporting into Strategic Transformation Board. TOR are established and have	April 2027	Assistant Director of Operations (ADO), Ambulance Care who is also Senior Responsible

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	been agreed by STB. Outcomes and resource responsibilities will be reported through the programme by April 2027. Evidence will be via Highlight reports, AAA – from the improvement programme to STB.		Officer (SRO) – NEPTS Improvement Programme
R1.2 Agree a shared delivery plan with the JCC and health boards, setting out roles, responsibilities, and joint actions.	The Trust will engage with JCC and will provide meeting minutes/correspondence to evidence engagement.	December 2026	ADO, Ambulance Care
R1.3 Set out resource requirements and what can be delivered within available resources, including where trade-offs or prioritisation are needed.	As R1.1	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R2 The Trust should fully establish its NEPTS Improvement Programme and ensure risks and oversight arrangements support delivery. It should:			
R2.1 Put in place core programme arrangements, including workstream leads, reporting, a full risk register, and measures of success.	The Trust accepts this recommendation and has already established a NEPTS Improvement Programme, supported by appropriate governance, reporting into Strategic Transformation Board. ToR are established and have been agreed by STB. A risk register has been developed as part of this programme and is reviewed at each programme board meeting. A workstream for benefits mapping is set to deliver	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	in September 2026 and this will also be reported to STB. Evidence will be via Highlight reports, AAA – from the improvement programme to STB.		
R2.2 Ensure NEPTS risks are clearly aligned across programme and corporate risk frameworks.	As R2.1	April 2027	ADO, Ambulance Care
R2.3 Strengthen links between priorities, risks, resources, and delivery plans.	The improvement programme workstreams have begun to review this and this will continue to be reviewed through the programme structures that are in place. Any requirements not deliverable within available resources will be routinely	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R2.4 Agree system-level oversight arrangements with the JCC and health boards to support delivery of the Future Vision across organisations.	highlighted to STB and also placed into consideration for future IMTP cycles. Evidence will be via Highlight reports, AAA – from the improvement programme to STB and through notes of STB meetings. WAST will establish regular engagement with commissioners to provide updates on both progress of the improvement programme and delivery of the future vision. However, it our view is that this will require JCC to lead this process as lead commissioners. This will be evidenced through minutes from these commissioning fora.	October 2026	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R3 The Trust should accelerate delivery of improvement actions and strengthen coordination with partners. It should:			
R3.1 Set out and deliver against a clear timeline for the actions to reduce cancellations and improve patient experience, including communication with patients.	The improvement programme will provide a clear timeline for agreed actions and patient engagement, which will be reported into STB. Progress with reducing cancellations will be reported through the MIQPR. Evidence will be provided through AAA/highlight reports into STB and the MIQPR.	April 2027	ADO, Ambulance Care
R3.2 Evaluate and apply learning from system-integration pilots.	We will ensure that this is built into the relevant workstreams within	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	the improvement programme and reflected within the benefits realisation plan.		
R4 The Trust should strengthen reporting and Board oversight to clearly show the impact of improvement actions on performance and patient experience. It should:			
R4.1 Link improvement actions to milestones, expected benefits, and outcomes in routine reporting, enabling the Board to track delivery.	This will be implemented through the improvement programme; We will ensure that this is reported quarterly through the improvement programme into the STB and to	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	Trust Board through reporting on IMTP delivery and via the MIQPR. Evidence will be provided through AAA/highlight reports into STB and the MIQPR.		
R4.2 Track and report progress against key measures, including cancellations, timeliness, and patient experience, so the Board can assess whether performance is improving.	As R4.1		ADO, Ambulance Care
R4.3 Use performance and patient feedback to assess whether improvements are delivering the intended impact and support the Board in challenging and refining	We have already established robust arrangements to capture, review and report patient feedback through patient surveys, feedback channels via SMS messaging, CMP surveys and	April 2027	ADO, Ambulance Care

Recommendation	Commentary on planned actions	Completion date	Responsible officer
the approach where progress is limited.	through PECI engagement with patients. We will ensure that this process remains able to capture the required information as delivery of the improvement programme progresses. This will be reported and reviewed at the WAST Operations Directorate Senior Operations Team (SOT) and Senior Leadership Team (SLT) meetings. Evidence will be provided through the NEPTS Quality Dashboard and minutes/AAA from the above meetings.		

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Agenda Item No.	10

REPORT TITLE

Feedback report from Audit Risk and Assurance Committee to Finance and Performance Committee Audit Wales Review of Digital Transformation

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, Director of Digital
Author(s) of report	Sarah Harland, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. The Audit Risk and Assurance Committee (ARAC) received and discussed the ***Audit Wales Digital Transformation Review*** at its meeting on 3 September 2026. This report summaries the discussion from that meeting in reference to this report.

2. On behalf of Audit Wales, Fflur Jones presented the Audit Wales review of Digital Transformation, which concluded that the Trust has a clear strategic ambition for digital transformation, strong leadership, and has established a strong foundation through its digital strategy and governance arrangements. The review recognised the progress made in developing digital capabilities and driving innovation across the organisation but identified opportunities to further strengthen workforce capacity, benefits realisation, prioritisation processes and long-term planning to support delivery of the Trust's digital ambitions. Audit Wales made a number of recommendations aimed at strengthening oversight, ensuring digital investments deliver measurable benefits and supporting sustainable implementation of future digital developments.

3. In the absence of Jonny Sammut, Keith Dorrington welcomed the findings and advised that the report reflected the Trust's current level of digital maturity and the significant progress made in recent years. Keith highlighted that several actions are already underway to address the recommendations, including the establishment of the Digital Oversight Group (DOG), development of a more structured approach to benefits realisation and enhancement of the Trust's digital governance framework.

4. Members welcomed the positive direction of travel and recognised the scale of change required to deliver digital transformation across the Trust. They also recognised that the report, which was part of the 2024 audit programme, conducted its fieldwork in November 2025 and that whilst there are a number of recommendations, many were in train or planned.

5. Discussion focused on organisational capacity and the need to ensure sufficient digital expertise and resources are available to support future ambitions. Members highlighted the importance of robust prioritisation arrangements, clear accountability for digital programmes and ensuring that expected benefits are tracked and realised. Assurance was provided that the new governance arrangements would strengthen oversight of digital programmes, resource allocation and strategic delivery. The actions will be overseen by the Finance and Performance Committee.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance and Performance committee is asked to:

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

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

ADDITIONAL PAPER(S)

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

The committee is requested to receive the following:

Annex 1 Audit Wales Review of Digital Transformation
Annex 2 Management Response Form Digital Transformation

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
3 September 2026	Audit, Risk and Assurance Committee

Archwilio Cymru
Audit Wales

Digital Transformation

Welsh Ambulance Services University NHS Trust

June 2026

About us

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

Contents

Audit snapshot

What we looked at

1 We looked at how the Welsh Ambulance Services University NHS Trust's (the Trust) approach to digital transformation is supporting service improvement. This included its approach to strategy, leadership and skills development. And we considered how the organisation manages risks around digital infrastructure, cyber resilience and artificial intelligence (AI).

Why this is important

2 Digital technology is a key enabler to many of the aims of A Healthier Wales. That plan says that new technologies and digital approaches will be an important part of the future whole system approach to health and care.

3 However, achieving digital transformation is challenging. It requires investment, the right infrastructure, and staff engagement and training. Systems need to communicate with one another, and organisations must manage ever-growing risks around cyber resilience.

4 Digital transformation isn't just about technology, it's about culture and leadership. The boards of NHS bodies have a key role in approving and owning the organisation's digital strategy. Boards also need assurance that digital transformation is being managed safely and effectively, and that investment is securing the intended benefits.

What we have found

5 The Trust has clear digital ambitions and strong leadership. Its Digital Plan aligns with national priorities, but does not set out clear milestones, ownership, or resource needs. It lacks a clear view of digital maturity. This, together with some weaknesses in reporting, makes it hard to track progress.

6 The Trust regularly reviews its strategic digital risks and has a range of cyber resilience controls. But longer-term planning around digital infrastructure and governance for AI is not clear enough to provide full assurance.

7 The Trust recognises the importance of digital skills and capacity, but its approach is not yet joined up. Skills are not assessed consistently, training is fragmented, and workforce planning is not based on a clear baseline.

8 The Trust recognises the importance of engagement and involvement. Staff and service users are involved in some projects, but this is not consistent across all digital developments. Although the Trust is committed to reducing digital exclusion, it does not have a clear plan or a dedicated lead to drive this work.

9 The Trust is delivering digital projects and working with national partners. But it does not have a clear, joined-up view of progress, risks, or benefits. Future plans for digital investment and evaluation are unclear, which limits assurance that digital work will deliver lasting value.

What we recommend

10 We have made nine recommendations to the Trust. These focus on:

- Strengthening the Digital Plan with clear milestones, ownership, resource needs, and success measures.
- Improving reporting to the Board, including clearer progress measures and risk updates.
- Strengthening Board oversight of digital transformation risks.

- Developing a costed digital infrastructure replacement plan with clear timelines and long-term investment needs.
- Introducing a clear AI strategy and governance framework.
- Building digital workforce capability through better skills assessment and training.
- Strengthening user engagement and digital inclusion.
- Setting out clear, costed investment plans beyond 2025-26.
- Introducing consistent post-implementation reviews to assess value.

Key facts and figures

Between 2021-22 and 2024-25, the Trust invested around £3.1 million in digital revenue and £16.9 million in digital capital.

Of the Trust's 4,400 staff, only 22 have completed the Health Education and Improvement Wales (HEIW) Digital Capability Framework self-assessment.

The Trust has not completed a Health Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model (EMRAM) assessment or Infrastructure and Adoption Model (INFRAM) assessment.

In 2025-26, the Trust reported no cyber incidents under the Network and Information Systems Regulations 2018.

Our findings

Strategy, planning, and leadership

The Trust shows clear digital ambitions and strong leadership, but gaps in planning, baseline measures, and reporting limit its ability to track progress and outcomes

Digital strategy and plans

11 The Board approved the Trust's Digital Plan - 'Our Digital Plan' - in July 2024. The plan outlines the Trust's aim of using simple, reliable digital technology and data to improve services and deliver high-quality care. To deliver this vision, the Trust has set out five key digital and data pillars[1] in the plan, one of which is 'transformation'. The plan aligns with national priorities, the Trust's long-term strategy and vision, and its Integrated Medium-Term Plan (IMTP) 2025-28. The Trust says that stakeholders were involved in developing the plan. But the plan does not clearly show who was involved or how their feedback shaped the Trust's digital priorities.

12 The plan reflects the Trust's view of its digital strengths and weaknesses, drawing on internal and external reviews and some benchmarking. It also describes the Digital Directorate in detail, including its structure, ways of working, and key areas for improvement. But the plan does not include a formal digital maturity assessment or set a clear baseline for the Trust. This makes it hard to track progress, demonstrate impact, and compare performance with other organisations.

[1] Its five digital and data key pillars are: (1) Everyday Essentials, (2) Security, Safety and Cyber, (3) Digital Pioneers, (4) Transformation, and (5) Data, Information and Insight.

13 The Trust's digital priorities are set out in the Digital and Data Roadmap within its IMTP 2025-28. The roadmap gives a clear picture of what the Trust aims to deliver in year one but provides less detail for years two and three. Also, it does not clearly assign ownership, resource needs, or how success will be measured. This makes it hard to understand how delivery will be managed and progress assessed.

Board ownership of digital transformation

14 The Board understands and supports the Digital Plan. Senior leaders also recognise the importance of digital for the Trust's long-term strategy. Digital issues are discussed regularly by the relevant committees (see **paragraph 17**). Board members have taken part in training on some areas, such as cyber security. More training is planned on areas such as AI and data. This helps the Board provide challenge and oversight. But more regular training would help Board members provide consistent leadership and challenge on digital matters.

15 The Chair of the Finance and Performance Committee is the Trust's Board-level Champion for Digital. This helps maintain the profile of digital at Board. The Chair also represents the Trust on the All-Wales Independent Member Digital Network. The Director of Digital Services represents the Trust on the All-Wales Directors of Digital forum. These groups provide useful opportunities to share learning and take part in national digital discussions that inform the Trust's digital change work.

Roles, responsibilities and accountability

16 The Trust has strong digital leadership and clear roles. The Director of Digital Services leads the Digital Plan and assistant directors lead day-to-day work.

17 The Board has a reasonable understanding of progress in digital work. Updates are provided every two months to the Finance and Performance Committee, with key issues raised at Board meetings through highlight reports. But these updates do not always include key information, such as progress against milestones, changes in risk, or if programmes are on track. Coverage is also uneven, with some areas reported in detail and others only briefly described. This makes it hard to see overall progress across the Digital Plan. Reports also tend to focus on activity rather than outcomes, and the link to strategic priorities is not always clear. More consistent reporting, clearer measures, and the use of simple visuals would help the Board monitor delivery more effectively.

18 Digital reports provide detailed updates on a wide range of programmes and activities, but the language is often technical. Specialist terms and system names are used, with limited explanation of what they mean or why they matter. This can make it hard for some committee members to quickly understand progress, identify emerging issues, and focus on the most important risks. Our observations of meetings found that discussions on digital matters are brief, with limited questioning and challenge. This suggests that the complexity of the reports may be limiting effective scrutiny.

Identifying and managing risks

The Trust regularly reviews its strategic digital risks and has a range of cyber resilience controls, but gaps remain in infrastructure planning and AI governance

Strategic digital risks

19 The Trust's Board Assurance Framework (BAF) includes two digital strategic risks: the unauthorised or inappropriate use of AI, and a major cyber-attack that could disrupt systems and services. Both risks are rated high, with scores of 16 and 20 in that order. The Board and Finance and Performance Committee review them regularly.

20 Reports list controls, track actions, and include some progress measures. But they do not clearly show how well controls are working or how actions are reducing risk. Clearer reporting on their effectiveness would strengthen Board oversight.

21 The BAF does not include a specific risk on digital transformation. This means the Trust may not fully consider risks that could affect delivery of its Digital Plan, such as delays or limited resources. As a result, the Board may find it hard to make informed decisions, target resources, and demonstrate clear management of strategic digital risks.

Digital infrastructure risks

22 The Digital Plan focuses on making sure the Trust's digital infrastructure is reliable and supports day-to-day services. It highlights the need for dependable systems, devices, and core technology to help staff do their jobs effectively and make sure patients can rely on digital services. But it does not explain how or when digital infrastructure will be upgraded.

23 The Trust is making progress in updating infrastructure in some areas. It is replacing high-risk systems, installing new servers for critical services, and moving some systems to the cloud. These actions show that the Trust responds when risks are identified. But most of this work is managed through separate projects, often linked to available funding. There is no single view of key gaps across the digital estate or a long-term funded plan for replacing outdated or unsupported systems. This makes it hard to assure the Board that infrastructure risks are managed in line with long-term goals.

Cyber resilience

24 The Trust has a Cyber Improvement Plan, which brings together actions from different reviews including Network and Information Systems (NIS) directive audits. Most high-risk actions are complete or now part of business as usual. At the time of our review, the Trust was updating the plan to better reflect operational and clinical impact.

25 The Trust provides cyber reports every two months to the Finance and Performance Committee. These reports cover cyber incidents and day-to-day issues. The March 2026 report notes a small number of incidents, including one involving a third-party supplier. The incident was found and resolved quickly using existing processes. However, the reports use technical language and limited use of plain English. This may make them harder for non-specialist Board members to fully understand the information.

26 The Trust uses a range of controls to improve cyber resilience. These include system updates, vulnerability checks, and testing recovery plans for critical systems such as 999 and 111. Cyber risks are also considered when new systems are introduced. These actions have reduced some risks, such as improving device security and reducing unused accounts. But some issues remain. Reports highlight weaknesses during busy periods, ongoing phishing attacks, and low take-up of cyber training. These issues reduce the overall effectiveness of controls.

Artificial intelligence

27 The Trust recognises that AI offers benefits, but its current use is limited. The Trust mainly uses AI to support staff with administrative tasks and data analysis. It is not used to support clinical decision-making. The Trust does not yet have a clear strategy setting out how it will use AI to improve efficiency and effectiveness and support change and innovation.

28 Positively, the Trust has recorded an AI risk in its BAF (see **paragraph 19**). The risk covers the data protection, legal, and reputational issues that could arise from AI use. The Trust is mitigating the risk through guidance, monitoring, and an AI Steering Group. But as use of AI grows, the Trust will need stronger governance to manage clinical, operational, and ethical risks.

Digital skills

The Trust recognises the importance of digital skills and capacity, but stronger assessment, training, and workforce planning are needed to support digital transformation

Assessing digital skills

29 The Trust recognises the importance of digital skills but does not assess them in a consistent or comprehensive way. Only 22 staff have completed the HEIW Digital Capability Framework self-assessment. This is low for an organisation of around 4,400 staff. The framework focuses mainly on basic IT confidence and does not cover the wider skills needed for digital transformation. There is no evidence that the Trust assesses these broader skills in other ways. As a result, it does not have a clear picture of its overall digital capability. This makes it hard to target training, allocate resources, and plan digital change.

Developing digital skills

30 The Trust wants to develop a digitally skilled workforce but does not yet have a clear, joined-up training programme. The Digital Plan and Strategic Workforce Plan both recognise the importance of digital skills and set an ambition for a digitally capable workforce. The Strategic Workforce Plan also commits to developing a Digital Skills Strategy for 2025–2030. But there is limited detail on what this strategy will include, how skills will be assessed, how gaps will be identified, or how training will be targeted and measured.

31 The Trust provides access to learning tools such as online courses, e-learning, and training linked to new systems. But these are not yet brought together into a single structured programme. As a result, the Trust cannot be confident that its approach will provide the skills needed to support digital transformation effectively.

32 At the time of our work, the Trust had 109.22 whole-time equivalent staff in digital roles. The Trust was also strengthening its Digital Directorate by recruiting a Head of Business Change and Benefits. The Digital Plan recognises the importance of having the right skills and capacity in the Digital Directorate. But it does not set out a clear baseline of digital skills and capacity. This makes it hard to assess if current staffing levels are sufficient to meet the Trust's digital needs.

Collaboration and involvement

The Trust recognises the importance of engagement and digital inclusion, but gaps in approach, leadership, and delivery limit the impact on digital transformation

Staff and service user involvement

33 The Trust involves staff, patients, and service users in some digital work and has received positive feedback from specific projects. It is also introducing new approaches, such as the Innovation Lab and the Digital Transformation and Innovation Programme Board. While this is positive, the Trust does not yet have a single clear approach to involving stakeholders and using their feedback to shape its digital priorities.

Reducing digital exclusion

34 The Trust's Digital Plan aims to prevent digital exclusion and make sure its digital services meet the needs of people with different levels of digital access and confidence. Its strong emphasis on user-friendly design and reducing barriers to access shows the Trust's commitment to improving digital inclusion.

35 But there is limited evidence of digital exclusion being reduced in practice. The Trust does not yet have a clear digital inclusion plan that sets out its aims, actions, or how success will be measured. Also, there is no dedicated lead for this work. The Trust is exploring how to strengthen this area, including improving reporting to the Digital Transformation and Innovation Programme Board and the Board.

Using digital developments to support service transformation

The Trust is delivering digital improvements, but gaps in planning, funding clarity, partnership working, and evaluation make it hard to show long-term impact and value

Investment in digital transformation

36 The Digital Plan sets out why digital investment matters and what the Trust aims to achieve. The IMTP 2025-28 shows how this supports the Trust's wider strategy. A separate paper to the Finance and Performance Committee included high-level cost options. But these documents do not clearly show the full cost of delivering the Digital Plan over time. They also do not explain how funding links to priorities or how delivery will be funded beyond these high-level figures.

37 **Exhibits 1** and **2** show that the Trust has invested significantly in digital in some years, but spending has been uneven. Between 2021-22 and 2023-24, capital investment ranged from £4.2 million to £6.6 million. In 2024-25, capital spending fell sharply to £1.6 million, suggesting fewer large projects were funded. Revenue spending was low between 2021-22 and 2023-24but rose to £1.5 million in 2024-25. This suggests a greater focus on running and supporting existing systems.

38 The Trust has set out planned digital spending for 2025-26, with £2.2 million for capital and £1.7 million for revenue. However, it has not provided capital figures for 2026-27 or 2027-28 and has shared little information on revenue funding beyond 2025-26. This makes it difficult to assess if the Trust will have enough funding in future years to maintain older systems or deliver its planned digital improvements.

Exhibit 1: Annual capital and revenue investment in digital (2021-22 to 2024-25)

Financial year	Capital (£m)	Revenue (£m)
2021-22	4.5	0.4
2022-23	4.2	0.7
2023-24	6.6	0.5
2024-25	1.6	1.5

Source: Trust supplied data

Exhibit 2: Planned levels of capital and revenue investment in digital (2025-26 to 2027-28)

Financial year	Capital (£m)	Revenue (£m)
2025-26	2.2	1.7
2026-27	-	0.3
2027-28	-	-

Source: Trust supplied data

Local and regional digital projects

39 The Trust is delivering a range of local digital and data projects to improve services, support staff, and increase efficiency. These include:

- improving NHS 111 by introducing new features such as online symptom checkers and virtual assistants;
- upgrading dispatch and control room systems;
- refreshing the electronic Patient Care Record (ePCR);

- updating cloud-based rostering and timesheets; and
- improving the use of data and performance reporting.

40 The Trust is also testing simple AI tools, mainly to support staff rather than clinical decision-making (see **paragraph 27**).

Adopting national digital systems

41 The Trust works with national and system partners to support delivery of its Digital Plan. It engages with the Welsh Government, Digital Health and Care Wales (DHCW), and national clinical groups and programmes on areas such as NHS 111, emergency response, and performance reporting. It also takes part in national digital programmes and data sharing, showing a commitment to the 'Once for Wales'.

42 Joint working with partners is stronger at a project level than at a strategic level. Reports describe many partner-led or partner-supported projects, but do not always clearly show roles and responsibilities, how partner delivery is overseen, or how partner risks are managed.

43 The Trust is beginning to improve its partnership governance arrangements. But it needs to do more to improve oversight of partner-led digital work and make better use of national digital expertise. This includes clearer responsibilities for partners, closer working with HEIW on digital skills, and providing more structured feedback to DHCW and the Welsh Government on national programmes and initiatives.

Evaluating digital solutions

44 The Trust does not yet have a clear or consistent approach to reviewing projects after delivery or checking if the expected benefits have been achieved. There is no dedicated evaluation function, and benefits such as improved efficiency, productivity, or patient experience are often described rather than measured.

45 The lack of regular post-implementation reviews makes it hard to learn from experience, understand the impact of digital projects, and show whether investment is delivering value. As a result, while digital systems are being delivered and used, the Board does not receive clear assurance that they are delivering sustained improvements.

Recommendations

47 The following table details the recommendations arising from our work.

R1	The Trust should strengthen its Digital Plan by:
1.1	outlining its current level of digital maturity and the measures it will use to track maturity and success over time. (**Paragraph 12**)
1.2	setting clear milestones, details of ownership, and resource needs. (**Paragraph 13**)
R2	The Trust should improve digital reporting by:
2.1	including clear milestones, measures of progress and outcome, risk updates and more consistent information across programmes. (**Paragraph 17**)
2.2	using plain language and explaining technical terms, so reports are easy to understand and support effective challenge. (**Paragraph 18**)
R3	The Trust should strengthen its Board Assurance Framework by clearly identifying and describing risks to digital transformation, including delivery, capacity, and resource related risks. (**Paragraph 21**)

R4 The Trust should develop a clear, costed digital infrastructure replacement plan with timelines, milestones, asset information, and long-term investment needs. This should be supported by clearer reporting on how effectively infrastructure risks are being managed. (**Paragraph 23**)

R5 The Trust should develop a clear AI strategy and governance framework. This should set out how AI will be used across the organisation, the expected benefits, how success will be measured, and how risks will be managed. (**Paragraph 27**)

R6 The Trust should develop a structured approach to understanding and building its digital workforce capability by:

6.1 maximising use of HEIW's Digital Capability Framework to assess basic digital confidence. (**Paragraph 29**)

6.2 developing a local assessment of the wider digital skills needed to deliver the Trust's digital ambitions. (**Paragraph 29**)

6.3 developing a targeted, role-specific training and learning programme beyond basic e-learning, including data and digital change skills. (**Paragraph 30 and 31**)

6.4 developing a strategic digital workforce plan that sets out required staffing levels, roles, competencies and future capacity needs, informed by a clear baseline of current digital workforce capability. (**Paragraph 32**)

R7 The Trust should develop a clear approach to engagement and digital inclusion by:

7.1 introducing a framework to involve staff and service users in digital design and delivery. **(Paragraph 33)**

7.2 developing a digital inclusion plan with clear priorities, actions, measures, and risk management arrangements. **(Paragraph 35)**

7.3 improving Board reporting on engagement and digital inclusion activity and impact. **(Paragraph 35)**

R8 The Trust should set out clear, costed investment plans for digital transformation, including capital and revenue needs beyond 2025-26. (**Paragraph 36**)

R9 The Trust should introduce a consistent post-implementation review process to assess whether digital investments deliver benefits, value for money, and better use of resources. **(Paragraph 45)**

Appendices

1 About our work

Scope of the audit

The goal of this audit is to find out if the Trust is using digital technology to support service modernisation and efficiency. This included the approach to strategy, leadership and skills development for digital transformation, and how risks around digital infrastructure, cyber resilience and artificial intelligence are being managed.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Trust have a well-led and appropriately resourced approach to digital transformation?
- Is the Trust developing the digital skills, capacity, and capability of its workforce?
- Does the Trust have a clear plan for managing its cyber resilience arrangements and digital infrastructure and how they will need to change to support its digital transformation ambitions?
- Does the Trust engage effectively with staff, partners, patients / service users to deliver its digital transformation ambitions and minimise digital exclusion risks?
- Is the Trust actively utilising new digital technology and data solutions to enhance the accessibility, quality, efficiency, and productivity of its services?

Criteria

Our audit questions were shaped by:

- External reference input from the Welsh Government, all-Wales NHS Directors of Digital, and Digital Health & Care Wales.

- Relevant Welsh Government strategies and plans.
- Relevant NHS Digital Transformation review reports completed by the National Audit Office and House of Commons Health and Social Care Committee.
- NHS England Department of Health & Social Care: A plan for digital health and social care policy paper.
- NHS England Transformation Directorate: What good looks like framework.

Methods

We asked the Trust to:

- Complete a self-assessment to help us understand how the organisation is undertaking digital transformation.
- Give us facts and figures about its spending on digital technology, staff digital skills, cyber resilience, and how it involves people in digital transformation.

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Finance and Performance Committee reports and Board papers.
- Key strategies and plans, including the Digital Plan, IMTP 2025-28 and Annual Plan.
- Key risk management documents, including the BAF.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Director of Digital Services.
- Interim Chief Executive.
- Assistant Director of Finance.

We observed Board meetings as well as meetings of the Finance and Performance Committee.

2 Key terms in this report

Term	Description
Digital Plan ('Our Digital Plan')	The Trust's strategy for digital.
Integrated Medium-Term Plan (IMTP)	An IMTP is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Digital and Data Roadmap	The programme of digital priorities within the IMTP.
Digital maturity	The organisation's capability to use digital effectively, often assessed against a framework.
Health Information and Management Systems Society (HIMSS)	The HIMSS is a global non-profit organisation dedicated to improving health through the best use of information technology and management systems.
Electronic Medical Record Adoption Model (EMRAM) Assessment	The EMRAM is a strategic, eight-stage (0–7) framework developed by HIMSS to measure, benchmark, and improve a hospital's digital maturity. It guides organizations from paper-based systems to a fully electronic, paperless environment, aiming to enhance patient safety, clinical outcomes, and efficiency.

Term	Description
Board Assurance Framework (BAF)	A BAF in the NHS is a structured, strategic tool used by boards to monitor risks that threaten the achievement of corporate objectives.
Network and Information Systems (NIS) Regulations 2018	The NIS Regulations 2018 aim to improve the cybersecurity and resilience of systems that provide essential services.
Artificial Intelligence (AI)	AI is the ability of machines, computer systems, or robots to mimic human intelligence, learning, and decision-making to perform specific tasks.
HEIW's Digital Capability Framework	A national model outlining the digital skills, behaviours and confidence health and care staff need, organised into six capability domains with a self-assessment tool for development.
User engagement	Involving staff, patients and service users in digital design and delivery.
Digital skills baseline	An assessment of current digital capability across the workforce.
Digital inclusion	Ensuring digital services are accessible to people with different needs and abilities.
Digital exclusion	Barriers that prevent people from accessing or using digital services.
NHS 111	The national non-emergency health advice service.
Electronic Patient Care Record (ePCR)	The digital record used by ambulance clinicians.

Term	Description
Dispatch and control room systems	Systems used to manage emergency response and deployment.
Cloud-based systems	Digital systems hosted online rather than on local servers.
Once For Wales	National approach in NHS Wales where a digital system, process or standard is designed, procured and implemented once at a national level, rather than each health board creating its own version.
Post-implementation review (PIR)	A review to assess whether a project delivered its intended benefits.

About us

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Management response form

Audit Wales use only	
Audited body	Welsh Ambulance Services University NHS Trust
Audit name	Digital Transformation
Issue date	June 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Trust should strengthen its Digital Plan by:			
R1.1	outlining its current level of digital maturity and the measures it will use to track maturity and success over time. (Paragraph 12)	The Trust accepts this recommendation. As part of the ongoing refresh of the Digital Plan, a formal digital maturity baseline will be established using recognised maturity frameworks, alongside locally agreed measures. The Trust will assess the most appropriate framework and benchmarking approach for its operational context,	March 2027	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		recognising its unique position as the only ambulance trust within NHS Wales. This will include consideration of relevant peer benchmarking beyond Wales, where appropriate, alongside national NHS Wales comparators and longitudinal assessment of the Trust's own maturity over time. This approach will provide a consistent means of assessing progress, identifying areas for improvement and demonstrating advancement against strategic outcomes rather than technology implementation alone.		
R1.2	setting clear milestones, details of ownership, and resource needs. (Paragraph 13)	The Trust agrees that future iterations of the Digital Plan should provide greater clarity around ownership, milestones and resource assumptions. This work will be delivered through the development of the Trust's new Digital, Data and Technology (DDaT) governance framework and Digital Oversight Group (DOG), which will provide strengthened governance, clearer accountability, delivery milestones and oversight arrangements across the digital portfolio.	March 2027	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R2	The Trust should improve digital reporting by:			
R2.1	including clear milestones, measures of progress and outcome, risk updates and more consistent information across programmes. (Paragraph 17)	The Trust accepts this recommendation. Work is already underway following the recent Good Governance Institute review to strengthen digital governance and assurance arrangements. Standardised reporting templates will be introduced to provide clearer milestones, delivery status, benefits, strategic alignment, key risks and outcome measures across all major digital programmes.	March 2027	Director of Digital Services
R2.2	using plain language and explaining technical terms, so reports are easy to understand and support effective challenge. (Paragraph 18)	The Trust agrees. Future Board reporting will place greater emphasis on strategic outcomes using plain English, supported by concise explanations of technical terminology where appropriate. Reporting will focus on enabling effective Board scrutiny rather than technical delivery updates alone.	December 2026	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R3	The Trust should strengthen its Board Assurance Framework by clearly identifying and describing risks to digital transformation, including delivery, capacity, and resource related risks. (Paragraph 21)	The Trust accepts this recommendation. As part of the wider review of corporate governance following the Good Governance Institute review, the Board Assurance Framework will be updated to include a dedicated strategic risk relating to digital transformation. This will better reflect risks associated with programme delivery, workforce capacity, dependency management, affordability and organisational change.	December 2026	Director of Digital Services
R4	The Trust should develop a clear, costed digital infrastructure replacement plan with timelines, milestones, asset information, and long-term investment needs. This should be supported by clearer reporting on how effectively infrastructure risks are being managed. (Paragraph 23)	The Trust agrees that a more strategic view of infrastructure investment would strengthen assurance. Existing lifecycle information, cyber risk assessments and infrastructure roadmaps will be consolidated into a longer-term infrastructure replacement plan identifying asset lifecycles, prioritised replacement requirements and estimated investment needs. However, the Trust notes that NHS Wales financial planning operates on an annual planning cycle, with future capital allocations confirmed annually. Whilst a longer-term costed replacement plan will improve strategic planning and prioritisation, it cannot	June 2027	Assistant Director of Digital: ICT

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		provide assurance that identified investment requirements beyond approved funding periods will be deliverable until funding allocations are confirmed.		
R5	The Trust should develop a clear AI strategy and governance framework. This should set out how AI will be used across the organisation, the expected benefits, how success will be measured, and how risks will be managed. (Paragraph 27)	The Trust accepts this recommendation. An AI Strategy and Governance Framework is already in development and is planned for implementation during the current financial year. This will build upon the existing AI Steering Group and Board oversight arrangements, setting out priority use cases, governance, ethical principles, benefits realisation and risk management aligned to emerging national guidance for NHS Wales.	June 2027	Assistant Director of Digital: IDS
R6	The Trust should develop a structured approach to understanding and building its digital workforce capability by:			

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6.1	maximising use of HEIW's Digital Capability Framework to assess basic digital confidence. (Paragraph 29)	The Trust accepts this recommendation. Greater promotion of the HEIW Digital Capability Framework will form part of the wider workforce development programme to improve understanding of baseline digital confidence across the organisation.	June 2027	Assistant Director of Digital: IDS
R6.2	developing a local assessment of the wider digital skills needed to deliver the Trust's digital ambitions. (Paragraph 29)	The Trust agrees with the principle of this recommendation. The Trust recognises the need to strengthen its approach to developing a digitally skilled workforce and has already begun taking tangible steps to address the gaps identified. The recent recruitment of a Head of Business Change and Benefits, alongside the appointment of a Digital Adoption Facilitator, provides dedicated leadership to establish a more structured and outcome-driven approach. Together, these roles will lead the development of a benefits realisation framework for digital projects, ensuring that digital investment translates into measurable improvements in capability and service delivery.	June 2027	Assistant Director of Digital Services: Innovation & Transformation

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		This work will be supported by a stronger focus on user-centred design, with staff actively involved in co-designing new systems to ensure solutions are intuitive and aligned to operational needs. In addition, the establishment of a Digital Champions network will create localised support and peer-led learning opportunities, helping to embed digital skills across the workforce and improve adoption of new technologies. These initiatives represent a shift towards a more coordinated and sustainable model for digital skills development, including clearer approaches to skills assessment, gap identification, targeted training, and measurement of impact.		
R6.3	developing a targeted, role-specific training and learning programme beyond basic e-learning, including data and	The Trust accepts this recommendation. A structured digital learning and capability programme will be developed bringing together existing training, digital change capability, data literacy, AI awareness and leadership development into a coherent programme aligned to role requirements.	June 2028	Director of People & Culture / Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	digital change skills. (Paragraph 30 and 31)	This recognises that previous investment priorities have necessarily focused on maintaining critical operational services rather than broader organisational capability development.		
R6.4	developing a strategic digital workforce plan that sets out required staffing levels, roles, competencies and future capacity needs, informed by a clear baseline of current digital workforce capability. (Paragraph 32)	The Trust agrees. A Digital Workforce Plan will be developed which establishes the current workforce baseline, future capability requirements and anticipated capacity needed to support delivery of the Digital Plan over the medium term.	September 2027	Director of Digital Services
R7	The Trust should develop a clear approach to engagement and digital inclusion by:			

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R7.1	introducing a framework to involve staff and service users in digital design and delivery. (Paragraph 33)	The Trust accepts this recommendation. The Trust's Innovation Lab, currently in development and planned to launch during the current financial year, will provide a structured mechanism for engaging staff, patients and service users in the design, testing and evaluation of digital services. This will form the foundation of a broader engagement framework supporting co-design across future digital transformation programmes.	March 2027	Head of Digital Benefits
R7.2	developing a digital inclusion plan with clear priorities, actions, measures, and risk management arrangements. (Paragraph 35)	The Trust agrees. A Digital Inclusion Plan will be developed, building upon existing commitments within the Digital Plan. This will identify key priorities, ownership, measures of success and governance arrangements whilst aligning with wider equality and inclusion strategies across the Trust.	June 2027	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R7.3	improving Board reporting on engagement and digital inclusion activity and impact. (Paragraph 35)	The Trust agrees. The development of the new DDaT governance framework and Digital Oversight Group (DOG) will strengthen reporting arrangements for engagement and digital inclusion. The DDaT governance group will be responsible for reviewing agreed performance measures and KPIs, ensuring regular reporting of engagement activity, digital inclusion outcomes and the impact of user feedback to support Board assurance.	June 2027	Director of Digital Services
R8	The Trust should set out clear, costed investment plans for digital transformation, including capital and revenue needs beyond 2025-26. (Paragraph 36)	The Trust partially accepts this recommendation. The Trust will continue to strengthen the financial planning underpinning the Digital Plan by developing indicative multi-year investment profiles aligned to organisational priorities and infrastructure lifecycle requirements. However, recognising the NHS Wales financial planning environment, detailed costed investment plans beyond confirmed funding periods will necessarily remain indicative and subject to annual IMTP approval, capital allocations and national funding decisions.	June 2027	Director of Digital Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R9	The Trust should introduce a consistent post-implementation review process to assess whether digital investments deliver benefits, value for money, and better use of resources. (Paragraph 45)	The Trust accepts this recommendation. Since completion of this audit, the Trust has appointed a Head of Business Change and Benefits whose role includes establishing a consistent benefits realisation and post-implementation review framework across the digital portfolio. This work has commenced and will be embedded within the emerging DDaT governance arrangements, providing clearer oversight of benefits, lessons learned and value for money across major digital investments.	March 2027	Head of Digital change and benefits

Agenda Item No.	11

REPORT TITLE

Digital Reporting

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, Director of Digital Services
Author(s) of report	Dr Leanne Smith – Assistant Director of Digital Services: Data & Analytics Kimberly Abraham, Digital Directorate Support Administrator Digital Leadership

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This report brings to the committee updates relating to activities of the Insight & Data Services (IDS), ICT, Digital Transformation & Innovation, and the Clinical Digital Unit (CDU) functions, aligned to the IMTP deliverables, Local Directorate Plan for 2026-27, and the Strategic Digital Plan 2024-29 (see the **Annex** for metrics and project status). Note that the timing of this month's report means data in the accompanying Metrics report will depict July data only (and not include August data as may be expected).

Alerts

2. **Workload & Prioritisation:** The Digital teams are still involved in a significant number of projects and delivery activities across WAST, often with competing timelines and a dependency on specialist capacity to facilitate all organisational needs. As demand continues to grow, we needed a clear and consistent approach to governance and prioritisation. The new Digital Oversight Group (DOG) (see paragraph 6) has been established to bring the right people together from across Operations, Clinical and Digital teams, to review and oversee all digital backlogs, new requests and project proposals. This new governance group will make it easier to manage digital requests fairly and consistently, and ensure work is prioritised against organisational needs, existing workload, risks and dependencies. Digital teams are currently reviewing their backlogs, with all outstanding requests being directed into the DOG process for reconsideration and to ensure the right priority and resource is assigned.

Highlights

3. We continue to make progress on recruitment for core roles across the directorate:

   - The new **Digital Business Manager** started with the Directorate early September.
   - The **Digital Adoption Facilitator** has now been recruited and is already scoping and planning the Digital Champions Network.
   - **Digital 111 Online (Digital Front End)**: Recruitment to the core leadership team is progressing well, with the Product Specialist now in post, the Head of Service expected to join in Q3, and interviews commencing in September for the Clinical Lead. Shortlisting is being carried out for the Business Analyst 111 digital front end with more than 267 applicants.
   - The **Data Engineering Lead** position is at advert across NHS Wales, with interviews expected to take place later in September.

4. **Clinical Model Transformation (CMT):** Digital continue to support the CMT with significant contribution already made throughout the first half of 2026/27 (see Annex for an overview of the workstreams). Highlights from the current reporting period include:

    - **Online Symptom Checkers (Digital Front End):** Progress continues on the development of the online symptom checkers. ICT has deployed the very latest supplier update to the test environment, and testing of the enhanced administration functionality is continuing. Build activities for the live system continue to progress with the completion of the firewall rules and server configurations along with taking the latest software update in line with the test system. The Live system is now in readiness for the cyber security Pen Test booked in for the middle of September. UAT conducted by operational testers remains ongoing to verify readiness for the next stages. Integration with the 999 CAD system is continuing and the address validation solution is now running on both environments.
    - Under the **CMT Benefits Realisation workstream** Digital are contributing to Call Flow Phase 3 initiatives, are supplying data to support the independent CMT Evaluation by academic partners, and are involved with other workstreams such as collating existing intel around Falls and APPs for the Urgent Community Metrics group. Whilst these are priorities that predominantly impact the IDS function, there are other requirements to support these workstreams across Digital, including CAD changes and system updates.
    - **Ambulance Performance Framework and ICCQ fixes:** The IDS team resolved an issue where the default priority on EMS incidents was incorrectly being set to NOW instead of RCS1 in the CAD system. The cause of this was due to a variety of changes implemented in the CAD system as part of the Clinical Model Transformation. The issue was investigated by IDS and a fix was identified. With endorsement from the Senior Operations Team, the issue will be corrected going forward but already-published stats will not be backdated due to the significant technical effort required. The solution will see the CAD system updated to robustly, and automatically, make NULL priorities default to RCS1 at the source, removing the reliance on internal data engineering to resolve.

5. **National DOS:** WAST Digital continue to support the national work to create a single Directory of Services (DOS). Feedback was provided earlier in Q2 on the Business Case drafted centrally which has since been submitted to Welsh Government for consideration and to support discussions on funding opportunities. In parallel, WAST have shared detail on the workings of the WAST DOS with the NHS Wales-led project group as part of a technical discovery phase. This part of the project aims to better understand the existing DOS landscape, data, integrations and constraints across Wales before progressing to solution design.

6. **Digital Oversight Group:** The Digital Oversight Group (DOG) has now been launched including the digital request application and supporting Siren pages. DOG has had its inaugural meeting where members from across the trust were given the opportunity to review and sign off the new request process including Standard Operating Procedure (SOP) and the Terms of Reference (TOR). Digital requests have already been submitted from colleagues across the Trust which have been reviewed by the Digital Request Prioritisation Forum (DRPF) on 1 September and submitted to DOG for sign-off. Work has started to identify, baseline and measure the benefits that DOG will bring to the Digital Directorate, our people and the wider Trust.

7. **ePCR refresh:** The wider application refresh programme continues to progress well and remains on track for deployment in Q4. WAST is the UK's official TerraPACE reference site, a significant recognition of the organisation's digital maturity and partnership with the supplier. This status provides WAST with early access to new platform capabilities - in September, we were shown an early development preview of TerraPACE's new ePCR refresh, ePR4, which was still in the initial stages of development at the time.

8. **eTimesheets**: Work completed between WAST, the supplier and DHCW regarding the Microsoft Azure tenant integration – which is now functional and allows login to GRS Cloud client. The specification has been submitted to vendor and is still under review.

9. **ESN Phase 2:** In June 2026 the Operational Communications Programme Board approved the endorsement from DLG to continue on the ESN journey with ARP and align with the English Ambulance Trusts. Both ARP and the Home Office have been made aware. An ESN Phase 2 FBC will be submitted to Welsh Government in September/October, encompassing Air to Ground, handheld radios, fixed vehicle devices (radio), field services and the resources required until 2031/32. Dates have been agreed with the relevant committees for the Governance route. The ESN Phase 2 FBC has been presented to and endorsed by OCP Programme Board on 23 July 2026 and the Executive Leadership Team meeting on 26 August 2026, and will progress to the Finance and Performance Committee on 15 September and at the Trust Board on 24 September.

10. **Strategic Data Plan:** following an earlier internal audit on Devolved Data Management across the organisation, and conversations with the Executive Leadership Team about the direction for data, analytics and AI within WAST, a strategic data plan is in development. It is recognised that current experiences across WAST see data being unavailable or hard to find, demand for insight and modelling outstripping specialist technical capacity, and duplication and inefficiency undermining confidence, and risking compliance and reputation. The strategic data plan aims to create a connected, well-governed, and high-quality data environment that empowers all our people with timely insight, supports evidence-based decision making, and underpins innovation. The plan will be supported by the professionalisation of the data and analytics workforce across WAST through a new

'Community of Practice', and by empowering a data-confident workforce more widely through self-serve and data literacy programmes. The development of this strategic plan will continue through Q2 and into Q3, with an aim for the full implementation plan to be published in Q4 2026/27.

Lowlights

11. Support continues for the **Clinical Model Transformation**, although some challenges regarding data flows and reporting are still present:
    - **Consult & Close (C&C):** complications and issues with this key metric have been uncovered since the introduction of the new ICCQ, with some endpoints for consultations not being captured correctly. This requires a fix from one of WAST's system suppliers, which is planned for October.
    - **Rapid Clinical Screening (RCS):** issues with negative times being captured by the system have been identified, and a fix developed in-house. This is now being applied, and backdated to correct historic data. Another issue related to the RCS data however requires a change by one of WAST's system suppliers, which is still awaiting confirmation of a date.
    - **Time to Start Triage (TTST):** issues with the TTST metric for RICS have also been identified. This may require a change to data definitions and logic, and/or a fix to the system by the supplier.
    - Whilst the IDS team continue to prioritise investigative and technical development work related to Ambulance Performance Framework, ICCQ, and wider CMT data and metrics issues, to support with **faster resolution** and timely decision making, a small cross-Directorate working group has been established which will meet twice-weekly from early September.

12. **CAD Replacement**: The Operations and Digital teams undertook a Design thinking workshop during June 2026 where human-centred design was used to start capturing the future CAD requirements. A formal project is still to be established due to capacity challenges across multiple Directorates and specialisms, including programme / project management. A project structure is hoped to be established by Q1 2027/28.

13. **AI Developments:** The Digital Directorate has received multiple asks to consider new Copilot Agents, developed by members of staff across WAST. Whilst the AI Steering Group (AISG) is able to support the thinking around the design and development of these Agentic AI tools, ensuring they align to the principles of Responsible AI and internal governance / compliance frameworks, the agents are not yet able to be fully rolled-out due to limitations in licencing, funding and governance. The Trust is also seeing growing AI-related risks associated with both workforce behaviours and technology adoption. Key concerns include risks of: staff over-reliance on AI without appropriate levels of judgement or critical thinking, leading to skill atrophy; use of unapproved AI tools; and suppliers introducing AI capabilities without sufficient governance oversight. These risks are being incorporated into AI

governance arrangements, organisational strategy and risk management processes, but there remains a gap in some management & governance mechanisms, and in the expert resource and capacity to develop these at pace.

14. **National Data Sharing:** A coordinated national approach to data sharing with system partners across NHS Wales remains dependent on central work being progressed with support of Welsh Government. To enable data to flow into the National Data Resource (NDR) and to support compliant onward sharing, there remains a need to resolve national legislative barriers and provide clarity on the respective roles and responsibilities of data controllers and processors. WAST's Data Protection Officer has contributed to this national work through the Information Governance Leads Group (IGMAG), which has been considering proposed next steps to support progress across Wales. As part of this work, IG Leads from all NHS Wales statutory bodies have collaborated to identify key obstacles and potential solutions. A paper has been developed to support Welsh Government in enabling data sharing across health and care in Wales. IGMAG has recognised that any sustainable solution will require a collaborative, cross-functional approach across all NHS Wales statutory bodies, with the Information Governance community prepared to support initiatives that enable progress. The paper covers the following areas: public engagement and transparency; citizen choice; clarification of the legal landscape and use of devolved powers; and proposed next steps. The paper is due to be presented to CEMT on 8 September 2026.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance & Performance Committee is requested to:

1. **RECEIVE ASSURANCE** on the progress of the Digital Plan activities, IMTP commitments and CMT involvement of the Digital Directorate teams.

ADDITIONAL PAPER(S)

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

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

Annex 1 Digital Reporting September 2026 Metrics

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
BAF Risks: • 671 – Inappropriate use of AI Technologies • 623 – Failure to comply with Data Protection Legislation (now managed locally by Digital Directorate) • 690 – SAR and disclosure of Records compliance

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

Digital Contribution 26/27

CMT
- CMT Evaluation — Data for academic evaluation
- CMT Benefits — Call Flow 3 + Urgent Community Metrics
- Digital Front End — Business case submitted; recruitment cont.

Everyday Essentials
- GRS migration
- Simplified sign-on — for RICS
- Paramount Migration

Cyber, Safety & Security
- Responsible AI — Interim mechanisms; policy in dev

Digital Pioneers
- DDaT Governance — DOG + DRPF launched
- SMS functionality — NEPTS opt-out ability live
- Benefits framework — finalising benefits training

Transformation
- CAD Replacements — Project support required
- ESN Phase 2 — Air to Ground endorsed
- ePCR Refresh — Contract renewed & demo received

Data, Information & Insight
- Connected Intel — Single Clinical Queue data assurances; Data Linkage planned to commence Q4
- National Sharing — dep on national work
- Strategic Data Plan — Target Operating Model in dev

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

RAG and progress based on Directorate Plan
Last updated 02/09/2026

CMT Digital Contribution 25/26

Remote Integrated Care Service

RICS Integrated CAD
Remote Monitoring
Low code Alignment
CPSS in 999s (pilot)
Video Triage
Welsh Clinical Portal Integration

Digital Front End

Virtual Assistant
Content Management System*
Symptom Checkers
Service Development*

*Subject to funding agreements and processes

Urgent Community Response

ePCR Access (e.g. falls responders)
Scheduling (APPs/pallative)

Emergency Response Service

Red Review Infrastructure
Call Category Changes
CPR in Community (Scoping)
Rapid Clinical Screening

Health Transport

Scoping for the art of the possible

Digital Overarching Support (all workstreams)

- Digital Capacity — Volume of projects, expected to progress in parallel, is not currently feasible
- Metrics & reporting — ICCQ data investigations & issues still ongoing in Q2, putting other projects at risk
- IG & Data Protection — Late engagement in projects, data protection issues, and competing priorities

Digital: Data & Analytics

Data Lifecycle: Jul 26

The 6 stages of the data and analytics lifecycle and related metrics.

Not including Police requests or ePCR processing

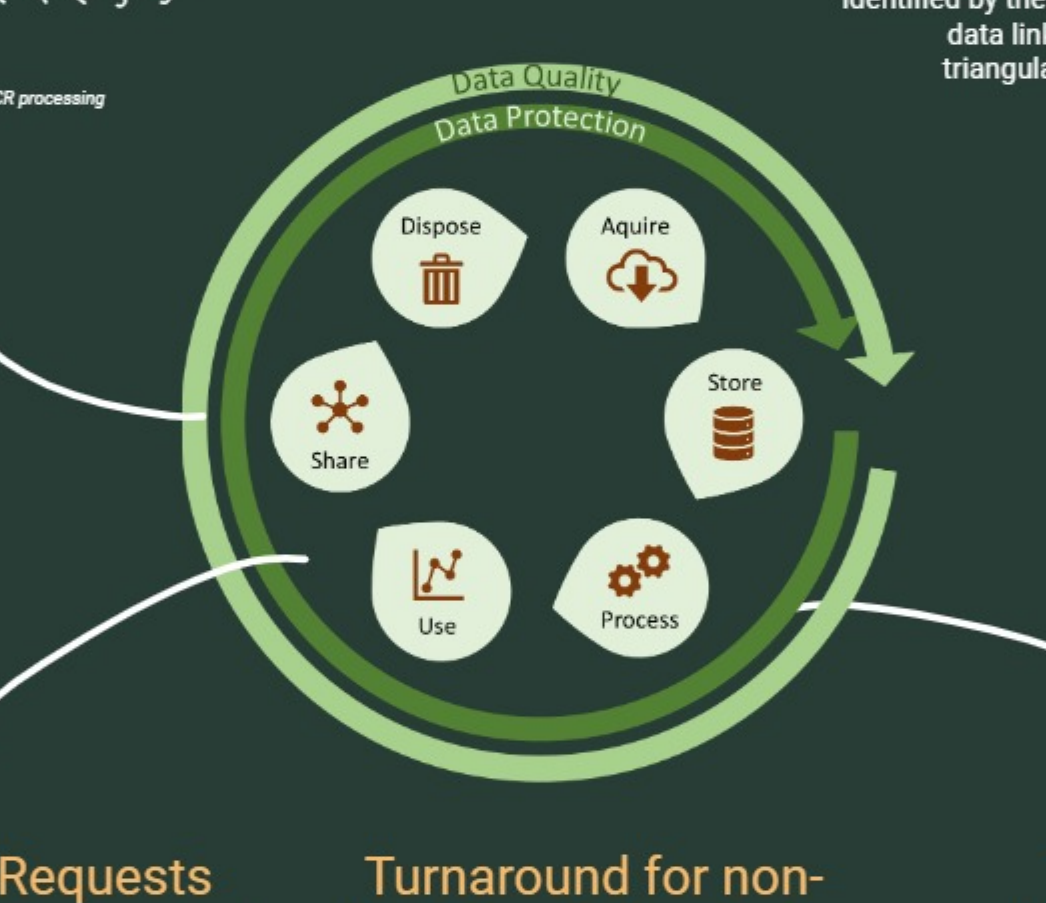
Timeliness of ASI Submission to Commissioners

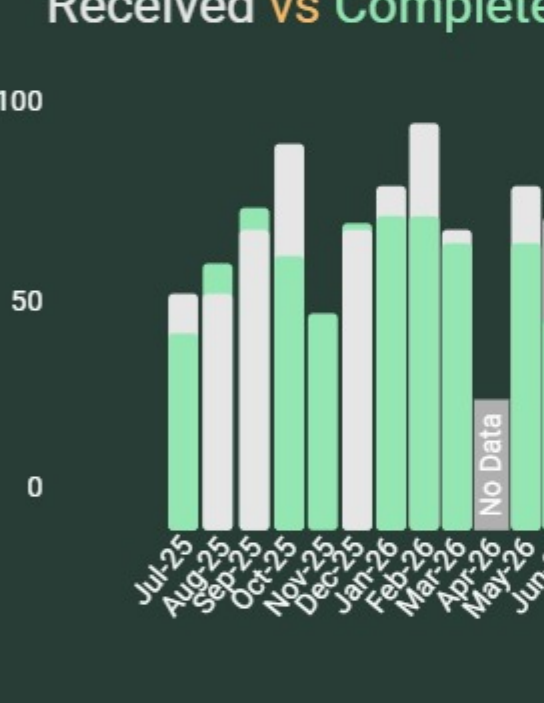
*August 2025 had agreed extension due to first release of new call categories (Arrest + Emergency); September also delayed 2-3 days

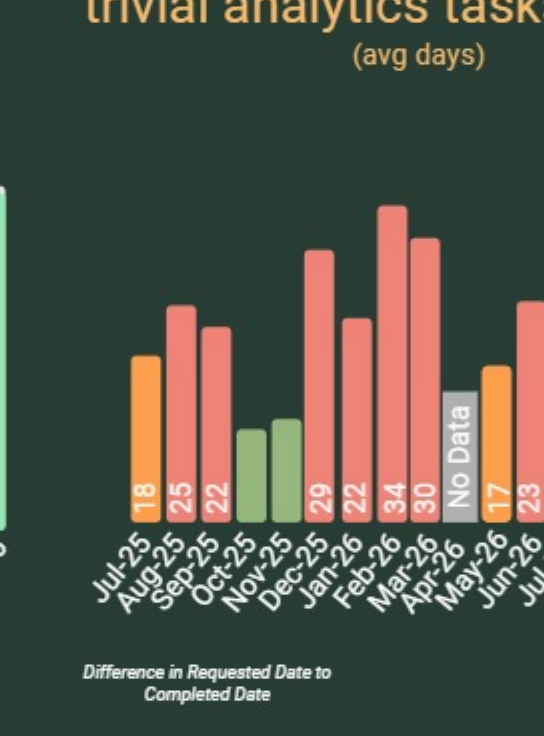
% EMS incidents where patient NHS Number was verified

67%

this represents the patients who can be identified by their NHS Number enabling data linkage projects and easier triangulation with Health Boards







Difference in Requested Date to Completed Date

Data Protection & Data Quality metrics found in Information Governance and Security Report

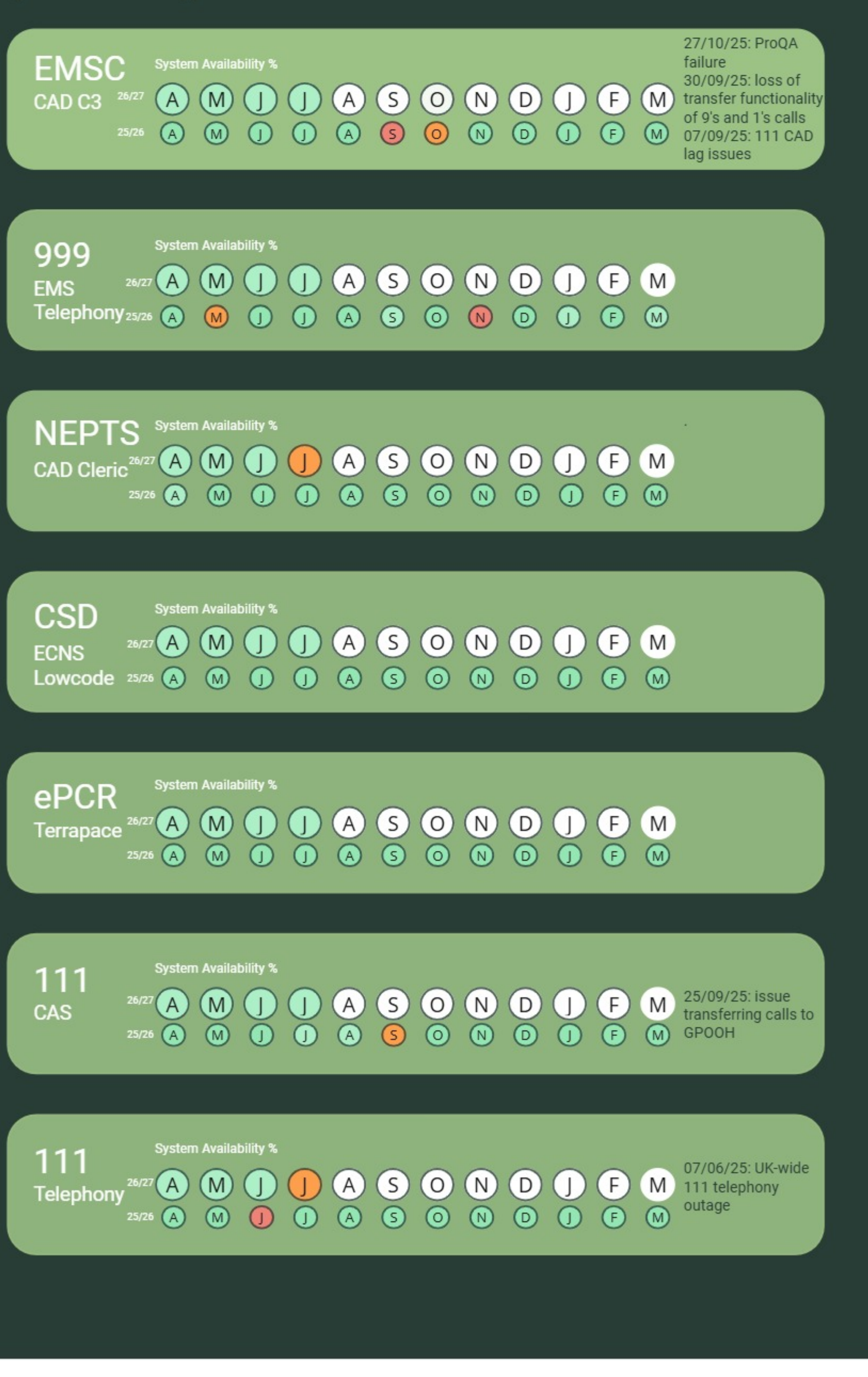
Digital: ICT Systems

Data for May 2026 unavailable at the time of writing the report

System availability metrics

Each circle represents availability per month.
N.B. these are not reflective of SLAs, and do not yet differentiate supplier issues & resolutions

Definitions based on industry standards
- <4.32 mins downtime >99.99%
- >4.32 and <43.8 mins >99.9%
- >43.8 mins downtime <99.9%



Digital: Service Provision

Quality, efficiency, and stakeholder feedback: Jul 26

ICT Service Desk

2601 calls logged Jun
2401 calls resolved Jun

6.5 Service Desk hours saved through use of RPA

Top 5 Jul Service Desk Requests
- Service Request 434
- Mobile Device 281
- ePCR 210
- M635 182
- Telephony 147

67% Incidents resolved within target
79% Requests resolved within target

Note: not all incidents or requests can be resolved by WAST

Records

RPA for PCR requests saved people hours in Jul 8.6

Assumes 10 minutes per request

IDS Inbox

Same day turnaround of 'quick' tasks

ON TRACK

If non-quick tasks = 3 days on average to complete, then 90 requests = 2000 people hours, which would require >13 FTE analysts to complete each month.

111 Website

47% Jul 26 engagement rate

The current position shows a steady trend across previous months

Engagement = users with a session >10 seconds, a conversion event, or 2 or more page views.

5328 Virtual Assistant conversations monthly

Agenda Item No.	12

REPORT TITLE

Information Governance Progress Report

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, Director of Digital Services
Author(s) of report	Dr Leanne Smith, Assistant Director of Digital Services: Data & Analytics

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This report brings to the committee an update on all Information Governance (IG) activities of the Trust and related areas, including Information Security, Records Requests and Management, Freedom of Information, and Data Quality. Information Governance Highlight Reports and related papers are presented monthly to the Information Governance Steering Group (IGSG) chaired by the Trust's Senior Information Risk Owner (SIRO, and Director of Digital Services). The IGSG reports via AAA to the Executive Leadership Team (ELT).

2. This paper covers data and intelligence from the period of **1 June 2026 to 31 July 2026**, and the topics discussed at the **July** and **August** meetings of IGSG.

Alerts

3. **Cyber Improvement Plan:** The Trust's Cyber Improvement Plan (CIP) currently contains 69 red actions and 98 amber actions. The Digital team are satisfied that the appropriate technical controls and oversight arrangements are in place, however, it is acknowledged that reporting to the Information Governance Steering Group (IGSG) could be strengthened and made more consistent with reporting that is received by the Finance & Performance Committee. It is not sufficiently easy for IGSG to distinguish between actions which are genuinely overdue, require additional funding or intervention, or represent a material risk. The Cyber team is revising the reporting for both the Finance & Performance Committee and IGSG for the next cycle, providing greater clarity and narrative around material risks, required decisions, and areas for escalation. This should enable a greater level of transparency, scrutiny and assurance, particularly for non-technical audiences.

4. **CCTV Recordings:** A significant Information Governance risk has been identified relating to the configuration of internal CCTV systems across the ambulance fleet. During a review of CCTV and surveillance systems as part of the CCTV Policy review process, it was identified that the recording settings on a substantial proportion of internal vehicle cameras were not configured in line with existing policy or consistently across the fleet. Whilst the recordings operated within existing strict controls for storage and access, and signage is posted inside vehicles, this configuration required corrective action to ensure we fully meet our data protection and privacy obligations, specifically in relation to transparency. A notice has been published for all staff, and configuration of all vehicles is well underway to ensure alignment with the agreed Trust position regarding recording activation. We are not aware of any incidents of inappropriate access or misuse of historic footage, however, the Trust was already strengthening CCTV governance arrangements through updated SOPs, clearer signage at sites, and ongoing compliance reviews and audits to ensure CCTV systems continue to support staff and patient safety and are used lawfully and transparently.

5. **Records Recovery and Capacity:** The Records Recovery Taskforce has delivered material improvements over the past few months, but with slower progress in the second phase due to competing priorities, risk and capacity challenges in the supporting areas (such as IG) and ongoing pressure on the Records team. Capacity is an issue, not only contributing to the existing BAF risk of SAR and Records Disclosure Compliance, but also for wellbeing of the team. Subject Access Request (SAR) demand has increased by 37% compared with the same period of the previous year. Pressure on the Records team also has a knock-on impact across WAST and the wider system, for example, complaints have been received regarding delayed records processing, and there are currently slightly longer processing times for coroner, medical examiner and police requests. However, there are several recruitment and resourcing activities underway to bolster the team capacity, and recovery against the backlog of SAR requests has been improving since the peak of statutory timeline breaches in April 2026.

6. **FOI Resilience and Compliance Risk:** A significant concern, and potentially developing risk, regarding capacity in the FOI function was raised in the August IGSG meeting. It was noted that compliance performance is expected to be challenged in the coming weeks. Demand remains steady, but requests are becoming increasingly complex, and with recovery efforts focused in other areas around the Trust, FOI services are potentially exposed.

7. **Unlawful Access to Patient Records:** Recent national cases of unlawful access to patient records have prompted enhanced scrutiny across the UK NHS. WAST's IG team has made significant progress in reducing the backlog of NIIAS access notifications and are reviewing new alerts daily. Monitoring is identifying inappropriate access incidents are occurring within WAST, however, the team is ensuring these are investigated and managed appropriately, with national guidance being adopted to strengthen controls further.

Highlights

8. **IG Toolkit Status:** The status of the 2026/27 IG Toolkit showed strong progress for this stage of the year, with 79% of activities complete already. The material outstanding actions relate to control gaps that need policy updates, information asset register updates, and Artificial Intelligence governance to be addressed. However, other tasks are more administrative in nature, and many already on track to be completed in the coming month.

9. **DPIA Recovery Plan:** Strong progress continues against the DPIA recovery programme, with 21 backlog DPIAs closed since April and recovery actions increasing from 33% to 50% complete. New training, improved visibility of the DPIA work planner and alignment with the Digital Oversight Group (DOG) have strengthened governance arrangements.

10. **Copilot Evaluation:** The AI Steering Group have commissioned work to understand the business value of Copilot, specifically for the use of Copilot to support in the production of AAA reports. The evaluation will primarily assess improvements in the report quality and consistency, and any reduction in rework by authors and reviewers. User confidence and

satisfaction with Copilot will also be explored through feedback sessions with those involved in AAA writing. The aim is to build a strong evidence base demonstrating the extent of value that Copilot might be delivering to WAST, and will form the organisation's first formal AI case study, contributing to a wider framework for AI benefits realisation.

11. **AI Maturity Assessment:** the AI Steering Group conducted a practical maturity assessment exercise, assessing WAST's current position and anticipated target position against a set of AI-related capability criteria, based around the themes of strategy, value, governance, people, and data. The results of this exercise were input to an industry-recognised assessment tool, and the outputs were shared back with the group for completeness. These assessment results will be used to inform a strategic discussion with the WAST Trust Board at a future Board Development session.

Lowlights

12. **Data Breach Log:** several breaches on the log remain open. Notably, the ECG data breach remains unresolved pending an internal report which is being escalated for progress. A previously reported breach related to a Fleet system has now been closed by the Information Commissioner's Office (ICO). Another previously identified breach relating to the new Single Clinical Queue functionality awaits a technical fix in September with the continuation of manual mitigation arrangements in the meantime. A recent incident affecting a WAST Charity system saw all data subjects notified in a timely manner, and has since been closed by the ICO, with internal remedial actions continuing to be worked on over coming months.

13. **AI Governance:** An AI Policy and EQIA are in development, and the AI Steering Group currently make use of interim mechanisms to ensure oversight and provide assurance of AI activity around the Trust. However, the current lack of an approved AI Policy, limited national guidance, and unconfirmed internal governance arrangements for AI, leaves a risk in controls and will impact the Trust's IG Toolkit submission if not resolved in the coming months. This is captured by the existing BAF risk regarding appropriate use of AI, and the development of an overarching governance framework will be prioritised by the AI Steering Group in coming months to ensure the progressive building of a coherent organisational approach.

14. **Meeting Recording Guidance and Policy:** Whilst Trust-wide guidance is being developed for the recording of Teams meetings, it was noted that there are specific use cases within People Services which may require a targeted approach. A DPIA, SOP, and privacy notice are in development with People Services colleagues, addressing some previously identified data protection concerns regarding transparency, retention and access. Although it was emphasised that there is a need for alignment of People Services guidance with broader organisational policy and technical controls, there was also understanding that to address a particular issue or risk, the People Service approach may not be able to delay. The IGSG will continue to review and support progress with this workstream.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Finance & Performance Committee is requested to: 1. **Receive assurance** on the progress of the Trust's Information Governance arrangements and related specialist activities for Data Quality, Records Management, Freedom of Information requests and Information Security.

ADDITIONAL PAPER(S)

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

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

BAF Risks:

- 623 – Failure to comply with data protection legislation (no longer on BAF, managed by Directorate)
- 260 - Significant and sustained cyber-attack resulting in denial of service and loss of critical system
- 671 – Unauthorised or inappropriate use of AI technologies
- 690 – SAR and disclosure of Records compliance

New Risks identified:

- FOI Resilience and Compliance
- Credential sharing

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
1 September 2026	Content taken from July & August 2026 IGSG AAA Highlight Reports
3 September 2026	Reviewed by members of the Digital Leadership Group

Agenda Item No. 13

REPORT TITLE

Annual Estates Infrastructure Report – September 2026

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Chris Turley - Executive Director of Finance and Corporate Resources
Author(s) of report	Richard Davies - Assistant Director Capital and Estates Chris Davies - Sustainability and Environmental Manager

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This report is the first time that a number of previously separately reported annual updates on the Trust estate has been consolidated into what is planned to be an annual report to the Committee. This will cover estates condition and backlog maintenance, waste and energy management alongside some environmental updates. The one area that remains subject to a separate update is that relating to Fire Safety management, in part due to the recent Internal Audit in this area, and which continues to be planned to be presented to the Committee in January. Further consideration will then be given as to whether this could also be consolidated into this wider infrastructure annual update going forward.

2. Specifically, this update will provide an update on:

   - The Trust's latest EFPMS submission
   - Backlog Maintenance values.
   - Backlog reduction plan.
   - ISO 14001 accreditation
   - Waste management
   - Energy management

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance and Performance Committee is requested to **Note** this update

ADDITIONAL PAPER(S)

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

n/a

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

SITUATION

1. This paper is a consolidation of previously provided annual reports to the committee, seeking to provide the Finance and Performance Committee with a more holistic annual estates infrastructure update including updates on the most recent annual Estates and Facilities Performance Management System (EFPMS) submission plus a brief overview on various aspects of the Trust's estate.

2. This paper will also provide an update on backlog maintenance values per risk category plus a backlog reduction plan, highlighting projects earmarked for this year. The paper will also provide an update on the Trust's continued accreditation to ISO 14001 for environmental management.

3. In addition, this report will also provide information on the management of waste identifying the various waste streams. There is also an update on energy management in relation to usage per form of energy used.

BACKGROUND

4. As Committee members will be aware, the Trust is required, along with all other NHS Wales organisations, to complete and return to NWSSP an annual review of the Trust' estate, covering its quality, compliance to statutory legislation and utilisation, known as EFPMS.

5. This report also provides data on backlog maintenance costs for the Trust's estate portfolio, segregated by risk.

6. As result of an internal audit (November 2023) a recommended action was to report backlog maintenance costs for high and significant risks to this committee.

ASSESSMENT

Summary overview of the Trust estate

7. Welsh Ambulance Service University NHS Trust's estate is comprised of 117 buildings with a total Gross Internal Area of 50,216 m2, and consists of various building uses such as;

    - Ambulance stations, including reporting and social deployment.
    - Make Ready Depots that allow ambulances to be routinely cleaned and stocked.

- Fleet workshops facilities that maintain the frontline fleet as well as commission new fleet for frontline use.
- Clinical contact centres that accommodate EMS coordination, Integrated Care and Ambulance Care coordination.
- Administration and training buildings, accommodates all corporate functions such as Finance, People & Culture, Digital, Estates, Clinical, Occupational Health, etc.

8. All WAST properties are either freehold (53%), leasehold (31%) or shared facilities through Memorandum of Terms of Occupation (MOTO) agreements (16%), these are usually with Fire services.

9. Not untypical for the NHS, the estate has an ageing profile, with 52% of buildings between 30 and 40 years old and a further 33% older than 40 years. In addition, 3% of buildings date from before 1948. The remaining 12% of the estate was built within the last 30 years. As the estate continues to age, the risk of backlog maintenance requirements and associated costs increases.

10. In 2025/26 the cost of maintaining the estate was £1,798,054 (pay and non-pay costs), including grounds maintenance.

11. Through the Trust's participation in the **NHS Wales Decarbonisation Strategic Delivery Plan**, photovoltaic (PV) systems have been installed on **21 buildings** across the estate, enabling the Trust to generate renewable electricity on site.

12. During **2025/26**, these PV installations generated **355,058 kWh of electricity**. This level of generation is equivalent to the annual electricity consumption of approximately **142 average UK homes**.

13. The electricity generated has delivered an estimated **cost saving of £53,400** to the Trust, reducing reliance on grid-supplied energy and supporting financial sustainability. Against a recurring budget set this presents as a combination of cost avoidance as well as cash releasing savings.

14. The programme contributes to the Trust's wider decarbonisation objectives by reducing carbon emissions and increasing the use of renewable energy sources. Further PV installations will be progressed across the estate as additional funding opportunities become available.

15. To support the Trust's transition from petrol and diesel vehicles to a lower-carbon fleet, **90 electric vehicle chargers (EVCs)** have been installed across **58 Trust premises** as a result of significant capital investment over a number of years.

16. During **2025/26**, a total of **134,843 kWh of electricity** was consumed through the Trust's EVC network. This is equivalent to the annual electricity consumption of approximately **50 average UK homes**.

17. The management, maintenance, and operational oversight of all EVC infrastructure is delivered by the Estates & Facilities Team, ensuring reliability and availability across the estate.

18. The electricity consumed would also provide enough energy for an electric **Rapid Response Vehicle** to travel around the globe approximately **17 times**.

19. The continued expansion and utilisation of EVC infrastructure plays a key role in enabling fleet decarbonisation, reducing carbon emissions, and supporting the Trust's wider sustainability objectives.

The NHS Wales Estates and Facilities Performance Management System (EFPMS)

20. The NHS Wales EFPMS encourages a disciplined approach to data collection, dissemination and review and supports strategic decision making at both a local and national level. The EFPMS data captures various estate data including, estate spend (both revenue and capital), floor area, space utilisation, energy use, renewable energy systems and levels of backlog maintenance cost.

21. It is essential that the physical condition of the NHS estate is accurately assessed and maintained to ensure it is fit for purpose. The NHS utilises a risk-based methodology for establishing and managing backlog maintenance, with condition rankings based on those given in 'Estatecode' (NHS Estates, 2002).

22. Physical condition surveys are completed every 5 years (quinquennial), and the Trust is currently going through the condition survey process and by end of this calendar year all surveys will have been completed.

23. Backlog maintenance cost (backlog) is the cost to maintain assets in condition B or bring them up to condition B. It is important to note that a building will always have some level of backlog maintenance cost assigned if over 12 months old for new builds and refurbishments. This is associated with statutory requirements and wear and tear.

24. The ongoing key investment focus has been to reduce the High and Significant backlog figures. These figures identify the major risk to the Trust's estate, and it is encouraging that 'high' has reduced by 79%, 'significant' reduced by 15%. *See Table 1.*

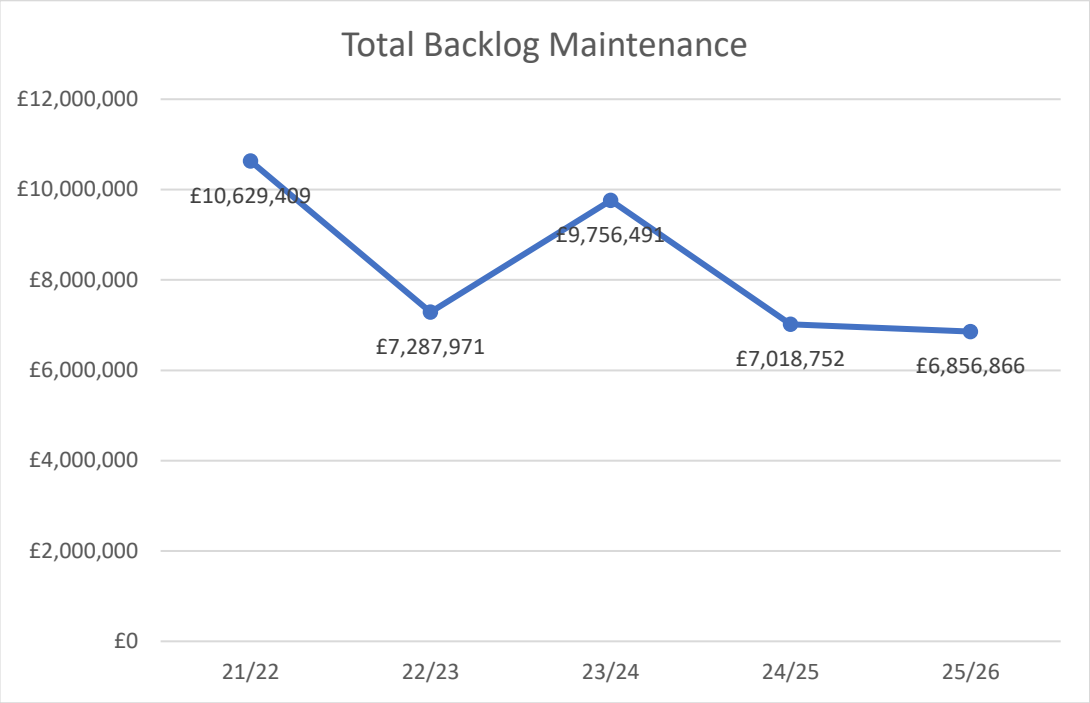
Table 1: Backlog Maintenance Figures 2024-25 & 2025-65: EFPMS Returns

	24/25	25/26	Diff 24/25 to 25/26	% Diff
High	£147,275	£31,569	-£115,706	-79%
Significant	£1,741,759	£1,485,050	-£256,709	-15%
Moderate	£3,002,534	£3,050,346	£47,812	2%
Low	£2,127,184	£2,289,901	£162,717	8%
Risk Adjusted	£2,250,302	£1,915,318	-£334,984	-15%
Total (exc RA)	£7,018,752	£6,856,866	-£161,886	-2%

Table 2: Backlog Maintenance Figures 2021-22 to 2025-26: EFPMS Returns

	21/22	22/23	23/24	24/25	25/26
High	£667,486	£283,153	£246,810	£147,275	£31,569
Significant	£2,855,208	£3,669,750	£2,919,130	£1,741,759	£1,485,050
Moderate	£3,170,304	£2,514,340	£3,853,246	£3,002,534	£3,050,346
Low	£3,936,411	£820,728	£2,737,305	£2,127,184	£2,289,901
Risk Adjusted	£7,184,233	£4,649,810	£3,782,840	£2,250,302	£1,915,318
Total (exc RA)	£10,629,409	£7,287,971	£9,756,491	£7,018,752	£6,856,866

Chart 1: Total Backlog Maintenance Costs 2021-22 to 2025-26: EFPMS Returns



25. It should be noted that, on top of the positive movements seen above, due to reporting parameters and the timing of some of the returns, the above figures for 2025/26 also include backlog risks which have now been resolved through recently completed capital works and disposals, e.g. Monmouth & Abergavenny stations and the disposal of Thanet House in Swansea. This will be further reflected in next year's EFPMS submission.

26. Previously Estates Facilities Advisory Board (EFAB) funded works helped improve the estate and target the funding appropriately. The current Targeted Estates Fund (TEF) is also assisting to improve infrastructure and reduce carbon emissions for specific schemes.

Backlog Reduction Plan

27. The reduction in backlog maintenance has been achieved by targeting the high and significant risk areas within the Estates Strategy prioritise capital spend; this includes the replacement of several roofs as well as upgrading fire alarm systems and electrical system improvements.

28. Alongside this, as Committee members may recall, TEF funding for 2025/26 has addressed and provided improvements to:

- HART – low carbon heating system
- Abergavenny – infrastructure improvements and renewable technology to reduce carbon emissions.

29. On top of this, discretionary capital monies has been prioritised to reduce some specific backlog maintenance issues which have now been completed, as follows:

- **Monmouth Ambulance Station**– full refurbishment of the former station, to include infrastructure improvements and the introduction of renewable technologies to reduce carbon emissions.
- **A new Dolgellau Ambulance Station**– refurbishment of a former garage facility into a fit for purpose ambulance station for frontline EMS and ambulance care crews
- **Thanet House** in Swansea – enhancements on the Matrix site has facilitated the disposal of this site which has been returned to its landlord.
- **Bassaleg Ambulance Station** – backlog costs for this project have been subtracted from the backlog maintenance calculations.
- **A new Bangor Fleet Workshop**.

30. It's not all about more significant capital schemes, however. During 2025/26, the Estates & Facilities team also used available revenue funding to deliver a range of improvement works across 26 WAST sites. These works included upgrades to staff welfare and accommodation areas, replacement of ageing furniture, improvements to security and access control systems, enhancements to lighting and building services, external site improvements, and fire safety works. Together, these works have helped improve the safety, condition and functionality of much of our estate, ensuring facilities remain fit for purpose and able to support operational service delivery.

31. As stated previously the estate is currently due its quinquennial survey. Surveyors are currently undertaking condition surveys across all of the Trust's estate. This data will be required to sense check current backlog data and to provide a baseline for a further 5-year cycle and potentially inform the development of an updated Estates Strategy for future capital and revenue investment.

32. Backlog maintenance continues to reduce; all large sites posing major backlog maintenance issues and costs have either been disposed of in recent years or handed back to landlords. Furthermore, once this year's capital projects for Pembroke Dock, Llandrindod Wells, Swansea (Cwmbwrla) including Samlet Road, Carmarthen, plus the TEF project at Rhyl are completed, backlog maintenance costs will be reduced further from the backlog maintenance figures in Table1 above.

Utilities

33. During 2025/26, total energy costs across the Trust estate reduced by approximately £27,000 compared to the previous year, falling from £1.58m to £1.55m. This was driven primarily by lower gas consumption and reduced gas expenditure, which decreased from £200k to £158k.

34. Electricity consumption and costs remained broadly consistent year-on-year, providing stability in overall utility expenditure despite continued volatility within energy markets.

35. The Trust continues to identify opportunities to improve energy efficiency and reduce consumption across its estate.

Table 3: Energy Consumption and Cost 2024/25 & 2025/26: EFPMS Returns

		2024/25	2025/26	Diff 24/25 to 25/26
Consumption (kWh)	**Electricity Usage**	3,907,336	3,897,089	-10,247
	Gas Usage	2,918,554	2,273,805	-644,749
	Oil Usage	17,555	57,310	39,755
	Total Energy Usage	6,843,445	6,228,204	-615,241
Cost	**Electricity Cost**	£1,378,120	£1,391,087	£12,967.00
	Gas Cost	£200,169	£158,038	-£42,131.00
	Oil Cost	£1,951	£4,122	£2,171.00
	Total Energy Cost	**£1,580,240**	**£1,553,247**	**-£26,993.00**

Waste Management

36. Waste management performance across the Trust estate remains positive, despite total waste volumes increasing from 222.5 tonnes in 2024/25 to 253.4 tonnes in 2025/26. This increase has primarily been driven by improved waste segregation and recycling activity, with recycling volumes rising by 32% from 89.1 tonnes to 117.8 tonnes and now representing approximately 46% of all waste generated.

37. Clinical and general waste volumes have remained relatively stable year-on-year, while food waste levels have reduced slightly.

38. Total waste management costs increased from £148k to £196k during the reporting period, reflecting wider market pressures and contractual cost increases.

39. The Trust continues to promote waste minimisation, segregation and recycling initiatives across its estate to improve resource efficiency, support sustainability objectives and maximise value from waste disposal contracts.

Table 4: Waste Weights & Costs 2024/25 & 2025/26: EFPMS Returns

	Clinical Waste		General Waste		Recycling		Food Waste		TOTAL WASTE	
	Weight (t)	**Cost**	**Weight (t)**	**Cost**	**Weight (t)**	**Cost**	**Weight (t)**	**Cost**	**Weight (t)**	**Cost**
2025/26	31.8	£96,258	95.3	£43,615	117.8	£49,380	8.6	£6,399	253.4	£195,652
2024/25	30.6	£94,864	94.1	£40,569	89.1	£46,900	9.0	£5,372	222.5	£148,179

ISO 14001 Environmental Governance System

40. ISO 14001 is the internationally recognised standard for Environmental Governance Systems (EGS), providing a structured framework for organisations to manage their environmental responsibilities, ensure legal compliance, drive continual improvement and reduce environmental impacts across their operations.

41. The Trust maintains ISO 14001 certification and is subject to annual external surveillance audits to demonstrate continued compliance with the standard. Audits are conducted on a regional basis, ensuring that each region is visited and assessed within a three-year certification cycle. During 2025/26, the South-East Region was selected for audit, with six ambulance stations reviewed as part of the assessment.

42. This year's audit formed part of the Trust's full recertification process, which involves a more detailed and rigorous review of the EGS than a standard surveillance audit. The assessment examined environmental governance arrangements, legal compliance processes, operational controls, performance monitoring, staff awareness and continual improvement activities. The Trust successfully retained certification, with only one minor non-conformance identified, demonstrating the overall effectiveness and maturity of the EGS.

43. Maintaining ISO 14001 certification provides independent assurance that environmental risks are being appropriately managed and that robust governance arrangements are in place to support the Trust's sustainability objectives. The Welsh Ambulance Services University NHS Trust remains the only Ambulance Trust in the United Kingdom to hold ISO 14001 certification, reflecting its longstanding commitment to environmental stewardship and continuous improvement in environmental performance.

RECOMMENDATION (S)

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

Agenda Item No.	14

REPORT TITLE

Risk Management and Board Assurance Framework Report

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance / Board Secretary
Author(s) of report	Julie Boalch, Assistant Director of Corporate Governance & Risk

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the eight risks that are relevant to this committee's remit.

2. The summary of these risks is set out in Annex 1, and the more detailed Board Assurance Framework (BAF) is in the reading room. This provides the committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable.

3. Members can take assurance that each of the principal risks have been reviewed since the last meeting and in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk
4. ratings of each principal risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

5. The ELT approved the principal risk activity on 12 August 2026 having considered the review of each risk undertaken throughout the period by risk owners.

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. The specific detail and planned mitigations of this risk will be considered in closed session of committee today due to the sensitive and security based nature of these and is not included in Annex 4.

7. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in public 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,* remains static at a score of 16 (4x4) and was discussed by committee in July 2026 with agreement that this would be removed from the BAF extract until later in the financial year whilst work is undertaken on the disaggregated elements of the risk. Members noted that while the risk retains its high score, mitigation continues to be constrained by capacity limitations.

9. **Risk 671** *Unauthorised or Inappropriate use of AI technologies* and **Risk 690** *SAR and Disclosure of Records Compliance* remain static at a score of 16 (4x4) in this review period despite a potential reduction in score being discussed by the ELT.

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). The ELT acknowledged that all internal actions have been explored and agreed to tolerate the risk at this level for this review period.

11. **Risk 139** *Failure to Deliver our Statutory Financial Duties* remains static at a score of 12 (3x4) in line with the financial position for 2026/27.

12. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* – Members are asked to note that the ELT considered proposals to reframe the risk to focus on the commissioning and contractual framework, including clear expectations, accountability and funding arrangements, and the associated impact on the delivery of safe and effective services. The detail of this will be presented at a later meeting.

13. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the risk owner to describe the rationale for each of the risk ratings which is particularly important where ratings have remained static or increased.

14. Additionally, a dashboard describing principal risk score trends and their movement over time is included at Annex 3. Risks that have achieved target score, been mitigated or closed have been de-escalated or removed from reporting. Whilst some risks have seen movement, most remain unchanged despite ongoing mitigation. Further consideration will be given through ELT discussions in October 2026 alongside the development of risk tolerance thresholds linked to Board approved risk appetite to strengthen future assessment of control and mitigation effectiveness.

15. As the Trust develops a more strategic approach to the BAF, there is an opportunity to enhance the clarity and usefulness of the reporting to track the status of actions and their impact on risk scores which could help demonstrate progress more clearly and support more informed oversight.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Finance and Performance Committee is requested to: 1. Consider contents of the report including: a. The controls in place against the risks. b. The actions described to further mitigate the risks.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
The Finance & Performance Committee is requested to receive the following: **Annex 1** Principal Risk Summary **Annex 2** Board Assurance Framework (in reading room) **Annex 3** Principal Risk Trending Data

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
As above, this paper goes to mitigations against finance and performance related risks.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
12 August 2026	Executive Leadership Team
03 September 2026	Audit, Risk and Assurance Committee

Annex 1 – Principal Risk Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**20 (4x5)** →
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	**IF** the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared **THEN** there is a RISK that the Trust's Incident Response will be suboptimal **RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	**20 (5x4)** →
671 FPC	Unauthorised or Inappropriate use of AI technologies	**IF** staff use Gen-AI tools such as ChatGPT, Co-Pilot or other AI enable platforms outside of approved organisational channels or without appropriate governance **THEN** information passed into, accessed by, or returned by the AI tools may breach information security and data protection controls, and use of the output may	Director of Digital	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		breach transparency, medical device, equality, Welsh Language and ethical requirements **RESULTING IN** potential breach of confidentiality and data protection law, data, damage to Trust, and non-compliance with other legislation, regulation and standards.		
690 FPC	SAR and Disclosure of Records Compliance	**IF** records requests from patients, the public or staff are not processed consistently or correctly **THEN** inappropriate withholding of information or disclosures may occur **RESULTING IN** harm to data subjects and financial or reputational damage to the Trust	Director of Digital	**16 (4x4)** →
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **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)** →
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	**IF** WAST fails to persuade JCC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support	Deputy Chief Executive	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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	**12 (3x4)** 

Committee	Directorate	Risk ID	Risk Title	Strategic Objective	Risk Appetite	Jun-24	Sep-24	Nov-24	Mar-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-25	Feb-26	Apr-26	May-26	Aug-26	Risk ID
FPC	Digital Services	260	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems			15	15	15	20	20	20	20	20	20	20	20	20	20	20	20	260
FPC	Operations	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	1	Open				20	20	20	20	20	20	20	20	20	20	20	20	641
FPC	Digital Services	671	Unauthorised or inappropriate use of AI technologies									16	16	16	16	16	16	16	16	16	671
FPC	Finance and Corporate Resources	542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan	6b	Open	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	542
FPC	Operations	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	1	Open	20	20	15	15	15	15	15	15	15	15	15	15	15	15	15	594
FPC	Digital Services	690	SAR and Disclosure of Records Compliance															16	16	16	690
FPC	Strategy, Planning & Performance	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	4	Open	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	100
FPC	Finance and Corporate Resources	139	Failure to Deliver our Statutory Financial Duties in accordance with legislation	6a	Cautious	8	8	8	8	8	8	8	8	8	8	8	8	8	12	12	139
FPC	Strategy, Planning & Performance	458	A confirmed commitment from JCC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning																		458

	Risk achieved target score and de-escalated to directorate level for ongoing monitoring
	Risk closed from all registers
	Risk not in existence

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

Agenda Item No.	15

REPORT TITLE

Audit Tracker 26-27 Q1 (Apr-Jun26) - Exception Reporting

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

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

EXECUTIVE SUMMARY

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

1. This paper provides the Committee with the 2026/27 quarter 1 position with respect to management actions for audits within the purview of this committee.

2. The Audit Handbook notes that it is the responsibility of this committee to:
   - Receive audits in their remit;
   - Monitor management actions to address recommendations; and
   - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

3. The Audit Tracker has been updated in quarter 1 of 2026/27. To reduce the volume of papers presented to committee, rather than supply a copy of the tracker, the committee is provided with an audit exception report containing details of high-rated audit actions, actions arising from limited assurance audits where a final revised date has been agreed, and any actions that remain open beyond their final agreed completion date

4. It is intended that exception reporting will provide committee with the information it requires to receive assurance regarding the mitigation in place to address the risks identified via internal audits, and where appropriate to levy appropriate challenge where further assurance may be needed. The content and format of the exception report will evolve as feedback is received regarding committee requirements.

Internal Audit

5. During 2026/27 quarter 1, there were a total of 65 open internal audit recommendations relevant to the committee. Of these 65 open internal audit recommendations, eight were due to be completed in quarter, and 57 were not yet due.

6. By end of quarter, two of the eight internal audit actions due for closure were confirmed as completed, neither of which related to high-priority recommendations or limited audits. Revised dates were given to the remaining six with two assigned final dates.

7. There were four actions (detailed below) that were not completed by their final revised implementation dates. All were medium priority findings.

Audit Ref. & Description	Original Date	1st Revised Date	2nd Revised Date
Audit Action ID 55 2024/25 Forecasting and Modelling Internal Audit Reasonable assurance - medium priority action	30/11/2025	31/03/2026	30/06/2026

Key finding:

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.

Theme: Policies & Procedures
Risk & Impact: 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.

Mitigations: SOP has been reviewed by directorate. AAA report now being regularly reported to SP&P Business Leadership Team. Further evidence forthcoming for closure re approval of SOP. Capacity reviewed and new posts in place.

Audit Ref. & Description	Original Date	1st Revised Date	2nd Revised Date
Audit Action ID 56 2024/25 Forecasting and Modelling Internal Audit Reasonable assurance – medium priority action	30/11/2025	31/03/2026	30/06/2026

Key finding:
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.

Theme: Information, Data Quality & Data Accuracy
Risk & Impact: 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 and Modelling SOP, confirm template(s) to be used for in-house reports.
- Build Welsh Government winter modelling scenario work into the SOP.

Expected evidence:
- Forecasting & Modelling SOP approved in SP&P BLT meeting.
- Forecasting and modelling reports incorporating WG analysis and data assumptions

Mitigations: SOP has been reviewed by directorate. Further evidence forthcoming for closure re approval of SOP.
Reporting template for internal reports now developed, and ensuring winter modelling scenarios from Welsh Government are built into process.
Note that a winter plan for 26/27 has been developed and submitted to Welsh Government.

Audit Ref. & Description	Original Date	1st Revised Date	2nd Revised Date
Audit Action ID 59 2024/25 Forecasting and Modelling Internal Audit Reasonable assurance – medium priority action	30/11/2025	31/03/2026	30/06/2026
Key Finding: 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. Theme: Lessons Learnt Risk & Impact: Ineffective organisational learning could lead to missed opportunities for improvements and poor decision making.			
Agreed Action: The forecasting and modelling tracker will record lessons learned.			
Expected Evidence: Forecasting & Modelling Report tracker; and identified as part of the AAA reporting up to SP&P BLT.			
Mitigations: The forecasting and modelling report tracker has been developed, and this action will be closed when reported into SP&P BLT.			

Audit Ref. & Description	Original Date	1st Revised Date	2nd Revised Date
Audit Action ID 130 2025/26 IMTP Development Process Substantial assurance – medium priority action	30/11/2025	31/03/2026	30/06/2026

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

Mitigations: IMTP deliverables embedded into the Clinical Model Transformation (CMT) Programme reporting and directorate level plans in place within interim excel based solution. Progress updates to be reported quarterly from Q1 onwards. Digital solution in development. Accountability and reporting arrangements are in place. Revised reporting of IMTP deliverables now going to board and committees and IMTP referencing is embedded. Evidence of change control process is required and interim excel solution, and confirmation as to whether a centralised digital solution will be advanced given the development work required for this as the action may need to be adjusted if not.

8. At the end of quarter 1, there were two existing high priority/limited assurance audit actions on their 2nd (final) revised date – these are reported to the private session of this committee.

9. At the end of quarter, there were fourteen remaining open actions, which are due for completion as shown below:

Year	Quarter	Period	No. Audit Action Due for Completion
2026/27	Quarter 2	July – September 2026	15*
	Quarter 3	October – December 2026	30
	Quarter 4	January – March 2027	21
2027/28	Quarter 1-4	April 2027 – March 2028	3
		Total	**69***

**Includes open audit actions reported to the private session of the committee*

External Audit

10. No exception reporting for external audits

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance and Performance Committee is requested to review and scrutinise the current position regarding the four high priority/limited assurance audit actions that are reported as overdue.

ADDITIONAL PAPER(S)

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

n/a

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment	N/A [DPIA Checklist > DPIA not indicated]

APPROVAL/SCRUTINY ROUTE

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

Agenda Item No.	19

REPORT TITLE

Finance and Performance Committee Cycle of Business Monitoring Report 2026/27

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	15 September 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The report updates the committee on progress against its agreed Cycle of Business (CoB) for 2026/27.

2. The CoB Monitoring report has been presented, as follows:

    2.1 The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting, items in beige indicate that they are a prompt at agenda setting, as they may be ad hoc items such as business cases or external reports. Items in yellow indicate that reporting is being developed for these items.

    2.2 The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or are ad hoc items which were discussed in agenda setting and scheduled. Items in grey have been considered and not scheduled. Items in orange were programmed for receipt but have been deferred to a future meeting.

3. The committee is asked to note that the EPRR reporting, previously deferred from the April meeting, has now been deferred to the November meeting. This is due to the EPRR unit transitioning Assistant Director of Operations portfolios this year and a temporary Head of Service being in place due to staff employment matters. Given the loss of continuity, colleagues are familiarising themselves with the working of the unit and this bundle will therefore be completed in time for November submission.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance and Performance Committee is requested to note the update.

ADDITIONAL PAPER(S)

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

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

Annex 1 Finance and Performance Committee Cycle of Business 2026/27 Monitoring Report

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2026-27											
TERMS OF REFERENCE NOTED IN RED TEXT											
STRATEGY DEVELOPMENT AND DELIVERY											
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	Central view of all long term plans aligned to LTS and their review/renewal dates **no longer required**
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	
FINANCE											
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	Capital M'ment Board	Annually							EDOF	Endorsement	
Financial report	ELT	Each meeting							EDOF	Assurance	Financial sustainability report may be included in this report or separately throughout the year; year end report May
Year end M12 report (same time as M1 in new year)	ELT	May meeting							EDOF	Assurance	
IMTP financial plan	STB/ELT	Annually							EDOF	Endorsement	
Financial Sustainability Report	TBC	Each meeting							DoP	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
COMMERCIAL											
Reporting to be developed in 2025/26 (commercial framework and partnerships)	TBC	TBC							EDSPP:DoPE	Assurance	Reporting to be developed in 2026/27 - Commercial Plan in May
PERFORMANCE											
Review of Ambulance Service Indicators	TBC	Bi-annually							EDSPP	Assurance	Timing of reporting to be agreed in 2026/27
Report on commissioning	TBC	TBC							EDSPP	Assurance	Scope of this element to be developed - see Note 1
QPMF update report	QPMF Steering Group	Bi-annually							EDSPP	Assurance	Assurance on the value of outcomes produced by the framework and effectiveness. Benefits mapping in May 25 then agree regular reportint cycle
Monthly Integrated Quality Performance report	ELT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	ELT/Board Committees	Annually							EDSPP	Endorsement	**Not required due to MIQPR review by Board March 2026**
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. **Include in the EPRR Annual Reports agenda item as separate line.** **Note 130826 (AW): EPRR reporting deferred to November meeting (previously deferred from April to September), The EPRR unit transitioned Assistant Director of Operations portfolios this year, and there is also a temporary Head of Service in place due to staff employment matters. Given the loss of continuity, colleagues are familiarising themselves with the working of the unit and this bundle will therefore be complete for November submission.**
Metrics for digital systems infrastructure	TBC	Each meeting							DD	Assurance	
PLANNING											
Commissioning arrangements	ELT	Consider annually							EDSPP	Endorsement	Consider potential annual report to be developed
Demand and capacity reviews	ELT	Ad Hoc							EDSPP	Endorsement	
INFRASTRUCTURE											
Estates Condition and Backlog Maintenance Update [EFPMS Data/Report]	TBC	Annually							EDOF	Assurance	This was added in as a future requirement (following initial receipt in September 2024) by CorGov.
Decarbonisation Update	Decarb Programme Board	Every other meeting							EDOF		Progress also against WG action plan and Trust Plan; metrics in development. Annually to include update on waste management.
Waste Management Update	Decarb Programme Board	Annually							EDOF	Assurance	Annual update aligned with Internal Audit recommendations. First report in September 2023. - all infrastructure reports to be combined into one annual report to include fire safety report in future years.
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	**Agreed in May 2026 that the report would be annual going forward.**
Fire safety exception report	TBC	Periodically as required							EDOF	Assurance	By exception outside of fire safety annual report
BUSINESS CONTINUITY AND CYBER											
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. **Include in the EPRR Annual Reports agenda item as separate line; add in to EPRR Annual Reports 'Pandemic Plan document to include COVID-related learning and progress' as separate line.** **Note 130826 (AW): EPRR reporting deferred to November meeting (previously deferred from April to September)**
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 **Include in the EPRR Annual Reports agenda item as separate line.** **Note 130826 (AW): EPRR reporting deferred to November meeting (previously deferred from April to September)**
Cyber Resilience and Cyber Security Reporting	TBC	TBC							DD	Assurance	
INFORMATION GOVERNANCE AND INFORMATION SECURITY											Reporting developing in 23/24 - start off at 3 times a year reporting; intention to bring to every meeting if possible. **Commissioning note 210726: future reporting to clearly distinguish between external cyber threats and controls within the Trust's influence, recognising that while cyber risk cannot be eliminated, continued focus is required on resilience, incident response and addressing known control weaknesses.**
Information Governance Toolkit	IGSC	Annually							DD	Assurance	tbc
Information Governance Report	IGSC	Each meeting							DD	Assurance	
POLICIES											
Policies for review and approval	Policy Group	Ad Hoc							BS	Approval	
RISK AND AUDIT											
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	Internal Audit Report - Capacity Management Plan (Ambulance Care)/Estates Assurance: Fire Safety/Digital Business Continuity and Data Management Practices / Devolved Data
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	**By exception only**
Committee Review of Annual Priorities	None	Every other meeting							Chair	Review	
SUB-GROUPS											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
PROMPTS											
External Reports	N/A	Ad Hoc							TBC	TBC	

EDOF - Exec Director of Finance and Corporate Resources
EDO - Exec Director of Operations
EDSPP - Exec Director of Strategy, Planning and Performance
DD - Digital Director
BS - Board Secretary
EDQN - Exec Director of Quality and Nursing
DP - Director of People

Key: Pre-agenda setting
- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting
- Presented as cycled
- Ah hoc / item considered - not programmed
- → Item deferred
- Reporting developing