Bundle Finance and Performance OPEN 16 September 2025

Agenda attachments

ITEM 00 FPC Agenda - 16 September 2025 - Open

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apols and Quorum

2 Declarations of Interest

ITEM 02 PDF Declarations of interest

3 Minutes of the Last Meeting: 21 July 2025

ITEM 03 2025-07-21 Draft OPEN F&P Minutes

4 Action Log & Matters Arising

ITEM 04 Action Log

4.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Financial Position for Month 4, 25/26

5.1 Financial Position for Month 5, 25/26 - Presentation

ITEM 05 Finance Report Month 4 25-26 Final

ITEM 05.1 Month 04 2025-26 - Welsh Ambulance Services NHS Trust - Monitoring Return - Final

6 10:10 - Phase 2 Ambulance Performance Framework and Wait 45 Initiative

ITEM 06 Ambulance Performance Framework Phase 2 Assurance Report V0.9

ITEM 06 Appendix 1 Trust Board Ambulance Performance Framework May_25 Final V0.5

ITEM 06 Appendix 2 JG to WAST to confirm Cabinet Secretary agreement of recommendations

ITEM 06 Appendix 3 WAST Response to JG re Phase 2 Call Categorisation

ITEM 06 Appendix 4 Ambulance Performance Framework Explainer v2

7 10:30 - Monthly Integrated Quality Performance Report

ITEM 07 MIQPR SBARN FPC July 2025

ITEM 07.1 MIQPR FPC July 2025

8 10:45 - Ambulance Service Indicators

ITEM 08 ASI SBARN FPC 20250916 Final

8.1 11:00 - COMFORT BREAK

9 11:15 - Digital Reporting

ITEM 09 Digital Reporting Sept 25 - Cover Paper

ITEM 09.1 Appendix 1 - Digital Reporting September 2025 - Metrics

ITEM 09.2 Appendix 2 - WAST Digital Transformation Review Board Self-Assessment

10 11:35 - Information Governance Report

ITEM 10 Information Governance Reporting September 2025

11 11:45 - Internal Audit Report: Manchester Arena Inquiry (inc. discussion from Audit, Risk and Assurance Committee)

ITEM 11 IA MAI Feedback from ARAC

ITEM 11.1 Manchester Arena Inquiry Internal Audit Report

12 11:55 - Integrated Medium Term Plan (IMTP) Progress Report

ITEM 12 2509 - Executive Summary - IMTP Delivery & Assurance Q2 2526

ITEM 12.1 Appendix A - 2507 - CMT Programme Highlight Report

ITEM 12.2 Appendix B - IMTP Cabinet Secretary Priorities

13 12:10 - Environment, Decarbonisation and Sustainability Update - August 2025

ITEM 13 Decarb and Sustainability Update

14 12:20 - Estates Condition & Backlog Maintenance Update - September 2025

ITEM 14 Estates Condition 16.09.2024

15 12:35 - Risk Management and Board Assurance Framework Report

ITEM 15 Executive Summary Risk Management Report FPC 160925

16 12:45 - Audit Tracker - June 2025 (2025/26 Q1)

Annex 1, 2 & 3 are available to view in the Reading Room

ITEM 16 Exec Summary Audit Tracker to Committees - 25-26 Q1 Reporting (Apr-Jun25) - FPC 160925 (Public)

16.1 12:50 - CLOSING ITEMS

17 Committee Cycle of Business Monitoring and Priorities Report 2025/26 Priorities

ITEM 17 Priorities and Cycle Monitoring report September 2025

ITEM 17.1 COB Monitoring report

ITEM 17.1a COB Notes

17.1 CONSENT ITEMS

18 Reflections and Summary of Decisions/Actions

19 Any Other Business

20 Date & Time of the Next Meeting: 18 November 2025

Length of Meeting:	03:25	Agenda Status:	[OPEN] FINANCE AND PERFORMANCE COMMITTEE - 16 SEPTEMBER 2025						Deadline: 05/09/25
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**
			OPENING ITEMS						
09:30	00:10	1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair	n/a
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a
		3	Minutes of the Last Meeting: 21 July 2025	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair	n/a
		4.1	21 July 2025 Committee AAA Report (alerts)	Paper	Discussion	Standing	n/a	Chair	Trish Mills
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:40	00:30	5	Financial Position for Month 4, 25/26 Financial Position for Month 5, 25/26	Paper Presentation	Assurance	CoB	FinCor	Ed Roberts	Ed Roberts
10:10	00:20	6	Phase 2 Ambulance Performance Framework and Wait 45 Assurance Update	Paper	Endorsement	*Ad hoc*	SPP	Lee Brooks	Hugh Bennett James Houston
10:30	00:15	7	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Estelle Hitchon	Hugh Bennett, Mark Thomas, Georgia Tizzard, Melanie
10:45	00:15	8	Ambulance Service Indicators	Paper	Assurance	CoB	SPP	Estelle Hitchon	Hugh Bennett
11:00	00:15		COMFORT BREAK						
11:15	00:20	9	Digital Reporting (to include reference to the final Audit Wales self-assessment as annex) 9.1 Metrics for digital systems infrastructure	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith (Osian Lloyd)
11:35	00:10	10	Information Governance Report	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
11:45	00:10	11	Internal Audit Report: Manchester Arena Inquiry (inc. discussion from ARAC)	Paper	Assurance	*Ad hoc*	Gov	Lee Brooks (Osian Lloyd)	Steve Owen
11:55	00:15	12	Integrated Medium Term Plan (IMTP) Progress Report	Paper	Assurance	CoB	SPP	Estelle Hitchon	Alex Crawford, Hugh Bennett
12:10	00:10	13	Environment, Decarbonisation and Sustainability Update - August 2025	Paper	Assurance	CoB	FinCor	Ed Roberts	Jo Williams
12:20	00:15	14	Estates Condition & Backlog Maintenance Update – September 2025	Paper	Assurance	CoB	FinCor	Ed Roberts	Richard Davies Susan Woodham
12:35	00:10	15	Risk Management and Board Assurance Framework Report	Paper	Assurance	CoB	Gov	Julie Boalch	n/a
12:45	00:05	16	Audit Tracker - June 2025 (2025/26 Q1)	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce
			CONSENT ITEMS: The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.						
12:50	00:00	17	Committee Cycle of Business Monitoring and Priorities Report 2025/26 Priorities: 1. A focus on financial sustainability. 2. A focus on Clinical Model Transformation performance. 3. A focus on organisational resilience including information security; 4. A focus on the progress of the Manchester Arena Inquiry recommendations.	Paper	Information	CoB	Cor Gov	Trish Mills	Steve Owen
			CLOSING ITEMS						
		18	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a
12:50	00:05	19	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a
		20	Date & Time of the Next Meeting: 18 November 2025	Verbal	Information	Standing	n/a	Chair	n/a
12:55	**03:25**		**CLOSE**						

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Chair and Non-Executive Director
Lee Brooks	Executive Director of Operations
Julie Boalch	Assistant Director of Corporate Governance and Risk
Estelle Hitchon	Director of Partnerships and Engagement
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital Services
Ed Roberts	Interim Assistant Director of Finance

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

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
EVANS, Bethan [continued]	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee		Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995	31 May 2025
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019	31 May 2025	18 July 2025
		Emeritus Professor - Swansea University	Non-Financial Professional	31 May 2025		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		

MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 21 JULY 2025 IN THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

Meeting started at 09:30

PRESENT:

Jayne Beeslee	Non-Executive Director and Chair
Peter Curran	Non-Executive Director (Left during Item 55/25)
Bethan Evans	Non-Executive Director

IN ATTENDANCE:

Rhiannon Beaumont-Wood	Non-Executive Director (Left during item 50/25)
Hugh Bennett	Assistant Director, Commissioning and Performance
Lee Brooks	Executive Director of Operations
Jason Collins	Head of Financial Management
Colin Dennis	Chair of the Trust Board
Fflur Jones	Audit Wales
Sarah Harland	Corporate Governance Officer
Wendy Herbert	Assistant Director of Quality and Nursing
Carl Kneeshaw	Director of People
Osian Lloyd	Head of Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner

APOLOGIES:

Rachel Marsh	Interim Chief Executive
Liam Williams	Executive Director of Quality and Nursing

45/25 PROCEDURAL MATTERS

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

Minutes: The minutes of the open session held on 20 May 2025 were considered by the Committee and confirmed as a correct record.

Matters Arising: Estelle Hitchon commented she would temporarily carry out the duties of the Executive Director of Strategy, Planning and Performance, pending Remuneration Committee approval, and clarified she was not a regular Committee member.

Action Log: Action 33/25: Integrated Medium Term Plan delivery/Assurance - End of Year report. *It was agreed that a highlight report from the Clinical Model Transformation (CMT) programme would be beneficial for the Committee to provide better oversight, instead of including it in the paper which covered a broad range of topics and making it easier to understand its impact on strategic objectives. Hugh Bennett agreed to explore this to use existing information to meet the request without creating additional reports.* The CMT programme highlight report is included with the papers. Action closed.

Action 33/25a: Integrated Medium Term Plan delivery/Assurance - End of Year report. *The committee acknowledged that the Cabinet Secretary's priorities were already monitored within existing work streams and rather than duplicate work it was proposed that a RAG rating system, against these priorities, would be incorporated into the next update to make it easier to identify areas needing attention and help focus the committee's attention on specific areas.* This information was incorporated in the report. Action closed.

Action 24/25: *Peter Curran raised a point regarding the average jobs per shift metric, which was currently classified as amber. Given its significant impact on patient harm, Hugh Bennett agreed to review the methodology used to classify the metrics and either amend it to red or provide an explanation for the current classification at the next meeting*. Hugh Bennett responded that he would need to investigate further, noting that the metric in question is average jobs per shift by all vehicle types. He suggested it would be useful to split out the data, particularly focusing on Emergency Ambulances (EA) for its correlation with handover. He observed an upward trend in EA jobs per shift but noticed a significant drop in apps, which he did not immediately understand, and stated he would investigate the connection further and provide an update before the next meeting. Action to remain open.

Action 39/25: report on Commissioning: *The report was not considered during the meeting given it was received after publication. It was agreed that the report would be circulated to the committee following the meeting and included at the next meeting for endorsement.* The report was circulated by e mail to committee members and included in today's papers. Action closed.

Action 40/25: Risk Management and Board Assurance Framework - *It was agreed to undertake a deep dive on the Decarbonisation Risk (Risk 542) in readiness for the next*

meeting which will include a detailed review of the controls and mitigations. This action was discussed offline at a meeting involving, Jayne Beeslee, Peter Curran and Chris Turley. Action closed.

Committee Highlight Report: The Committee highlight report dated 20 May 2025 was received.

The Committee RESOLVED TO:

(1) Approve the minutes of the Finance and Performance Committee held on 20 May 2025.
(2) Consider the Action log and noted the update as described above.
(3) Receive the Committee highlight report dated 20 May 2025.

46/25 OPERATIONS UPDATE

Lee Brooks highlighted key points from the Operations Report: -

1. Handover delays have significantly decreased, with June showing the lowest lost hours in some time. This improvement was being closely monitored, especially at the Royal Glamorgan and Morriston hospitals, where targeted actions have been implemented.

2. Multi Agency Incident Transfer (MAIT), which enabled electronic transfer of Computer Aided Dispatch (CAD) incidents between services, went live with two police agencies in mid-June. There was early positive staff feedback, and it was anticipated this move will reduce telephony activity between agencies.

3. The team was providing planned support to Yorkshire Ambulance Service while they transitioned their 999 triage system. The Trust was handling 100–150 calls per day for Yorkshire, and members were assured that this support has not negatively impacted performance.

4. There has been a slight improvement in sickness rates in Emergency Medical Services Contact Centres (EMSCC) since the last quarter's update, following workshops conducted by the EMSCC leadership team, Trade Union partners, and people services.

5. Emergency Ambulance Practitioner (EAP) training continued to progress well, there were a total of 40 staff currently on courses, and a further 174 staff due to complete the course prior to the end of the year.

6. On 01 July 2025, the Trust went live with its new approach to high-priority incident responses. The current red category was replaced by three new classifications: Purple Arrest, Red Emergency, and Red Category 0 (RCS0). As part of this transition, Urgent Care Service (UCS) began responding to Purple calls. They will act as first and

co-response resource, like Community First Responders, to deliver Basic Life Support (BLS). Emergency Medical Services (EMS) will continue to be dispatched.

The Chair congratulated Lee Brooks and the team for the successful launch of the new performance framework, recognising the significant effort required across the Trust, including clinical and digital teams. She also acknowledged the positive development regarding the utilisation of UCS staff, recalling previous discussions with team members who were eager for increased involvement. Furthermore, she extended congratulations to Laura Charles for receiving the King's Medal.

Peter Curran asked about the MAIT system, specifically whether it was linked to the Emergency Services Network, and inquired about the potential benefits of expanding it. Lee Brooks clarified that the MAIT system was slightly disconnected from the broader Emergency Services Network programme and confirmed there were significant benefits, including reduced telephony activity by enabling electronic transfers and improved, auditable communication directly within the CAD.

The Chair raised a question about the level of confidence that the new Taskforce focused on the 45-minute handover target would gain the necessary traction to keep all Health Boards in Wales focused, especially given recent improvements and potential momentum. Lee Brooks advised that the Taskforce has recently been convened. He emphasised that while there has been a reduction in handover delays, it was important not to become complacent.

The Committee RESOLVED To note the update.

47/25 FINANCIAL POSITION FOR MONTH TWO 2025/26 AND MONTH THREE 2025/26

MONTH TWO 2025/26

The paper providing the financial update to Month 2 was noted, but Chris Turley requested that the Committee focus on the updated position as at Month 3, given some of the challenges that had emerged over the last week or so.

MONTH THREE 20525/26

An update was given by Chris Turley who provided the Committee with details in the following areas:

1. Chris advised the Committee of some emerging external financial risks. He reported that for the first time in a long period, the year-to-date financial position showed an emerging overspend/deficit of just under £200k, moving from a previously balanced position. The main reasons for this shift were two external factors: a reduction in expected income and an increase in spend, particularly related to the Welsh Risk Pool (WRP).

2. The WRP has substantially increased its previous forecast of in year spend, which, if it materialises would require an increased contribution from all Welsh NHS bodies. For the Trust this could require an increased contribution of c£829K in year.

3. Furthermore, Welsh Government (WG) has recently advised that it was not able to cover the full costs associated with the increase in employers' National Insurance contributions (NICs). This was due to a gap in the funding provided for this from the UK Treasury for the public sector in Wales. This gap for the Trust, which at month three was estimated at c£300k could now be over £1m in year, based on updated detail received in month.

4. These challenges may worsen finances over the year, possibly resulting in a deficit forecast by month four. The Trust plans to use its contingency fund to offset some impact, but if both issues persist, total in-year pressure could reach £2M.

5. Chris Turley added that the Executive Leadership Team (ELT) will be discussing possible mitigations in the coming weeks and will continue to discuss the issues with WG and NWSSP to understand the extent of the additional costs, particularly with reference to the WRP.

6. Despite these pressures, the forecast for the end of quarter one remained to break even, but the risk of not achieving this has increased significantly.

7. The capital plan was on track, and savings targets were being slightly overachieved, but these internal achievements have not fully offset the external pressures.

Peter Curran commented that compared to last year, the financial situation was much riskier, with more variables and unknowns now present. He expressed concern about the unexpected increase in WRP costs and highlighted the difficulty of operating without clear financial information, referencing the NIC funding gap as a challenging factor.

Peter Curran inquired if, in a worst-case scenario, were there times in the year where planned spending could be withheld or delayed mitigating the deficit. Chris Turley confirmed ELT will be working through all options, including reviewing planned increases that have not yet materialised and considering slippage or stopping certain expenditures. He added that contingency funds have been used to offset some pressures.

Wendy Herbert expressed disappointment about the late increase in WRP costs and asked if this would impact the legal team. Chris did not yet know the likely detailed impact of this as yet but acknowledged the point and advised more information was being requested.

The Committee appreciated early sight of the risk and were assured the Trust was taking all appropriate action. It further noted that such a position for the Trust, in recent years was unprecedented.

The Chair acknowledged that the Committee was confident the situation was being managed appropriately and supported the current approach. Further details may need to

be addressed in the AAA report for the Trust Board, as they will expect this matter to have been thoroughly examined by this Committee.

The Committee RESOLVED To:

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

48/25 FINANCIAL SUSTAINABILITY PROGRAMME (FSP) UPDATE

Carl Kneeshaw presented the report and updated the Committee on the following points:

1. Early performance against a savings target of £8.5m showed a slight overachievement, but there remains a reliance on non-recurrent savings.

2. Recruitment for the Head of Commercial Development position has concluded. This role was responsible for income generation and commercial initiatives, and was aligned with the Financial Sustainability Programme (FSP).

3. A Task and Finish Group has been established with Trade Union partners to develop recommendations for Emergency Ambulance crew composition. An options paper has been submitted to ELT, with a further iteration to come back shortly.

4. An administration and support review was initiated in 2023 however capacity constraints, staff turnover, and competing priorities have delayed progress.

5. A service review has led to 16 mini business cases following a comprehensive review across 50+ service areas. A tiered implementation model and governance structure has been agreed.

Peter Curran inquired whether there was an expectation of income or return on investment from the Head of Commercial Development role within the current year, or if benefits were anticipated in the following year. Chris Turley clarified that no significant income from this role had been assumed in the current year's financial plan, so there was no risk to the plan if immediate returns were not realised.

The Chair commented that the appointment for the new Head of Commercial Development was later than expected, making it crucial to set clear objectives so they can start effectively and present viable options quickly. Financial sustainability remained a Committee priority; so timely, comprehensive updates were essential.

The Committee RESOLVED To Note the report.

49/25 REPORT ON COMMISSIONING

Hugh Bennett provided a brief commissioning update, stating that the governance of the JCC (Joint Commissioning Committee) remained fluid. He noted that while formal governance was still developing at the JCC, there were established informal working relationships and strong internal governance within their own organisation.

The Committee RESOLVED To Note the continuing development of the new commissioning arrangements within the JCC.

50/25 INTEGRATED MEDIUM TERM PLAN (IMTP) PROGRESS REPORT

Hugh Bennett updated the Committee on the following:

1. The Clinical Model Transformation (CMT) programme was progressing at pace, with a recent successful launch of phase one of the new Ambulance Performance Framework on 1 July, described as a monumental effort.
2. The programme was RAG-rated yellow (cautionary) due to the rapid pace of change and the significant demand on staff, with concerns about potential burnout and the need for ongoing prioritisation. This was an improvement from amber in the previous period.
3. Five balanced scorecards for benefits and outcomes have been developed for the programme, supported by more detailed logic benefits maps.
4. Internal feedback has led to improvements in communications and digital tools, and the programme was now using Microsoft Project and Planner for better management.

It was noted that progress on Cabinet Secretary priorities was good, with no red-rated items reported. The priorities were being tracked and reported alongside the CMT and Directorate Integrated Medium Term Plan (IMTP) actions.

With respect to the Directorate-Led IMTP Deliverables, quarter one saw 12 deliverables, three were complete, three were on target, one was yellow, and five were red. The red items were due to capacity issues and have been reprogrammed to later in the year, which was considered reasonable. Strategic Objective 2 (enabling our people to be the best they can be) deliverables were reviewed in detail, with seven green, three yellow, and one amber status, with no reds.

The Committee asked about the two red items in the digital front end section of the report, specifically questioning whether these were temporary short-term issues due to delays and if there was confidence that the reasons for them being red would be resolved. Jonny Sammut responded by clarifying the current status of the virtual assistant and symptom checker projects, indicating that both had progressed and their risk status had improved.

The Committee agreed that assurance against 'what good looks like' within the IMTP will be presented bi-annually, commencing at the September meeting. The Committee acknowledged the positive progress made to date, while emphasising the importance of maintaining momentum and avoiding complacency, particularly as Phase 2 of the framework was introduced.

Jonny Sammut wanted the Committee to acknowledge the significant effort and cost contributed by staff, especially those in corporate services, in supporting the CMT's work. While this may not be clearly stated in the report, he emphasised the importance of recognising this contribution. Hugh Bennett confirmed a RAG rating summary for each of the CMT, IMTP deliverables, and Cabinet Secretary priorities would be provided for the Board's information.

The Chair found the high-level synopsis valuable, as it offered key insights into overall programme progress and maintained a strategic outlook. The Committee should continue monitoring workloads to prevent burnout, supporting executives in prioritising tasks since not everything can be achieved at once. It was encouraging to see Cabinet Secretary's priorities reflected. The Committee agreed the proposed approach to reporting on strategic outcomes and benefits, in line with the report recommendations.

The Committee RESOLVED To:

1. **Agree to the proposed approach to reporting on strategic outcomes and benefits;**
2. **Note the CMT programme end of Q1 position.**
3. **Note the Directorate-led IMTP end of Q1 position.**
4. **Note the Q1 position for the Cabinet Secretary's priorities set out in the 2025-26 planning framework.**
5. **Advise of any further assurance needed for the Board.**

51/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR)

Hugh Bennett provided an update:

1. He reported June's Red 8-minute performance at 50.7% and noted improvement in the Amber One median to one hour and 29 minutes, compared to the 12-month average of one hour and 51 minutes, attributing this to reduced handover delays.

2. He highlighted that handover hours dropped to 15,278, the lowest in four years, but emphasised this was still nearly three times higher than what rosters can handle.

3. He also mentioned that while Emergency Ambulance production was at 95%, it had dipped slightly and would be monitored.

4. It was noted that 111 call handling performance has stabilised, but the Trust did not achieve the 5% abandonment rate in June 2025, with performance decreasing slightly to 10% from 10.5% in May 2025.

A discussion followed on why average jobs per shift (all resource types) remained below expectations despite reduced handover delays. It was acknowledged that this metric was influenced by multiple factors including resource type, training abstractions, vacancies, and operational changes. An upward trend in the average jobs per shift for emergency ambulances was noted, but it was agreed that further analysis, was needed to better understand the correlation. Hugh Bennett agreed that he would investigate further, noting that the metric in question was average jobs per shift by all vehicle types. He suggested it would be useful to split out the data, particularly focusing on Emergency Ambulances (EA) for its correlation with handover.

The Committee RESOLVED To consider and took assurance from the May 2025 / June 2025 Integrated Quality & Performance Report and actions being taken.

52/25 QUALITY PERFORMANCE MANAGEMENT FRAMEWORK – LOGIC BENEFITS MAP

Hugh Bennett explained that the purpose of this report was to obtain approval from the Committee for the Quality Performance Management Framework (QPMF Logic Benefit Map [LBM]).

Hugh Bennett explained that the benefits map was created to address the question of what success looks like for the QPMF. He described the map as starting with inputs and moving through activities, outputs, outcomes, benefits, benefit measures, and impact.

The Chair queried if it was suitable for this document to be over two pages, as there was a lot of detailed information. The framework purpose and assumptions could serve as a cover sheet, leaving just the map on a single page. As more arrows appear, particularly on the right side, the layout becomes confusing. Hugh Bennett added that the benefits map was best viewed on A3 paper due to its detailed content. He explained that benefits maps often featured complex, non-linear connections such as audit assurance linking to multiple elements.

Trish Mills suggested that as the QPMF Steering Group progressed this year, it would be useful to review and streamline some groups and categories, since several benefit measures overlap, hence the multiple arrows.

The Chair added that balancing an accurate map with the Framework was challenging without duplicating existing work. At this stage she was not comfortable approving the LBM at this stage and recognised the substantial effort in this strong first draft and suggest the QPMF steering group addressed the amendments raised.

In terms of the QPMF benefits map and the benefits measures it was agreed that further work would be done to clarify the flows between inputs, activities, outputs and benefits. It was agreed that the QPMF Steering Group would consider this in further detail and that Hugh Bennett would provide an update at the next meeting following discussion at the QPMG Steering Group The Committee acknowledged that this was a strong first version

that would be refined over time. Assurance was provided to the Committee on governance structures and processes for feedback loops, audits and tracking benefits.

The Committee RESOLVED To:

1. **Consider the contents the Q&PMF 2025-28 LBM.**
2. **Identify any further amendments.**
3. **Consider the Quality Performance Management Framework – Logic Benefits Map noting it would be considered and endorsed by the QPMF Steering Group for Committee approval going forward.**

53/25 ANNUAL HAZARDOUS AREA RESPONSE TEAM (HART) – KEY PERFORMANCE INDICATORS (KPI) REPORT

Lee Brooks opened with an update on the Manchester Arena Inquiry (MAI) report. The Trust submitted its response to Welsh Government (WG) and the Joint Commissioning Committee (JCC) in August 2024. Commissioners reviewed these reports in March and April 2025, and feedback was expected in August. Some recommendations have been delayed, as previously reported to the Trust Board.

Lee Brooks presented the Annual Hazard Area Response Team (HART) Key Performance Indicator (KPI) report for Q4. Assurance meetings with Commissioners had taken place in March and April, allowing scrutiny of the Trust's submission, and feedback from Commissioners was expected in August. He acknowledged some slippage on recommendations, previously covered at Trust Board, and noted that an internal audit was underway to review governance arrangements.

Lee Brooks explained that the annual WG return for HART and specialist teams was a KPI report based on a provided template, covering activity numbers and team composition.

Notably, on 08 March 2025, HART was unable to provide full team cover due to short-notice absences. This incident highlighted the importance of the MAI recommendation to increase the HART team size from six to eight operatives to enhance resilience.

It was noted that funding was received to increase the Special Operations Response Team (SORT) capacity from 150 to about 290 operatives. Procurement for equipment has been achieved at lower than anticipated costs, but there have been challenges with vehicle procurement. The training programme to reach the new SORT staffing level was expected to be completed within the calendar year.

The Committee RESOLVED to Note the Annual Hazardous Area Response Team (HART) – Key Performance Indicators (KPI) Report.

54/25 BUSINESS CONTINUITY ANNUAL REPORT – 2024/25

Lee Brooks reported that the Business Continuity (BC) Annual Report demonstrated the Trust's compliance with the Civil Contingency Act 2004, the adoption of a new governance structure for Business Continuity, and the rollout of new BC software.

The main change this year was the rollout of new BC software, which would provide auditable business impact assessments and continuity plans, replacing the current paper-based process. The new system will offer dashboards and improved oversight, and its implementation was expected this year.

He added that once visibility increased, follow-up work may be needed, and the report included current completion rates for business impact assessments and continuity plans, with more work required for visibility.

The Committee RESOLVED To Note the Business Continuity Annual report 2024/25.

55/25 WELSH GOVERNMENT ANNUAL EMERGENCY PLANNING REPORT

1. Lee Brooks stated that the annual Welsh Government EPRR (Emergency Preparedness, Resilience and Response) report was submitted each year.
2. The report included updates on key national inquiries, progress against last year's priorities, and set out the current year's priorities.
3. He highlighted the incorporation of the Charter for Families Bereaved by Public Tragedy into Trust documentation, including the incident response plan, command policy, and debriefing process.
4. Progress was reported on the MAI (with 68 recommendations completed and 18 requiring financial investment, now monitored as a corporate risk), the Grenfell Inquiry and improvements in communications and tactical advisor training.
5. SORT growth and embedding remained a priority, with BC structures and software rollout ongoing.
6. The COVID Inquiry was pending, especially Module 3 outcomes.
7. A new focus this year was developing the role of volunteers in major incidents, with progress expected in engaging volunteers.
8. A robust programme of training and exercising had taken place; however, it identified a need for more frontline staff exercising.

The Committee RESOLVED To Note the Welsh Government Annual Emergency Planning Report.

56/25 RESOURCE ESCALATION ACTION PLAN

Lee Brooks advised that the Resource Escalation Action Plan (REAP) document has been reviewed both as part of its annual cycle and to prepare for the 01 July 2025 changes, with adjustments made to triggers to align with the new clinical model and to support the direction of the service, such as consolidating remote clinicians under single triggers.

The changes were described as self-explanatory, and a further review was anticipated to coincide with phase two of the ambulance performance framework, which will require another update to ensure triggers remained current. The next version of REAP will be developed in the coming months to complement these ongoing changes.

The Chair queried what steps could be taken if access to software was not possible due to a cyber-attack. Jonny Sammut explained that the Trust has a catastrophic outage recovery plan for total system failures, with multiple failover options to switch networks and restore service. The cloud-hosted Business Continuity Management System was intentionally kept separate from the Trust, allowing continued access even if there was a complete outage.

Bethan Evans raised a question about the number of SORT staff in post, observing that the South region appeared underrepresented compared to other regions. Lee Brooks updated the Committee on current numbers: North, 76, Central and West, 93 and South, 73. He added that the Trust was moving toward a staff count of 290. He remained reasonably confident that this goal will be achieved. Once the target staffing was attained, the focus will shift to understanding how many staff members were on duty at any given time and their locations, to help ensure an even distribution.

Regarding the Emergency Preparedness report, members noticed that the response options were limited to simply 'yes' or 'no.' In the Trust's case, it selected 'no,' but provided additional context explaining that some criteria were partially met, which seemed entirely reasonable. Given that this approach highlighted existing gaps and resource challenges was any specific feedback or response from WG upon their review of the report expected.

Lee Brooks commented there should be no surprise to WG about this report. The Team completing the report carefully evaluated its position to ensure consistency and challenged itself throughout the process.

The Chair emphasised that, from her perspective, the key consideration was not the reaction but rather whether the Trust's response was justifiable.

RESOLVED: The Committee RESOLVED To

1. Note the revised Resource Escalation Action Plan.

2. Confirm it was assured that a robust annual review of EPRR plans and activities has been undertaken, and to inform the Trust Board of its assurance.

57/25 DIGITAL REPORTING

Jonny Sammut gave an update on the report.:

Highlights

1. Recruitment across Digital was progressing well.
2. There has been a successful soft launch of the NHS 111 Wales Virtual Assistant chatbot, supporting multilingual access and improved user experience.

3. A technical go-live of video consultation for 111 clinicians took place on 8 July.
4. Phase 2 of the Microsoft Copilot pilot began on 01 July, with 150 licences distributed.
5. A refresh of the Electronic Patient Care record (ePCR) application was in development, aiming to reduce on-scene times and improve data quality.
6. The Cyber Resilience Unit audit has been completed.
7. There was a significant contribution by the digital team to the go-live of new call categories on 01 July.

Lowlights

8. The iPad replacement programme was paused pending agreement on a charitable donation scheme for existing devices.
9. Video Compliance Progress was delayed due to competing priorities.
10. Enhanced Interactive Voice response (IVR) (111) was deprioritised due to the Clinical Model Transformation (CMT) development demands.
11. The Reporting of new 999 Computer Aided Dispatch (CAD) metrics was currently reliant on a temporary solution; a full CAD upgrade was still unplanned.

Red Flags

12. Sustained pressure on the Information Governance (IG) team due to urgent demand from across the CMT programme.
13. All-Wales data sharing via the National Data Resource (NDR) remained unresolved, with legal and regulatory risks under active review by the Trust's Data Protection Officer (DPO) and IG team.
14. Unknown requirements for 2025/26 and 2026/27 under the CMT programme posed a capacity risk to the Digital Directorate, potentially impacting delivery of the local Digital Plan.

Jonny Sammut presented a deep dive into the digital plan, which was structured around five pillars: everyday essentials, digital pioneers, digital transformation, security/safety/cyber, and data.

Jonny described the digital team's structure and highlighted 2025/26 priorities, including iPad replacement, automation, Windows 11 upgrade, AI/innovation lab, emergency services network upgrades, electronic patient record improvements, smart stations, and national data resource collaboration.

He commented on the EMS server improvement programme, the development of an AI policy and ethics panel, and the launch of an innovation lab and mobile digital support hub for direct engagement with crews. Jonny also referenced the ongoing development of the MIQPR always-on report and stressed maintaining core digital services, including system uptime and resilience measures.

Jonny Sammut explained that the Trust was conducting a digital transformation self-assessment to inform the Audit Wales digital deep dive. The self-assessment included a series of questions, and members were invited to provide comments and feedback. The submission deadline was in August, with results being reported at the next meeting for transparency.

Bethan Evans said the digital report was clear, praised the Trust's digital transformation goals, and highlighted the impressive ePCR visuals and "help desk on wheels" concept. She noted these will greatly enhance the Trust's digital capabilities.

The Chair welcomed the report the update regarding AI and the current work being undertaken in this area. Additionally, on behalf of the Committee she extended formal congratulations to Jonny on his appointment as Chair of the Wales hub of the British Computer Society.

The Committee RESOLVED To Note the contents of the report, the Digital Directorate Deep Dive and the trends in the metrics presented.

58/25 INFORMATION GOVERNANCE REPORT

An update was given by Jonny Sammut:

1. Two projects progressed without initial Information Governance (IG) involvement; however, internal procedures identified this and paused their advancement to ensure appropriate support.
2. He highlighted ongoing AI risk management, noting a drafted notice on generative AI and the need for an NHS Wales-wide policy, given the proliferation of large language models.
3. Two accounts were compromised via a password spray attack, but multi-factor authentication prevented any network access or data compromise.
4. The phased reintroduction of copy and paste for ePCR was approved, aiming to improve usability, with close monitoring before broader rollout.
5. Mandatory IG training compliance reached over 90%. A series of letters were being sent to anyone whose training was 6 months or older with locality, managers being copied.
6. The 111 Wales website privacy policy was fully reviewed to support the virtual agent launch.

While it was assuring to see the compliance rate of IG training improve, the Chair inquired about the confidence levels that early involvement was recognised. Jonny Sammut was confident that the Trust has established the appropriate processes both at the IG and procurement levels. Each of these processes and procedures references IG, which encouraged early engagement. The existing processes were robust and going forward, the plan was to develop a broader IG awareness initiative beyond formal IG training with the aim to provide greater context for why these practices were important.

The Committee RESOLVED To Note the report.

59/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

The Committee received the Risk and Board Assurance Framework (BAF) report noting that all risks have undergone their quarterly review, with no changes in scores. It was

emphasised that the highest rated risks were considered when setting the agenda ensuring that these were integrated into the papers and discussions throughout the meeting.

The current BAF was updated recently and reviewed by the ELT, with all risks reviewed within their designated timeframes. For the cyber risk (risk 260), detailed information was kept in the closed session due to sensitivity, but high-level details were included in the open paper.

The Committee acknowledged that Risk 542 (Decarbonisation) was a complex and multifaceted risk and challenging to mitigate given its nature and external dependencies; however, there was an aspiration to reduce this from a score of 16 to 8. Non-Executive Directors met with management recently to review this risk, and the ambition was to reframe it to focus on what was within the Trust's control.

The Committee RESOLVED To Note:

1. **The contents of the report.**
2. **The controls in place against the risks.**
3. **The actions described to further mitigate the risk.**

60/25 INTERNAL AUDIT REPORTS

The following Internal Audit reports were presented:

Capital Systems – Reasonable Assurance: Chris Turley stated that the capital systems internal audit received reasonable assurance and noted that every aspect of the audit had at least reasonable assurance. He mentioned that most recommendations were already completed, and that the management responses were provided. Osian Lloyd added that issues around interactions with procurement were a common theme across Wales and not entirely within the Trust's control.

Contract Management – Advisory Report: Chris Turley commented that the advisory report format was more beneficial than a different approach would have been. He confirmed the report was discussed at the Audit Risk and Assurance Committee (ARAC) and that the advisory format was appropriate. The main actions for the Trust arising from this had either been actioned or were in progress.

Emergency Communication Nurse System (ECNS) Implementation – Reasonable Assurance: Lee Brooks highlighted the need for better understanding and completion of benefits realisation. He emphasised that while there was evidence of benefit consideration, the report reinforced the importance of this process across all programmes of work.

Forecasting & Modelling – Reasonable Assurance: Hugh Bennett advised that the forecasting and modelling internal audit found reasonable structures in place and a strong culture of forecasting and modelling within the Trust. He acknowledged the need to tighten processes, which was already recognised at the start of the audit, and confirmed there were a series of agreed recommendations to deliver.

Members noted that the audit reports had been presented by Internal Audit at the June ARAC meeting. All actions will be tracked for oversight by this committee

The Committee RESOLVED To note the following reports: Capital Systems, Contract Management, Emergency Communication Nurse System (ECNS) Implementation, and Forecasting & Modelling.

61/25 POLICIES FOR APPROVAL

NHS Wales No Purchase Order No Pay Policy: Chris Turley explained that the No Purchase Order, No Pay Policy was a national NHS Wales policy requiring invoices to have a purchase order before payment. He stated the Committee was being asked to approve minor amendments to the policy, which had already been reviewed by the ARAC.

The Committee approved the updates to the NHS Wales No Purchase Order No Pay Policy.

The Committee RESOLVED To approve the NHS Wales No Purchase Order No Pay Policy.

62/25 AUDIT WALES URGENT AND EMERGENCY CARE – ARRANGEMENTS FOR MANAGING DEMAND REPORT

Lee Brooks presented the report which provided a timely and comprehensive assessment of the Trust's response to ongoing pressures in urgent and emergency care and confirmed that robust plans were in place and beginning to deliver improvements. It was particularly relevant as the Trust continued to advance its Clinical Model Transformation Programme and work towards a more integrated model of care.

Key developments included the expansion of the clinical desk, deployment of advanced paramedic practitioners, and the introduction of rapid clinical screening and clinical navigators, which have increased remote resolution of 999 calls. Early signs from Connected Support Cymru were also promising. However, challenges persisted, particularly (at the time of the audit fieldwork) severe handover delays, fragmented data sharing with health boards, and inconsistent access to alternative care pathways.

The report also identified persistent challenges that the Trust must continue to address:

1. Severe handover delays at Emergency Departments, with only 16% of patients handed over within the 15-minute target in February 2025.
2. A lack of joined-up data between the Trust and health boards, which limited the ability to track the full patient journey and evaluate the effectiveness of alternative pathways.
3. Inconsistent access to alternative services such as Same Day Emergency Care and Urgent Primary Care Centres, which undermined the Trust's ability to divert patients from Emergency Departments.

To support continued progress, the report made two key recommendations:

1. That the Trust work with partners to ensure the accuracy of information on the 111 Wales website, particularly the symptom checker and contact details.
2. That the Trust collaborate with health boards to maintain accurate and up-to-date directories of service, ensuring staff can reliably access and refer to alternative care pathways.

The Trust has accepted both recommendations and have already taken steps to address them. Business cases have been drafted to improve governance and digital infrastructure, and discussions with Welsh Government were ongoing to secure the necessary funding and support.

In conclusion, this report affirmed that the Trust was on the right path. It validated the direction of the Clinical Model Transformation Programme and reinforced the importance of continued collaboration with partners across the health and care system. By addressing the challenges identified and implementing the recommendations the Trust can further reduce avoidable harm and deliver a more integrated and resilient urgent and emergency care service for the people of Wales.

Fflur Jones concurred with Lee Brooks' summary, acknowledging the constructive discussions that occurred during fieldwork and clearance. She emphasised the Trust's proactive approach, stating that the report accurately represented the Trust's initiatives and its ongoing commitment to exerting influence where appropriate.

Hugh Bennett raised a minor detail within the report. It referred to a hospital conveyance rate of approximately 60%, based on 999 calls. To clarify, he believed this figure pertained specifically to responded incidents.

The Committee RESOLVED To note the Audit Wales Urgent And Emergency Care – Arrangements For Managing Demand Report.

63/25 COMMITTEE CYCLE OF BUSINESS MONITORING REPORT AND PRIORITIES UPDATE

Trish Mills advised the Committee that the Committee's annual priorities were reviewed and were progressing well. The Cycle of Business Monitoring Report noted that the Value Based Healthcare Report, due in May 205 has been deferred and will be the subject of a Board Development session to draw out the issues as they relate to the Trust, as agreed with the Chair and Liam Williams.

The Committee RESOLVED To note the update.

64/25 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

The Committee reflected that this meeting was a good example of where complex reports and business can be presented clearly and in such a way which draws out the pertinent elements, and there was a good balance of such matters at this meeting. Additionally, the

Chair reflected the positive impact of the new Ambulance Performance Framework and that the early notice of the financial risks, as highlighted in the alert section, was important. Jonny Sammut was congratulated for his recent appointment as the Chair of the BCS (Chartered Institute for IT) in Wales.

Meeting concluded at 13:30

Date of Next Meeting: 16 September 2025

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

Action	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
53/25	21 July 2025	Quality and Performance Management Framework (QPMF) Logic Benefits Map	In terms of the QPMF benefits map and the benefits measures it was agreed that the QPMF Steering Group would consider this in further detail. It was agreed an update would be provided at the next meeting following discussion at the QPMG Steering Group.	Hugh Bennett	16 September 2025	Update for 16 September 2025 The QPMF Steering Group further considered this on 4 September. Whilst some amendments were agreed, both Hugh Bennett and Trish Mills would benefit from a discussion with the committee chair and Peter Curran on the mapping and the best way to represent benefit going forward.	Open

AGENDA ITEM No	**5**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

Financial Performance as at Month 4 – 2025/26

MEETING	Finance & Performance Committee
DATE	16 September 2025
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Interim Assistant Director of Finance) Steph Taylor (Assistant Head of Capital Planning)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

This paper presents to the Committee the latest Financial Performance Report of the 2025/26 financial year, the reported position as at Month 4 (July 2025). As is the more usual practice now, an update on the position to Month 5 (August 2025) will be presented to the meeting on 16th September 2025.

The Committee is asked to review, comment, note and receive assurance on the financial position and 2025/26 outlook and forecast of the Trust, noting the risks to in year delivery in doing so.

RECOMMENDED that the Committee:

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

KEY ISSUES/IMPLICATIONS
Key highlights from the report for the Committee to note are: ➢ The Trust is now reporting a revenue year to date deficit (£246k) for month 4 2025/26; ➢ In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust is currently forecasting to breakeven by the 2025/26 financial year end; ➢ Capital expenditure plans continue to be progressed with plans to fully achieve in year; ➢ In line with the financial plans that support the IMTP, gross savings of £2.884m have been achieved in month 4 against a target of £2.796m; ➢ Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.7% for the number, and 99.0% of the value of non NHS invoices paid within 30 days

REPORT APPROVAL ROUTE
➢ EFG / ELT – 27th August 2025 – presentation on M04 financial position and updated year end forecast ➢ FPC – 16th September – to note ➢ Trust Board – 25th September 2025 – updated paper to provide M05 financial performance

REPORT APPENDICES
Appendices 1 – 2 *– Monitoring return submitted to Welsh Government for month 4 – as required by WG* ***Appendix 3*** *– Savings performance*

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

FINANCE & PERFORMANCE COMMITTEE

FINANCIAL PERFORMANCE AS AT MONTH 4 2025/26

INTRODUCTION

1. This report provides the Committee with a summary of the revenue financial performance of the Trust as at 31st July 2025 (Month 4 2025/26), along with an update on the 2025/26 capital programme.

BACKGROUND

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

   - The cumulative revenue financial position reported is an **overspend against budget of £0.246m**, based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2025/26. The underlying year-end forecast for 2025/26 is currently a balanced position;

   - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of **£2.884m** have been achieved against a target of **£2.796m**;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 98.7% for the number, and 99.0% of the value** of non-NHS invoices paid within 30 days.

3. Whilst any adverse movement in the financial position in month is not welcomed, the month 4 deficit of £49k does represent an improvement from that delivered as at the end of Q1. Not only is it a reduced run rate from the average monthly deficit as at month 3, the underlying position is even further improved when the fact that the full annual impact of the now expected funding shortfall in relation to Employers NI is considered. Some of the external in year pressures which have in large part driven the current YTD position have been previously reported through to both the Committee, and Trust Board, in July 2025.

4. This Month 4 position does therefore give some positive signs for future months and the Trust's ability to further slow this overspending position and potentially recover it before the year end.

5. This has in part been achieved through the delay in the timing of some elements of additional unavoidable costs commencing, some further improvements in variable pay spends, reduced sickness absence rates and the start of some impact of reduced handover delays (albeit mostly efficiency gains rather than cost reduction). The Trust's Executive Finance Group (EFG) met on 30th July to further explore what other choices and options are available to further delay or reprofile spend through the next few months, again with a view of at the very least returning to a position of in month balance as soon as possible. Beyond this, recovering the YTD position by March 2026 will then be the next key priority and further updates on the ability to do so will be provided over the next couple of months.

6. Given some of the above, we have again at this stage not reflected any change to the year end forecast, which remains at breakeven and one we will continue to do all that we possibly can to achieve. This is also in part to seek to ensure some consistency across NHS Wales in terms of how some of the external pressures continue to be treated.

7. 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. However, given that as discussed above these risks now do reflect an element of the financial shortfall.

REVENUE FINANCIAL PERFORMANCE – MONTH 4 2025/26

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

Revenue Financial Position for the period 1st April - 31st July				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-319,051	-103,647	-103,519	128
Expenditure				
Pay	235,446	77,638	77,143	-495
Non-pay	63,257	20,303	20,825	521
Total pay & non-pay expenditure	298,703	97,941	97,968	26
Depreciation & Impairments / interest payable & receivable	20,349	5,706	5,798	92
Total	**0**	**0**	**246**	**246**

Income

9. Reported Income against the initial budget set to Month 4 shows an underachievement of **£0.128m**.

Pay Costs

10. Overall, the total pay variance at Month 4 is an underspend of **£0.495m**.

Non-pay Costs

11. The overall non-pay position at Month 4 is an overspend of **£0.521m**. In addition, for reporting purposes Depreciation, Impairment and interest is excluded from the above figure, overspend of **£0.092m,** hence the total overspend to budget of **£0.246m**.

Savings

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

13. Month 4 in month performance was, plan of £0.723m and £0.748m achieved, therefore an overachievement of £0.025m (recurrent overachievement of £0.067m and non recurrent underachievement of £0.042m), as per the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Themes	6,225	534	601	67	2,038	1,975	-62	6,225	5,970	-255
Non Recurrent Schemes / Themes	2,275	190	147	-42	758	910	151	2,275	2,530	255
Overall Total	**8,500**	**723**	**748**	**25**	**2,796**	**2,884**	**89**	**8,500**	**8,500**	**0**

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

14. The split between savings and net income generation as at month 4 is shown on the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Savings (Cash releasing and Cost Aviodance)	8,350	719	743	24	2,780	2,867	88	8,350	8,450	100
Net Income Generation	150	4	4	0	17	17	0	150	50	-100
Accountancy Gains	0	0	0	0	0	0	0	0	0	0
Overall Total	**8,500**	**723**	**747**	**24**	**2,796**	**2,884**	**88**	**8,500**	**8,500**	**0**

15. ***Appendix 3*** provides the overall detail for Month 4 by theme. This is now further split over recurring and non-recurring schemes.

Financial Performance by Directorate

16. Whilst there is an overall deficit reported at Month 4, there are also some small variances between Directorates, as shown in the table below, when compared to the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature, but they will be continued to be closely monitored.

Financial position by Directorate @ 31st July	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	216,408	71,373	70,947	-426	-0.6%
Chief Executive Directorate	2,161	766	766	-0	0.0%
Board Secretary	671	211	210	-1	-0.3%
Partnerships & Engagement Directorate	614	184	183	-1	-0.4%
Finance and Corporate Resources Directorate	36,432	11,360	11,769	409	3.6%
Planning and Performance Directorate	3,005	937	915	-22	-2.3%
Quality, Safety and Patient Experience Directorate	7,070	2,305	2,248	-57	-2.5%
Digital Directorate	16,542	5,142	5,004	-138	-2.7%
People and Culture	6,286	2,013	1,960	-53	-2.6%
Medical & Clinical Services Directorate	6,301	1,916	1,925	8	0.4%
Trust Reserves	1,188	159	304	145	91.1%
Trust Income (mainly JCC)	-296,677	-96,366	-95,984	382	0.4%
Overall Trust Position	**0**	**0**	**246**	**246**	

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

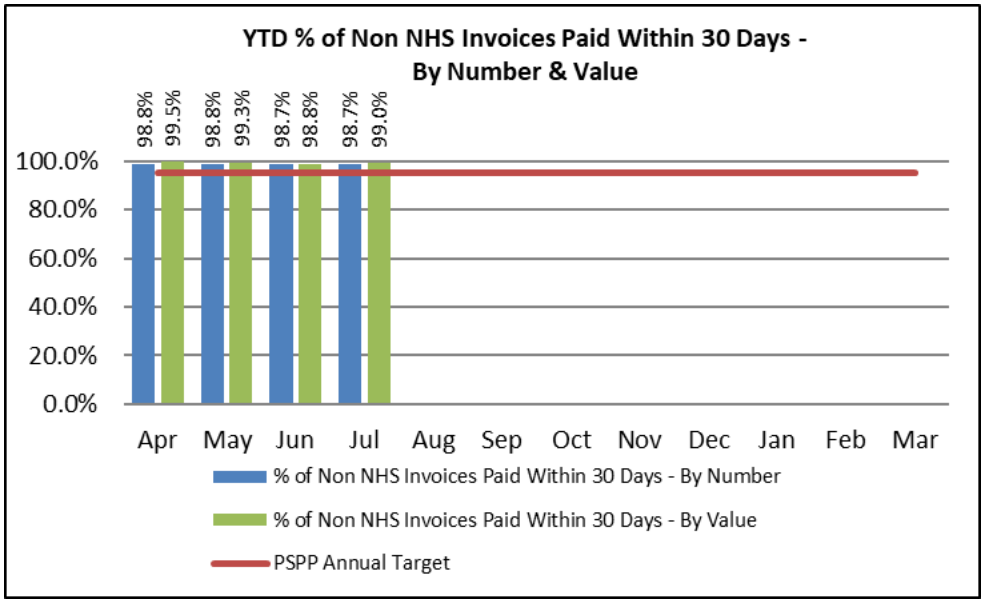
- Most directorates broadly in line with budget plan for Month 4 with the exception of Trust reserves, Finance and Corporate Resources and Trust income. It is through these areas that the previously highlighted main drivers of the current YTD position are reported, as follows:
  - Core budgets set for **Finance and Corporate resources** at opening of the financial year are broadly balanced with the exclusion of the current cost pressure around Welsh Risk Pool (WRP) as follows.
    i. **Forecasted Increase:** The forecast spend in relation to the Welsh Risk Pool has increased by £42 million across Wales, over and above the £36 million already included in organisational plans. This leaves a balance to be covered across NHS Wales under the risk share agreement.
    ii. **Provisions and Cases:** At the end of March last year, there were £1.7 billion of provisions for 1,100 cases across NHS Wales. The increase in forecasted losses is attributed to additional court dates being opened up, possibly due to a backlog from COVID-19. This has led to more trials being booked earlier in the year, limiting the scope for settlements to move.

iii. **Impact of Personal Injury Discount Rate:** The change in the personal injury discount rate in January was expected to shift claimant preference towards periodic payment orders rather than lump sums. However, this shift has not been observed, with some cases potentially settling for significantly higher amounts than forecasted.

- Core budgets set for **Income** at the opening of the 2025/26 financial year included two main components
  - Income from main commissioner (JCC) for core services provision of EMS, Ambulance Care and 111 related services
  - Income from WG for the increased costs of the changes to Employers National Insurance from April 2025 which is where a cost pressure has emerged since Month 3.
    i. The rate of employer's National Insurance Contributions (NICs) increased by 1.2%, bringing it to 15%. The Employer's NI Secondary Threshold also decreased from £9,100 to £5,000.
    ii. Impact on WAST was a cost increase of c£4.69m and this was included in the opening financial plan with assumed full income coverage from WG.
    iii. Discussions in Deputy Directors of Finance in June 2025 via WG updates had flagged a potential funding shortfall of c7% (WAST risk of £0.330m) for NHS Wales organisations and hence based on this M3 ¼ of this (£0.082m) was included in the M3 financial reported position.
    iv. Further correspondence then received from WG in July 2025 identified a much larger shortfall figure of c25% (c£1.2m) based on the full NHS Wales funding allocated for Employers NI, due to UK treasury funding being far less than the public sector costs.
    v. This has resulted in the Trust only being able to invoice WG for £3.540m.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

18. Public Sector Payment Policy (PSPP) compliance to Month 4 was **98.7%** against the **95%** WG target set for non-NHS invoices by number and **99.0%** by value.



2025-26 INITIAL CAPITAL PROGRAMME

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

20. At Month 4, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2025/26 is **£32.216m**. This includes **£26.268m** of All Wales Approved schemes and **£5.948m** for Discretionary schemes.

21. There is no suggestion at this stage of the financial year that this value won't be spent in full.

	Actual £'000	Plan £'000
All Wales Capital Programme: Schemes:		
ESMCP - Control Room Solutions	0	439
MDVS	0	2,080
Special Operational Response Teams (SORT) Enhancement Equipment	0	290
Welsh Ambulance Services NHS Trust – Vehicle Replacement Programme – 2025-26	2,003	22,452
TEF - Infrastructure	8	301
TEF - Decarbonisation	8	707
Sub Total	**2,018**	**26,268**
Discretionary:		
I.T.	186	1,149
Equipment	36	250
Statutory Compliance	0	0
Estates	(27)	4,350
Other	11	180
Unallocated Discretionary Capital	0	19
Sub Total	**206**	**5,948**
Total	**2,224**	**32,216**
Less NBV reinvested		
Total Funding from WG	**2,224**	**32,216**

RISKS AND ASSUMPTIONS

22. As we progress through the financial year, we will continue to review the risks to ensure that the level of likelihood is assessed along with the financial value. Depending on the outcome of some of the issues highlighted elsewhere in this report, we may continue to move towards higher risks having to be reported, alongside ensuring that Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.

23. 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.

24. It continues however that the risk of not achieving financial balance this financial year has increased over the last couple of months, and arguably more so in month 4 with the full extent of the Employers NI funding shortfall being recognised. Whilst there continue to be further elements of mitigation that we can reasonably expect to be delivered between now and the end of the financial year, and we continue to explore any and all opportunities for more in this regard, it would not be reasonable at this stage to expect all of this to be able to be absorbed, and certainly not without some potential service impacts. This does all mean that we will then further have to deliver a reduced spend and manage existing plans to ensure that the Trust can continue to forecast a year end break even. Therefore, the Trust has included a figure of **£1.000m at this stage** (high risk).

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

26. The risk associated with the non-delivery of the initial identified savings has now been removed, as the Trust continues to make good progress with these schemes.

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

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

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

30. Full consideration and management of all these risks will clearly be high on the agenda for the Trust Board and its relevant Committees, including Finance and Quality Committees. Alongside this, the risk of non-delivery of statutory financial duties continues to be included on the Trust's Corporate Risk Register.

RECOMMENDED that the Committee:

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

Appendix 1

Attached

Appendix 2

Ibabs reading Room

Appendix 3

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

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 25-26

Reporting Month 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
Apprentice Income	50	4	4	0	17	17	0	50	50	0
Balance Sheet Flexibility	200	0	0	0	50	50	0	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	0	-100
Disposals	250	20	20	0	20	20	0	250	250	0
End of Shift Overrun	100	9	9	0	36	34	-2	100	98	-2
Fuel	230	20	150	130	79	232	153	230	417	187
Interest Receivable	516	43	-3	-46	172	79	-93	516	208	-308
Non Pay Local Schemes - Corporate	914	64	58	-6	255	215	-39	914	924	10
Non Pay Local Schemes - Operations	650	54	38	-16	211	168	-43	650	607	-43
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	312	316	5	1,191	1,152	-39	3,140	3,140	0
Pay Vacancy Management - Corporate	2,275	190	147	-42	758	910	151	2,275	2,530	255
Pay Vacancy Management - Corporate 25-26	75	8	8	0	8	8	0	75	75	0
Totals	**8,500**	**723**	**748**	**25**	**2,796**	**2,884**	**89**	**8,500**	**8,500**	**0**

Savings Performance by Theme 25-26 - 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
Apprentice Income	50	4	4	0	17	17	0	50	50	0
Balance Sheet Flexibility	200	0	0	0	50	50	0	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	0	-100
Disposals	250	20	20	0	20	20	0	250	250	0
End of Shift Overrun	100	9	9	0	36	34	-2	100	98	-2
Fuel	230	20	150	130	79	232	153	230	417	187
Interest Receivable	516	43	-3	-46	172	79	-93	516	208	-308
Non Pay Local Schemes - Corporate	914	64	58	-6	255	215	-39	914	924	10
Non Pay Local Schemes - Operations	650	54	38	-16	211	168	-43	650	607	-43
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	312	316	5	1,191	1,152	-39	3,140	3,140	0
Pay Vacancy Management - Corporate	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate 25-26	75	8	8	0	8	8	0	75	75	0
Totals	**6,225**	**534**	**601**	**67**	**2,038**	**1,975**	**-62**	**6,225**	**5,970**	**-255**

Savings Performance by Theme 25-26 - 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
Apprentice Income	0	0	0	0	0	0	0	0	0	0
Balance Sheet Flexibility	0	0	0	0	0	0	0	0	0	0
Commercialisation Opportunities	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
End of Shift Overrun	0	0	0	0	0	0	0	0	0	0
Fuel	0	0	0	0	0	0	0	0	0	0
Interest Receivable	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Corporate	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Operations	0	0	0	0	0	0	0	0	0	0
Pay Cost Management (Variable / Net Vacancies) - Operations	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,275	190	147	-42	758	910	151	2,275	2,530	255
Pay Vacancy Management - Corporate 25-26	0	0	0	0	0	0	0	0	0	0
Totals	**2,275**	**190**	**147**	**-42**	**758**	**910**	**151**	**2,275**	**2,530**	**255**

Please note figures are rounded to the nearest whole number

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

Cadeirydd
Chair: Colin Dennis

Prif Weithredwr
Chief Executive: Jason Killens

Swyddfa Cyllid ac Adnoddau Corfforaethol

Finance and Corporate Resource Office

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

13th August 2025

Your ref:

Dear Andrea,

Re: JULY 2025 (MONTH 04 2025/26) MONITORING RETURN

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

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

In line with our submitted IMTP, our opening budgets and financial plan for the year reflected the level of assumed funding, expenditure plans and savings requirement included and submitted and supported by our Commissioners and approved by the Trust Board in March 2025.

The Trust's performance against financial targets for month 04 2025/26 is as follows: -

1. **Actual Year to Date 2025/26 (Tables A, B & B2)**

Income assumptions reflect those agreed within the IMTP and are used to support cost pressures identified in the Trust's detailed budget setting. The key funding assumptions at the outset of 2025/26 being that the 2024/25 funding is, where applicable, fully recurrent, and the 2025/26 funding will include: -

- The nationally made available 1.77% uplift for core cost growth, which excludes any funding to meet the 2025/26 pay award costs, (which will be subject to a future additional funding allocation);
- Impact of previously agreed developments/other adjustments including income support, in line with support by Commissioners in previous and current IMTPs, along with funding for other nationally delivered projects.

Included within the income assumptions is the full pass through of 2024/25 pay funding and an assumed level of funding for Employers National Insurance contribution increase for 2025/26 funding (see below); this wasn't included in the month 4 payment from JCC and when the pay matrix is finalised it is assumed this will then pass through to the Trust.

The resulting reported performance at month 4 as per Table B, is a overspend against budget / deficit of **£0.246m**

The reported total pay variance against plan as at month 4 is an underspend of **£0.495m**, set against the budgets.

The non-pay position at month 4 is a reported overspend of **£0.613m**.

Income at month 4 shows an underachievement of **£0.128m**.

Whilst any adverse movement in the financial position in month is not welcomed, the month 4 deficit of £49k does represent an improvement from that delivered as at the end of Q1. Not only is it a reduced run rate from the average monthly deficit we ended up having to post YTD as at month 3, the underlying position is even further improved when the fact that the full annual impact of the now expected funding shortfall in relation to Employers NI is considered. This does give some positive signs for future months and the Trust's ability to further slow this overspending position and potentially recover it before the year end.

This has in part been achieved through the delay in the timing of some elements of additional unavoidable costs commencing , some further improvements in variable pay spends, reduced sickness absence rates and the start of some impact of reduced handover delays (albeit mostly efficiency gains rather than cost reduction). The Trust's Executive Finance Group (EFG) met on 30th July to further explore what other choices and options are available to further delay or reduce spend through the next few months, again with a view of at the very least returning to a position of in month balance as soon as possible. Beyond this, recovering the YTD position by March 2026 will then be the next key priority and further updates on the ability to do so will be provided over the next couple of months. The EFG is due to meet again on 27th August.

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

It is also noted the issues highlighted in the month 3 response letter in terms of the way some of the unfortunate need to move to an in-year deficit position was reported through some of the submitted returns. We have sought to address what we can in relation to these and I know some in my team have also discussed with WG colleagues, as looking to present some of this in the way we needed to didn't seem to be achievable in some of the tables, potentially throwing out validation errors. Hopefully these have been resolved now and I also trust that you will agree that the initial focus in the limited time we had for month 3 reporting, following the updates on some of the external cost pressure issues, was on ensuring we captured the impact bottom line on the Trust, in terms of YTD, forecast and risk stratification and, crucially immediately initiating actions internally in terms of what we would be able to do in response.

2. Movement (Table A)

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

Following detailed conversation with the team the following **(Action Points 3.2a-d)** were addressed by revising table A and B2 to ensure the detail was able to be presented in the correct format. Following the conversation it was also agreed that given the way the Trust accounts for the WRP element, which differs from the HB's that the Trust would need to use the free text sections **(Action Point 3.1 & 3.3)**

The minor movements have been reversed in month 4 and incorporated via table B2 **(Action Point 3.4)**

3. Underlying Position (Table A1)

Table A1 has been adjusted to agree with Table A

4. Risk (Table A2)

Understandably this early in the financial year, the risks reported in Table A2 are still being fully assessed, but as we move through the next few months we will continue to review the risks to ensure that the level of likelihood is

assessed along with the financial value. Depending on the outcome of some of the issues highlighted elsewhere in this return, we may continue to move towards higher risks, as noted above, having to be reported, alongside ensuring that the Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.

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

It continues however that the risk of not achieving financial balance this financial year has significantly increased over the last couple of months, and arguably more so in month 4 with the full extent of the Employers NI funding shortfall being recognised. Whilst there continue to be further elements of mitigation that we can reasonably expect to be delivered between now and the end of the financial year, and we continue to explore any and all opportunities for more in this regard, it would not be reasonable at this stage to expect all of this to be able to be absorbed, and certainly not without some potential service impacts. This does all mean that we will then further have to deliver a reduce spend and manage existing plans to ensure that the Trust can continue to forecast a year end break even. Currently it would have to be stated that there is a high risk of this not being achievable.

A low risk has been included around any JCC additional, in year, saving request, this is currently low at present however this is on the basis that the Trust has had no direct contact from the JCC on any further ask. However in light of the comment contained in the month 1 reply letter, the Trust acknowledges this could be an increased risk should such an in-year request be made. However, it remains that our current breakeven forecast assumes the current level of core funding and savings (which are significant and challenging as they stand), supported as such by the JCC in our IMTP and financial plan, and in part is following the Trust receiving no additional funding for the Band 4 to 5 technician grade re-banding**.**

The risk associated with the non-delivery of the green risks have now been removed, as the Trust continues to make good progress with these schemes. **(Action Point 3.6)**

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

Now excluded from the tables as requested is the risk relate to the costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if this recommendation is to be taken forward additional funding would be required in order to deliver. As previously noted within the returns, whilst this is less of a financial risk as only if funding was made available would the costs transpire, however the risks to the services are much more than financial. **(Action Point 3.5)**

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

Also in the opportunity table, is the possible VAT rebate for the Microsoft licences following the guidance around this, subject to additional advice, it is noted that some of this may be top sliced from DHCW to assist with the procurement of future Microsoft licenses.

5. Monthly Profiles (Table B)

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

The forecasted expenditure is based on local intelligence and as can be seen from month 4 the Trust has in fact overspent compared with the previous forecast therefore it was correct to assume an increase in expenditure. **(Action Point 3.6)**

Per month 3 return the Non-cash hasn't been included at the close of the period however the Trust can now confirm this has been included in the ledger and return for month 4 **(Action Point 3.7)**

6. Expenditure Movement (Table B2)

Table B2 has been completed in accordance with the guidance,

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

Agency costs for month 4 totalled £0.103m. The current percentage of agency costs against the total pay figure remains very small, at 0.5%. This is to cover a small number of vacancies, in areas across the Trust which the Trust is having difficulties recruiting into, however it is hoped that some of these agency staff will be replaced by permanent staff in the near future. Forecasts have been updated to show expenditure stopping after September.

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

For month 4 the Trust is reporting planned savings (including Income generation) of £2.796m and actual savings of £2.884m.

As can be seen from Table C3, the Trust overachieved its savings target in month 4 but it still forecasting to achieve the total original savings target for the year. As detailed above, this doesn't take into account any further ask on the Trust to manage either the additional external cost pressure or reduction from assumed funding, or any additional in year ask via the JCC,

Savings are monitored on a monthly basis and any changes or forecasted adjustments are reflected through the tables. **(Action Point 3.9)**

The sheets have been amended for current and future months to include only whole numbers, however it should be noted that to remove the decimal places from the totals, adjustments have been included in month 12. **(Action Point 3.10)**

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

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

The Trust income assumptions are included within table E1, please note the JCC income figure quoted assumes the funding for the 24-25 pay award, however this is yet to be paid.

The 25-26 pay award assumed funding has been included in the anticipated income section as requested in prior months, however this income nor expenditure is not profiled into the position, as it is assumed that it will have a net impact on the tables **(Action Point 3.8)**

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

Please note the April figures have now been amended to reflect the Audited accounts. **(Action Point 3.11)**

At month 4 there was 5 invoices over 11 weeks, there are no issues with these invoices and expect them all to be paid in month 5.

The Trust can confirm that invoice that made up part of the Agreement of Balances was paid during month 4 **(Action Point 3.13)**

11. Cash flow (Table G)

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

	Apr £,000	May £,000	Jun £,000	Jul £,000	Aug £,000	Sep £,000	Oct £,000	Nov £,000	Dec £,000	Jan £,000	Feb £,000	Mar £,000	Total £,000
RECEIPTS													
other (specify in narrative)													
CRU Income	16	12	15	13	13	13	13	13	13	13	13	13	160
Other Non NHS Income	329	268	293	135	266	266	266	266	266	266	266	270	3,157
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	0	435	384	0	1,003	400	400	400	400	400	400	400	4,622
Risk Pool Refund	1,519	0	1,020	0	0	0	0	0	0	0	0	0	2,539
Total	1,864	715	1,712	148	1,282	679	679	679	679	679	679	683	10,478

Due to the dates of the CEL being released and the closing of the ledger the revised CEL wasn't incorporated into the month 3 return, the month 4 cashflow includes the most update released CEL figures **(Action Point 3.12)**

12. Public Sector Payment Compliance (Table H)

As per the guidance this had been completed for quarter 1.

13. Capital (Tables I, J and K)

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

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

14. Committee to receive Financial Monitoring Return

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

The month 4 Financial Monitoring Return will be presented to the Trust Board on 25th September 2025.

Governance arrangements for formal sign off of the monitoring return narrative in the absence of the Director of Finance or Chief Executive will be delegated to their Deputies but in exceptional circumstances could be signed by a Senior Finance Manager and an Executive Director. Signatures on this return contain Edward Roberts, Interim Assistant Director of Finance and Rachel Marsh, Interim Chief Executive.

15. Other Issues

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

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

Yours sincerely

Edward Roberts
Interim Assistant Director of Finance

Rachel Marsh
Interim Chief Executive

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

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

Agenda Item No.	06

ASSURANCE REPORT: Phase 2 Ambulance Performance Framework Go Live and 'Wait 45' Initiative

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	16 September 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Lee Brooks (Executive Director of Operations) Estelle Hitchon (Interim Executive Director of Strategy, Planning and Performance)
Author(s) of report	James Houston (Head of Strategy Development) Oliver Watson (Strategy Development 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. The purpose of this paper is to provide Committee with an assurance update regarding the internal arrangements in place to implement and pilot the second phase of changes to the Ambulance Performance Framework.

2. On 1st July 2025, the Trust successfully implemented the Phase 1 changes to the Ambulance Performance Framework for a 12-month pilot period. This involved replacing the previous 'Red' category with a new 'Purple Arrest', 'Red Emergency' and 'RCS0' call categories. This change was undertaken to provide greater emphasis on clinical outcomes over time-based targets, with a bundle of measures related to the 'Chain of Survival'.

3. Upon announcement of the Phase 1 changes described above, the Welsh Government led Ambulance Target Review group reconvened to review the remaining Amber and Green categories.

4. The review found that the broad scope of the current Amber category does not allow for a nuanced response to truly time sensitive incidents, such as patients with symptoms of stroke, STEMI (a type of heart attack) and fractured hips. With increasing handover delays and higher volumes of 'Red' categorised incidents, Amber response times have increased. Furthermore, variation was identified in how ambulance performance is measured across the UK, with England and Scotland making use of a set of 'Clinical Quality Indicators' to measure patient experience and outcomes.

5. Following consideration of the available clinical evidence and evidence relating to what matters most to patients & staff, the review group concluded new categories were required to replace the current Amber and Green categories. These three new response categories are: Orange Now, Yellow Soon and Green Planned, descriptions of which are shown in Table 1.

Table 1: New Phase 2 Ambulance Categories

Category	Descriptor	Types of Complaint
ORANGE NOW	Refers to incidents likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	▪ Stroke ▪ Heart attack
YELLOW SOON	Refers to incidents where further clinical assessment to support clinician decision making (remote or face to face) is required for discharge at scene and/or an alternative pathway, and/or planned transport to a treating facility.	▪ Abdominal pain
GREEN PLANNED	Refers to incidents where there is high potential for the ambulance service to manage the care episode in its entirety or in collaboration with a community service or planned care provider.	▪ Chest infection ▪ Palliative care ▪ Mental health ▪ Urinary tract infection.

6. As seen for the new Purple Arrest and Red Emergency categories in Phase 1, a bundle of out of hospital care measures are being introduced for time-sensitive complaints, including stroke and STEMI. WAST will also report on the median and 90th percentile of response times in line with the Institute of Healthcare Improvement's (IHI) advice for all three new categories. Table 2 below shows the full breakdown of the proposed measures.

Table 2: New Measures for Ambulance Response Categories

Category	Measures
ORANGE NOW	▪ Median and 90th percentile of response of most appropriate resource ▪ Stroke care bundle including call to door median and % arrival at a specialist site. ▪ STEMI care bundle including call to door median and % arrival at specialist site. ▪ Further measures to be developed over time.
YELLOW SOON	▪ Median response of most appropriate resource ▪ 90th percentile. ▪ % by disposition
GREEN PLANNED	▪ Median response of most appropriate resource ▪ 90th percentile. ▪ % by disposition

7. The proposed changes to the Ambulance Performance Framework were accepted by the Cabinet Secretary for Health & Social Care in July. WAST has been requested to implement these changes by 1st December 2025. However, given of the proximity to winter pressures, the Trust is, if possible, seeking to go-live sooner. However, should 1st December not be achievable given a high dependency on the external CAD supplier to develop software changes, we would seek to go-live in February 2026 to maximise operational capacity on reducing patient risk during the busiest operational period.

8. Phase 2 also includes the introduction of new screening codes RCS1-3 alongside RCS0. RCS1-3 will be used as part of the Phase 2 pilot to support prioritisation of calls for screening based on the propensity of the presentation having high risk markers. During the transitional phase, RCS codes will be adapted from the current Amber 1, Amber 2 and Green code sets with further development due as the new model embeds.

9. In preparation to introduce and operationalise Phase 2 of the Ambulance Performance Framework, the Trust has rapidly commenced detailed planning and implementation arrangements. To deliver the changes, a range of key packages of work have been identified and are being progressed at pace, including:

   9.1 Project Management & Delivery: The Task & Finish group established in Phase 1 remains in place to lead all aspects of operational delivery and performance reporting arrangements to successfully embed the changes for Phase 2.

9.2 Quality Impact Assessment (QIA) / Equality Impact Assessment (EqIA): A detailed QIA and EQIA have been developed and are currently being reviewed. Both impact assessments will be available to the Trust Board as part of the assurance paper submission.

9.3 Data Definitions & Performance Reporting: Development of key data definitions for the three new response categories is now complete. These were reviewed by key leads on 14th August 2025 and received support from commissioners prior to submission to the CAD supplier on 18th August 2025. This is in line with project timescales agreed for go-live for 1st December 2025.

9.4 Monitoring & Assurance: In addition to the key performance metrics for the new categories, a key requirement is to ensure that there are robust daily performance and quality reporting arrangements in place to monitor the patient safety and service delivery impacts of when the changes are introduced. Work is currently underway to develop the monitoring and assurance approach which will include both the requirements for quantitative performance and quality data, alongside qualitative patient level experience information.

9.5 Operational Readiness: A significant amount of work is underway to ensure the operational readiness for the changes, including:

- *Technical CAD Development:* Significant technical changes are required to the 999 CAD architecture to reflect the new categories. Urgent engagement has commenced with the external CAD supplier given this is the most significant risk for the success of the project. As a result, an additional layer of senior oversight and a specific process to streamline formal raising of any issues from either party has been introduced. Internal teams have prioritised data definition development to provide these to the supplier in accordance with deadlines set.
- *Operational Procedures:* The same approach taken in Phase 1 to support systematic review and prioritised refresh of all relevant Standard Operating Procedures (SOPs) will be applied. Plans are in place to undertake this work, supported by a streamlined approval process where changes are made consistent with the category changes.
- *Staff Familiarisation & Training*: A staff Familiarisation and Training plan will be created and delivered as seen Phase 1 to ensure that all staff directly affected fully understand the changes and the impact on their day-to-day role.

9.6 Communications: Following positive feedback from the approach taken in Phase 1, the communications approach taken previously will be largely replicated for Phase 2. Key materials are now being reviewed and updated, again following a hybrid approach using different communication tools and collateral to maximise reach.

9.7 Finance: There are currently no known direct financial implications for the Trust to enable the changes to be successfully implemented. Whilst not a dependency for Phase 2 of the performance framework, to fully realise the benefits of our integrated clinical services model, an options appraisal has identified a preferred option to have a combined remote assessment queue across both of our CAD systems. This has received support from CMT Programme Board and is due to be considered at Capital Management Board for final approval.

9.8 Risks: There are two high level risks with a risk score of 16 or over that have been identified. These relate to the ability of an external supplier to deliver the technical CAD changes and to the potential time constraints of establishing internal reporting. Both risks are being closely monitored and proactively managed.

9.9 Evaluation: Implementation of Phase 2 changes will be independently evaluated as part of the broader comprehensive evaluation approach for the entire Clinical Model Transformation programme. The Trust is nearing completion of the procurement process to confirm the preferred external evaluation partner.

10. *Next Steps:* Following consideration by the committee, the assurance report and copies of the QIA and EQIA (subject to separate governance processes) will be submitted to an extraordinary Trust Board meeting being arranged for Mid-October for assurance and endorsement to proceed with implementation of the phase 2 changes. Following completion of the Phase 1 and 2 pilots, the findings of the independent external evaluation will inform the next steps. If the new Ambulance Performance Framework is adopted permanently, consideration should be given to undertaking a further Demand & Capacity review given these changes, the wider changes being delivered by the Clinical Model Transformation programme and potential implications of the Wait-45 initiative.

11. *Wait-45 Initiative:* A national handover taskforce has been established to oversee the recommendation from an independent Ministerial Advisory Group that no ambulance handover should exceed 45 minutes. A series of workshops are taking place in Q2 with WAST attendance for accelerated design and planning.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

1. **Note** that the QIA and EQIA are being developed, and each shall be subject to the appropriate quality governance mechanisms, and both shall accompany this paper at the time of final approval being sought from the Trust Board. The committee is asked to note that it may be necessary to make minor adjustments to this paper ahead of its final submission to Trust Board following the internal review process. It is requested that the committee allow for minor changes to this assurance paper prior to submission to Trust Board, providing any change does not materially alter the direction or outcomes.
2. **Endorse** onward submission to Trust Board, confirming that the Committee is **assured** that the organisational preparedness meets with the appropriate requirements to implement the changes safely and effectively.
3. **Endorse** that the Ambulance Performance Framework (phase 2) proceed to implementation, with oversight of implementation be provided by the Clinical Model Transformation Board.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
Appendix 1 – Phase 1 Ambulance Performance Framework Trust Board Paper
Appendix 2 – Letter from Welsh Government – 14/07/2025
Appendix 3 – WAST Response to Letter from Welsh Government
Appendix 4 – New Ambulance Performance Framework Explainer Document

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 Risks (BAF) 223 & 224

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	This change requires the completion of a Quality Impact Assessment (QIA) and Equality Impact Assessment (EQIA). Both impact assessments are being taken through the respective governance and approvals routes and will be available for inclusion in the assurance paper being presented to Trust Board.

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
26/08/2025	Call Flow Categorisation Group
08/09/2025	Clinical Model Transformation Programme Board
16/09/2025	Finance and Performance Committee
22/09/2025	Strategic Transformation Board
October (date tbc)	Extraordinary Trust Board (being arranged for Mid-Oct)

SITUATION

1. The purpose of this paper is to provide Committee with an assurance update regarding the internal arrangements to implement and pilot the second phase of changes to the Ambulance Performance Framework, in addition to providing an update on the Wait-45 initiative.

BACKGROUND

2. On the 1st July, the Trust successfully implemented the Welsh Government endorsed Phase 1 changes to the Ambulance Performance Framework for a 12-month pilot period and subsequent evaluation. These changes included the introduction of a Purple Arrest, Red Emergency and RCS0 call categories, replacing the previous 'Red' call category. Further information is provided in the WAST Trust Board Phase 1 Assurance Paper (see Appendix 1).

3. Initial data on the first phase of changes to the Ambulance Performance Framework was released on the 21st August. For patients in cardiac arrest for whom resuscitation was attempted, 21.4% had a return of spontaneous circulation

(ROSC) at the time of arrival to hospital. There was a total of 814 calls categorised as Purple Arrest (2.3% of all calls) and 4,449 calls categorised as Red Emergency (12.6% of all calls). The median response times for Purple Arrest and Red Emergency calls were 7 minutes and 35 seconds, and 8 minutes and 47 seconds respectively.

4. Upon announcement of the Phase 1 changes, the Welsh Government led Ambulance Target Review group reconvened to review the remaining Amber and Green categories to ensure that they are fit for purpose and support improved clinical outcomes and patient experience.

5. Details of the current Amber and Green categories are shown in Table 3. There are no formal time standards/targets set by Welsh Government for these categories. Welsh Government currently publish the combined call volume and combined median response times for Amber 1 and 2 calls.

6. The Amber 1 & 2 call categories are the largest category by volume and account for circa 70% of all 999 reported incidents. The volume and broad scope of 'complaints' included in the Amber category can lead to challenges responding to these calls, with patients often experiencing long delays for an ambulance response.

Table 3: *Current Amber and Green categories*

Category	Descriptor	Types of Complaint	Response Standard
Amber 1 & 2	Serious but not immediately life-threatening incidents	Most medical and trauma cases including: ▪ Chest pain ▪ Fractures ▪ Most types of stroke	▪ No current time standards/targets.
Green	Neither serious nor life-threatening.	▪ Minor injuries. ▪ Generally unwell. ▪ Earache	▪ No current time standards/targets.

ASSESSMENT

National Ambulance Target Review Task Group

7. The National Target Review Task Group was re-established to lead the Phase 2 review of the Amber and Green Categories with the responsibility of putting forward recommendations to the Cabinet Secretary for Health & Social Care on the future Ambulance Performance framework for these categories.

8. The Task Group, led by Welsh Government included a broad mix of senior experts including policy leads, statisticians, ambulance commissioners and operational / clinical leaders with ambulance and pre-hospital emergency care experience. The Trust was represented by senior executive directors including Rachel Marsh, Andy Swinburn, Liam Williams and Lee Brooks.

9. This second phase of the review process considered the available evidence from across the UK and internationally to inform the proposed changes for the Amber and Green categories. The high-level findings of the review were as follows:

- The current Amber category accounts for the majority of total 999 calls (around 70%). Whilst the number of incidents categorised as Amber has remained fairly stable, a higher volume of 'Red' incidents and increasing handover delays have reduced resource availability. This has increased Amber response times.
- The broad scope of the current Amber category does not allow for a nuanced response to incidents that are truly time sensitive, such as patients with symptoms of stroke, STEMI (heart attack) or fractured hips.
- Ambulance response time performance is measured and reported differently across the UK and internationally. All other UK nations (excluding Wales) use an outcomes-driven approach to ambulance performance frameworks. In England and Scotland, a set of 'Clinical Quality Indicators' measure patients' experience and outcomes.
- WAST indicates an average time of 2.5 hours for stroke responses from a 999 call being received to a response arriving on scene, which is the highest of all UK nations.
- Response times for STEMI patients are also higher in Wales than in other UK nations, with the Welsh Cardiovascular Society identifying avoidable harm as a result of increased times for response and treatment.

New Ambulance Performance Framework (Phase 2)

10. Following careful consideration, the task review group concluded that changes to the Amber and Green categories were required and proposed three new response categories, for patients requiring a face-to-face response including new 'Orange Now', 'Yellow Soon' and 'Green Planned' categories.

11. The Orange Now category is for time-sensitive incidents that are likely to need diagnostics and transport to hospital or specialist care (e.g. stroke). The aim is for rapid arrival at a specialist or emergency care facility as soon as possible. As such, it is anticipated that dispatch would occur within 1 hour of an incident being categorised as Orange Now.

12. The Yellow Soon category will include cases where attendance at scene is required for further clinical assessment which could support remote clinical decision making to an alternative care pathway, and/or discharge at scene, and/or planned transport to a treating facility (e.g. a patient with abdominal pain). This category seeks to prevent unnecessary escalation of care through a view of supporting patients to remain in the community.

13. The Green Planned category will include those cases which have a high potential for the ambulance service to manage the care episode in its entirety or in collaboration with a community service or planned care provider e.g. chest infection, palliative care, mental health or UTI. This category aims to ensure the right resource attends for the need of the patient in a planned way. This may include managing the incident for a period of time within the system whilst awaiting the ideal clinical response to become available.

Table 4: Phase 2 New Ambulance Categories

Category	Descriptor	Types of Complaint
ORANGE NOW	Refers to incidents where patients are likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	▪ Stroke ▪ Heart attack
YELLOW SOON	Refers to incidents where further clinical assessment to support clinician decision making (remote or face to face) is required for discharge at scene and/or an alternative pathway, and/or planned transport to a treating facility.	▪ Abdominal pain ▪ Lower leg fracture.
GREEN PLANNED	Refers to incidents where there is high potential for the ambulance service to manage the care episode in its entirety or in collaboration with a community service or planned care provider.	▪ Chest infection ▪ Palliative care ▪ Urinary tract infection

Orange Now Category Measures

14. As seen in Phase 1 of the ambulance target review group's recommendations, it was agreed that there should be more emphasis on measuring patient outcomes rather than solely on median response times for incidents.

15. The first phase found that response time targets alone do not provide the right focus on truly improving patient care. For instance, prioritising rapid response vehicles for stroke victims to meet the target, despite these vehicles being unable to transport patients for treatment, could cause delays and impact outcomes. As a result, the Orange Now category includes a bundle of out-of-hospital care measures for time-sensitive complaints (see Table 5 for a full breakdown).

16. Transitioning to the publication of call-to-door times and eventually to call-to-treatment times for conditions such as stroke and STEMI will enhance transparency on the entire system's focus on outcomes, aligning with health and care quality standards.

17. Although there will be no time-based target initially, this will be reviewed after 12 months to consider if such a target would add value. This pilot approach will be supported by a thorough evaluation to determine if time-based targets would contribute to improved outcomes and experience.

18. In line with advice from the Institute of Healthcare Improvement (IHI), WAST will report on the median and 90th percentile of response for all categories. This is a change from the current position whereby statistics published by Welsh Government only include a combined median response time for Amber 1 and 2 calls.

Table 5: Orange Now measures

Category	Measures
ORANGE NOW	▪ Median and 90th percentile of response of most appropriate resource ▪ Stroke care bundle including call to door median and % arrival at a specialist site. ▪ STEMI care bundle including call to door median and % arrival at specialist site. ▪ Further measures to be developed over time.

Yellow Soon Category Measures

19. For the Yellow Soon category, it is recognised that a prompt response is required to minimise pain/discomfort and prevent deterioration. A response will also assist with gathering further information to inform appropriate care planning. Therefore, it is anticipated that dispatch of a resource would occur within four hours of a call being categorised as a Yellow Soon incident.

20. As with current Amber and Green categories, there will not be set response time targets for the Yellow Soon or Green Planned categories. WAST will report on the following measures for the Yellow Soon category:

Table 6: Yellow (Soon) measures

Category	Measures
YELLOW SOON	▪ Median response of most appropriate resource ▪ 90th percentile.

	▪ % by disposition

Green Planned Category Measures

21. The aim of the Green Planned category is to ensure patients receive the right response based on clinical need which could be for a see and treat/refer pathway or conveyance to a definitive care centre away from the Emergency Department (e.g. Minor Injury Unit). Responses will be in a timeframe that is most appropriate for the nature of the planned response and may exceed four hours (e.g. for 6 hours overnight whilst waiting for an Advanced Paramedic Practitioner to be available to respond). The planned nature of this category will also allow for multiple contacts as appropriate to support the safe delivery of care. This may be via the Remote Integrated Care Service to remotely monitor the patient condition, supported by our volunteer network providing face to face contact and/or undertaking observations to inform decision making.

22. WAST will report on the following measures for the Green Planned category:

Table 7: Green (Planned) measures

Category	Measures
GREEN PLANNED	▪ Median response of most appropriate resource ▪ 90th percentile. ▪ % by disposition

Welsh Government Approval

23. The proposed changes were approved by the Cabinet Secretary for Health & Social Care. The Trust received formal correspondence of this by letter from Welsh Government on 14th July 2025 (Appendix 2).

24. The Cabinet Secretary's letter requested that the Trust implement the changes by the 1st December 2025. Feasibility of the proposed implementation date has been considered by the executive team and key leads who have noted the potential challenges and risks associated with making the changes in close proximity of winter pressures and during our busiest months of the year. The Trust recognises the additional challenge this could pose, and as such will seek to go live sooner than 1st December, if possible. This carries a high dependence on the external supplier to make the technical changes required to the CAD system. Should the original deadline not be achievable, we would seek to go live in February 2026 to avoid additional strain on operational capacity during the busiest period. This option has been presented to the Cabinet Secretary for consideration, and the Trust is awaiting a formal decision (Appendix 3).

25. We are awaiting further guidance from Welsh Government and NHS Wales Joint Commissioning Committee on the length of the pilot of the second phase of changes to the performance framework and how this may link to the first phase.

Internal Screening Categorisation Codes

26. Our Integrated Clinical Services Model adopts a 'screen first' approach for all calls, except for those categorised as Purple Arrest or Red Emergency (i.e. patients in or at high risk of cardiac or respiratory arrest).

27. Phase 1 of the Ambulance Performance Framework introduced a new RCS0 code to prioritise incidents from the previous Red category that were deemed suitable for Rapid Clinical Screening.

28. Phase 2 will see the introduction of new screening codes RCS1-3 alongside RCS0. RCS1-3 will be used as part of the Phase 2 pilot to support Clinical Navigators in prioritising calls for screening based on the likelihood of the presentation (propensity) having high-risk clinical markers. Table 8 lists the new RCS categories.

Table 8: New Rapid Clinical Screening Codes

Category	Descriptor	Measures
RCS1	High propensity for high-risk markers	▪ Median time to clinical screening. ▪ Median time to clinical consultation. ▪ % outcome
RCS2	Medium propensity for high-risk markers	
RCS3	No/low propensity for high-risk makers.	

29. The new RCS codes will also be used for prioritisation of remote assessment internally to promote uniformity in categorisation across the service. This has been agreed at the Clinical Prioritisation Assessment Software (CPAS) group. For external reporting of 111 activity, cases categorised internally as RCS1 will continue to be reported externally as P1. This also applies to RCS2/P2 and RCS3/P3.

30. During the transitional phase of the model, the RCS codes will be adapted from the current Amber 1, Amber 2 and Green code sets. This will form an initial approach for delivery of the new screening codes. There will be further continuous review and development based upon an evidence-based quality improvement approach that will respond to findings as the new model embeds.

Wider Internal Categorisation Changes: Time-Purpose-Skill

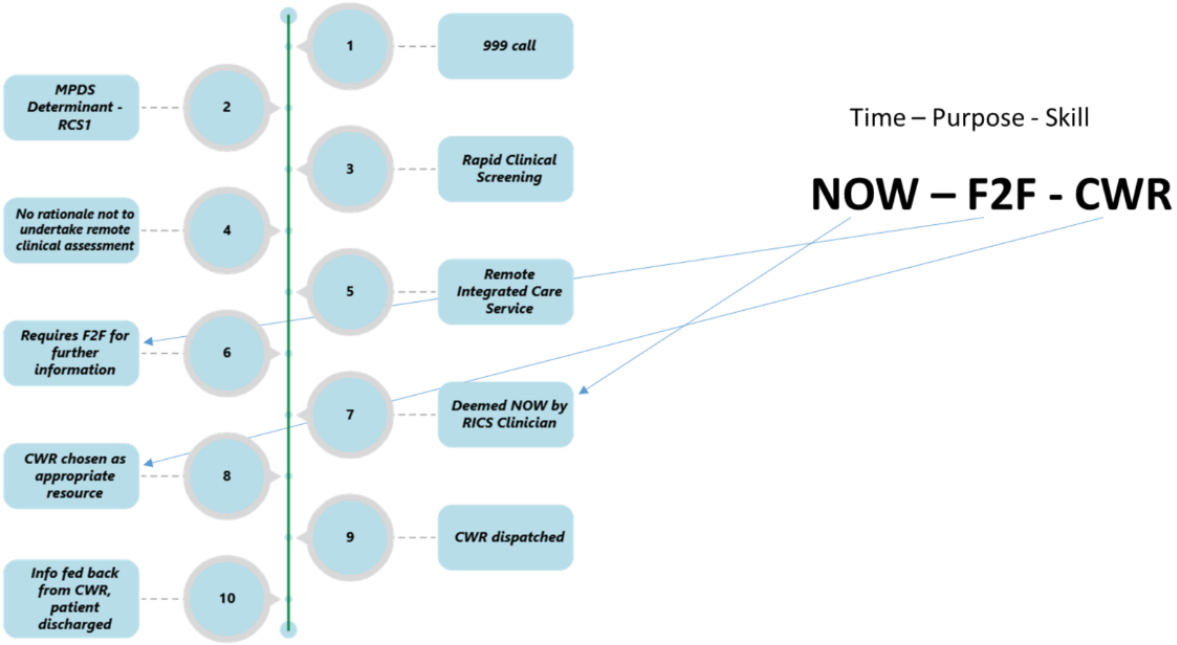
31. Categories from both Phase 1 and Phase 2 form part of our broader changes towards a more integrated clinical services model. The five new categories address the important 'Time' element for colleagues to identify urgency and priority.

32. However, the 'Purpose' of a response is also key to providing the most effective and appropriate resource. The 'Purpose' of a response will be based on the anticipated outcome, either for 'Face-to-Face' (F2F) assessment or to 'Convey'. This will assist Resource Coordinators in identifying the most suitable resources based upon the need for attendance.

33. The third aspect of 'Skill' provides the Resource Coordinator with an indication of the most appropriate skillset a patient would require, guiding the most optimal resource choice. This could provide a range of resource options or identify the need for specialist clinicians (e.g. APP or Mental Health Practitioner). Overall, this promotes effective resource utilisation and supports patient care remaining in the community.

34. Time-Purpose-Skill classification will be undertaken by the Clinical Navigator reviewing the incident or by the Integrated Care Clinician in RICS passing the incident to the dispatch queue.

35. The figure below demonstrates how Time-Purpose-Skill is applied in practice.



36. This concept will continue to develop and be subsequently formally implemented as we further transform our services towards a more integrated clinical services model. We wait to understand how this can be integrated into the CAD system by our supplier.

WAST Preparedness

37. This section of the paper provides a progress update across the preparatory work underway to implement and embed the Phase 2 changes.

38. Overall, the planning and project delivery areas are progressing well and are on track for the proposed go-live date of the 1st December. All key work streams have been identified, and plans are either in place or being developed, with actions being assigned to key leads.

39. As with Phase 1, there remains a high dependency on the external CAD system supplier (MIS) to deliver the technical system changes in readiness for go-live (this is further explored in the Technical Development section).

Project Management & Delivery

40. The Task & Finish group (T&F Group) project delivery arrangements for Phase 1 remain in place and are taking forward the responsibility of leading the detailed planning, implementation and delivery of Phase 2.

41. The Executive Sponsor for the group remains in place for Phase 2 with Lee Brooks (Executive Director of Operations) continuing in this role. There is however a change to the Senior Responsible Owner (SRO) with Ceri Griffiths (Deputy Director of Remote Clinical Care) stepping into this role. We would like to put on record our thanks to the Phase 1 SRO Gregory Lloyd for his outstanding leadership during the implementation of Phase 1 and to all colleagues who were involved in delivering the changes.

42. The T&F group continues to include a broad range of internal WAST leads covering the breadth of expertise required for this work along with external representatives from the Commissioning team. The T&F group continues to meet weekly with the full suite of project management processes and support in place. In line with best practice project governance, the Terms of Reference have been reviewed and updated to reflect the required changes for Phase 2.

Governance Process

43. The Call Categorisation T&F group continues to report to the Emergency Response work stream as part of the broader Clinical Model Transformation (CMT) programme structure.

44. To ensure robust internal governance arrangements, all of the key outputs from the work stream that require formal review & approval will be submitted to the following groups, Call Categorisation T&F group, Clinical and Quality Governance Group (CQGG), Clinical Priority Assessment Group (CPAS) for incident categorisation changes and Clinical Model Transformation (CMT) Programme Board. Key risks and issues that may impact the successful delivery of the work will be escalated by the Executive Sponsor / SRO through the formal CMT Programme channels.

45. To ensure that that the Joint Commissioning Committee (JCC) is robustly sighted and assured on the planned changes, it has been agreed that the assurance paper will be shared with the Director of Commissioning for Ambulance Services and 111 following Trust Board to inform the JCC Board.

46. In the Cabinet Secretary's letter, the Trust was required to respond to the implementation timescales by the 31st July and confirm the conclusion of the development of the data definitions by the 30th September. The Trust completed the data definitions and submitted these to the system supplier and commissioners by 18th August 2025. There is no formal requirement to submit the monitoring and assurance plan for Phase 2, despite this being a requirement for Phase 1. For transparency the Trust has offered to share this information with Welsh Government if requested.

Impact Assessment

47. A comprehensive Quality Impact Assessment (QIA) is being undertaken on the Phase 2 changes. This assessment has been conducted in collaboration with key work stream leads. The QIA has been reviewed and endorsed by the T&F group and will be reviewed by the Clinical Advisory Group (CAG) on the 16th Sept and then CQGG on 22nd September. The QIA will be submitted to an extraordinary Trust Board with the assurance report for Phase 2 in October.

48. As part of the Trust's commitment to embedding Equality, Diversity and Inclusion (EDI) across its transformation agenda, an Equality Impact Assessment (EQIA) has been developed for the Emergency Response work stream. This has been conducted with support from organisational EQIA experts and key leads from the work stream. The EQIA will include and give full consideration to the impact of the phase 2 changes along with the wider pieces of work being led by the group.

The EQIA has been reviewed by the T&F group and SRO and will be submitted to CAG for endorsement. A copy of the EQIA will be available for submission with the assurance report to extraordinary Trust Board as outlined above.

Technical CAD System Development & Data Definitions

49. Significant technical changes are required to the 999 CAD architecture to reflect the new categories. Urgent engagement has commenced with the external CAD supplier (MIS) who have confirmed the allocation of dedicated developer capacity to undertake the technical changes to the CAD.

50. The technical CAD changes are the most critical and highest risk factor to the success of the project. To effectively mitigate this risk an additional layer of senior oversight has been built into the supplier relationship arrangements to ensure a 'tight' grip and increased expediency of issue resolution. These arrangements include weekly meetings between WAST project leads and technical supplier experts and a fortnightly executive level meeting. A revised process to raise 'issues' has also been put into place which will flow direct to a senior MIS manager and formally logged.

51. Technical changes are also required to the CAD in Integrated Care to reflect the internal change of categorisation from P1/2/3 to RCS 1/2/3. These changes are to be made by our CAD administration teams internally and are not dependent on the system supplier. Enacting this change has been factored into readiness plans.

52. The detailed data definitions for the new Orange Now, Yellow Soon and Green Planned categories have been produced and were reviewed by key leads on the 14th August 2025. These were submitted to commissioners on the same day who provided support, allowing for submission to our CAD system supplier on 18th August 2025. This is in accordance with the agreed project timescales between WAST and MIS for go-live by 1st December 2025. The data definitions received retrospective approval from the Call Categorisation Group on 19th August 2025 and will be received by the CMT Programme Board on 8th September 2025.

53. The Information and Data Services (IDS) team have continued to prioritise this work and the development of the performance reporting processes. The team has been organised into two sub-team. The first team are continuing to concentrate on the completion of the remaining actions for Phase 1 which is on track and no reported issues), and the second team are working on the Phase 2 changes.

Monitoring & Assurance

54. A key requirement in readiness for go-live is to ensure that there are robust daily performance and quality reporting arrangements in place to monitor the patient safety and service delivery impacts of the changes. An overview of the monitoring and assurance arrangements will be shared with Welsh Government for information.

55. Work is currently underway to develop the monitoring and assurance approach which will include both the requirements for quantitative performance and quality data alongside qualitative patient level experience information. This will include detailed operational level reporting and performance information (e.g., Splash reports). This work has also been prioritised by the IDS team to ensure that there is full accessibility to the right performance data to ensure the changes and impacts can be effectively and proactively monitored.

56. Fortnightly quality and safety assurance meetings will be held with the JCC and WAST from the outset of delivery of phase two to track progress against all new measures, including those not captured within the performance framework. These arrangements will be scaled back accordingly as confidence is established. Future monitoring will be led by the JCC.

Operational Readiness

57. Considerable work is also required, aligned to the changes undertaken as part of the Phase 1 implementation plan to ensure operational teams are well prepared and ready for go-live. This includes a review of key operational procedures, process familiarisation and training for all staff directly impacted by the changes.

58. *Explainer Document:* A detailed explainer document has been developed outlining the objectives, developments, and anticipated outcomes of Phase 2, as WAST continues its drive for improved emergency response and clinical effectiveness (Appendix 4).

59. *Operational Procedures:* The same approach adopted during Phase 1 to support the systematic review and refresh of all of the operational Standard Operating Procedures (SOPs) will be applied for Phase 2. This work has already commenced with operational colleagues. Plans are in place to undertake this work at pace over the coming months and SOPs will be reviewed in priority order, supported by a streamlined review and approval process.

60. *Staff Familiarisation & Training*: A similar approach to that taken in Phase 1 will be repeated for Phase 2 to develop the staff familiarisation and training plan. Once data definition development has been completed, a full training need analysis for specific roles, creation of materials, and subsequent delivery of training will be planned & undertaken. This will ensure all operational teams fully understand the changes and the impact on their day-to-day role.

Communications (Internal & External)

61. The changes outlined for Phase 2 will require effective communication across a broad range of internal and external stakeholders to ensure they are appropriately informed and understand the changes to the Ambulance Performance Framework.

62. Following the completion of the Phase 1 changes, the Trust received positive feedback from a small sample of stakeholders regarding the communication materials. This feedback has helpfully informed the decision to largely replicate the approach for the Phase 2 communication plan.

63. Work has commenced to refresh the internal and external communications plans which will continue to be managed and delivered by the P&E work stream with key materials being reviewed by the Call Categorisation T&F Group and signed off by the CMT Programme Board.

64. The communication plans will adopt a hybrid communications approach and will include a range of tailored communication materials including FAQs, letters, briefing packs, videos and social media content to maximise its reach and describe the changes in an easy and understandable way. All public facing information will be created bi-lingually and will be available on the website.

65. It is understood that Welsh Government will maintain the position that WAST holds the delegated responsibility to manage the communications approach in line with the position for Phase 1. Key materials will be shared with Welsh Government for sighting and comment to ensure policy alignment with the key messaging prior to formal release.

Evaluation

66. Implementation of the phase 2 changes will be independently evaluated as part of the broader evaluation approach for the entirety of the Clinical Model Transformation programme. The evaluation will include an assessment of the

patient, service and system impacts considering a broad range of qualitative and quantitative data.

67. The Trust is nearing the completion of the procurement processes to confirm the preferred external partner. Work will then commence to finalise the evaluation work portfolio and key evaluation priorities.

Finance

68. There are currently no known direct financial implications for the Trust to enable the Phase 2 changes to be successfully implemented. The technical system changes on the CAD, as with Phase 1, are covered within the development arrangements with the supplier (MIS) with no additional costs as the changes are policy and Welsh Government led.

69. Whilst this is not a dependency for the implementation of Phase 2, it is important to note that there has been additional investment approved by the Executive Finance Group (EFG) to increase the Band 6 Integrated Care Clinical workforce by up to 12FTEs from November, which is expected to return to establishment by the new financial year.

70. Whilst not a dependency for Phase 2, as part of broader changes for the integrated clinical services model, an £138k capital and £42k recurrent revenue cost is required to adopt a combined remote assessment queue across both CAD systems. An options appraisal identified this as the preferred option to provide the safest and most consistent care for all patients and improves internal efficiencies. Identification of this as the preferred option has been supported at CMT Programme Board and is due for consideration at Capital Management Board on 12th September for financial approval.

Risks

71. The changes to the Ambulance Performance Framework will form part of the broad suite of mitigating actions against corporate risks 223 (The Trust's inability to reach patients in the community causing patient harm and death) and 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).

72. As part of the project arrangements, the T&F group regularly review and assess the associated risks. There are two high level risks with a risk score of 16 or over. One is related to the ability of an external supplier to deliver the technical CAD changes described in the system developments section (see paragraph 50).

73. The other risk relates to potential time constraints of establishing internal reporting for these changes. This work is being prioritised by the Insights and Data team with a timeline to be produced that ensures those reports required prior to go-live will be available.

Table 9: Project Risk Log (High Level Risk only)

Phase 2 - Failure to deliver due to capacity and understanding of the third party supplier (MIS)	IF the third party supplier (MIS) does not have the capacity or understanding to undertake the CAD development in the required timeframe	THEN the trust will not be able to deliver the required changes for the 1st December	Resulting in: 1 - Reputational damage	Project or Progr...	4	4	16
Delay of Internal Reporting	IF there is not sufficient time for the creation of internal reporting for the go-live of the phase 2 call categories changes	THEN there will be limited assurance available on the changes to patient flow	Resulting in: 1 - Inability to provide consistent data on the safety and patient experience of the new call flows	People or Huma...	4	4	16

Wait 45 Initiative

74. In October 2024, the Cabinet Secretary for Health and Social Care announced appointment of an external independent Ministerial Advisory Group (MAG) on Performance and Productivity in NHS Wales. The MAG published a series of recommendations in April 2025, one of which was to adopt a maximum ambulance handover time of 45 minutes by October 2025. This recommendation was partially accepted by Welsh Government, noting the need to explore feasibility of the timescale proposed.

75. In response, the NHS Wales Leadership Board launched a national handover taskforce to oversee delivery of the programme of work that will take a clinical collaborative approach to handover improvement. Liam Williams (Executive Director of Quality and Nursing) and Andy Swinburn (Executive Director of Paramedicine) represent WAST as members of this group.

76. Each health board will host an accelerated design workshop in Q2 to support development of plans to achieve the 45-minute maximum ambulance handover time expectation. Arrangements have been made for operational, clinical and planning leads from WAST to attend each of these workshops.

RECOMMENDATION

Committee is asked to: -

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

78. **Endorse** onward submission to Trust Board, confirming that the Committee is **assured** that the organisational preparedness meets with the appropriate requirements to implement the changes safely and effectively.

79. **Endorse** that the Ambulance Performance Framework (phase 2) proceed to implementation, with oversight of implementation be provided by the Clinical Model Transformation Board.

NEXT STEPS

80. Following consideration by the committee, the assurance report and copies of the QIA and EQIA will be submitted to an extraordinary Trust Board meeting being arranged for Mid-October for assurance and approval to proceed with implementation of the phase 2 changes.

81. Following completion of the phase 1 & 2 pilots, the findings of the independent external evaluation will inform the next steps and subsequent actions that may be required to permanently adopt the changes.

82. If the outcome of the evaluation determines that the new Ambulance Performance Framework should be implemented on a permanent basis consideration should be given to undertaking a further Demand & Capacity review. This would be a prudent approach considering the significant changes to the Ambulance Performance Framework, wider changes being delivered by the Clinical Model Transformation Programme and the potential system and operational implications following the implementation of the Wait 45 initiative. Undertaking this work would be consistent and in-line with the Trust's approach of undertaking regular strategic modelling of demand and capacity requirements.

AGENDA ITEM No	
CLOSED	
No of ANNEXES ATTACHED	2

New Ambulance Performance Framework

MEETING	Extraordinary Trust Board
DATE	7th May 2025
EXECUTIVE	Rachel Marsh Executive Director of Strategy, Planning & Performance
AUTHOR	James Houston Head of Strategy Development
CONTACT	Rachel.Marsh3@wales.nhs.uk James.houston@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide the Trust Board with an update and assurance regarding the internal arrangements to pilot changes to the Ambulance Performance Framework from the 1st July 2025, following the announcement by the Cabinet Secretary for Health and Social Care Services in March (see appendix 1).

The 8-minute ambulance response target has been in place in Wales since its introduction in 1974. Across the UK and internationally there is significant variation in how ambulance services are currently measured, whilst maintaining the traditional time-based response target.

Following discussion by the Health & Social Care Committee, it was recommended that a review was undertaken regarding the 'appropriateness' of the current 8-minute target. In response, Welsh Government convened an Ambulance Target Review group to consider the available evidence and put forward proposals for future ambulance targets.

The review found that there is a lack of clinical evidence to support the link between the '8-minute' target and clinical outcomes. There was, however, clear evidence linking improved clinical outcomes and the 'Cardiac Chain of Survival.'

The review group agreed that a more balanced approach is required, aligned to the 'Chain of Survival,' with a greater focus on clinical outcome and quality measures, rather than just a 'time based' response target.

A range of options were considered, and the preferred option put forward a proposal to split the current Red category into separate categories (1) Purple Arrest and (2) Red Emergency. By segmenting the categories, it allows bespoke condition-specific clinical outcome measures to be developed, supporting the shift away from the emphasis on response targets.

Table 1: New Ambulance Categories & Measures

Category	Descriptor	Types of Complaint
PURPLE ARREST	**ARREST:** Refers to incidents where a person is in cardiac or respiratory arrest.	▪ Cardiac arrest ▪ Respiratory arrest
RED EMERGENCY	**EMERGENCY:** Refers to incidents where a person is at risk of cardiac or respiratory arrest.	▪ Choking ▪ Major trauma

Category	Measures
PURPLE ARREST	**Purple: cardiac arrest 'bundle' of measures** ▪ % of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return Of Spontaneous Circulation) ▪ Time of call handler to commence CPR instructions ▪ Time to defibrillator at scene /patient side ▪ Median response time target range of 6-8 minutes ▪ 90% receive an ambulance response within 20 mins
RED EMERGENCY	▪ Clinical performance indicators (to be developed) ▪ Median ambulance response time target range of 6-8 minutes ▪ 90% receive an ambulance response within 20 mins

The proposed changes to the Ambulance Framework were accepted by the Cabinet Secretary for Health & Social Care in March. It was agreed that the changes would be tested for a 12-month pilot period commencing on the 1st July 2025. A decision regarding the permanent introduction of the changes will be subject to the findings of a detailed evaluation.

In preparation to introduce and operationalise the new Ambulance Performance Framework the Trust has rapidly commenced detailed planning and implementation arrangements. The implementation arrangements are progressing well and on-track in readiness for the changes to go-live on the 1st July.

To deliver the changes, a range of key packages of work have been identified and are being progressed at pace, including:

Project Management & Delivery: a Task & Finish group has been established to lead all aspects of operational delivery and performance reporting arrangements to successfully embed the changes.

Quality Impact Assessment (QIA) / Equality Impact Assessment (EqIA): a detailed Quality Impact Assessment has been undertaken on the changes to the ambulance performance framework. The QIA is currently being finalised in readiness for submission to CQGG on the 12th May. A CMT programme wide EqIA has been drafted and is currently in the review stage in readiness for submission to the CMT Programme Board on the 6th May.

Data Definitions & Performance Reporting: Strong progress has been made to review and develop all the technical data definitions that make up the new categories. The development of the data definitions is a key dependency to build the data reporting systems to ensure effective reporting systems are in place for the new measures. This critical work has been prioritised by the

Information and Data Services (IDS) team who will be leading the development of the performance reporting processes.

Monitoring & Assurance: In addition to the key performance metrics for the new categories, a key requirement is to ensure that there are robust daily performance and quality reporting arrangements in place to monitor the patient safety and service delivery impacts of when the changes are introduced. Work is currently underway to develop the monitoring and assurance approach which will include both the requirements for quantitative performance and quality data alongside qualitative patient level experience information.

Operational Readiness: A significant amount of work is underway to ensure the operational readiness for the changes, including:

- *Technical CAD Development*: Significant technical changes are required to the 999 CAD architecture to reflect the new categories. Early engagement has commenced with the external CAD supplier and work is continuing at pace to finalise the technical specification. Given the importance and complexity of this area of work, and the reliance on an external supplier, this element of the preparatory work has been flagged as a potential risk to the overall delivery of the changes. All mitigatory actions are in place and the Trust will maintain close and regular dialogue with the supplier to monitor and oversee delivery of this work.
- *Operational Procedures:* A full review of the Operational Standard Operating Procedures (SOPs) has been undertaken with over 30 SOPs requiring revision. Work is underway to work through the changes to the SOPs in priority order which will be supported by a streamlined approval process where changes are made consistent with the category changes.
- *Staff Familiarisation & Training*: A staff Familiarisation and Training plan is being developed to ensure that all staff directly affected by the changes fully understand the changes, the impact on their day-to-day role and that they receive any required training.

Communications: Detailed communications plans are in development setting out how the Trust will effectively communicate the changes with both internal staff and volunteers, and also externally with the public, wider stakeholders and partner organisations. The plans adopt a hybrid approach using different communication approaches, tools and collateral to maximise its reach.

Finance: There are currently no known financial implications for the Trust to enable the changes to be successfully implemented.

Risks: There is one high level risk with a risk score of 16 or over that has been identified. This is related to the ability of an external supplier to deliver the technical CAD changes described in the operational readiness section. This risk is being proactively managed by the Trust with close monitoring and regular dialogue to track progress and foresee any potential issues.

Evaluation: As part of the wider changes to the Integrated Clinical Services Model, the Trust along with Commissioners are working jointly to procure an

independent external partner to undertake a detailed and comprehensive evaluation. A key aspect of the evaluation process will focus upon evaluating the impact of the changes to the ambulance performance framework following the introduction of the Purple Arrest and Red Emergency categories.

Next Steps: Following completion of the initial Welsh Government led review of the current 'Red' performance target, the Ambulance Target Review group has been reconvened to undertake a second phase of the review, to consider the performance framework for the remaining Amber and Green categories. This review work has commenced and is projected to conclude in two months. The findings will be presented to the Cabinet Secretary for Health and Social Care for consideration and approval.

Recommendations

Trust Board is asked to: -

1. **Note** the requirement for the Trust to alter its model of service delivery and reporting to meet Welsh Government instructions.
2. Confirm that the Board is **assured** that the organisational preparedness meets with the appropriate requirements to implement the changes safely and effectively.

REPORT APPROVAL ROUTE
Executive Director review Clinical Transformation Programme Board (CMT) (7th May 2025)

REPORT APPENDICES
Attachment 1: Cabinet Secretary for Health & Social Care 'New Emergency Ambulance Performance Framework' letter
Attachment 2a & 2b: Trust Board Briefing Paper: Proposals to 'evolve' the Clinical Services Model & SBAR

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

SITUATION

3. The purpose of this paper is to provide the Trust Board with an update and assurance regarding the internal arrangements to pilot changes to the Ambulance Performance Framework from the 1st July 2025, following the announcement by the Cabinet Secretary for Health and Social Care Services in March (see appendix 1).

BACKGROUND

999 Ambulance Targets (Red)

4. In 1974 the 8-minute ambulance response target was introduced by ORCON (Operational Research Consultancy) as a standard for monitoring ambulance service performance across the United Kingdom and subsequently adopted by a number of countries internationally.

5. The 8-minute ambulance response target is for the highest acuity 'Red' 999 calls encompassing conditions such as Cardiac Arrest or Choking where there is an 'immediate threat to life' therefore requiring an immediate ambulance dispatch and 'blue light' response.

6. The current Welsh Government (WG) performance target for emergency ambulance response in Wales is 65% arrival within 8 minutes.

Table 1: *Current Red Ambulance Response Target*

Category	Descriptor	Types of Complaint	Response Standard
Red	Immediately life-threatening incidents	▪ Choking ▪ Cardiac arrest ▪ Respiratory arrest ▪ Major haemorrhage ▪ Breathing problems	▪ 65% of emergency responses to arrive within 8 minutes (Pan Wales) ▪ 60% within 8-minutes at a local Health Board level

7. Historically the Trust has delivered mixed performance against the 8-minute ambulance response target. Following the introduction of the new 'Clinical Response Model' in 2015 the Trust performed well against the target, however performance has since fallen below the 65% target and was last met in June 2020. The factors impacting ambulance response times and target attainment are complex and well-documented.

Health & Social Care Committee Recommendation

8. During a review of ambulance performance, the Senedd's Health & Social Care Committee (H&SC) discussed the broader system challenges impacting ambulance service provision and the limitations associated with the current 8-minute ambulance performance target.

9. As a result, the H&SC Committee published a series of recommendations in Aug-24 to enable improvement. One of the recommendations, accepted by the Cabinet Secretary for Health and Social Care, was to '*review the existing national target for ambulance response, and to determine whether it is still appropriate.*'

WAST Integrated Clinical Services Model

10. In parallel to the H&SC Committee recommendations, a briefing paper was presented to a closed Trust Board meeting in Sep-24 outlining the emerging plans to 'evolve' WAST's Clinical Response Model to improve clinical outcomes and reduce the current levels of 'avoidable' harm as a result of delays receiving definitive care. This was considered by Board in advance of the briefing being shared with the Joint Commissioning Committee (JCC).

11. The briefing paper provided an overview of the proposed changes to support the shift from the current service model centred on 'ambulance response,' towards an 'Integrated Clinical Services Model' bringing together the three core services (111, EMS and Ambulance Care) to maximise patient and system benefits.

12. The briefing paper set out the approach to safely manage and resolve more 999 calls without requiring an 'ambulance' dispatch. A key aspect of the model is the introduction of a new process called Rapid Clinical Screening to enable earlier clinical review of 999 calls to determine the most 'appropriate' care options to best meet patient need. In addition to this, the paper set out an early description of the establishment of the Remote Integrated Care Service (RICS) which seeks to leverage the benefits of remote clinicians in both 111 and the 999 Clinical Support Desk (CSD) into a single function and maximise the ability to manage more care remotely.

13. As part of the early development of the clinical model, consideration was given to the potential challenges of the current ambulance targets and limitations of the time-based performance measure. An early 'WAST position' on the opportunities to develop more clinically focussed metrics was presented in the briefing paper.

ASSESSMENT

National Ambulance Target Review Task Group

14. In response to the H&SC Committee recommendation, a National Ambulance Target Review Task Group was established. The task group was responsible for leading the review, considering the available evidence and putting forward a preferred recommendation to the Cabinet Secretary for Health & Social Care on the future Ambulance Performance framework.

15. The Task Group, chaired by WG, included a broad mix of expert leads including policy leads and statisticians, ambulance commissioners, and senior clinicians with

experience of ambulance and pre-hospital emergency care. WAST membership included senior executive directors (Rachel Marsh, Andy Swinburn and Liam Williams).

16. The first phase of the review process considered the available evidence base to understand the history, challenges and opportunities for change. The review process adopted a mixed methodology approach and considered expert insight, population survey data, literature reviews and data modelling. The high-level findings of the review found the following:

- Wales remains the only UK nation to retain an 8-minute response time target;
- There is wide international variation in ambulance performance frameworks;
- No clinical evidence available to make the link between an **8-minute** ambulance response and improved patient outcomes.
- Questioned the clinical efficacy of binary 'time based' targets and clinical outcomes whereby the response could exceed 8 minutes however the patient's life could be saved.
- Clear evidence that outcomes can be improved through timely interventions known as the 'Chain of Survival' for people in out of hospital cardiac arrest;
- The existing Red category has 'broadened' over time, resulting in the inefficient use of precious ambulance resources. This can result in an immediate ambulance dispatch to people who initially appear seriously ill but later transpire to be well enough to be discharged at scene *without* transport to hospital. These patients are subject to the **same** 8-minute target as a person with a clear clinical need for an immediate response in minutes e.g. a person in cardiac arrest.

New Ambulance Performance Framework

17. Following careful consideration of the available evidence, the task review group concluded that the current 8-minute ambulance target is not 'fit for purpose' and that a 'new' performance framework should be developed.

18. It was agreed that a more balanced approach would be required, with a greater focus on clinical outcome and quality measures, which will have a greater significance for patient care, rather than just a 'time based' response target.

19. It was recognised that the current 'Red' category had broadened overtime in terms of the level of acuity, reaching circa 15% of all verified 999 incidents. The current category includes patients with an immediate threat to life and patients with a less acute presentation that may not require an immediate ambulance dispatch. This prompted a discussion about the importance of improving clinical outcomes for patients in cardiac / respiratory arrest and it was agreed that future measures should be built around the 'Chain of Survival,' with the goal of improving 'Return of Spontaneous Circulation' (ROSC) and subsequent survival to hospital discharge.

Fig 1: Cardiac Chain of Survival

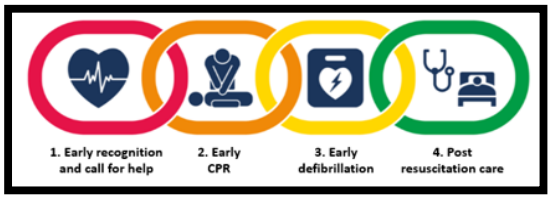
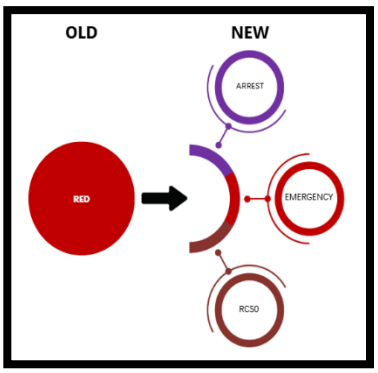


Fig 2: Old & New Categories



20. A range of options were considered and the preferred option put forward a proposal to split the current Red category into three separate categories.

21. The Purple Arrest category includes cardiac / respiratory arrest only. By segmenting these conditions, it enables them to be measured differently with targeted clinical outcome measures aligned to ROSC and the Chain of Survival.

22. The Red Emergency category includes other life-threatening complaints (previously in the old 'red' category) that require an immediate emergency ambulance response. These calls are no less important than the Purple Arrest category calls and would be placed on the same queue and dispatched in time order. This separation allows more targeted clinical outcome measures to be developed specific to the type of presenting complaint.

23. The RCS0 category whilst outside of the scope of the new ambulance targets, will include the remaining conditions from the previous Red category that have been deemed suitable for rapid clinical screening (where a clinician may listen live to the incident, or become involved as soon as the call has concluded, and determines the appropriateness for further clinical assessment or a face to face response).

Table 2: New Ambulance Categories

Category	Descriptor	Types of Complaint
PURPLE ARREST	**ARREST:** Refers to incidents where a person is in cardiac or respiratory arrest.	▪ Cardiac arrest ▪ Respiratory arrest
RED EMERGENCY	**EMERGENCY:** Refers to incidents where a person is at risk of cardiac or respiratory arrest.	▪ Choking ▪ Major trauma
RCS0	**RCS0:** incidents that have been deemed suitable for rapid clinical screening.	▪ Breathing problems ▪ Allergy

Purple Arrest Category Measures

24. The Purple Arrest category includes a bundle of measures focused upon improving clinical outcomes for patients in cardiac or respiratory arrest (see table 3 below for a full breakdown).

25. The overarching clinical outcome measure for the Purple Arrest category is the % of Return of Spontaneous Circulation (ROSC) along with key measures across each link in the chain of survival. These clinically focussed measures will shift the

emphasis from speed of a WAST response to a broader system response focussed on clinical effectiveness and improving patient outcomes.

26. By measuring the chain of survival, it emphasises the importance of the societal role in helping to 'save a life' through bystander CPR and the availability and utilisation of Public Access-Defibrillators (PADS), alongside the ambulance response and timely clinical intervention.

27. The organisational transition of Save a Life Cymru (SALC) into WAST will be a catalyst to deliver targeted and demonstrable improvement across each of the 'links' in the chain of survival. The expected outcome will mean more lives will be saved and the overall %ROSC rates in Wales should increase from current levels of circa 20%, to more comparable levels in other leading countries (e.g., over 40% ROSC rate in the Netherlands).

28. In addition to the clinical outcome measures, the speed of response will continue to be monitored. A median response time target of 6-8 minutes will be introduced alongside a back stop target of 90% of Arrest calls to receive a response within 20 minutes.

Table 3: Purple (Arrest) measures

Category	Measures
PURPLE ARREST	**Purple: cardiac arrest 'bundle' of measures** ▪ % of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return Of Spontaneous Circulation) ▪ Time of call handler to commence CPR instructions ▪ Time to defibrillator at scene /patient side ▪ Median response time target range of 6-8 minutes ▪ 90% receive an ambulance response within 20 mins

Red Emergency Category Measures

29. The Red Emergency category includes immediately life-threatening incidents where there is a risk of cardiac or respiratory arrest if help does not arrive quickly and includes choking, major haemorrhage or major trauma.

30. A bundle of clinical measures will be developed for this category.

31. In addition to the clinical measures, this category will also report against the same two time-based measures included in the Purple Arrest category to ensure there is parity in ambulance response.

Table 4: Red (Emergency) measures

Category	Measures

RED EMERGENCY	▪ Clinical performance indicators (to be developed) ▪ Median ambulance response time target range of 6-8 minutes ▪ 90% receive an ambulance response within 20 mins

RCS0 Category Measures

32. Further work is required to develop the key measures for the RCS0 category. This work is aligned and dependent upon the planned review of the remaining Amber and Green categories. Further information is provided in the next steps section.

Welsh Government Approval

33. The proposed changes were presented to the Cabinet Secretary for Health & Social Care in Jan-25 for consideration. The proposals were approved and formally announced on the 11th March and presented to the Senedd receiving positive support across political parties.

34. It was agreed that the changes would be piloted for a 12-month period commencing on the 1st July 2025. A decision regarding the permanent introduction of the changes would be subject to the findings of the evaluation.

WAST Preparedness

35. The breadth of preparatory work and organisational changes required to embed the new ambulance performance framework, in less than three months, cannot be understated. This section of the paper details the key areas of planning and preparatory work underway to enable the successful implementation of the new performance framework for go-live on the 1st July.

36. Overall, the planning and project delivery areas are progressing well and on track for the go-live date. All key work streams have been identified, and plans are either in place or being developed, with key actions being assigned to key leads.

37. There remains a high dependency on delivering technology change with the WAST CAD system. The supplier is engaged, and there is a delivery timeline that supports the 1st July go-live, however this will be subject to successful development and testing.

Project Management & Delivery

38. To take this work forward an urgent Call Categorisation Task & Finish group has been formed, tasked with the responsibility of leading the planning and implementation of all the required changes.

39. The Executive Sponsor for the group is Lee Brooks (Executive Director of Operations) and the Senior Responsible Officer is Greg Lloyd (Assistant Director

of Clinical Delivery). The group includes a broad range of internal WAST leads and external commissioners. The group meets weekly with full project support and underpinned with the full package of project management processes.

Governance Process

40. The Call Categorisation T&F group sits within the Clinical Model Transformation (CMT) programme structure. Key outputs of the group requiring formal review and approval will follow the agreed governance processes. This will include the Clinical Quality and Governance Group (CQGG) and CMT Programme Board.

41. Discussions are continuing with the Joint Commissioning Committee (JCC) via Ross Whitehead (Director of Commissioning for Ambulance & 111) to confirm the role of the JCC in the governance and approvals process for the changes.

42. There is also a requirement, as set out in the Cabinet Secretary's letter to provide written assurance to Welsh Government by the 31st May regarding the monitoring & assurance process, and development of the data definitions. Work is continuing at pace across both these areas of work in readiness to submit these by mid-May. Further information is provided in the corresponding sub-sections below.

Quality Impact Assessment / Equality Impact Assessment

43. A comprehensive Quality Impact Assessment (QIA) has been developed and is on track to be completed and approved in May. The governance process for the QIA will mirror the agreed approach for the CMT Programme. The document will be reviewed initially by the Clinical Advisory Group (CAG) on the 25th April in readiness for submission to CQGG on the 12th May.

44. As part of the Trust's commitment to embedding Equality, Diversity and Inclusion (EDI) across its transformation agenda, the CMT Programme established a dedicated Task and Finish Group to lead the completion of the Equality Impact Assessment (EqIA) (see appendix 2). The EqIA will be considered at the CMT Programme Board on the 6th May and any changes will be updated verbally to the Trust Board on the 7th May.

45. In addition to the programme-level EQIA, an individual EqIA was also undertaken for the implementation of Rapid Clinical Screening (RCS), acknowledging its role in introducing a new clinical decision-making touchpoint. This work also included a commitment to review the categorisation of calls, in line with the principles of the Chain of Survival. As the forthcoming changes to call categories are a core component of the RCS model, enabling improved clinical prioritisation based on patient acuity, these changes align directly with the processes and patient flows assessed through the RCS EqIA – namely, direct dispatch or routing to remote clinical assessment.

46. The programme-level EDI Definition Document and the RCS EqIA collectively demonstrate how equality considerations have informed the design and delivery of the revised call categories and provide assurance that the Trust's statutory responsibilities under the Equality Act 2010 are being met.

Data Definitions & Performance Reporting

47. Strong progress has been made to review and develop all the technical data definitions that make up the Purple Arrest, Red Emergency and RCS0 categories. The definitions cover all the internal and external measures across each of the three categories. The development of the data definitions is a key dependency to build the data reporting systems to ensure effective reporting systems are in place for the new measures. This critical work has been prioritised by the Information and Data Services (IDS) team who will be leading the development of the performance reporting processes.

48. The development of the data definitions is nearing completion in readiness for formal internal review and sign off. The review and approval process will follow the agreed governance processes and will be presented to the CMT Programme Board on the 6th May in readiness for submission as part of the assurance letter to Welsh Government by the 31st May.

Monitoring & Assurance

49. In addition to the key performance metrics for the new categories, a key requirement in readiness for go-live is to ensure that there are robust daily performance and quality reporting arrangements in place to monitor the patient safety and service delivery impacts of the changes. An overview of the monitoring and assurance arrangements are required to be submitted to WG by the end of May and will follow the agreed internal governance arrangements for approval.

50. Work is currently underway to develop the monitoring and assurance approach which will include both the requirements for quantitative performance and quality data alongside qualitative patient level experience information.

51. A key enabler for this work is the requirement to review and update the identified operational level performance reports to reflect the new performance categories. This work has been prioritised by the IDS team as a matter of urgency to ensure that there is full accessibility to the right data to ensure the changes can be effectively and proactively monitored.

Operational Readiness

52. Considerable work is required to be undertaken as part of operational readiness to embed the changes. This includes the review of key operational procedures, technical changes to the 999 CAD, and familiarisation & training for all staff directly impacted by the changes.

53. *Technical CAD Changes*: Significant technical changes are required to the 999 CAD architecture to reflect the new categories. Earlier engagement has commenced with MIS (external CAD supplier) who have confirmed the allocation of dedicated developer capacity to undertake the technical CAD changes. Work is continuing at pace to finalise the technical specification for the CAD development. Given the importance and complexity of this area of work, and the reliance on an external supplier, this element of the preparatory work has been flagged as a potential risk to the overall delivery of the changes (see risk section). All mitigatory actions are in place and the Trust will maintain close and regular dialogue with the supplier to monitor and oversee delivery of this work.

54. *Operational Procedures:* A full review of the Operational Standard Operating Procedures (SOPs) has been undertaken to identify those that require revision and updating. Over 30 SOPs to date have been flagged as requiring revision. Work is underway to work through the changes to the SOPs in priority order which will be supported by a streamlined approval process where changes are made consistent with category changes.

55. *Staff Familiarisation & Training*: A staff familiarisation and training plan is being developed to ensure that all operational staff directly affected fully understand the changes, the impact on their day-to-day role and appropriate training is provided. This work will align with the timescales to review and refresh the operational policies.

Communications (Internal & External)

56. Effective communication will be required to ensure that all internal staff / volunteers, external stakeholders and the public are informed and understand the changes to the ambulance performance framework. A dual but linked approach has been agreed to develop two clear communication plans to cover the internal and external communications plans. Both plans will initially be reviewed by the Call Categorisation T&F Group and signed off by the CMT Programme Board.

57. *Internal Communications:* The internal communications plan is currently in development and sets out in detail the approach to communicate with all WAST staff and volunteers. The plan adopts a hybrid approach using different communication tools and collateral to maximise its reach across the organisation and describe the changes in an easy and understandable way.

58. *External Communications:* The external communications plan is also being drafted and is framed around three different stakeholder groups (1. Organisations impacted by the changes, 2. Wider external stakeholders and 3. Public). In recognition of the wider external communications & engagement associated with the changes to the wider Clinical Services Model, it was prudent to dovetail the communication messaging to include and inform stakeholders of both the model and ambulance target changes. The plan adopts a hybrid approach using different communication approaches, tools and collateral to maximise its external reach including using the media, social media, videos and key documentation (FAQs, letters). All public facing information will be created bi-lingually and will be available on the website.

59. Discussions are taking place with Welsh Government to confirm their expectations and role in the external communications approach with the public. It is possible that a joint approach may be advised between WG, WAST and Commissioners working together on this element of the plan.

Evaluation

60. As part of the wider changes to the Integrated Clinical Services Model, the Trust along with Commissioners are working jointly to procure an independent external partner to undertake a detailed and comprehensive evaluation. The proposed approach is to undertake a phased evaluation covering the lifespan of the programme, focussing on specific elements of the clinical service model following its respective implementation building up to a comprehensive overall evaluation. A key aspect of the evaluation process will focus upon evaluating the impact of the changes to the ambulance performance framework following the introduction of the Purple Arrest and Red Emergency categories.

61. The Trust is currently in the procurement and formal application phase to identify potential bidders. Application shortlisting is planned for the 1st May.

Finance

62. There are currently no known financial implications for the Trust to enable the changes to be successfully implemented. In relation to the technical system changes on the CAD, the current understanding with the supplier (MIS) is that the technical development work will be completed at no additional cost as the changes are policy and Welsh Government led.

Risks

63. As part of the project arrangements, the T&F group regularly review and assess the associated risks. There is one high level risk with a risk score of 16 or over. This is related to the ability of an external supplier to deliver the technical CAD changes described in the operational readiness section (see paragraph 49).

Table 5: Project Risk Log (High Level Risk only)

Failure to deliver due to the capacity of a third party (MIS)	Lee Brooks (Welsh An	IF the third party supplier (MIS) does not have the capacity to undertake the CAD development in the required timeframe	THEN the trust will not be able to deliver the required changes for the 1st of July	Resulting in: 1 - Reputational damage	Reputational	4	4	16

Next Steps

64. Following completion of the initial Welsh Government led review of the current 'Red' performance target, the Ambulance Target Review group has been reconvened to undertake a second phase of the review, to consider the performance framework for the remaining Amber and Green categories.

65. This review work has commenced and is projected to conclude in two months. The findings will be presented to the Cabinet Secretary for Health and Social Care for consideration and approval. Pending the outcome of the review, the Trust may be required to undertake further work to implement and operationalise the recommended changes.

RECOMMENDATIONS

Trust Board is asked to: -

i. **Note** the requirement for the Trust to alter its model of service delivery and reporting to meet Welsh Government instructions.

ii. Confirm that the Board is **assured** that the organisational preparedness meets with the appropriate requirements to implement the changes safely and effectively.

APPENDICES

Attachment 1: Cabinet Secretary for Health & Social Care 'New Emergency Ambulance Performance Framework' letter

1. JG letter to WAST CEO and Dir of Amb

Attachment 2: CMT Programme Equality Impact Assessment

2.%20CMT%20Programme%20EQIA%20D

Grŵp Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Gweithrediadau, GIG Cymru

Health and Social Services Group
Director of Operations, NHS Wales

Llywodraeth Cymru
Welsh Government

Jason Killens
Chief Executive
Welsh Ambulance Services University NHS Trust

Ross Whitehead
Director of Commissioning for Ambulance Services & 111
NHS Wales Joint Commissioning Committee

Our Ref: JG/A58841243

14 July 2025

Dear colleagues,

Further changes to the emergency ambulance performance framework

Firstly, thank you to you and your teams for your contributions and support in the second phase review of the emergency ambulance performance framework for categories which fall outside of the new arrest and emergency categories, i.e. the amber and green categories.

I am writing to inform you that the Cabinet Secretary for Health and Social Care has approved the recommendations of the review.

The new performance framework (enclosed at appendix 1) is designed to focus on clinical outcome and enhance the efficiency and effectiveness of emergency ambulance services.

As with the first phase, we now need your support with development of clear and precise definitions for the new performance metrics agreed by the Cabinet Secretary. These definitions will be crucial in accurately measuring and reporting performance against the new framework, and in identifying areas for continuous improvement. We should appreciate it if this work is concluded **by 30 September.**

I appreciate the Trust will need time to make the required technical and operational changes to respond to the new performance framework. Therefore, please come back to me by **31 July** with a proposed launch date. This will need to be ahead of 1 December 2025 to enable changes to be implemented ahead of winter in line with commitment made by the Cabinet Secretary's expectations.

Officials will keep in touch with your teams through regular communication over the coming weeks to ensure we maintain an aligned approach towards launch.

Thank you for your ongoing commitment.

Yours sincerely,

Jeremy Griffith

Director of Operations
NHS Wales / Health, Social Care and Early Years Group, Welsh Government

Cc: Judith Paget, Director General Health and Social Services / NHS Chief Executive, HSCEY Group, WG
Nick Wood, Deputy Chief Executive, NHS Wales, HSCEY Group, WG
Aled Brown, Head of Emergency Care Policy, HSCEY Group, WG
Ryan Pike, Head of Hospital Statistics, WG

Appendix 1: New ambulance performance framework

	Category	Description	Aim	Measures
Respond immediately	PURPLE: ARREST	Cardiac or respiratory arrest.	Increase ROSC rates	• ROSC rate • Median time to identify cardiac arrest • Median time to commence CPR instruction • Median time for defibrillator arrival • Median response (6-8 minutes) • 90th percentile (20 minutes)
	RED: EMERGENCY	At high risk of cardiac or respiratory arrest	Prevent deterioration into arrest	• Median response (6-8 minutes) • 90th percentile (20 minutes) • Outcome measure (Pain, NEWS, Spo2)
Time sensitive	ORANGE: NOW	Likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	Rapid arrival at specialist or emergency care facility as soon as possible	• Median response of most appropriate resource • 90th percentile • Stroke care bundle inc. call to door median and % arrival at specialist site. • STEMI care bundle inc. call to door median and % arrival at specialist site. • Further measures developed over time
Assess and respond	YELLOW: SOON	Further clinical assessment with potential to support remote clinician decision making for alternative pathway, and/or discharge at scene, and/or planned transport to treating facility, e.g. a person with a suspected broken leg	Prevent unnecessary escalation of care	• Median response of most appropriate resource • 90th percentile • % by disposition
Planned response	GREEN: PLANNED	High potential for discharge at scene or referral to community or another planned pathway e.g. a person with earache	Right response for need	• Median response of most appropriate resource • 90th percentile • % by disposition

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Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
University NHS Trust

Cadeirydd
Chair: Colin Dennis

Prif Weithredwr Dros dro
Interim Chief Executive:
Rachel Marsh

Swyddfa'r Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services Office

Our Ref: RM046

31 July 2025

Jeremy Griffiths
Director of Operations NHS Wales, Health, Social Care and Early Years Group
Welsh Government

Sent via e-mail:- Jeremy.griffiths001@gov.wales

Dear Jeremy

RE: New Ambulance Performance Framework Phase 2

Thank you for your letter of 14th July 2025 confirming the approval by the Cabinet Secretary for Health & Social Care of the move to the next phase of the new Ambulance Performance Framework, in particular, Time Sensitive (Orange Now), Assess and Respond (Yellow Soon) and Planned Response (Green Planned).

In your letter, you requested that the Trust confirm its proposed implementation date with a back stop date of the 1st December 2025. Following extensive consideration, and given the complexity of the changes and the dependency on our CAD supplier, at present we are working towards an implementation date of the 1st December 2025.

However, our preference would be to implement these changes earlier if at all possible. December is usually our busiest month of the year and earlier implementation would allow staff to adopt change ahead of peak activity, and should there be any technological challenges post go-live, we would again avoid the peak activity period to deploy fixes. In this regard, if there is an opportunity to bring forward the implementation date we may call on your support to deploy a change mid-month, which we know is not advantageous statistically, but would go some way to mitigating the risks. We will notify you as soon as possible if this possibility materialises.

It is also important to note though that if the 1st December date becomes unachievable, we would need to hold off the go-live until the 1st of February 2026 in order to preserve our operational capacity to minimise patient risk during the challenging months of December and January.

As noted, the Trust has a high dependency on the CAD supplier, which has not been without its challenges during phase one, despite our close attention to this identified risk. We will be further increasing our risk management controls for phase two and will be aiming to submit the work on the data definitions to the CAD supplier by the 18 August, to give them time to develop the changes into their systems.

The Director of Commissioning, Ambulance and 111 Services is on the Call Categorisation Task and Finish Group and will also be actively involved in the sub-group leading on the definitions. We note that Welsh Government want the definitions by 30th September 2025, but as outlined here, we will be required to complete this work much earlier to support meeting the back stop go-live date of 1st December.

In relation to the monitoring arrangements for assurance purposes, again, we will work closely with the Director of Commissioning, Ambulance and 111 Services. We produced a monitoring and assurance plan for phase one and intend to do the same for phase two, which we can make available to you if required.

If there are any questions, please let us know as soon as possible.

Yours sincerely

Rachel Marsh
Interim Chief Executive
Prif Weithredwr Dros dro

Ross Whitehead
Director of Commissioning for Ambulance Services & 111

cc. Estelle Hitchon, Interim Executive Director of Strategy, Planning and Performance
Andy Swinburn, Executive Director of Paramedicine
Lee Brooks, Executive Director of Operations

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

Welsh Ambulance Services University NHS Trust

Ambulance Performance Framework

Explainer Document

Version 2.0 26th August 2025

Table of Contents

Version Control Sheet

Version	Date	Author	Summary of Changes	Review Due
0.5	13/05/2025	Elliot Miller	Draft document released to key roles to inform review of training material and SOPs	28/05/2025
1.0	20/05/2025	Elliot Miller	Formal Approval of Document	30/06/2026
1.1	10/06/2025	Elliot Miller	Updates to Red Emergency definition [Exec Summary, 2.1, 5.1, 5.4.]	30/06/2026
2.0	26/08/2025	Elliot Miller	Expansion of Document to incorporate Phase 2 changes. Introduction of Orange Now, Yellow Soon, and Green Planned categories.	01/12/2026
Keywords	Purple Arrest, Red Emergency, RCS0, Ambulance Performance Framework			

Document Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Call Flow Prioritisation Project Group	26th August 2025	Approved

Disclaimer

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Operations Support Manager.

Executive Summary

This executive summary provides a focused overview of Phase 2 of the Ambulance Performance Framework (APF) for the Welsh Ambulance Services University NHS Trust (WAST), building on the foundations established during Phase 1. The main priority of this document is to detail the objectives, developments, and anticipated outcomes of Phase 2, as WAST continues its drive for improved emergency response, patient safety and clinical effectiveness.

Background

The Call Flow Prioritisation Project Group was formed in response to the Health and Social Care Committee's recommendations surrounding existing ambulance response time targets. The initial assessment led to significant changes in how emergency responses are categorised and measured, culminating in the introduction of new categories - '**Purple Arrest**' and '**Red Emergency**' - in Phase 1 (from 1 July 2025).

Transition to Phase 2

Following the launch of Phase 1, focused on outcome-based performance for cardiac arrest and immediately life-threatened patients, Phase 2 represents a further and comprehensive evolution of the remaining call categories. This represents most patients presenting to 999 services and the core aim of Phase 2 is to extend the principles of outcome-driven, clinically relevant performance measurement across all emergency ambulance service categories. This document introduces the further 3 new categories: **Orange Now**, **Yellow Soon**, and **Green Planned**, and their respective definitions and metrics.

Objectives of Phase 2

- Expand the adoption of outcome-based metrics to encompass the full spectrum of emergency ambulance care, moving beyond the initial focus on cardiac arrest and critical illness.
- Refine performance targets and measurement methods to ensure they remain clinically meaningful and aligned with both patient outcomes and service improvement.
- Consolidate learning from the first phase to establish best practices and set new operational standards for emergency response in Wales.

- Engage with a broad range of stakeholders including clinical teams, commissioning bodies, and governance groups, to ensure robust implementation and accountability.

Key Activities in Phase 2

- Continued evaluation and adjustment of the framework based on real-world data and feedback from frontline staff and patients.
- Introduction of additional performance indicators tailored to the unique needs of various emergency situations (such as ST Elevated Myocardial Infarction (STEMI) and Stroke).
- Enhanced reporting and monitoring mechanisms, enabling more detailed insights into patient journeys and clinical outcomes.

Expected Impact

- Broader and more nuanced measurement of ambulance service effectiveness, capturing not just speed, but the quality and result of care delivered.
- Improved patient outcomes through a sharper focus on clinical interventions.
- Ongoing service development driven by evidence, partnership, and a shared commitment to excellence in urgent and emergency care.

Conclusion

Phase 2 of the Ambulance Performance Framework marks a pivotal stage in the transformation of pre-hospital and emergency care in Wales. By expanding outcome-based standards and involving a wider array of clinical and organisational stakeholders, WAST aims to ensure the ambulance service remains responsive, clinically effective, and continually improving for all patients.

Updates on further developments, time standards, and additional performance metrics will accompany the roll-out of Phase 2 as the framework matures and evolves in line with national health priorities and patient needs.

Transitioning to the Ambulance Performance Framework (Phase 2)

1. INTRODUCTION

1.1. Following the implementation of Phase 1 of the Ambulance Performance Framework (APF), WAST is now able to transition the rest of the APF. The purpose of this 'version 2' of the Explainer Document is to summarise the findings of the second phase of work undertaken by the task group established to review the emergency APF and provide detail of the full APF moving forward.

1.2. In February 2025, the Cabinet Secretary received advice (MA-JMHSC-0429-25) on the findings and recommendations from a National Ambulance response target task group. This group was established in response to a Health and Social Care Committee recommendation to assess whether the existing national ambulance response time target continues to be appropriate.

1.3. In summary, the task group, which included representation from a number of clinical executive directors, the national clinical lead for emergency care, the NHS Wales Joint Commissioning Committee and Welsh Government, found the pre-existing target for the 'Red' (immediately life threatened) category of patients was no longer appropriate.

1.4. The Cabinet Secretary subsequently approved implementation of a new APF for WAST introducing the new '**Purple Arrest**' and '**Red Emergency**' categories with a focus on clinical outcomes, especially outcomes from cardiac arrest. This was 'phase one' of the review work programme.

1.5. It was agreed that phase one of the APF would take effect from 1 July 2025, and (commencing in August) the **Purple Arrest** category will report on (but not limited to):

- The percentage of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (return of spontaneous circulation (ROSC)); and

- The median time it takes for a 999 call handler to identify a cardiac or respiratory arrest, median time to commence cardio pulmonary resuscitation (CPR) instructions, and median time for an automated electronic defibrillator (AED) to be brought to the scene following an out of hospital cardiac or respiratory arrest.

1.6. Additionally, WAST will report performance for both the **Purple Arrest** and **Red Emergency** categories against the following time standards:

- Median emergency ambulance response standard of 6-8 minutes.
- Aim for 90% receive an emergency ambulance response within 20 minutes.

1.7. As part of work to evolve its clinical model, WAST has implemented operational changes to enable *'rapid clinical screening'* for all calls not classified as an arrest or emergency. This brings a clinician to the forefront of decision making, ensuring a more tailored approach which takes account both of a person's symptoms and their environment (where the incident occurred).

1.8. Recognising the need to focus, as far as possible, on outcomes for all service users, and particularly those with time-critical conditions, the Cabinet Secretary committed to a phase two of the review work.

1.9. This saw the extension of the review to 999 incidents which fall outside of the **Purple Arrest** and **Red Emergency** categories – i.e. the current 'Amber' (serious but not immediately life threatening) and 'Green' (neither serious nor life threatening) categories. Table one illustrates the phased approach and status following the launch of phase 1.

	PHASE ONE		RAPID CLINICAL SCREENING	CURRENT STATE		
	ARREST	EMERG		AMBER 1	AMBER 2	GREEN
	c. 10% of calls			c. 70% of calls		c. 20% of calls
Category description	Cardiac or respiratory arrest	At high risk of cardiac or respiratory arrest		Serious but not immediately life-threatening		Neither serious nor life threatening
Typical conditions	Cardiac arrest Respiratory arrest	Choking Major haemorrhage Major trauma		Most medical and trauma cases including: Chest pain Fractures Most stroke		Minor injuries Generally unwell Earache
Response type	Immediate dispatch (no rapid clinical screening)	Immediate dispatch (no rapid clinical screening)		Emergency response – most suitable clinical resource based on response profile – includes management via remote "hear & treat" services		Ideally suited to management via secondary telephone assessment
Standards	Median response 6-8mins 90% within 20mins			**No current time standards / targets**		

1.10. *Table 1: phase one and two (current state) of ambulance response target review*

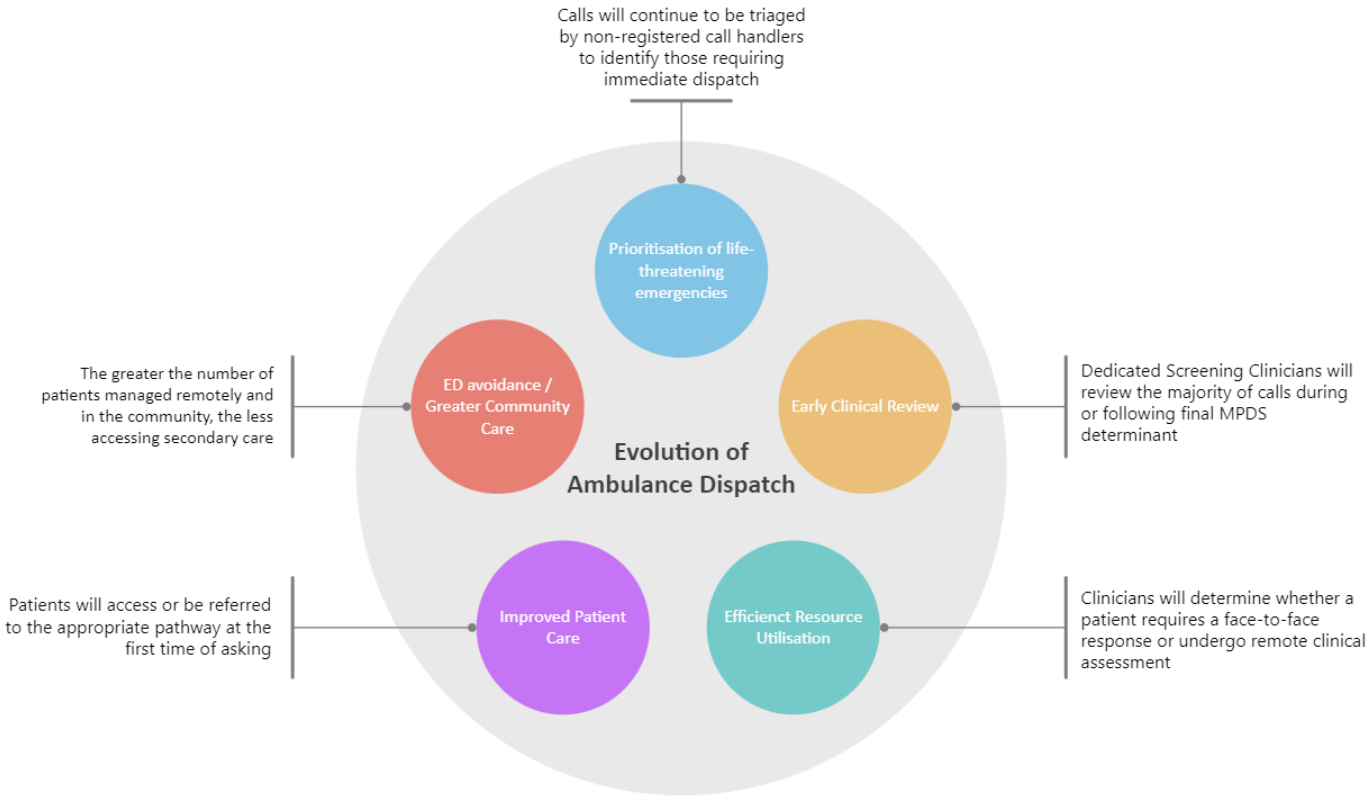
1.11. As it stands, statistics published by Welsh Government include call volumes and a combined median response time for Amber one and Amber two calls.[1] There is no target response time for the Amber or Green categories.

1.12. This transition reflects a movement within healthcare towards integrated, patient-centred care models, where ambulance services play a role both in

[1] Emergency responses: minute-by-minute performance for amber calls, by Local Health Board and month

emergency situations and in supporting the system to meet diverse patient needs. The WAST Integrated Clinical Services Model aims to enhance the efficiency, effectiveness, and responsiveness of our ambulance service, ensuring it is equipped to meet the evolving needs of the population it serves.

1.13. The review of the new and current categories aligns with the Trust's strategic intention to deliver a 'whole system' approach to responding to emergencies, whilst also ensuring that the response sent is the most clinically suitable on the first occasion. This document has been developed to provide information on these changes and provides further details on the new categories and process flows.



1.14. *Figure 1: Future Evolution of Ambulance Dispatch in the Integrated Clinical Services Model*

2. PHASE 2: THE CASE FOR CHANGE

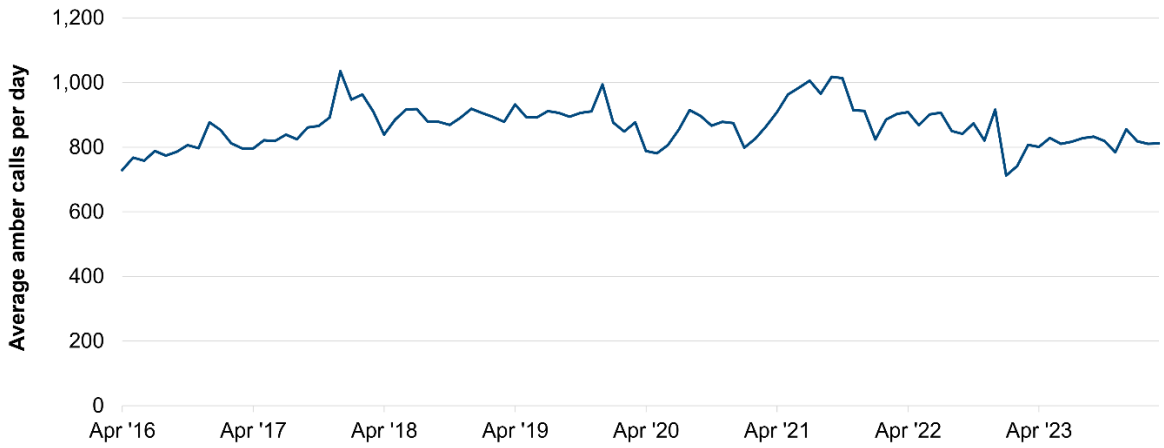
2.1. The second phase of the task group focused on;

- Current performance outcomes for Amber / Green incidents;
- UK and international measures for equivalent categories / conditions;
- Evidence relating to *what matters* to patients and staff; and
- Proposed categories and performance measures.

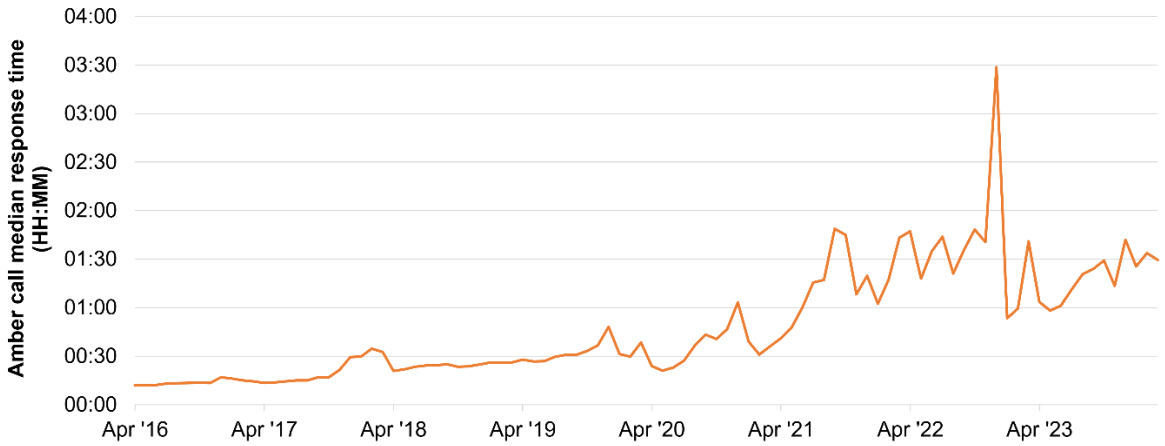
The group's findings are summarised below:

2.2. Limitations with current Amber category

2.3. The Amber category accounts for the majority of total 999 incidents / calls (c.70%). The volume of these incidents has been relatively stable over the long term, as shown in Graph 1. Median response times to Amber category incidents have increased significantly, reaching around five times higher than in 2016, as shown in Graph 2.



2.4. *Graph 1: Average Amber calls per day, April 2016 to March 2024*



2.5. *Graph 2: Median Amber call response times, April 2016 to March 2024*

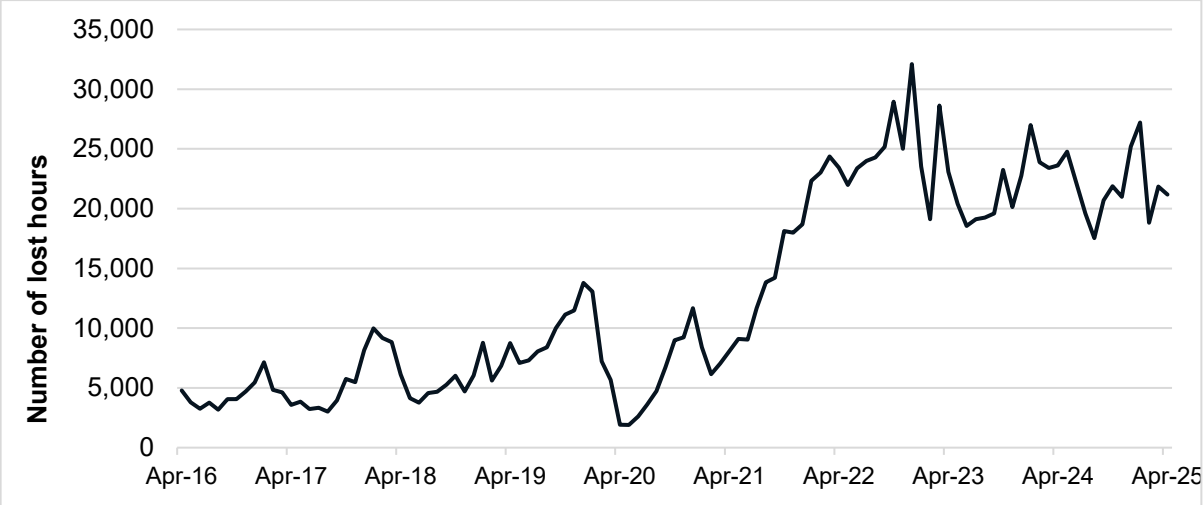
2.6. In December 2022, the median response time for Amber category incidents was a record 3 hours and 29 minutes. This was due to a high volume of 'Red' category calls using most resources, along with reduced availability caused by ambulance handover delays (see section 2.11).

2.7. The types of conditions within the Amber category include most medical and trauma cases such as chest pain, strokes and limb fractures. A number of these conditions require an ambulance response and transport to the right diagnostics, care and treatment in a timely manner to optimise outcomes. For example, for a patient in stroke, every minute counts as evidence suggests a loss of 2 million brain cells every minute.

2.8. The current management of the Amber category, which represents around 70% of total demand, does not allow for a nuanced response to *truly* time-sensitive complaints. Patients with evident symptoms of stroke, STEMI (a type of heart attack) or fractured hips are grouped in this broad category and managed through a system that, despite being internationally accredited and well-evidenced, has high sensitivity but sometimes low specificity. This approach can have an impact on how quickly people who have a clear clinical need for a rapid response receive help.

2.9. Operational challenges faced by the ambulance service

2.10. There is a clear correlation between increasing Amber response times and rising lost hours due to ambulance patient handover delays. There has been a significant increase in ambulance patient handover delays in recent years, with around five times as many hours lost in 2023-24 compared with 2016-17. This position has shown little sign of improving with an additional 1.5% of capacity lost in 2024-25 when compared to the previous year (Graph 3).



2.11. *Graph 3: Lost hours for the ambulance service following notification to handover at Emergency Departments, April 2016 to April 2025*

2.12. Currently, the reduced ambulance availability because of Emergency Department handover delays is having a significant impact on response times. This has also resulted in patients either being informed that an ambulance is not able to be sent or led to the patient cancelling an ambulance before it arrives and taking measures themselves.

2.13. Health boards will need to significantly improve ambulance patient handover performance to maximise the opportunities the new APF model could bring. The national ambulance patient handover guidance (WHC/2024/04) reaffirms that every effort should be made to handover the care of a patient from ambulance clinicians to Emergency Department staff within 15 minutes of the ambulance arrival.

2.14. Meeting recommendations set by the Ministerial Advisory Group for a **maximum** 45-minute ambulance patient handover has been communicated

as an expectation to health boards. Additional support will be provided via an executive director clinical taskforce, WAST and NHS Performance and Improvement.

2.15. Increasing focus on outcomes where time matters

2.16. Ambulance response time performance is measured and reported differently across the UK and internationally. England, Scotland, Northern Ireland and the Republic of Ireland all use an outcomes-driven approach to ambulance performance frameworks.

2.17. Stroke

The Stroke Association Wales (SAW) has raised concerns about the lengthy ambulance response times for stroke patients in Wales, which are slower compared to the rest of the UK. SAW reports that 80% of stroke patients now wait over 30 minutes for an ambulance. WAST indicates an average 'call-to-door time' of 2.5 hours for stroke responses, whereas other parts of the UK perform better. This issue is exacerbated by ambulance handover delays, which are significantly higher in Wales than in other UK regions.

2.18. SAW also felt there is a need to raise the profile of 'onset' or 'call-to-door times' for people in stroke, and to use Stroke Sentinel National Audit Programme (SSNAP) data to hold health board executive teams to account for their role in this metric to help drive improvement in diagnostic, assessment and treatment times.

2.19. Dr Shakeel Ahmad, National Clinical Lead for Stroke, acknowledges that prioritising all stroke calls could cause harm due to about 52% being false alarms or 'mimics'. Thus, efficiently assessing these calls is crucial to ensure ambulance resources are allocated to patients truly in need of rapid response and onward transport to the right specialist service.

2.20. ST-Elevation Myocardial Infarction (STEMI) – a type of heart attack

Wales is also an outlier for 'call-to-door' times for STEMI compared to the rest of the UK. In a letter to the Cabinet secretary on 25 November 2024, the Welsh Cardiovascular Society highlighted that delayed ambulance

responses in Wales are contributing to longer call-to-door and call-to-treatment times, which was resulting in avoidable harm to patients. The British Heart Foundation advised that long ambulance and emergency department delays are leaving seriously ill patients worse off and even costing lives.

2.21. Dr Jonathan Goodfellow and the Wales Cardiac Network identified STEMI 'call-to-balloon time' as crucial for improving patient outcomes. They also emphasised the importance of early access to ECG results to ensure proper treatment.

2.22. The network raised concerns around patients who self-present to hospital, who have longer treatment times because of the triage required in the emergency department and often need inter-hospital transfer to a primary percutaneous coronary intervention (PPCI) centre. Calling 999 for heart attack symptoms enables swift assessment, accurate diagnosis with an ECG, resuscitation (if needed), and direct admission to PPCI centres, bypassing emergency departments and other non-primary PCI hospitals.

2.23. Different approaches used across the UK

2.24. To understand the impact of ambulance response on patients with stroke and STEMI, the NHS in England and Scotland use a set of 'Clinical Quality Indicators' to measure patients' experience and outcomes. These indicators focus on both clinical outcomes and 'care bundle' compliance by ambulance clinicians and the continuum of the patient journey.

2.25. Some of the related key performance measures used internationally are listed below.

2.26. For Stroke:

- Time from call to hospital arrival (call-to-door)
- Time from hospital arrival to CT scan
- Time from call to thrombolysis (if applicable)
- Overall call to intervention time
- Stroke care bundle compliance, which includes:

- Face Arm Speech Test (FAST) documented
- Blood glucose recorded
- Time of onset recorded

2.27. For STEMI:

- Time from call to arrival at a specialist heart centre (call-to-door)
- Door to angiography or primary percutaneous coronary intervention (PPCI) (call-to-ballon)
- Overall call to intervention time
- STEMI care bundle compliance, which includes:
  - 12-lead ECG performed
  - Aspirin administered
  - Glyceryl trinitrate (GTN) administered
  - Pain score recorded

2.28. In England and Scotland these indicators are collected and published monthly and are used to assess both timeliness and quality of pre-hospital care, which are critical for improving outcomes in time-sensitive conditions like stroke and STEMI.

2.29. Additionally, measuring the remainder of the patient journey as an overall call to intervention time provides a comprehensive assessment of the entire process, from accessing help to the delivery of the required intervention.

2.30. Comprehensive measurement of the pathway is crucial for accurate reporting of clinical outcomes. A plan to enable data linkage is currently being developed.

2.31. Wider approach to performance measurement

2.32. The current performance framework is at odds with performance frameworks used for ambulance performance in all other parts of the UK where 'average' response time performance is captured and reported alongside a suite of clinical indicators and a 90th or 95th percentile (representing the 'longest response' time) for all categories.

2.33. Following the Institute for Healthcare Improvement's (IHI) recommendation, both the median and the 90th percentile have been adopted in Wales and will be used to better understand overall performance and variability in response times from 1 July 2025 for **Purple Arrest** and **Red Emergency** incidents.

3. PHASE 2: THE TASK GROUP FINDINGS

3.1. The proposed changes after phase 2 review completion are closely tied to WAST's management of patient flows and how the Trust aims to respond based on clinical prioritisation.

3.2. The involvement of clinicians much earlier in a patient's 999 journey is the foundation of WAST's evolved clinical model. It also sees much closer working between 999 and 111 services. This is intended to ensure that whatever the entry point to the ambulance service, a patient receives an equitable, clinically prioritised response (remote *or* face-to-face) which is focused on improving outcomes. This aligns to the principles of the health and care quality standards and the six goals policy handbook.

3.3. Based on the efforts of phase 1, WAST aims to consolidate its pilot program for Rapid Clinical Screening for all 999 service users who are **not** classified as '**Purple Arrest**' or '**Red Emergency**'.

3.4. The Rapid Clinical Screening (RCS) will occur immediately after the call handler stage. For the most serious calls (**RCS0**), ambulance resources will be dispatched immediately if the screening is not completed quickly enough based on the caller's assumed clinical priority (commenced within 60 seconds of final MPDS code).

3.5. The clinical screening process itself is not expected to take longer than 90 seconds and will provide a 'safety net' to ensure a rapid face-to-face ambulance response is not required for those not already categorised at call handler stage as '**Purple Arrest**' or '**Red Emergency**'.

3.6. The NHS Wales JCC and WAST will monitor and report, via the JCC website, monthly on the following indicators:

- the median time to clinical screening;
- the median time to a clinical decision by screener; and
- the outcome of the clinical interaction.

3.7. Most service users will be screened and likely will not need a rapid face-to-face response. They will be prioritised for a detailed clinical assessment by WAST clinicians through the Remote Integrated Care Service. Users can

expect a callback within one to four hours, depending on their symptoms and the incident location. Higher-risk callers, for example patients with breathing difficulties, will receive priority for this assessment.

3.8. 999 calls pre-identified for the Remote Integrated Care Service will bypass Rapid Clinical Screening and be warm transferred to a call handler for a CPSS (111 non-clinical call handler) assessment. For example, this would typically include presentations such as lower back pain, abdominal pain and people who are vomiting and can often have their care successfully managed without an emergency ambulance attendance.

3.9. WAST and its commissioners will monitor and report monthly on:

- the median time and 90th percentile time to remote clinical assessment; and
- the disposition following in-depth remote clinical assessment.

3.10. If the Remote Integrated Care Service deems a face-to-face response is required then the ambulance service will either dispatch immediately (**Arrest/Emerg/Now**), within a short time frame (**Soon**), or schedule a person's care or transport to the right place (**Planned**). They may also decide for a face-to-face assessment to better inform the remote clinical decision e.g. sending a volunteer Community Welfare Responder.

3.11. The proposed modifications to the APF are centred on the face-to-face response component.

3.12. During the initial introduction of these changes, officials will hold fortnightly quality and safety assurance meetings with the NHS Wales JCC and WAST from the launch to track progress against all new measures, including those not captured within the APF. These arrangements will be scaled back accordingly as confidence is established, with future monitoring led by the NHS Wales JCC.

3.13. Changes to Amber and Green categories

3.14. To align with the evolving clinical model, new categories are to replace 'Amber' and 'Green'. These are:

Orange Now: time sensitive
Yellow Soon: assess and respond
Green Planned: planned response

3.15. Task group members concluded there is a need for new measures and standards for emergency ambulance response to incidents not categorised in the '**Purple Arrest**' or '**Red Emergency**' categories. This should be driven by available clinical evidence and what matters most to the public.

3.16. There was consensus for using median and the 90th percentile for any new categories, in line with IHI advice.

3.17. The group felt there should be *more* emphasis on measuring patient outcomes rather than solely median response times for calls. This is consistent with the changes already introduced as part of phase 1 and aligns to approaches used by the rest of the UK.

3.18. Like phase 1, there is an opportunity to introduce a 'bundle' of out-of-hospital care measures for time-sensitive complaints. This would improve public understanding of how each part of the pathway, including ambulance interventions, contributes to outcomes.

3.19. During the Task Groups Options Appraisal, there was an emphasis on the importance of directing individuals with time-sensitive complaints to the appropriate specialist promptly, ensuring that the treatment is administered in a timely fashion. Transitioning to the publication of call-to-door times and eventually call-to-treatment times for conditions such as stroke and STEMI will enhance transparency regarding the entire system's focus on outcomes, aligning with health and care quality standards.

3.20. The first phase found that time-based targets may lead to 'hitting the target but missing the point'. For instance, prioritising rapid response vehicles for stroke victims to meet the target, despite these vehicles being unable to

transport patients for proper diagnostics and treatment, could cause delays and impact outcomes. Therefore, enabling more nuanced assessment and response without a blunt time target is the preferred route- subsequently the new category targets will be without specified response targets.

3.21. Although there would be no time-based target initially, this would be reviewed after 12 months to consider if a target would add value. This pilot approach would enable a thorough evaluation to be undertaken to determine whether time standards would contribute to improved outcomes and experience.

3.22. It has been agreed that as part of the new approach, commissioners/LHBs will revisit setting of aspirations for 'consult and close' as part of the commissioning performance framework to coalesce with the new response approach.

4. CALL CATEGORISATION AND FLOW: THE INTEGRATED CLINICAL SERVICES MODEL

4.1. Phase 1- Call Flow & Screening

4.2. In accordance with the July 1st pilot, **Purple Arrest** and **Red Emergency** incidents should continue to be dispatched in time order with the closest suitable and available resource.

4.3. **RCS0** will continue to be utilised in line with current practice. If this screening cannot commence within 60 seconds of final MPDS code, this category will default to **Red Emergency** and be presented to the dispatch queue as a safety measure.

4.4. These measures will continue to be reported to the JCC and Welsh Government as the suitability and effectiveness of these measures continues to be assessed.

4.5. Phase 2- Screening

4.6. In line with the Integrated Clinical Services Model and a 'Screen first' approach, all other calls will be subject to Rapid Clinical Screening prior to a dispatch decision being made.

4.7. These screening codes will align to the definitions relating to propensity for high-risk markers and present to the Clinical Navigators accordingly. Median time to both clinical screening and clinical decision will be measured, as well as the percentage breakdown of outcome per screening category. Although no time target has been formally set against these codes, they will continue to be monitored and reviewed for patient safety purposes.

4.8. A smaller subset of calls will continue to be identified at final determinant (this is the incident code as determined by the 999-call handler using the Medical Priority Dispatch System (MPDS) as suitable for direct transfer to the Remote Integrated Care Service (RICS). These will continue to be streamed to the most appropriate RICS queue and measures for these are established later in this explainer document.

4.9. A breakdown of the initial screening approach to 999 calls can be found in the table below.

<table>
<tr><td rowspan="2">Respond Immediately</td><td colspan="2">PURPLE
ARREST
Cardiac or respiratory arrest</td><td>RED
EMERGENCY
At high risk of cardiac or respiratory arrest</td><td>See face to face response table for measures</td></tr>
<tr><td rowspan="4">Screen Now*
*A proportion of RCS codes will stream directly to RICS as appropriate (driven by MPDS coding)</td><td>RCS0</td><td colspan="2">High priority for rapid clinical screening</td><td rowspan="4">Median time to clinical screening
Median time to clinical consultation
% outcome</td></tr>
<tr><td>RCS1</td><td colspan="2">High propensity for high-risk markers</td></tr>
<tr><td>RCS2</td><td colspan="2">Medium propensity for high-risk markers</td></tr>
<tr><td>RCS3</td><td colspan="2">No/Low propensity for high-risk markers</td></tr>
</table>

4.10. RCS1-3 are new categories introduced as part of the Phase 2 pilot. These screening categories are used to support Clinical Navigators in identifying call propensity for high-risk markers and provide a priority order for assessment.

4.11. During the transitional phase of the model, the RCS codes will be adapted from the current Amber1, Amber2 and Green code sets. This will form an initial approach to delivery of the new screening codes and aid a swift delivery of the revised approach. This will be continuously reviewed and developed based upon an evidence-based quality improvement approach that will respond to findings as the model embeds.

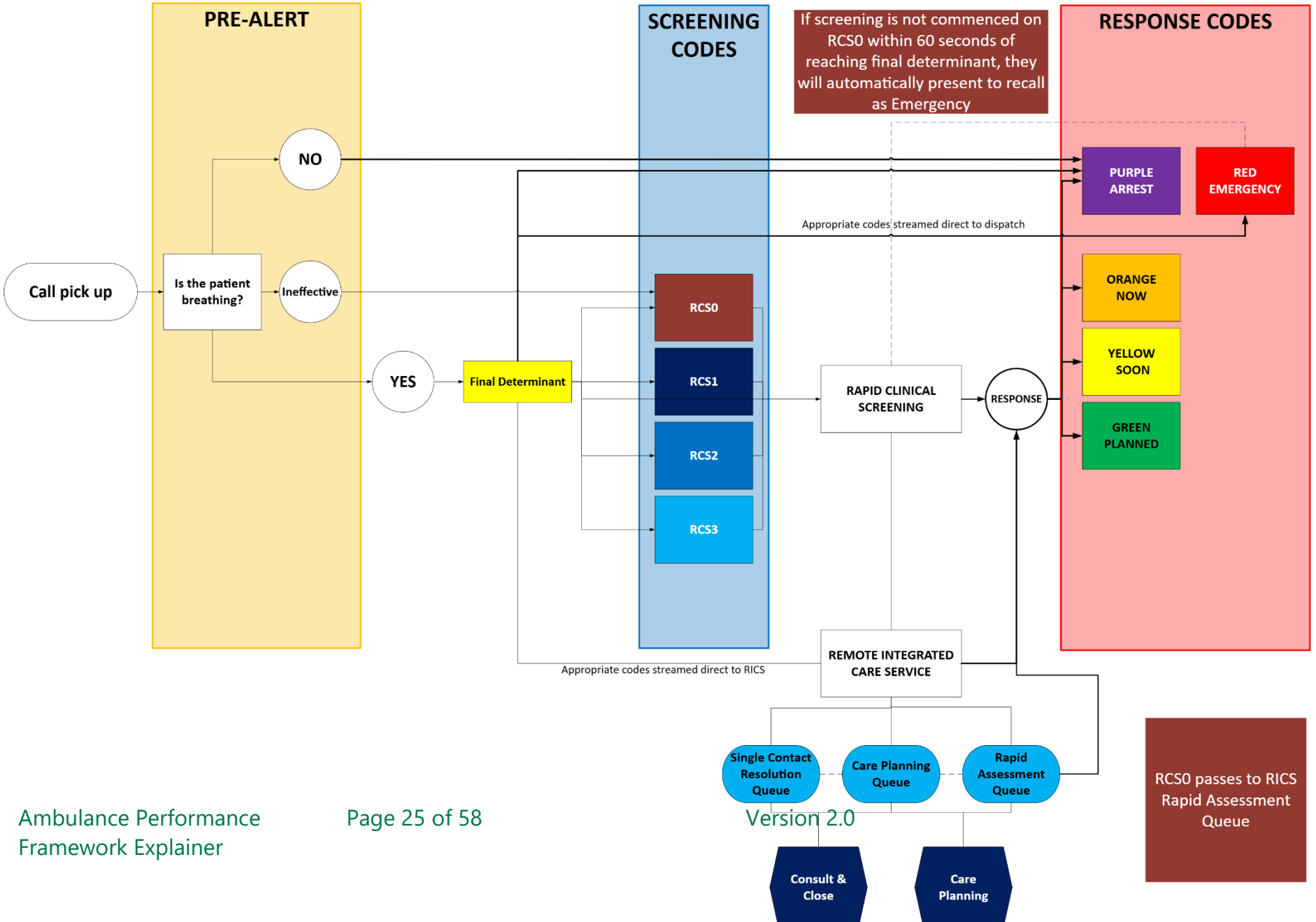
4.12. Some incidents will be identified at the MPDS stage as unsuitable for RCS (such as the current Amber1 CHARU dispatch codes). A small number of incidents will continue to stream direct to the Recall Queue and bypass RCS.

4.13. Phase 2 Response Categories

4.14. The Phase 2 pilot now means that WAST will have 5 distinct response categories available for the dispatch of assets. The categories provide a patient centric approach to resource allocation that support decision making rather than dictate it. The timeliness of response will continue to be an important focus of response (particularly for **Purple Arrest**, **Red Emergency** and **Orange Now** categories), but the category now supports the wider goal of ensuring the most appropriate care is delivered on the first occasion.

4.15. A summary of the 5 targets, their respective descriptions and measures, as well as a full flow diagram of the Phase 2 process can be found on the following pages.

	Category	Description	Aim	Measures
Respond Immediately	PURPLE: ARREST	Cardiac or respiratory arrest	Increase ROSC rates	• ROSC rate • Median time to identify cardiac arrest • Median time to commence CPR instruction • Median time for defibrillator arrival • Median response (6-8 minutes) • 90th percentile (20 minutes)
	RED: EMERGENCY	At high risk of cardiac or respiratory arrest	Prevent deterioration into arrest	• Median response (6-8 minutes) • 90th percentile (20 minutes) • Outcome measure (Pain, NEWS, Spo2)
Time Sensitive	ORANGE: NOW	Likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	Rapid arrival at specialist or emergency care facility as soon as possible	• Median response of most appropriate resource • 90th percentile • Stroke care bundle inc. call to door median and % arrival at specialist site • STEMI care bundle inc. call to door median and % arrival at specialist site • Further measures developed over time
Assess and Respond	YELLOW: SOON	Further clinical assessment to support clinician decision making (remote or face to face) for discharge at scene, and/or alternative pathway, and/or planned transport to treating facility, e.g. a person with abdominal pain.	Prevent unnecessary escalation of care	• Median response of most appropriate resource • 90th percentile • % by disposition
Planned Response	GREEN: PLANNED	High potential for the Ambulance Service to manage the care episode in its entirety or in collaboration with community service or planned care provider, e.g. chest infection, palliative care, mental health or UTI.	Right response for need	• Median response of most appropriate resource • 90th percentile • % by disposition


PRE-ALERT
SCREENING CODES
If screening is not commenced on RCS0 within 60 seconds of reaching final determinant, they will automatically present to recall as Emergency
RESPONSE CODES
Call pick up
Is the patient breathing?
NO
Ineffective
YES
Final Determinant
RCS0
RCS1
RCS2
RCS3
Appropriate codes streamed direct to dispatch
Appropriate codes streamed direct to RICS
RAPID CLINICAL SCREENING
RESPONSE
PURPLE ARREST
RED EMERGENCY
ORANGE NOW
YELLOW SOON
GREEN PLANNED
REMOTE INTEGRATED CARE SERVICE
Single Contact Resolution Queue
Care Planning Queue
Rapid Assessment Queue
Consult & Close
Care Planning
RCS0 passes to RICS Rapid Assessment Queue

4.16. Time Purpose Skill

4.17. The categories form part of the revised, clinically focussed and patient centred approach to the ambulance service's response model. Categories are intended to allow for identification to Emergency Medical Services Coordination (EMSC) staff and responding clinicians the urgency and priority order that must be considered in providing a suitable response. The category will reflect the 'Time' scale in which a resource must ideally be allocated.

4.18. However, to ensure the most effective and appropriate response possible it is recognised that the *purpose* of the response (what are we anticipating the outcome to be), and the most appropriate *skill* set of the response also have an impact on the patient outcome (to best resolve or manage the presenting condition). Therefore, the new framework will reflect a move towards this with a '**Time-Purpose-Skill**' decision deployed.

4.19. The 'Purpose' of a response will be 'Face to Face' (F2F) or 'Convey'. This will assist Resource Coordinators with identifying suitable resources based upon the need for a conveying asset.

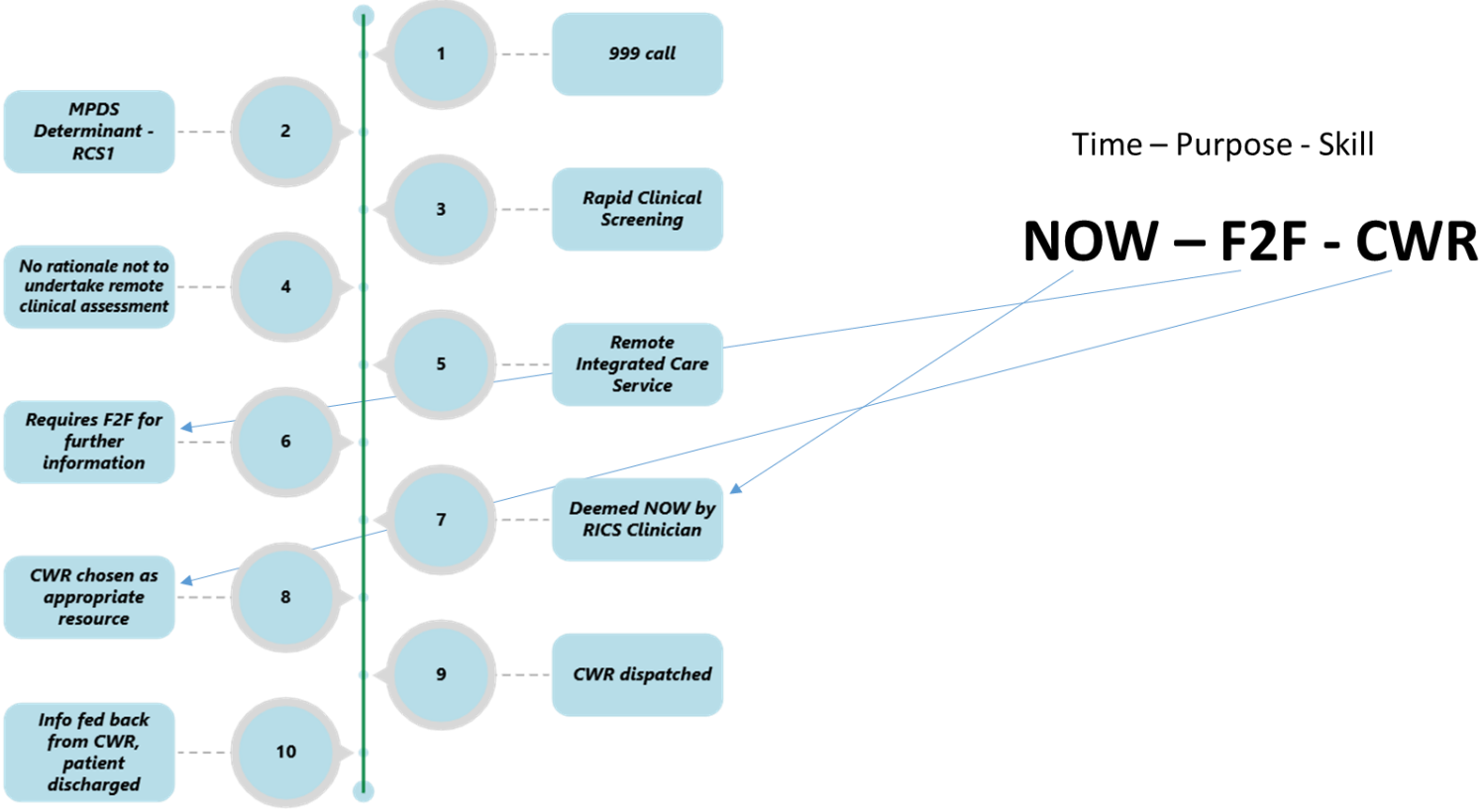
4.20. The 'Skill' will provide a range of suitable options for the dispatcher to choose from, as well as assist in guiding the most optimal resource choice. The skill required could be a range of suitable clinical responses or identified as requiring a specialist asset (such as an APP or Mental Health Practitioner). This supports the deployment of the most suitable resource to patients, ensuring effective utilisation, improved patient care and greater emphasis upon resolving cases as close to the patient's home as possible.

4.21. The Time-Purpose-Skill will be provided by the Clinical Navigator or RICS clinician prior to passing the incident to the Recall Queue (dispatch queue).

4.22. Additionally, the triaging clinician in RICS will provide a Time-Purpose-Skill specification when streaming calls to ensure that the most appropriate assessment queue is utilised. The 'Time' in this instance will be indicated by the RCS code of the call. Clinical Navigators will pass the call across at the current RCS code for review and a process to alert cases that are needing to

be assigned to the Rapid Assessment Queue will be available for situations that are felt to be of a highly urgent nature.

4.23. An example of a potential application of the Time-Purpose-Skill model is detailed below.



4.24. The primary intention behind Time-Purpose-Skill is to ensure that patients receive the correct response on the first occasion. At times, there may be an unavailability of the most appropriate response and therefore Resource Coordinators will be required to utilise the 'Time' category to understand if the urgency of the situation can wait for the correct response to become available.

4.25. This is a key shift in concept to the Integrated Services Clinical Model- resources may be available to respond to an incident but do not align with the most appropriate clinical response to the case. As such, holding calls for a period of time awaiting the correct response may be the most appropriate course of action to take. This differs from the current model whereby an incident of any category would have the next available resource dispatched to it regardless of whether a more appropriate unit was scheduled to become available in the near future.

4.26. This key change is instrumental in the delivery of the new service model. Ensuring the most appropriate response on the first occasion is likely to improve the subsequent care for the individual and provide a more efficient provision of services. This will require a greater level of decision making and risk stratification during the dispatch process than at present. Clinicians tasked with setting the Time-Purpose-Skill matrix should ensure that clear rationales and instruction are provided to support Resource Coordinators in interpreting and actioning the requests.

4.27. The protection of Emergency Ambulances (EA) to respond rapidly to time sensitive situations must be maintained to provide the safe service required to our most acutely unwell patients. This is of paramount importance as WAST aims to provide a high level of conveyance to Emergency Departments and Specialist Centres for this resource and therefore cases that are likely to be discharged at scene or managed via an alternative care pathway should aim to avoid the EA dispatch.

5. CALL CATEGORISATION AND FLOW: PURPLE ARREST CATEGORY

5.1. The first and most significant change within our new call categorisation system is **Purple Arrest**, which specifically focuses on cardiac and respiratory arrest incidents. These are the most time-sensitive emergencies, where swift identification, early effective CPR, access to a defibrillator, rapid dispatch, and immediate attendance, are crucial to patient survival. Our commitment to providing a prompt and effective response for these cases will be strengthened under the new model. Our protocols shall ensure that these incidents are prioritised and handled with the utmost urgency including CAD auto-dispatch.

5.2. **Definition:** Incidents where a person is in cardiac or respiratory arrest.

5.3. **Response:** Immediate dispatch (supported by auto-dispatch CAD functionality) with the fastest possible response, ensuring that paramedic and conveying resources also attend the scene as soon as possible. This will include the use of volunteer responders and GoodSam. Enhanced Care capabilities, such as CHARU, **must** be dispatched, where available. **Purple Arrest** and **Red Emergency** **must** be dispatched upon in time order.

5.4. **Purpose of Attendance and Skillset**: To swiftly respond to patients in cardiac or respiratory arrest, increasing ROSC rates that are subsequently transferred to an appropriate hospital facility. This includes the early provision of bystander CPR and the retrieval/use of a defibrillator to the patient, and a paramedic-led attendance to undertake high-quality resuscitative and post-ROSC care.

5.5. **Measurement**

5.6. While our operational response remains consistent, this represents a significant shift in how we measure the effectiveness of our response to cardiac and respiratory arrests. Traditionally, the 8-minute response time has been used as the standard metric for these cases. However, this time-based target lacks direct clinical evidence linking it to improved patient outcomes, particularly in terms of survival rates.

5.7. Instead, we shall measure performance according to the **Chain of Survival**. This concept encompasses a series of critical steps that have been clinically proven to increase the likelihood of survival and recovery for patients experiencing cardiac arrest. The links in the Chain of Survival are:

- Early recognition of a cardiac arrest,
- Early CPR initiation,
- Early use of a defibrillator,
- Prompt ambulance crew response and access to enhanced/critical care, particularly in the post resuscitation phase.

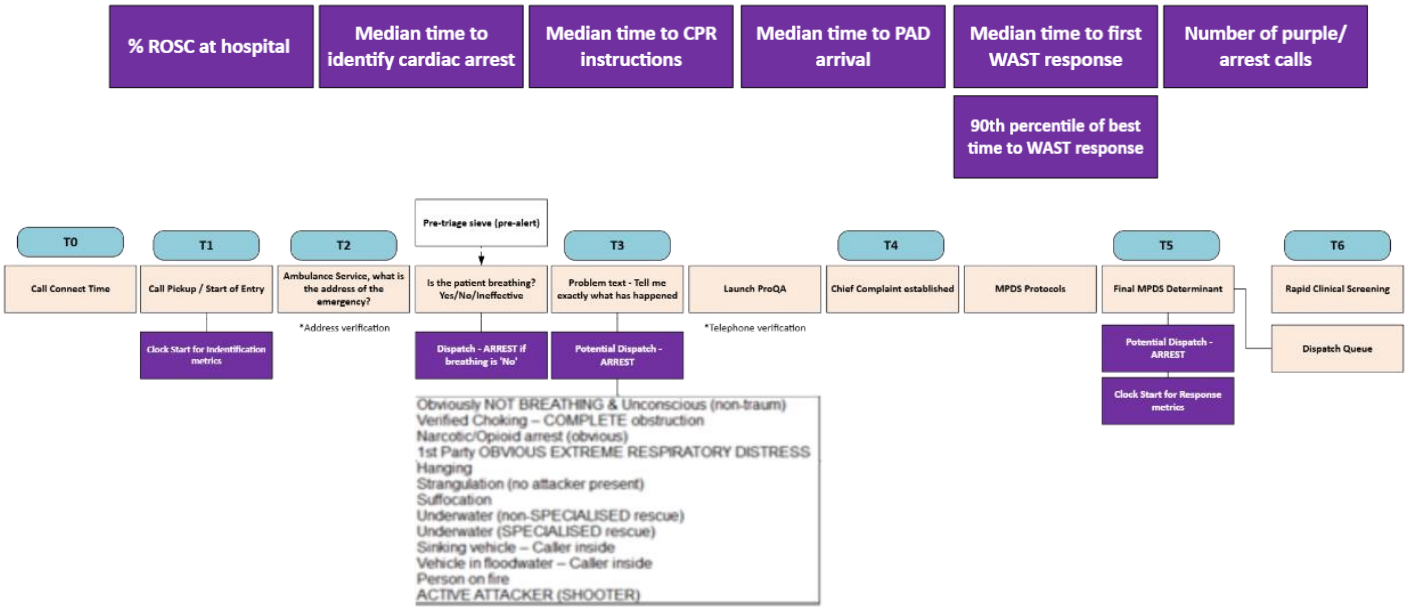
5.8. By focusing on the **Chain of Survival** rather than an arbitrary response time, we can more accurately assess and improve the quality of care provided. This approach emphasises the entire continuum of care, from the moment of arrest to the delivery of advanced life support and hospital transport, ensuring that each step is optimised to enhance patient outcomes. Measuring our performance based on these clinically relevant indicators aligns our practices with the best available evidence and reinforces our commitment to delivering the highest standard of care in the most critical situations

5.9. The overarching metric against which the service will be measured against in this category is **ROSC sustained to hospital arrival**. This will ensure that 'success' of the system can be aligned to multiple factors aimed at improving overall patient care, not simply whether an ambulance arrived within an arbitrary time.

5.10. Other metrics such as time taken to recognise cardiac arrest, time taken to commence CPR instruction, time taken for a defibrillator to arrive at the patient, and time taken to get a WAST resource to scene will also be recorded and allow for data points across the whole chain of survival to be taken and addressed. A comprehensive list of these metrics can be found in the Appendix.

5.11. The clock start measures are indicated below.

ARREST measurement



***Purple Arrest* Key Points**

- Immediate dispatch and rapid response are crucial for **Purple Arrest** incidents. Auto-dispatch will be active for these incidents, and they are to be treated as the same dispatch priority as **Red Emergency**.
- Performance will be measured according to the Chain of Survival, focusing on steps proven to enhance patient survival.
- Metrics such as recognition time, time to commence CPR instruction, defibrillator arrival time, WAST resource arrival time, and ROSC sustained to hospital arrival will be recorded for comprehensive analysis.
- The target median response time for **Purple Arrest** incidents is 6-8 minutes, with a 90th percentile response in 20 minutes.

6. CALL CATEGORISATION AND FLOW: RED EMERGENCY CATEGORY

6.1. The **Red Emergency** category is designated for incidents where a person is identified as being at high risk of cardiac or respiratory arrest and therefore require immediate clinical intervention. These situations are clinically determined as inappropriate for rapid clinical screening before dispatch due to the urgency and severity of the patient's condition and the likelihood of conveyance to secondary care. As a result, once the initial call handling process is completed, these incidents bypass any further assessment and proceed directly to dispatch, ensuring that help is on the way without delay. CAD auto-dispatch functionality shall be enabled for the **Red Emergency** category.

6.2. Calls within this category are time-sensitive and are likely to necessitate a higher level of clinical skill for effective intervention. These cases often involve complex emergencies where swift, expert care is critical to preventing deterioration and improving patient outcomes. Therefore, it is essential that our response to these emergencies remains both rapid and well-equipped, with highly skilled clinicians prepared to deliver enhanced medical interventions on scene.

6.3. Maintaining this direct to dispatch approach (including CAD system driven auto-dispatch) for the **Red Emergency** category aligns with our commitment to prioritising patient safety and delivering timely care where it is most needed. This approach ensures that our resources are mobilised quickly and effectively to address the most urgent cases, minimising the time to intervention and enhancing the chances of a positive outcome.

6.4. **Definition:** Incidents where a person is identified as at high risk of cardiac or respiratory arrest.

6.5. **Response:** Immediate dispatch. To attend the scene as soon as possible (supported by auto-dispatch CAD functionality), with both a WAST median response time measure and 90th percentile measure in 20 minutes inclusive of CFR & UFR for the median response time (90th percentile excludes CFR/UFR response times). **Purple Arrest** and **Red Emergency** **must** be dispatched in time order.

6.6. **Purpose of Attendance and Skillset:** To prevent patient deterioration into cardiac or respiratory arrest and to provide immediate aid to high-acuity patients. Paramedic with advanced life support capabilities should, subject to local dispatch protocols and where possible, be dispatched to these patients. Some of these cases may be clinically determined as appropriate for a single paramedic responder ahead of a determination for transport, like the pre-existing approach to some of the Red activity.

6.7. **Measurement**

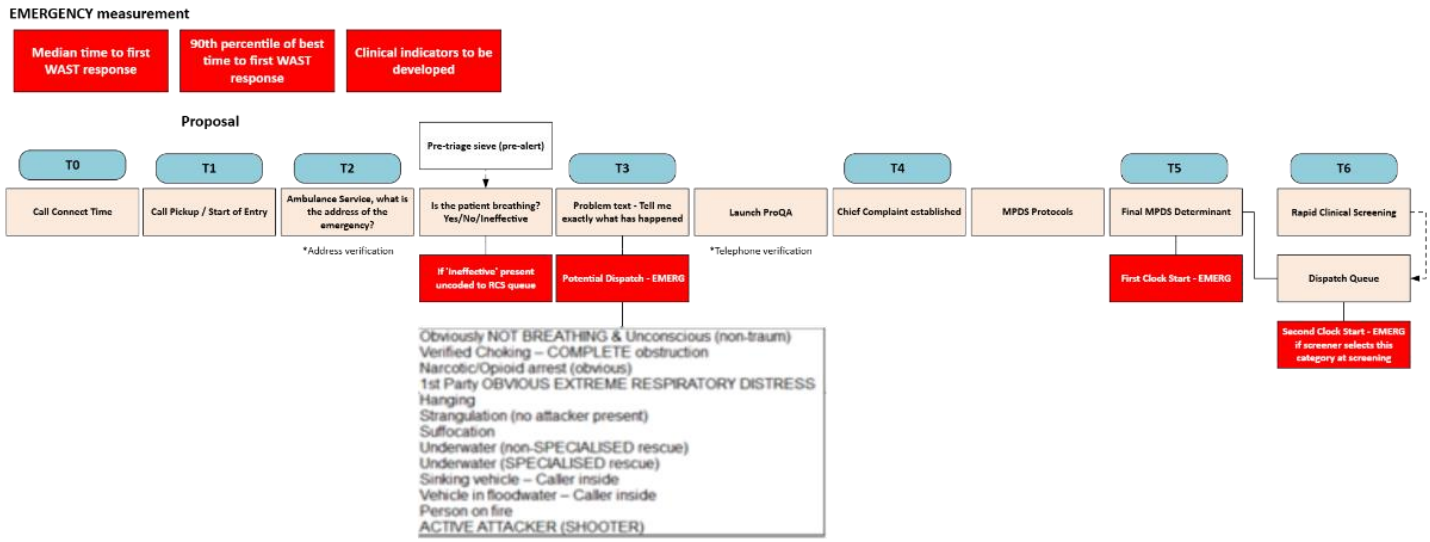
6.8. It is to remain our priority to attend incidents in this category with the appropriately skilled clinician as soon as possible with an expectation that the median response time will be in 6-8 minutes.

6.9. To maintain the integrity of the **Purple Arrest** category and sustain patient safety, a 90th percentile measurement in 20 minutes will also apply to the **Red Emergency** category. This ensures that calls within this category receive a timely response while preventing the inappropriate reclassification of cases into the **Purple Arrest** category merely to achieve faster response times. This issue has been observed since the introduction of the Clinical Response Model in 2015, where some MPDS determinants were shifted to the Red category to limit in-community wait times. It ensures that the **Red Emergency** category is managed independently of the **Purple Arrest** category, with each maintaining its specific criteria and response measurement. This approach not only protects the integrity of both categories but also reinforces our commitment to patient safety, ensuring that the right resources are deployed to the right cases based on clinical need rather than arbitrary time targets.

6.10. The median response time of the first WAST response shall be 6-8 minutes with a 90th percentile time to WAST response of 20 minutes. Any uniformed WAST response will 'stop the clock'; however, CFR & UFR will be excluded from the 90th centile metric. Additional measurements will record the arrival of 'conveying resources', appreciating that this could be different from the first resource on scene.

6.11. The 'Clock Start' time is measured from time of presentation to the dispatch queue (e.g. if received from **Rapid Clinical Screening - RCS/ Remote Integrated Care Service - RICS**, or via **Pre-Triage Sieve**) or at time of final **MPDS** Determinant.

6.12. The clock start measures are indicated below.



***Red Emergency* Key Points**

- **Red Emergency** category incidents require immediate dispatch to prevent cardiac or respiratory arrest. These are to be treated as the same priority as **Purple Arrest** incidents.
- Maintaining rapid response times with skilled clinicians is essential for patient safety and positive outcomes.
- **Red Emergency** has a targeted median response time of 6-8 minutes with a Best Response 90th percentile time of 20 minutes.

7. CALL CATEGORISATION AND FLOW: RAPID CLINICAL SCREENING PRIOR TO DISPATCH (RCS0, RCS1, RCS2, RCS3)

7.1. **Rapid Clinical Screening** (**RCS**) encompasses incidents that require a preliminary clinical assessment before dispatching emergency resources and is completed before the incident presents to a dispatch queue.

7.2. This provides a clinician-led review of incidents to identify those who require immediate face-to-face response, versus those who may benefit from an extensive remote clinical assessment to determine an appropriate pathway. By tailoring our response to better meet the specific needs of these individuals, we can ensure that emergency resources are preserved for those who require them most urgently. This approach allows us to provide high-quality care while optimising the allocation of emergency response units.

7.3. This will allow a clinically informed decision to respond to a patient immediately, or stream individuals to a further remote assessment as a priority patient. The intention of RCS is to ensure that the first response is the correct response and reduce incidents where emergency ambulance response does not result in an emergency transfer to hospital.

7.4. **Definition:** Incidents that, by virtue of not requiring an immediate response, have been identified as appropriate for rapid clinical screening to determine the appropriate next steps.

7.5. **Response:** **RCS0** High Acuity Live Review of incidents, including the active listening to calls in progress. Screening to commence within 60 seconds of final determinant, by a **Clinical Navigator** within the Emergency Medical Services Coordination Centre (EMSCC). A default backstop to **Red Emergency** exists for safety. All other calls to be streamed in priority order given the propensity for high-risk markers. No backstop is prescribed but calls should be screened as promptly as possible.

7.6. **Purpose of Intervention and Skillset:** Identification of incidents that require immediate intervention versus those that would benefit from additional time to gather information and inform the most appropriate response. The **Clinical Navigators** should assess the incident and determine

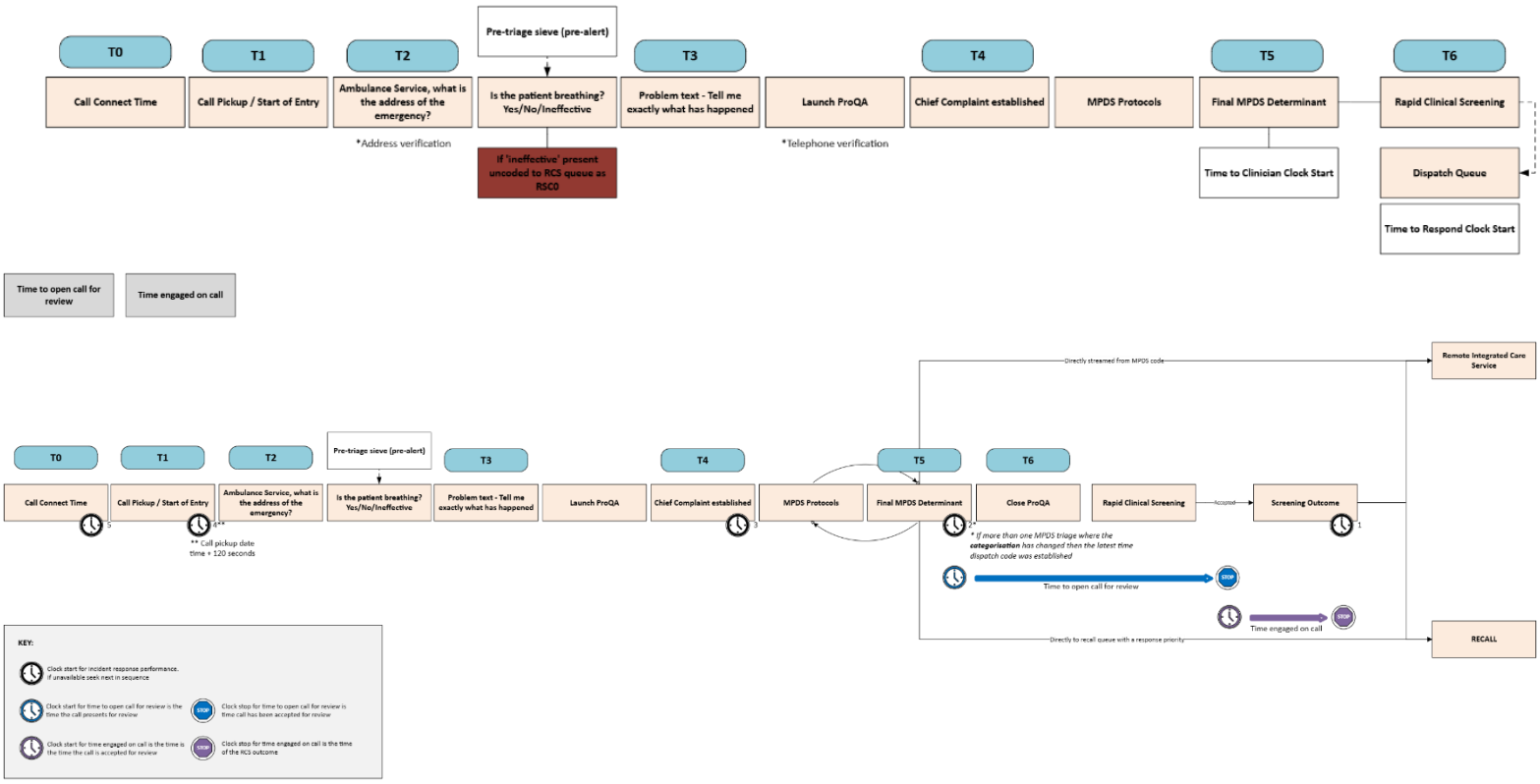
if there are any reasons that a remote clinical assessment should not take place and stream accordingly. The **Clinical Navigator** skillset is well defined and provides a suitably senior review capacity for the role undertaken.

7.7. Measurement and Safety Backstops

7.8. For this category, the key metric will be **median time to clinician**, measuring how quickly a patient is reviewed by a **Clinical Navigator** after the call handling process. Additional internal measures will be introduced to identify how long a clinician was engaged in the incident (median), as well as the recording of the outcomes of these assessments (**Purple Arrest**/**Red Emergency**, other response category, RICS).

7.9. **RCS0** has a safety backstop: if rapid clinical screening does not commence within 60 seconds of the final MPDS determinant, these cases will automatically flow to dispatch as **Red Emergency**. This safeguard ensures that even if remote management is being considered, patients at the highest risk will still receive a timely and appropriate response, maintaining patient safety as the top priority. Other RCS categories will not have a backstop timeframe but will continue to be screened in priority order as soon as possible.

7.10. The clock start measures are indicated below.



7.11. Clinical Navigator Review

7.12. A key innovation in this category is the introduction of the **Clinical Navigator**, a more senior clinician responsible for reviewing cases within these subgroups. The **Clinical Navigator** will apply their expertise and clinical judgment to assess whether the identified incident is suitable for deeper remote management or if it requires a more immediate response.

7.13. This represents a significant paradigm shift: to a position that these cases should receive further remote consultation by **RICS**, rather than an immediate ambulance dispatch, unless there are clear, clinical reasons why this should not happen. This change allows for more flexible and effective management of potential emergency cases, ensuring that patients receive care that is both timely and appropriate to their clinical needs.

7.14. Progression to dispatch from RCS

7.15. After the **RCS** process, if it is determined that an incident is not suitable for management through **RICS**, the case will progress to dispatch at the

clinically appropriate priority for response. This progression is part of a carefully structured system that ensures patients receive the most appropriate level of care based on their clinical needs.

7.16. Our broader ambition is to direct as much clinically appropriate activity as possible to **RICS**, thereby leveraging the efficiency and comprehensive care options that the service and wider urgent and emergency care system offers. However, recognising the complexity of this transition, there shall be a phased approach. This allows us to carefully monitor and adjust the process as we gain confidence in **RICS** operations, ensuring a smooth and safe transition.

7.17. Initially, a wide spectrum of response categories will be available to the **Clinical Navigator** during this transition (all 5 categories will be available for selection). These categories will provide flexibility as we fine-tune the **RICS** processes and gradually shift more activity into the **RICS** system. Over time, as we refine and optimise these processes, we anticipate narrowing the range of dispatch options available to the **Clinical Navigator**.

RCS Key Points

- **Rapid Clinical Screening (RCS**) will screen the vast majority of incidents prior to dispatch, ensuring clinical assessment informs the most appropriate response.
- A **Clinical Navigator** will review incidents to determine if they are suitable for remote assessment via the **Remote Integrated Care Service** (**RICS**) or require an immediate or time-sensitive face-to-face response.
- Key metrics, including time to clinician and outcomes of assessments, will be used to measure the effectiveness and safety of this approach.

8. CALL CATEGORISATION AND FLOW: ORANGE NOW CATEGORY

8.1. **Definition:** A patient likely to need timely diagnostics, treatment and/or transport to hospital or specialist care e.g. a person in stroke or heart attack.

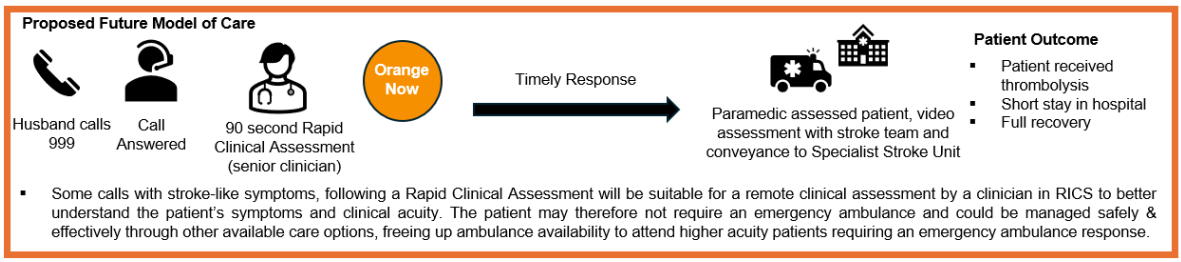
8.2. **Response:** Determined by the clinical need of the patient and recommended by the triaging clinician. In the case of STEMI or Stroke, this will in almost all cases be an emergency ambulance, but additional responses can be considered. Auto dispatch disabled, this category will normally be responded to with emergency warning devices. It is anticipated that this would occur within 1 hour of categorising or prioritising as an **Orange Now** incident.

8.3. **Purpose of Attendance and Skillset**: Rapid arrival at specialist or emergency care facility as soon as possible.

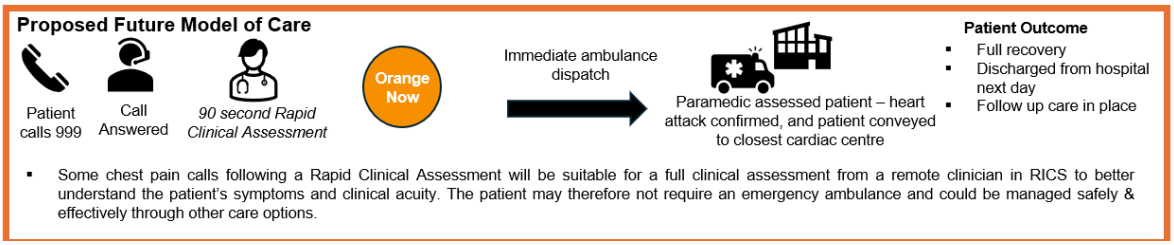
8.4. **Measurement**

- Median response of most appropriate resource
- 90th percentile
- Stroke care bundle inc. call to door median and % arrival at specialist site
- STEMI care bundle inc. call to door median and % arrival at specialist site
- Further measures developed over time

8.5. This change aims to manage time-sensitive complaints in the current 'Amber' category differently by prioritising ambulance dispatch. Case study examples of a suspected stoke and a significant heart attack 'STEMI' are provided below (at figure one and two) to illustrate the changes to current model.

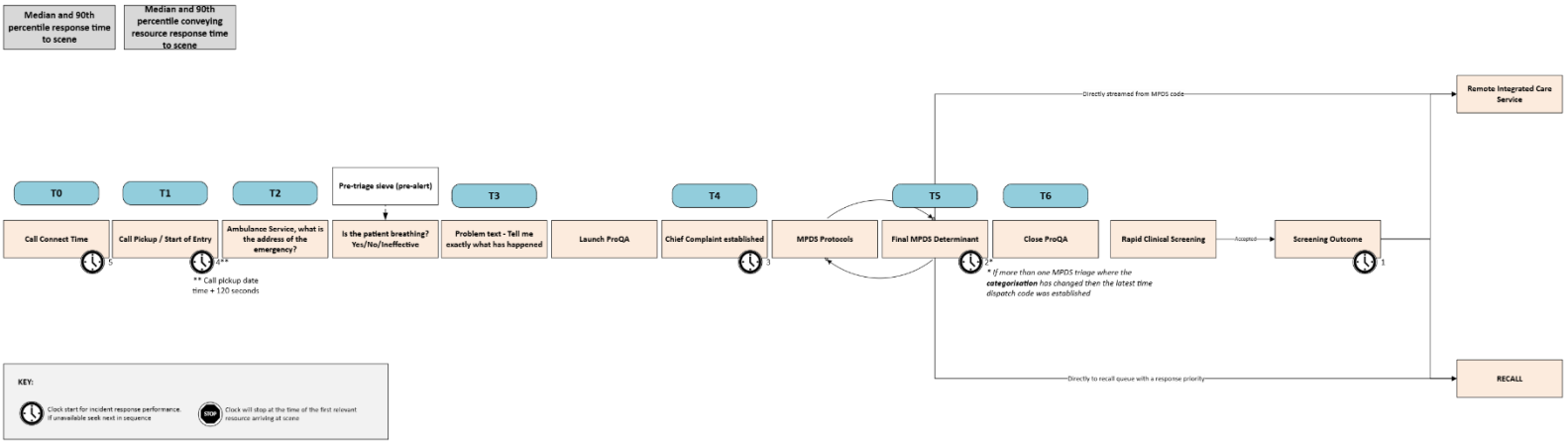


8.6. *Figure one: Case study example of stroke management*



8.7. *Figure two: Case study example of STEMI management*

8.8. ***Place holder for Clock Start/Stop Diagram (TBD)***



Orange Now Key Points

- For cases where there is a confirmed or potentially time sensitive marker present and the patient may require a face-to-face assessment as soon as possible.
- It is anticipated that this would occur within 1 hour of categorising or prioritising as an **Orange Now** incident.
- In the case of Stroke and STEMI, separate clinical bundles will be measured as well as 'call-to-door' times.
- Median and 90th percentile measured, focus on a 'timely response'.

9. CALL CATEGORISATION AND FLOW: YELLOW SOON CATEGORY

9.1. **Definition:** Further clinical assessment to support clinician decision making (remote or face to face) for discharge at scene, and/or alternative pathway, and/or planned transport to treating facility, e.g. a person with abdominal pain.

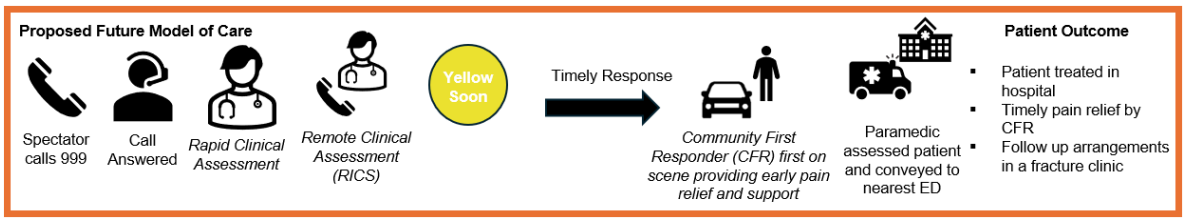
9.2. **Response:** Determined by the clinical need of the patient and recommended by the triaging clinician. An emergency ambulance may be required, but suitable alternative response options may be able to resolve the situation. Conveying resource requirement to be identified at remote assessment if possible. Auto dispatch disabled, this category would not normally be responded to with emergency warning devices. It is anticipated that this would occur within 4 hours of categorising or prioritising as a **Yellow Soon** incident.

9.3. **Purpose of Attendance and Skillset**: To prevent unnecessary escalation of care, provide a prompt response to cases to minimise pain or distress, assist with gathering further information to inform appropriate care planning. Skillsets will be determined by the clinical need, and as closely aligned with best practice as possible. The use of the volunteer network may support effective deployment of resources.

9.4. **Measurement**

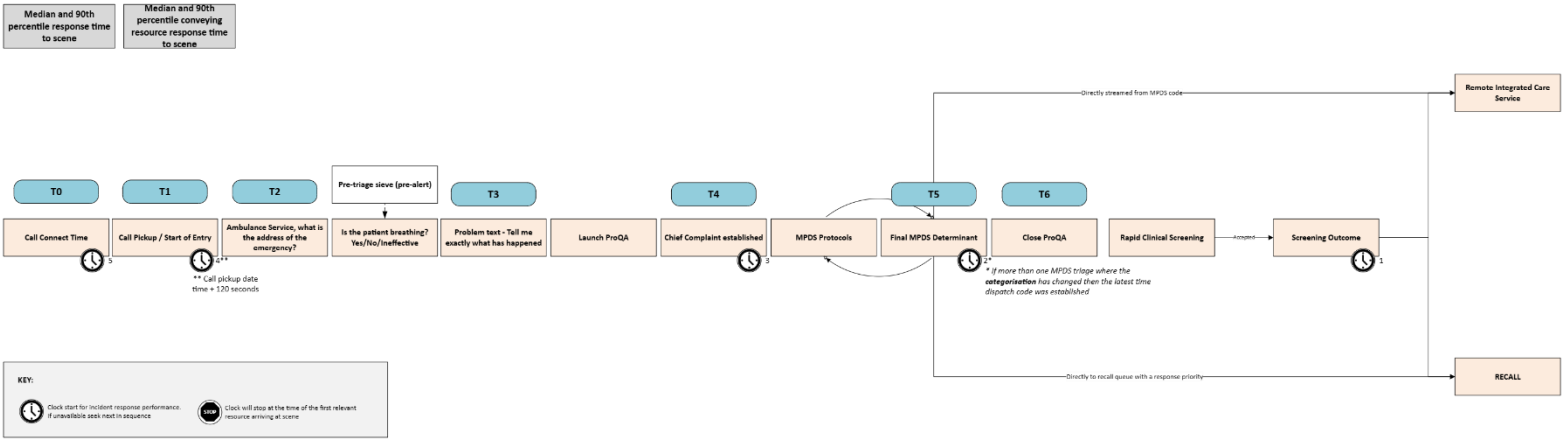
- Median response of most appropriate resource
- 90th percentile
- % by disposition

9.5. The screening process is designed to enable more detailed clinical decision-making for individuals who have experienced a serious injury or are acutely unwell in an environment that may affect their outcome. An example of a serious sports injury in harsh weather conditions is illustrated below.



9.6. *Figure three: Case study example of management of leg fracture on a rugby field.*

9.7. ***Place holder for Clock Start/Stop Diagram (TBD)***



***Yellow Soon* Key Points**

- Resource utilisation should be focussed upon resolving case in most effective way possible.
- No time sensitive markers identified but requires prompt response to minimise pain or discomfort and prevent deterioration.
- It is anticipated that this would occur within 4 hours of categorising or prioritising as a **Yellow Soon** incident.
- Alternatives to Emergency Ambulance response may be of high impact.

10. CALL CATEGORISATION AND FLOW: GREEN PLANNED CATEGORY

10.1. Definition: High potential for the Ambulance Service to manage the care episode in its entirety or in collaboration with community service or planned care provider, e.g. chest infection, palliative care, mental health or UTI.

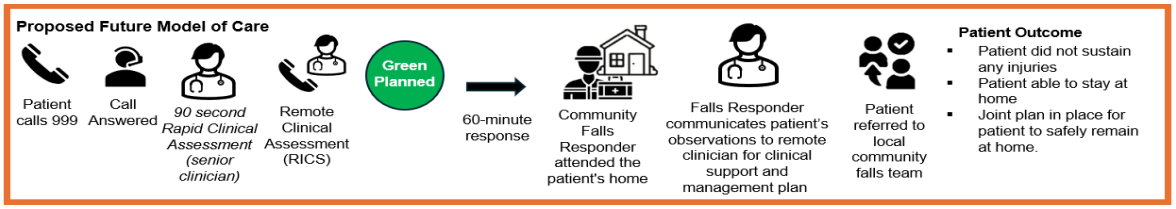
10.2. Response: Community or non-emergency based responses. Auto dispatch disabled. This will be responded to in a timeframe that is most appropriate for the nature of the planned response and may exceed 4 hours if appropriate (e.g. for 6 hours overnight whilst awaiting transfer to an in-hours service such as an Advanced Paramedic Practitioner).

10.3. Purpose of Attendance and Skillset: Right response for need and this may be for a see and treat/refer disposition or for a conveyance to a definitive care centre away from the Emergency Department (e.g. Minor Injury Unit). Skillset will be aligned with the most suitable for clinical presentation (e.g. Falls Responder for fallen person).

10.4. Measurement

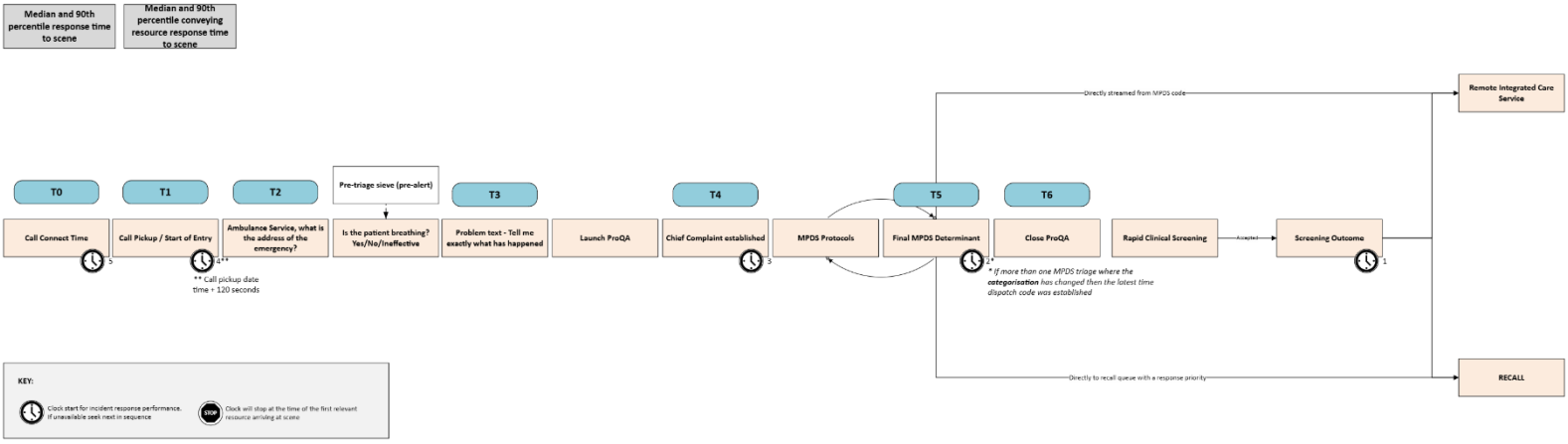
- Median response of most appropriate resource
- 90th percentile
- % by disposition

10.5. Individuals who have fallen will have their needs evaluated through the screening process. If it is determined that a fall responder may be necessary, one will be dispatched while simultaneously forwarding the case to the Remote Integrated Care Service. This allows for a remote clinician to conduct an intervention and assessment before the fall responder arrives, thereby decreasing the chances of prolonged lying on the floor or other negative outcomes.



10.6. *Figure four: Case study example of elderly falls management*

10.7. *Place holder for Clock Start/Stop Diagram (TBD)*



Green Planned Key Points

- To facilitate effective community-based care or non-emergency hospital transportation.
- Focussed upon 'planned' work rather than a specific timeframe- this could be within an hour (e.g. falls responder) or held overnight until services open the following day (supported by clear communication and risk-based decision making).
- Aligns with the Care Planning functions of RICS.

11. REMOTE INTEGRATED CARE SERVICE (RICS)

11.1. **RICS** represents a significant advancement that goes beyond the simple merging of our **Clinical Support Desk (CSD)** and **NHS 111 Wales** services. **RICS** is an expanded, multi-disciplinary team (MDT) with enhanced capabilities, offering more than traditional triage, 'consult and close' or 'consult and refer' functions. This unified approach combines the expertise and resources of both services to deliver a more comprehensive and patient-centred care model. By utilising the full range of skills and support from our teams, **RICS** ensures improved delivery of care and effectiveness.

11.2. Flow to Assessment or Care Planning

11.3. Following the flow determination in the **RCS** process, it is anticipated that a majority of **RCS** incidents will stream to **RICS**. These will transfer across as an '**RCS**' code, streamed to the most appropriate queue by the Clinical Navigator.

11.4. Any **RCS0** incident identified as suitable for remote assessment by the Clinical Navigator will stream to the Rapid Assessment Queue. These consultations will happen as soon as possible; however, the aim is to commence a consultation within 15 minutes of the incident presenting to the queue.

11.5. Other **RCS** codes will pass to the queue most relevant to their clinical need. Again, this will be streamed by the Clinical Navigator in the same process in place for the Amber and Green calls now. A flag to indicate a need for a Rapid Clinical Assessment requirement will continue to be available to highlight non-RCS0 incidents that are felt to require a faster assessment.

11.6. It is anticipated that a proportion of incidents streamed to **RICS** will not require an ambulance dispatch and may be managed appropriately via an alternative arrangement. These calls may result in a single contact resolution, or a transfer into Care Planning for ongoing management. Transfer to Care Planning may require the incident to be recategorised to the most appropriate response category to allow the dispatch of ideal or interim responses.

11.7. All **RCS** screening codes will pass from **RCS** to **RICS** and transition to the identified queue by the **Clinical Navigator**, as is current process now. The nature of the call may be assessed by the **Senior Clinician** (SC), **Point of Contact** (POC), or **Operations Manager** (OM) who can identify amendments to an alternative queue if required. If this does not occur (e.g. due to capacity of the SC), all non-**RCS0** cases will stream to the Single Contact Queue as a default fallback position.

11.8. At the launch of the new categories, the Trust will be utilising the existing C3/CAD system and therefore the mechanism for moving calls between queues will be broadly akin the current approach. However, the intention will be to transition to a single CAD model that will improve the ease of transferring and/or holding calls within the Integrated Care space. Details of this will be shared in due course.

11.9. Call Flow from RICS to Dispatch

11.10. When an incident is assessed within the **RICS** and deemed necessary for a face-to-face assessment or conveyance, the case will flow to dispatch with an ideal and interim resource(s) recommendation. This pathway is also applicable for any patient accessing healthcare via NHS 111 Wales but needs a physical response. This process is designed to ensure clarity and precision in how dispatch staff manage and allocate resources, with specific categories to illustrate response times, and purposes of attendance clearly defined. The single CAD solution will support this when live, but the interim measure mirrors current process; the category reflects the *Time* nature of the response, and the Ideal response will provide an indication of both *Purpose* (Face to Face or Convey) and the *Skill* level required.

11.11. When passing this call back to dispatch, the **RICS** clinician will select most appropriate category for the incident type. For example, if the clinician undertakes a rapid assessment and identifies that the patient may be critically unwell (high risk of cardiac arrest), they could amend and pass back the call as **Red Emergency**. However, if the patient is identified as requiring a face-to-face response but is more clinically stable, this could be streamed back to the dispatch queue as a different category incident as appropriate

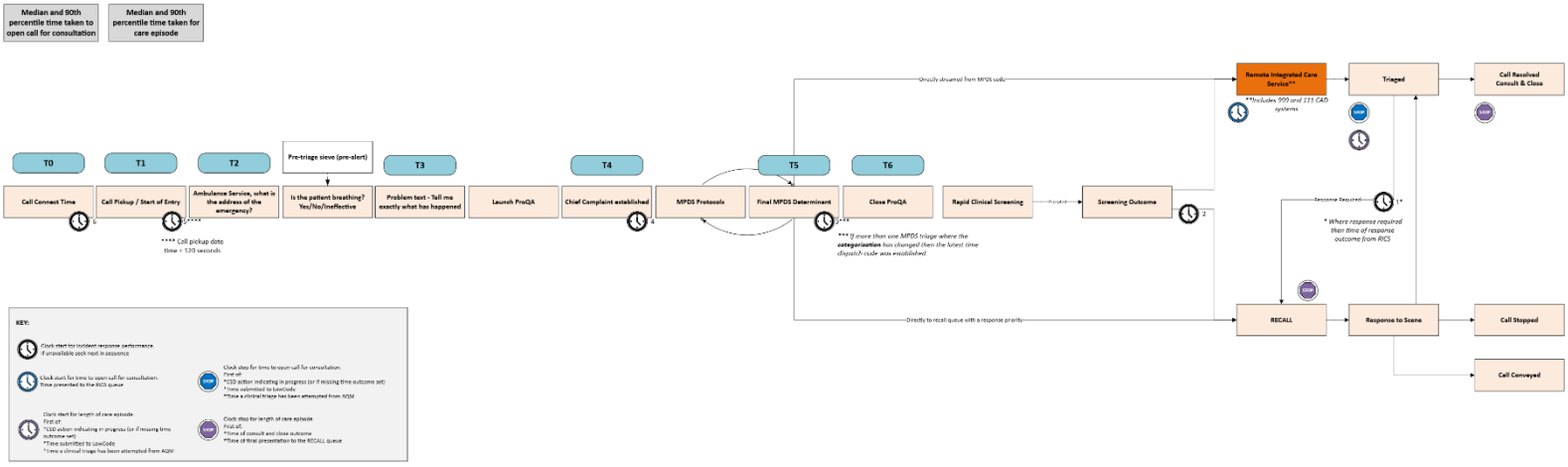
(such as **Orange Now** or **Yellow Soon**). All incidents will need to be amended from their 'RCS' status, thereby prompting a decision by the triaging clinician regarding the urgency of the response.

11.12. The RICS clinician should also indicate the most appropriate *Purpose* and *Skill* when streaming the call to the Recall Queue to assist the Resource Coordinator in identifying the correct asset to respond to the incident. This will be via the Ideal and Interim resources. When selecting these resources, the IC clinician should consider the anticipated clinical course of the patient and aim to provide a recommendation that will provide a definitive solution for the patient. This may be for a conveying resource to transfer the patient to a definitive treatment location, or face-to-face resources to support information gathering (such as a Community Welfare Responder).

11.13. Measurement

11.14. All categories within RICS will be measured for median time to assessment, as well as the ultimate final disposition for incidents.

	Category	Measure
Remote Integrated Care Service – Clinical Assessment	**RCS0**	• Median time to remote assessment • % Outcome
	RCS1	• Median time to remote assessment • % disposition
	RCS2	• Median time to remote assessment • % disposition
	RCS3	• Median time to remote assessment • % disposition



Remote Integrated Care Service Key Points

- **RICS** combines the Clinical Support Desk and NHS 111 Wales services into a unified, multi-disciplinary team to provide comprehensive patient-centred care.
- **RCS** incidents identified as suitable for **RICS** are streamed to the most appropriate queue for assessment by clinicians, ensuring safe and timely evaluation of cases.
- Incidents requiring physical intervention or face-to-face response are passed to dispatch with appropriate categorisation to optimise resource allocation and response times/intentions.

12. APPENDIX A: PURPLE ARREST DATA MEASURES

12.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
ARR1a	PURPLE ARREST Coded Calls
ARR1b	PURPLE ARREST Scene Attendance Time
ARR2	ROSC at Hospital
ARR3a	Time to Identify Cardiac Arrest
ARR3b	Time to Identify if the Patient is not Breathing
ARR3c	Time to Commence CPR Instructions
ARR3d	Time to ARREST MPDS Code
ARR4a	Incidents with Bystander CPR
ARR4b	Number of ARREST Calls with no Time to Commence CPR
ARR5a	Incidents where a PAD was Available
ARR5b	Incidents where a PAD was Allocated
ARR5c	Incidents where a PAD was Brought to Scene
ARR6a	Instruction to Retrieve an Available PAD
ARR6b	PAD Retrieval Time
ARR6c	Time to PAD Arrival
ARR7a	Time to First Alert: WAST Resource
ARR7b	Time to First Mobilisation: WAST Resource
ARR8a	Time to First Alert: Paramedic Resource
ARR8b	Time to First Mobilisation: Paramedic Resource
ARR9a	Time to First Alert: GoodSAM
ARR9b	Time to First Mobilisation: GoodSAM
ARR9c	Response Time: GoodSAM
ARR10a	Time to Conveying Resource Response
ARR10b	Time to Enhanced Care Response

13. APPENDIX B: RED EMERGENCY DATA MEASURES

13.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
EMR1a	RED EMERGENCY Coded Calls
EMR1b	RED EMERGENCY Scene Attendance Time
EMR2	EMERGENCY Calls with CPR Instructions
EMR3	Time to Conveying Resource Response

14. APPENDIX C: RCS DATA MEASURES

14.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

14.2. RCS0

REF	METRIC
RCS 1	RCS0 Categorised Incidents
RCS 2a	How long does a clinical navigator take to open an RCS0 call for review?
RCS 2b	How many RCS0 calls wait longer than 60 seconds for screening?
RCS 3	How long is the clinical navigator engaged with a RCS0 call?
RCS 4a	How many RCS0 calls are streamed to dispatch as PURPLE ARREST or RED EMERG?
RCS 4b	How many RCS0 calls are streamed to dispatch as ORANGE NOW, YELLOW SOON or GREEN PLANNED?
RCS 4c	How many RCS0 calls are sent to Integrated Care?
RCS 4d	How many RCS0 calls timeout and do not have a High Acuity Live Review (HALR) applied?
RCS 4e	RSC0 Exceptions

14.3. RCS1

REF	METRIC
RCS 5a	How many RCS1 categorised calls are received?
RCS 5b	How many RCS1 categorised call are streamed directly to remote integrated care without screening?
RCS 6a	How long does a clinical navigator take to open an RCS1 call for review?
RCS 6b	How long is the clinical navigator engaged with a RCS1 call?
RCS 7a	How many RCS1 calls are streamed to dispatch?
RCS 7b	How many RCS1 calls are streamed to remote integrated care?

14.4. RCS2

REF	METRIC
RCS 8a	How many RCS2 categorised calls are received?
RCS 8b	How many RCS2 categorised call are streamed directly to remote integrated care without screening?
RCS 9a	How long does a clinical navigator take to open an RCS2 call for review?
RCS 9b	How long is the clinical navigator engaged with a RCS2 call?
RCS 10a	How many RCS2 calls are streamed to dispatch?
RCS 10b	How many RCS2 calls are streamed to remote integrated care?

14.5. RCS3

REF	METRIC
RCS 11a	How many RCS3 categorised calls are received?

RCS 11b	How many RCS3 categorised call are streamed directly to remote integrated care without screening?
RCS 12a	How long does a clinical navigator take to open an RCS3 call for review?
RCS 12b	How long is the clinical navigator engaged with a RCS3 call?
RCS 13a	How many RCS3 calls are streamed to dispatch?
RCS 13b	How many RCS3 calls are streamed to remote integrated care?

15. APPENDIX D: ORANGE NOW DATA MEASURES

15.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
NOW 1a	How many ORANGE NOW incidents are received?
NOW 1b	How long do ORANGE NOW incidents take to receive a response to scene?
NOW 1c	How long do ORANGE NOW calls take to receive a conveying resource response to scene?
NOW 2	Percentage of suspected stroke patients who are documented as receiving appropriate stroke care bundle with a subsequent conveyance to an appropriate care setting
NOW 3	Percentage of ST segment elevation myocardial infarction (STEMI) patients who are documented as receiving appropriate STEMI care bundle with a subsequent conveyance to an appropriate care setting
NOW 4a	How many ORANGE NOW incidents are resolved through remote clinical assessment (Consult and Close)?
NOW 4b	How many ORANGE NOW incidents are resolved (see, treat, refer) at scene after a response has arrived?
NOW 4c	How many ORANGE NOW incidents result in a conveyance to hospital and what type of hospital are they conveyed to?

16. APPENDIX E: YELLOW SOON DATA MEASURES

16.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
SOON 1a	How many YELLOW SOON incidents are received?
SOON 1b	How long do YELLOW SOON incidents take to receive a response to scene?
SOON 1c	How many YELLOW SOON incidents receive an ideal or interim response?
SOON 1d	How long do YELLOW SOON incidents take to receive an ideal or interim response to scene?
SOON 2a	How many YELLOW SOON incidents are resolved through remote clinical assessment (Consult and Close)
SOON 2b	How many YELLOW SOON incidents are resolved (see, treat, refer) at scene after a response has arrived?
SOON 2c	How many YELLOW SOON incidents result in a conveyance to hospital and what type of hospital are they conveyed to?

17. APPENDIX F: GREEN PLANNED DATA MEASURES

17.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
PLAN1a	How many GREEN PLANNED incidents are received?
PLAN 1b	How many GREEN PLANNED incidents receive an ideal or interim response as determined by a clinician?
PLAN 1c	How long do GREEN PLANNED incidents take to receive a response to scene?
PLAN 1d	How long do GREEN PLANNED incidents take to receive an ideal or interim response to scene?
PLAN 2a	How many GREEN PLANNED incidents are resolved through remote clinical assessment (Consult and Close)
PLAN 2b	How many GREEN PLANNED incidents are resolved (see, treat, refer) at scene after a response has arrived?
PLAN 2c	How many GREEN PLANNED incidents result in a conveyance to hospital and what type of hospital are they conveyed to?

18. APPENDIX G: RICS DATA MEASURES

18.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
RICS 1	How many 999 incidents flow to remote integrated care service (RICS)?
RICS 2	How long does a remote integrated care service (RICS) call take to open for consultation?
RICS 3	How long does the care episode in remote integrated care service (RICS) take?
RICS 4	How many remote integrated care service (RICS) consultations are prioritised for response and what response category are they?
RICS 5	How many remote integrated care service (RICS) consultations are resolved as consult and close and what outcomes are they?

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

Agenda Item No. 7

MEETING

Name of meeting	Finance & Performance Committee (FPC)
Date of meeting	16 September 2025
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

Executive sponsor	Estelle Hitchon - Interim Director of Strategy, Planning & Performance
Author(s) of report	Hugh Bennett – Interim Deputy Director, Commissioning & Performance Mark Thomas - Commissioning & Performance Manager Melanie O'Connor = Senior Performance Analyst

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

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

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

3. There are a few acknowledged data quality issues in the report e.g. APP data. There is a clear executive focus on Phase 2 of the Ambulance Performance Framework, so this is the current priority, but additional capacity is being sort for Insight and Data Services function. Some additional capacity is already in place and further interviews are taking place on the 3rd to 5th Sept. The pressures on IDS are being actively manged through a CMT workplan.

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

5. The Trust continued to see lost hours to handover reduce, with the figure for July 2025 of being the lowest levels for four years. However, this level of lost capacity is still difficult to compensate for.

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

7. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in July 2025 and is unlikely to do so within the existing commissioned financial envelope i.e. capacity (including efficiencies) is not sufficient to meet demand.

8. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is stable, with both oncology and renal journeys remaining above target in July 2025.

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

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance & Performance Committee is requested to:

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

ADDITIONAL PAPER(S)

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

1. Annex 1 - Monthly Integrated Quality & 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

160 - High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service

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

100 - Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience

139 - Failure to deliver our Statutory Financial Duties in accordance with Legislation

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
02.09.2025	Estelle Hitchon - Interim Director of Strategy, Planning & Performance

SITUATION

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

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

Slide Title	Slide Number
111 Call Answering/Abandoned Performance Indicators	3
111 Clinical Assessment Start Time Performance Indicators	4
999 Call Performance Indicators	5
Arrest Purple Performance Indicators	6
Arrest Purple Performance Indicators	7
Emerg. Red Performance Indicators	8
Amber Performance Indicators	9
Patient Experience – Influencing Ambulance Care Indicators	10
Capacity - Ambulance Abstractions and Production Indicators	20
Shift Overruns	24
Ambulance Care Indicators	26
Finance Indicators	27
EMS Utilisation	28
Average Job/Shift Times	29
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators	30
Consult & Close Indicators	31
Conveyance to ED Indicators	32

BACKGROUND

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

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

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

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

7. **999** call answering times improved in July 2025 with the 95th percentile decreasing to 12 seconds, compared to 26 seconds in June 2025. The 65th percentile and median performance remain consistently good; and data quality checks have been undertaken. Work is currently being undertaken on demand and capacity analysis of 999 call demand.

8. **111 call answering performance has minimally decreased over recent weeks,** with the call abandonment performance for July 2025 being 10.1%, not achieving the 5% target. We might expect to see an improvement in performance in the summer, traditionally a period with lower demand and sickness. However, the external rostering review suggests there is a demand and capacity gap within the current funded establishment and the Trust is therefore unlikely to reach performance without an increased workforce (including efficiencies).

9. 111 demand in July 2025 was 2.7% lower than during July 2024. The Trust procured a third party in January 2025 to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.

10. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 99%. Response times for lower priority calls declined, recording 69.2% and 61% for P2CT and P3CT respectively. This is consistent with previous years with an increase in demand but needs to be monitored closely over the coming months.

11. **Ambulance Response** (safety / patient experience): On 1 July 2025, our new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest(Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. In July 2025, there were 814 purple calls to the ambulance service, around 2.3% of all calls, and 4,449 red calls, around 12.6% of all calls. The median response times for purple and red calls were 7 minutes 35 seconds 8 minutes 47 seconds respectively.

    The Amber 1 median in July 2025 was 1 hour and 19 minutes and the Amber 1 95th percentile was 3 hours 34 minutes. The Clinical Safety Plan and CHARUs will protect Arrest and Emergency demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on avoidable patient harm. Amber will be replaced by Orange and Yellow in quarter three this year. The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand.

12. Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good, and handover lost hours have significantly improved; this improvement is particularly feeding through into the amber categories' performance. Whilst handover lost hours has sig. improved, we are still seeing levels that are double what the rosters are designed to cope with. Health Boards are implementing new actions in order to further reduce hand over last hours. The Trust's main focus is to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme, elements of which have been implemented. Areas of focus for 2025/26 include: -

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

13. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 12,565 hours were lost during July 2025. All health boards have seen reductions, compared to last month, particularly Swansea Bay (35.7%) , Powys (32.4%) and Aneurin Bevan (29.2%). While bigger improvements have been seen in other health boards, Betsi Cadwaladr health board remains significantly high but just below its two-year average figure, with 5,367 hours being lost within the health board during July 2025. WG has re-iterated to health boards the critical importance of improvements in this area and the reduction of all over 45-minute waits was a recommendation from the recent Ministerial Advisory Group on Performance and Productivity. The W45 initiative would see hand over lost hours reduce approximately to what the EMS rosters are designed to cope with.

14. **Ambulance Care (Patient Experience)**: Oncology performance in July 2025 was 75.56%, achieving the 70% target. Renal performance remained just above target, achieving 70.72% and advanced discharge & transfer journey performance increased marginally to 83% (95% target), this will primarily be an issue with capacity. Same day discharge & transfer journey performance also achieved 95%, target at 95%. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive Health Transport

transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is currently re-rostering NEPTS transport (now started) which will better align available capacity with changing demand patterns (on target). This is proving complex and difficult but will be delivered.

15. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported four NRIs to the NHS Executive in July 2025, more than June 2025 (8) and 12 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In July 2025 complaint response times dropped to 53%, compared to the 88% recorded in July 2025, not achieving the 75% target. However, a PTR recovery plan is in place, recognising that cases remain complex.

16. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 87.8% in July 2025, minimally decreasing and remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system, and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate increased to 21.4% in July 2025 compared to 19.3% in June 2025.

17. The Trust can report on call to door times for Stroke and STEMI patients. For July 2025, these highlight call to hospital door times of two hours and 19 minutes for stroke patients and two hours and eighteen minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, because of the pressures and issues outlined in this report.

18. In July 2025, 5,816 patients **cancelled** their ambulance (this figure excludes patients who refused treatment). This is a significant reduction on previous levels. This reduction is likely to be the impact of switching on RCS through the winter. The Trust believes that 50% (of the pre-RCS switch on figure) of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Caution is required at this stage though as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its Clinical Safety Plan in December, removing the “can’t send” application, with the option remaining at the strategic commander’s discretion in the new plan.

Our People (workforce resourcing, experience, and safety)

19. **Hours Produced**: The Trust produced 119,098 Ambulance Response unit hours during July 2025 and delivered an emergency ambulance unit hours production (UHP) of 90%, remaining below the 95% target (This will be a product of abstractions being above benchmark and the vacancy factor).

20. **Response Abstractions:** EMS abstraction levels increased minimally to 33.98% in July 2025, remaining minimally above the 30% benchmark figure. Response sickness abstractions stood at 7.30% (benchmark 5.99%).

21. **Trust sickness absence:** the Trust's overall sickness percentage was 7.82% in July 2025, up on the 7.49% recorded in June 2025, which is in line with seasonal factors. Actions within the IMTP concentrate on staff well-being with an aim to reduce this level to the IMTP ambition of 6%.

22. **Staff training and PADRs:** PADR rates did not achieve the 85% target in July 2025 and decreased slightly to 75.46%. Compliance for Statutory and Mandatory training increased slightly to 88.98% continuing to achieve the 85% target.

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

Finance & Value

24. **Financial Balance**: the reported outturn performance at Month 4 is a deficit of £0.246m with a forecast to the year-end of breakeven. The Trust is forecasting the achievement of both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

25. The consult & close rate was 18.9% in July 2025, a slight decrease from the previous month continuing to achieve the IMTP ambition (and Welsh Government target) of 17%.

26. Same Day Emergency Care (SDEC) centres continue to see only a low level of ambulance activity and handover levels remain double what the EMS rosters are designed to cope with which makes further work on the clinical model, before next winter, a tactical imperative.

RECOMMENDATION

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

NEXT STEPS

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

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

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

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

July 2025

Annex 1 – Top Indicator Dashboard

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

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2025/26	Jun-25	Jul-25	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	10.0%	10.1%	9.1%	R
111 Clinical Triage Call Back Time (P1)	90%	96.5%	99.0%	97.6%	G
999 Call Answer Times 95th Percentile	00:06	00:26	00:12	00:23	R
Arrest (Purple) Median	6-8 Minutes	N/A	07:35	N/A	G
Emerg. (Red) Median	6-8 Minutes	N/A	08:47	N/A	A
999 Amber 1 Median	00:18	01:29	01:19	01:36	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	76.3%	75.6%	73.8%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	80.0%	83.0%	79.7%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	19.3%	21.4%	19.9%	A
Stroke Patients with Appropriate Care	95%	89.8%	87.8%	84.1%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:24	02:19	02:25	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	70.4%	76.6%	58.4%	R
National Reportable Incidents reports (NRI)		8	4	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	5,953	5,816	8,519	G
Concerns Response within 30 Days	75%	89%	53%	58%	G
Enactment of the Duty of Candour Total		10	6	5	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	91%	90%	89%	A

Top Monthly Indicators	Target 2025/26	Jun-25	Jul-25	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	7.49%	7.82%	7.74%	R
Mental Health Absence Rates	Reduction Trend	2.58%	2.78%	2.37%	R
Staff Turnover Rate	Reduction Trend	8.44%	8.23%	8.24%	G
Statutory & Mandatory Training	>85%	88.05%	88.98%	79.60%	G
PADR/Medical Appraisal	>85%	81.81%	75.46%	74.13%	A
Number of Shift Overruns	Reduction Trend	3,441	3,551	3,704	G
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	2.53%	2.19%	1.9%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	26.6%	25.3%	28%	A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.74	2.83	2.39	G
NEPTS on the Day Cancellations	Reduction Trend	14.7%	15.4%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	19.1%	18.9%	15.5%	G
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	10.09%	9.58%	11.1%	R
Number of Handover Lost Hours	7,500	15,278	12,565	21,346	R
NHS111					
NHS111 Dental Calls	Increasing Trend	8,749	8,803	7,946	G
Consult & Close Volumes by NHS111	Increasing Trend	2,238	2,175	1,357	G

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

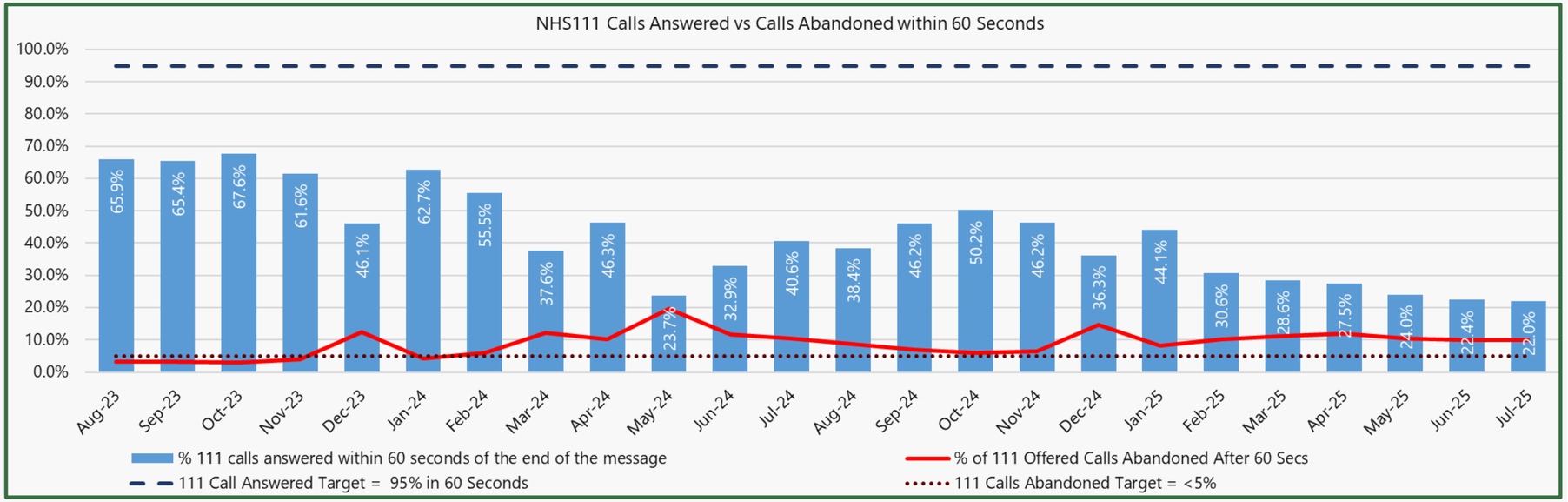
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

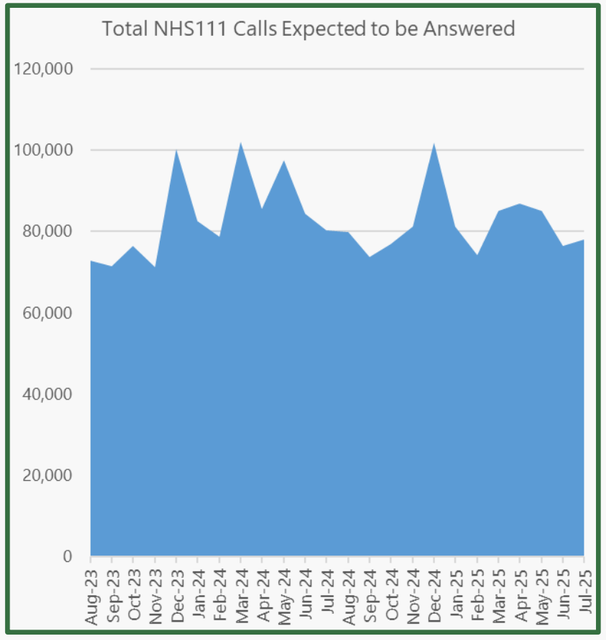
(Responsible Officer: Lee Brooks)

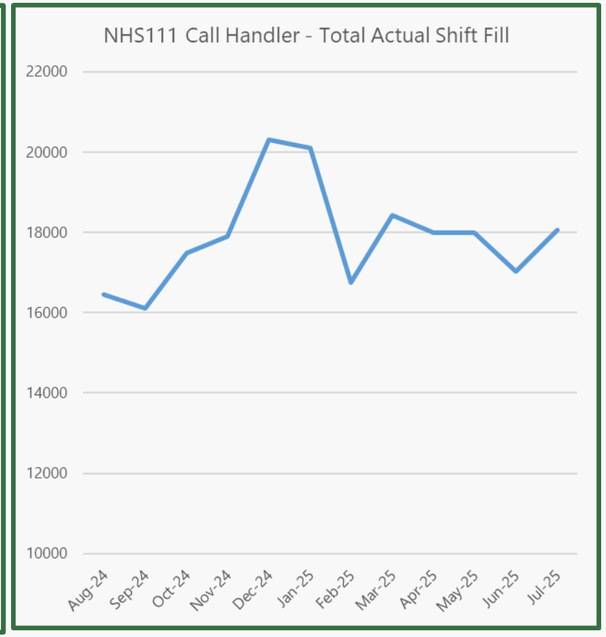
Abandonment Rate R

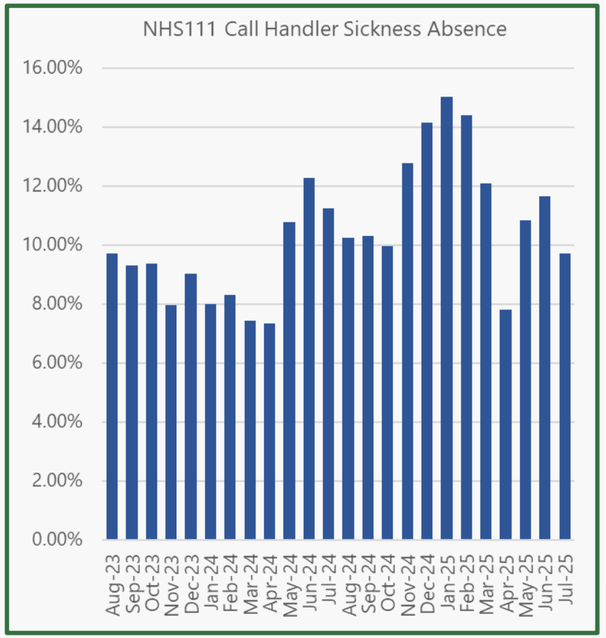
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate fell slightly to 10.1% in July 2025 from 10% in June 2025. The percentage of 111 calls answered within 60 seconds also declined from 22.4% in June 2025 to 22% in July 2025 and continues to remain significantly below the 95% target.

This call answer rate of 22% in July 2025 is the lowest seen in the past two years and is significantly below the 62.2% recorded in July 2023. This is at a time when UHP capacity for call handlers has increased slightly and is higher than the levels seen in July 2024.

Remedial Plans and Actions

Key actions include:

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

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

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

Actions are underway to increase the utilisation of virtual queuing and review the way patients who are re-accessing for the same care episode could be managed differently.

Expected Performance Trajectory

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

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

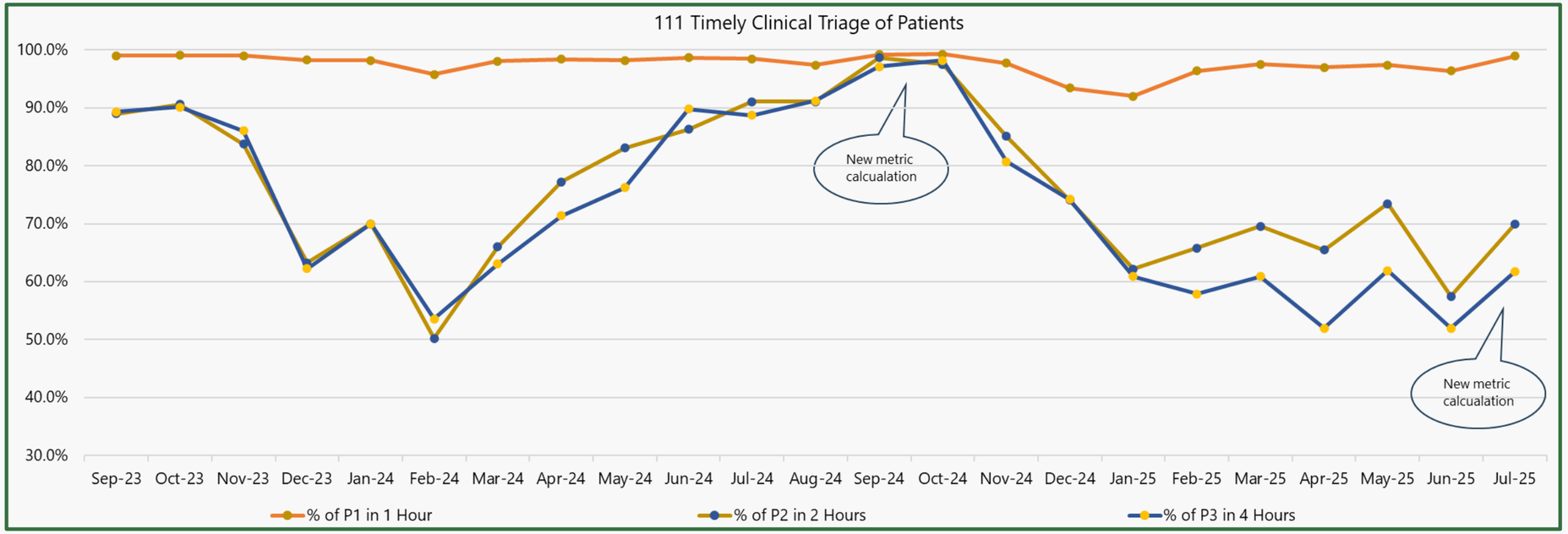
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

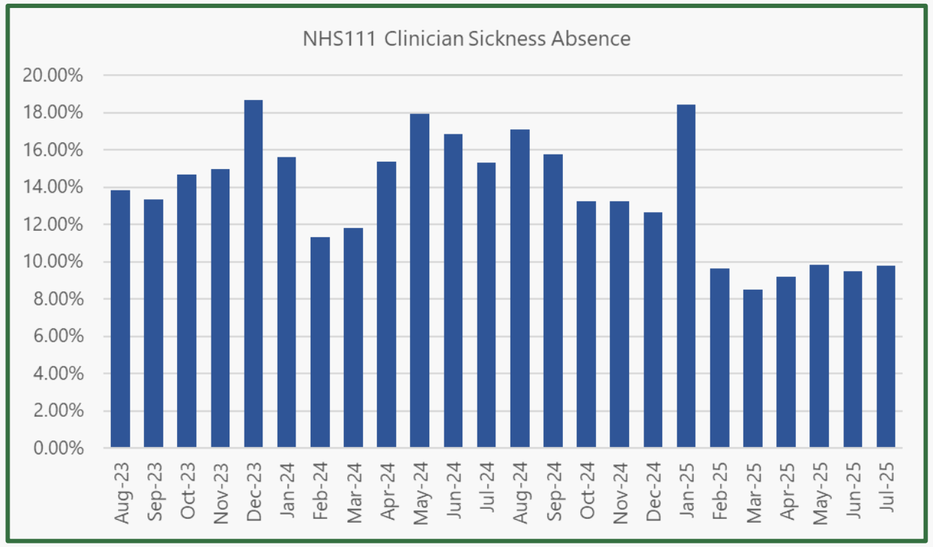
(Responsible Officer: Lee Brooks)

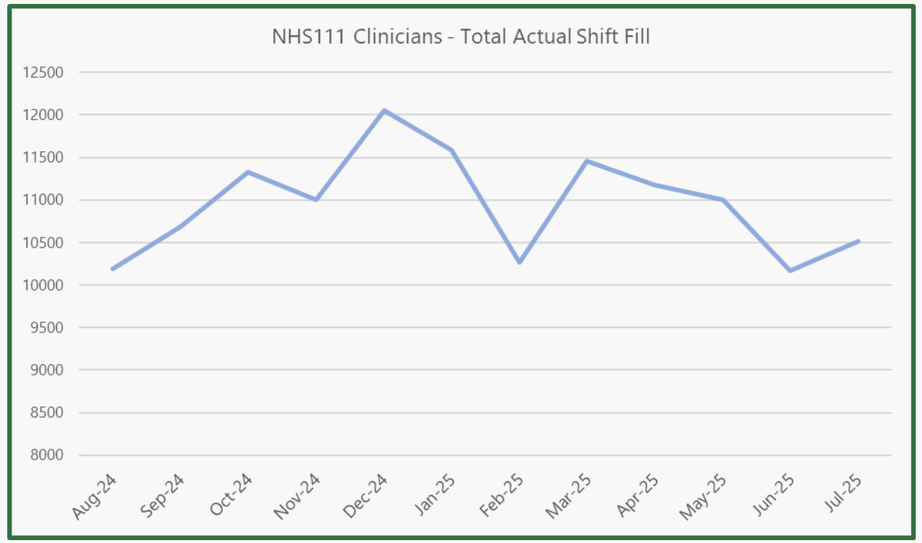
P1CT G

FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 99.03% in July 2025.

Ring back times for lower category calls increased during July 2025, with P2CT calls at 69.2% and P3CT at 60.97%.

Numbers of clinician hours produced increased slightly during July 2025, from 10,173 hours in June 2025 to 10,519 hours in July 2025, albeit with one additional day during the month. However, they remain low compared with those being produced during the first half of the year.

Remedial Plans and Actions

The key actions include:

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

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

The P1-P3 metric calculation has changed. Previously it was when the Trust called back, now it is when the patient answers, this will be reversed in August.

Expected Performance Trajectory

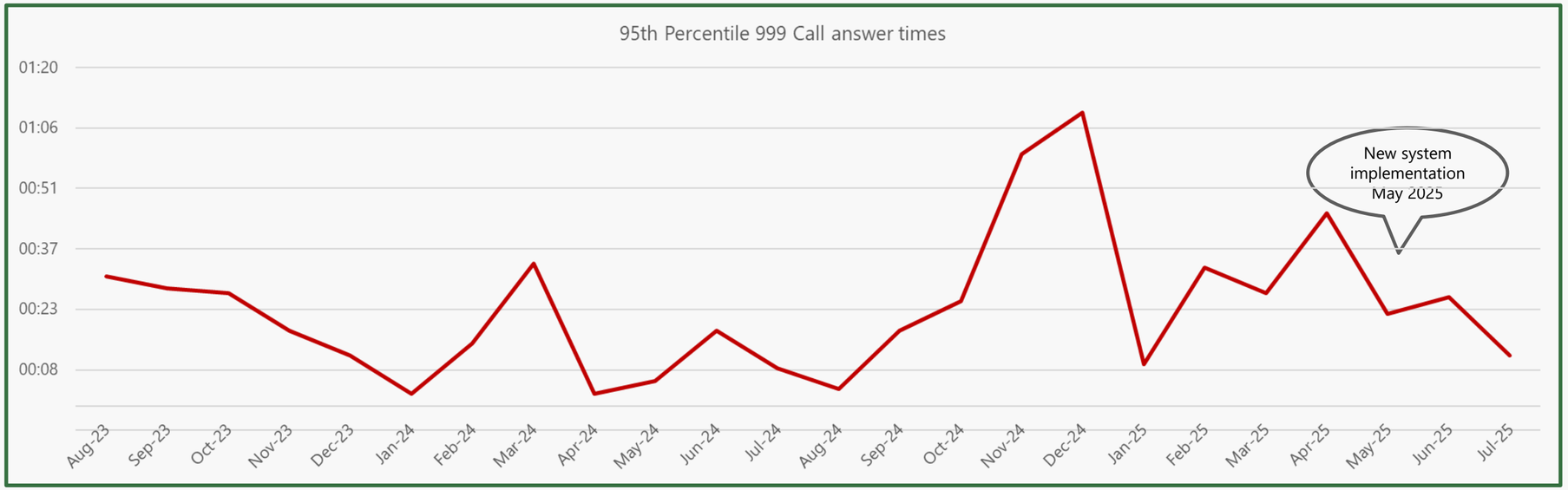
It is likely that there will be a performance improvement through the summer however the external rostering review suggests there is a demand and capacity gap within the current funded establishment and the Trust is therefore unlikely to reach performance without an increased workforce.

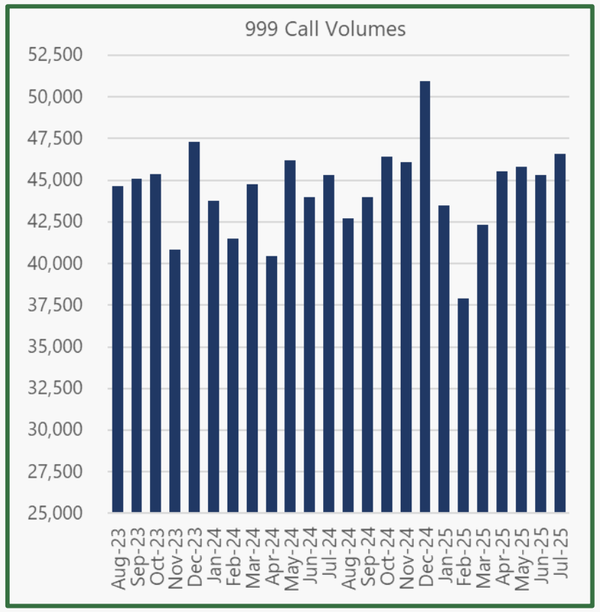
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

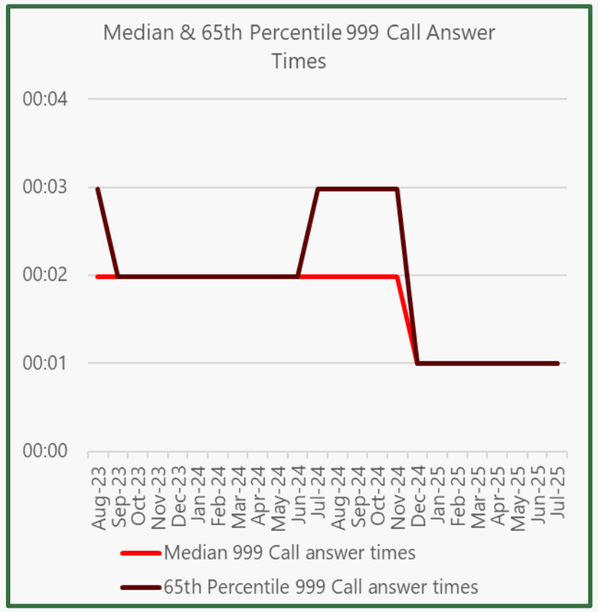
(Responsible Officer: Lee Brooks)

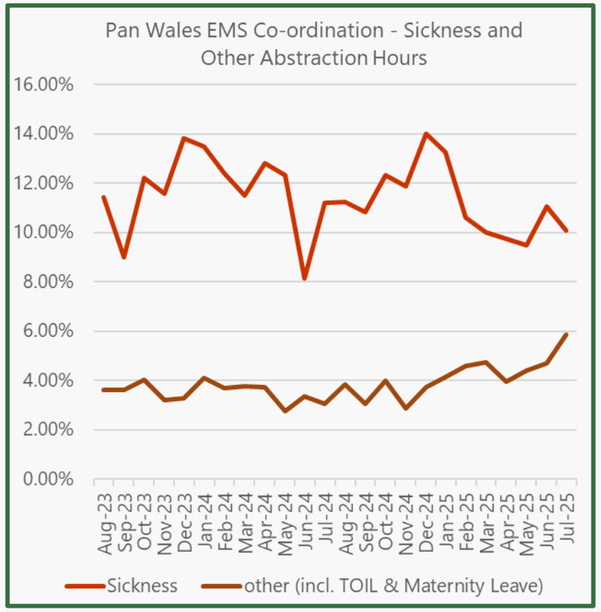
R FPC CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance improved decreasing to 12 seconds in July 2025, remaining above the 6 second target; however, the median call answer time for the 999-service has been consistently good at 1 second. The new system is now aligned with reporting and is signed off.

There was a slight increase in demand during July 2025 to 46,610 calls from 45,286 in June 2025.

UHP for the month of July was at 96% and sickness levels saw a decrease, from 11.05% in June 2025 to 10.10% in July 2025.

Remedial Plans and Actions

- Currently 10.45 above establishment with EMDs and Call Handlers at 99.45WTE. Training ongoing with 5, who are due to go-live at the end of September. A further training cohort will commence on September 8th.
- Work is ongoing to identify what is contributing to high sickness via the Managing Attendance at Work Policy and attrition via the recruitment and selection processes.

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

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

Expected Performance Trajectory

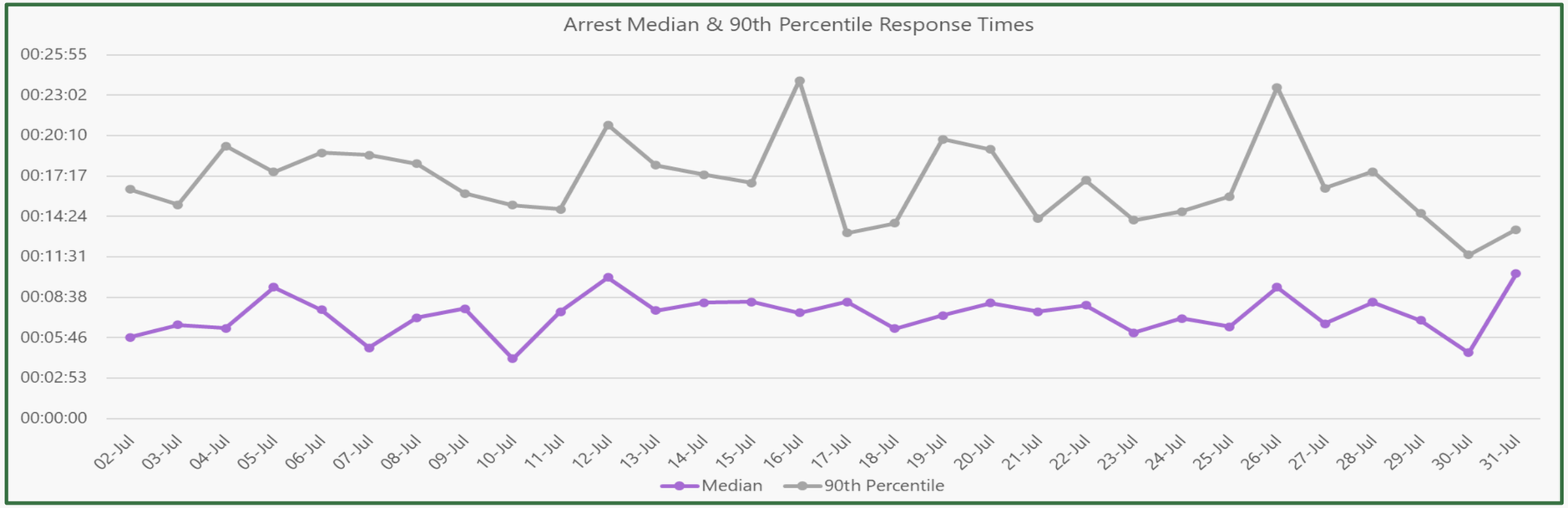
The median and 65th percentile are performing very well and are stable. Paper currently to be drafted on future resilience of EMSC i.e. winter demand v capacity (with efficiencies).

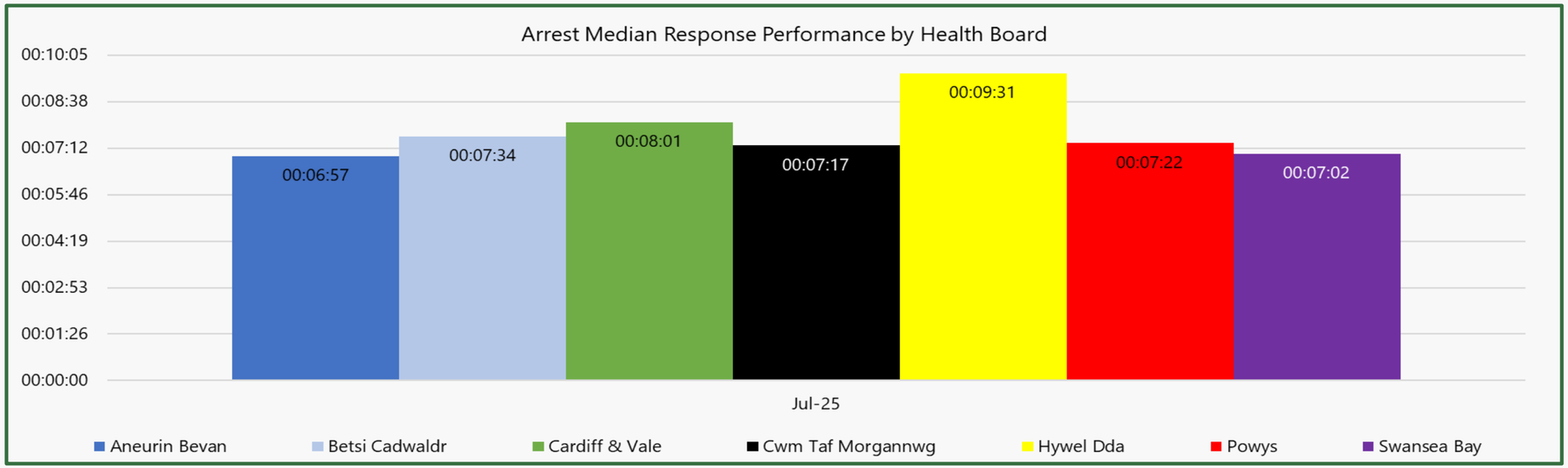
Our Patients: Quality, Safety & Patient Experience
Arrest Purple Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

G | CI | QUEST | FPC

(Responsible Officer: Lee Brooks)





Analysis

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

In July there were 814 Arrest (purple) calls received, around 2.3% of all calls.

The median response times for Arrest (purple) was 7 minutes 35 seconds. Aneurin Bevan had the lowest median time of 6 minutes and 57 seconds and Hywel Dda had the highest at 9 minutes and 31 seconds.

The 90th percentile response time for Arrest (purple) calls was 17 minutes 47 seconds. For which, Aneurin Bevan had the lowest time of 13 minutes and 46 seconds, and Powys had the highest at 26 minutes and 21 seconds.

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

NB: The new model was implemented at 8:30am on 1 July 2025. As such, to record full days worth of data the data set runs from 2 July 2025.

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

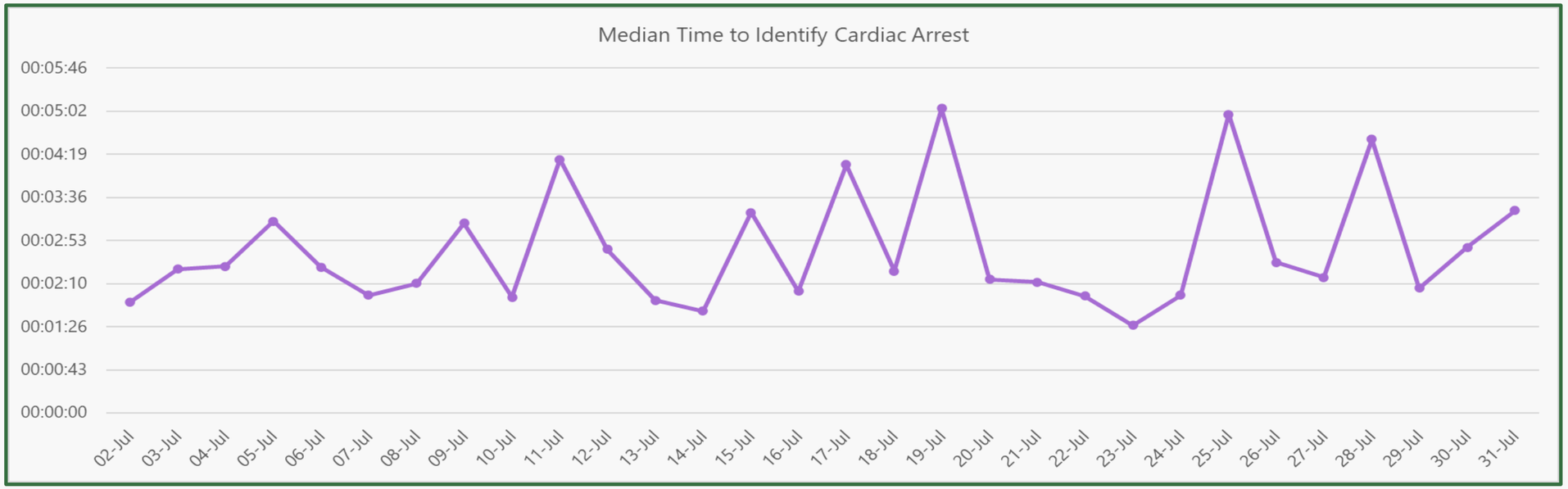
Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

CI

QUEST

FPC



Analysis

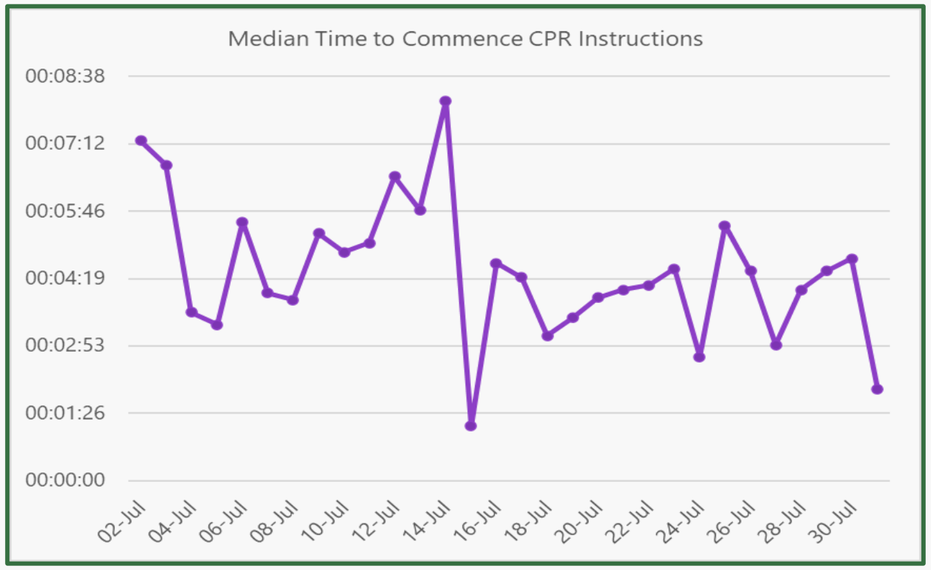
As part of the go live on Purple (Arrest) more measures have been introduced to help better understand and manage the chain of survival.

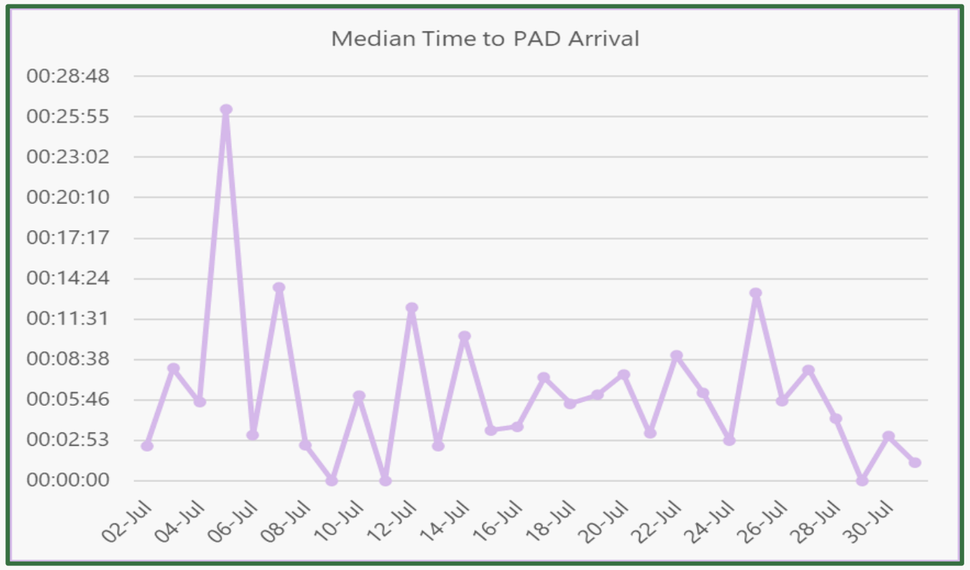
In July, the:
Average Median time to identify cardiac arrest was 2 minutes and 21 seconds.

Average Median time to commence CPR instructions was 4 minutes and 6 seconds.

Average (Median) time for a defibrillator (PAD) arrival to scene was 5 minutes and 35 seconds.

NB: The new model was implemented at 8:30am on 1 July 2025. As such, to record full days worth of data the data set runs from 2 July 2025.





Our Patients: Quality, Safety & Patient Experience
RED EMERG Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

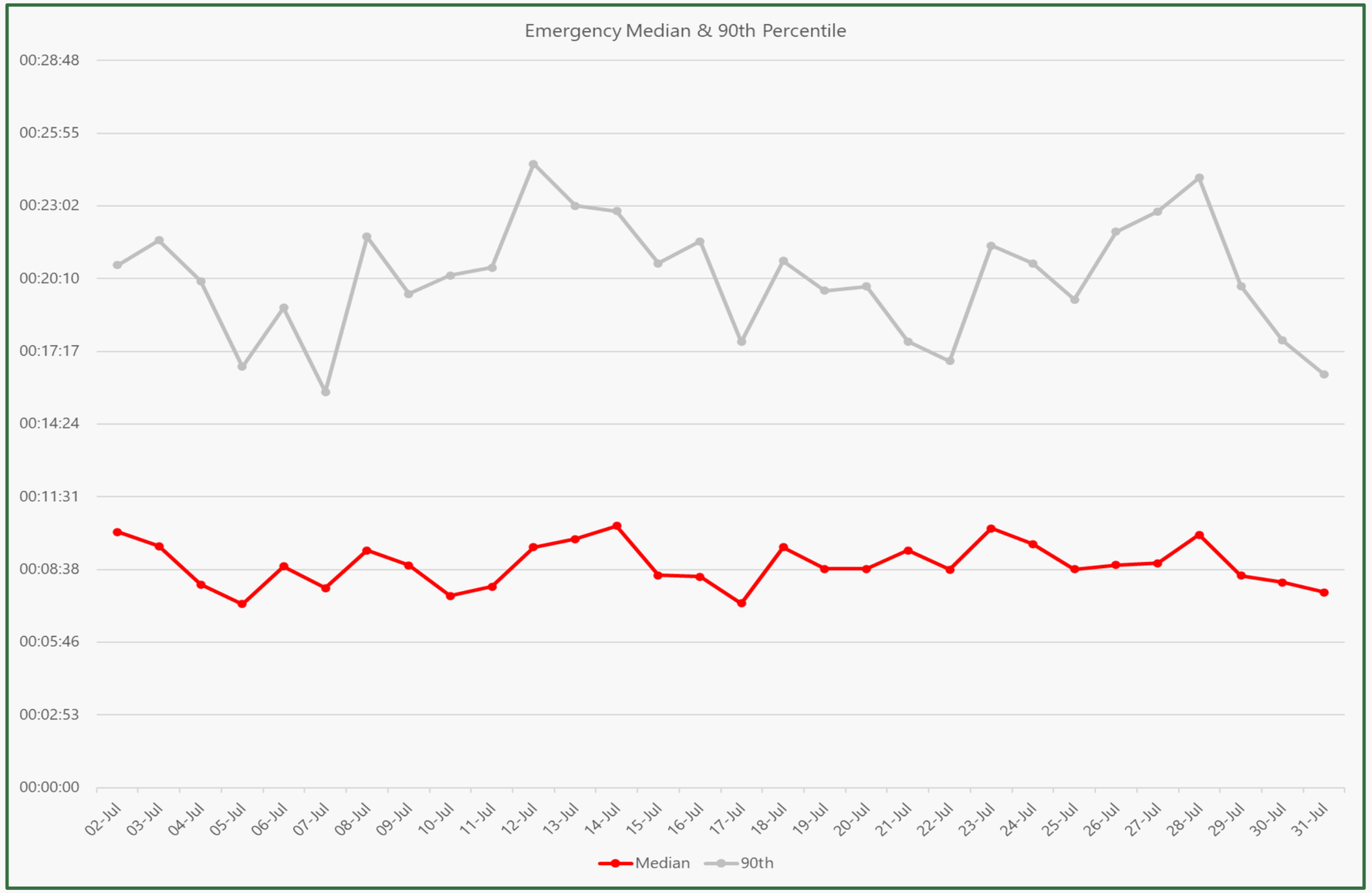
A

QUEST

FPC

CI

(Responsible Officer: Lee Brooks)



Analysis

In July there were 4,449 Emerg (red) calls, around 12.6% of all calls.

The median response time in July 2025 for Emerg (red) was 8 minutes 47 seconds. Cardiff and Vale health board had the lowest median time of 8 minutes and 10 seconds, and Powys had the highest at 11 minutes and 26 seconds.

For red calls, 90th percentile response times was 20 minutes 45 seconds. For which, Cardiff and Vale had the lowest time of 17 minutes and 19 seconds, and Powys had the highest at 33 minutes and 6 seconds.

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

Remedial Plans & Actions

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

NB: The new model was implemented at 8:30am on 1 July 2025. As such, to record full days worth of data the data set runs from 2 July 2025.

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

(Responsible Officer: Lee Brooks)

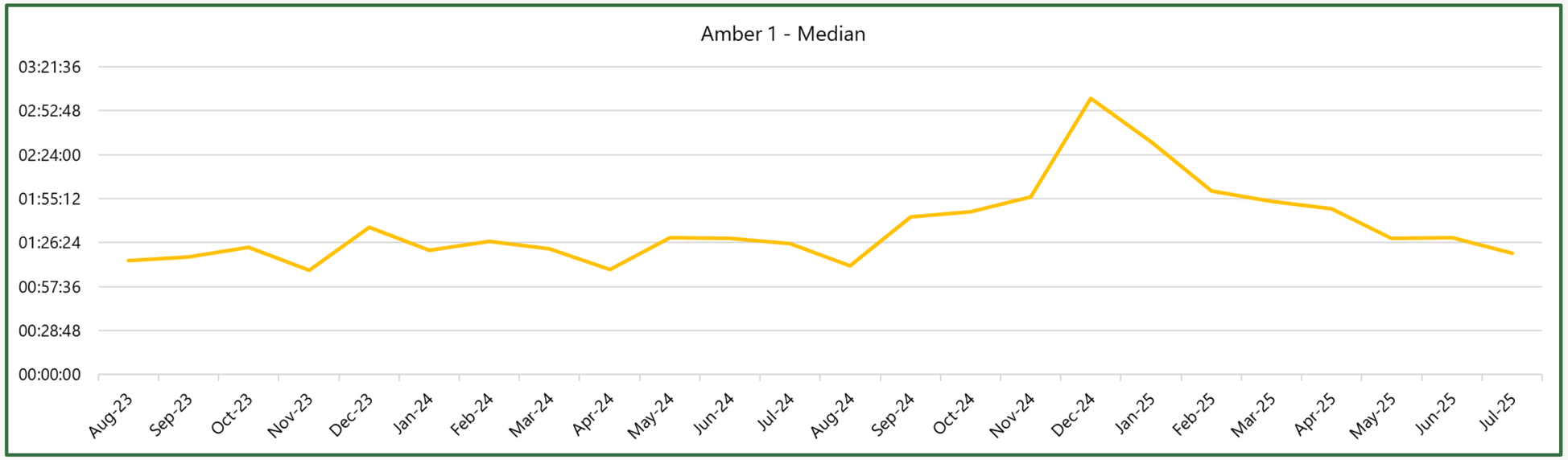
R

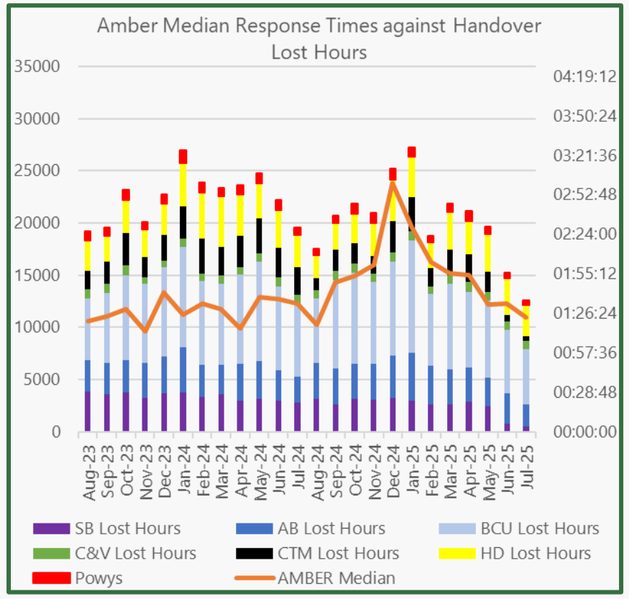
FPC

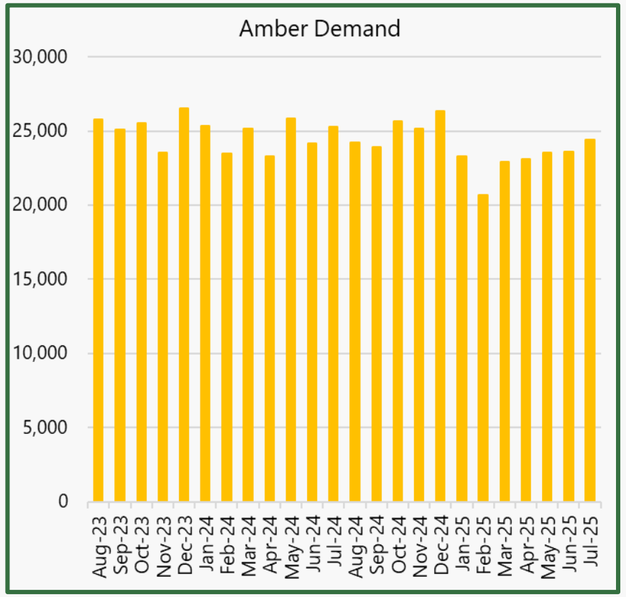
CI

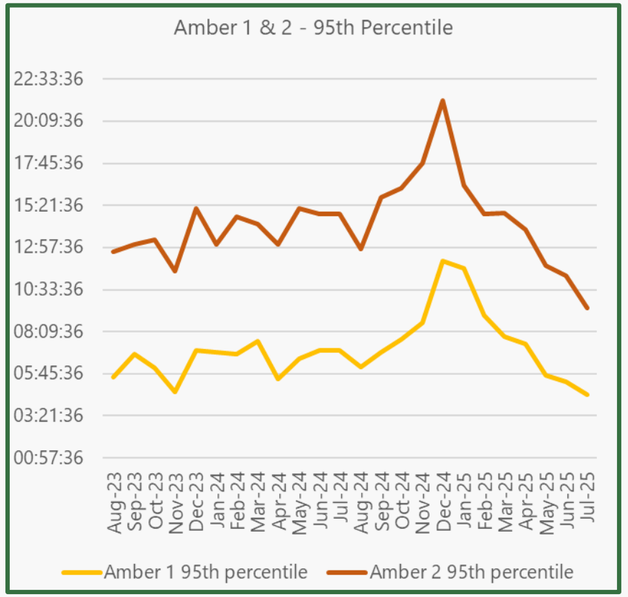
QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time remained consistent during July 2025 at 1 hour and 19 minutes. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile decreased during July 2025 to 4 hours 34 minutes, down from 5 hours 18 minutes in June 2025. This time remains currently below the 2-year average figure of 7 hours 9 minutes.

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

Remedial Plans and Actions

Welsh Government has recently announced further changes to the Ambulance Performance Framework that will affect the existing Amber category at the of 2025.

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience

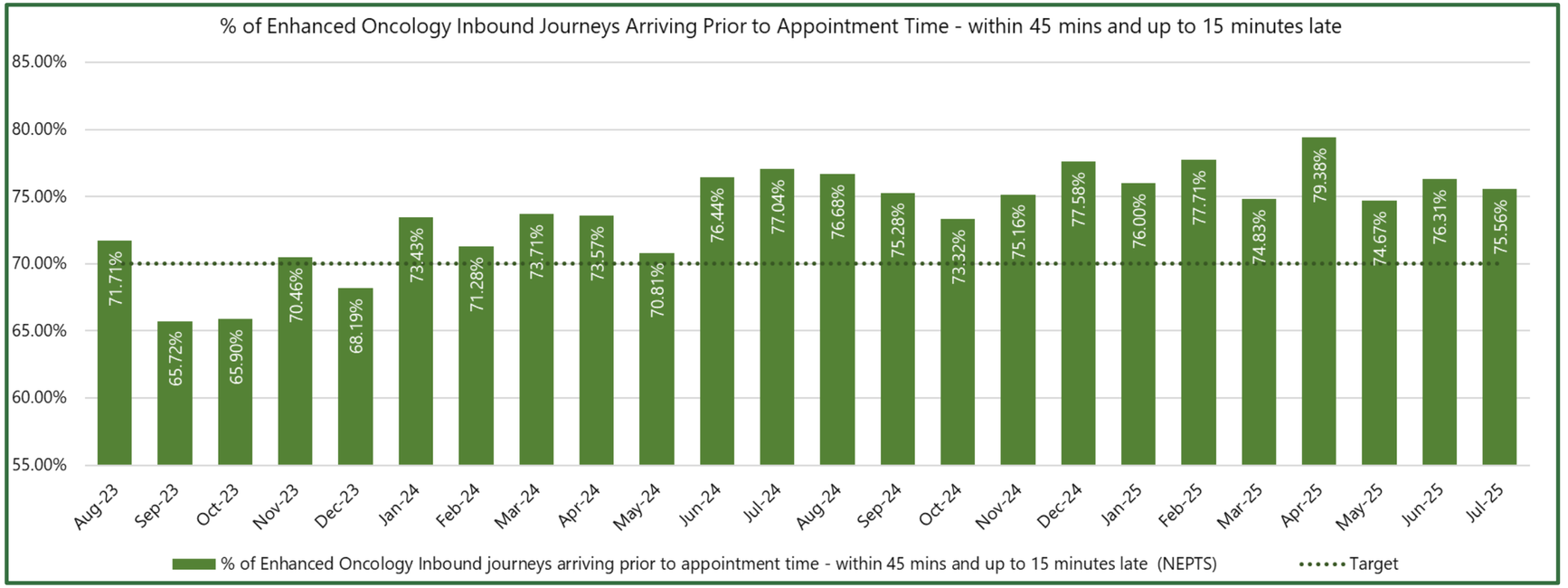
Patient Experience – Influencing Ambulance Care Indicators

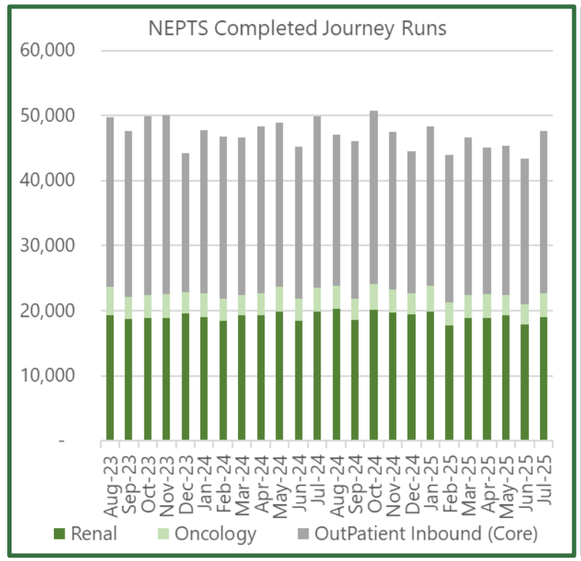
(Responsible Officer: Lee Brooks)

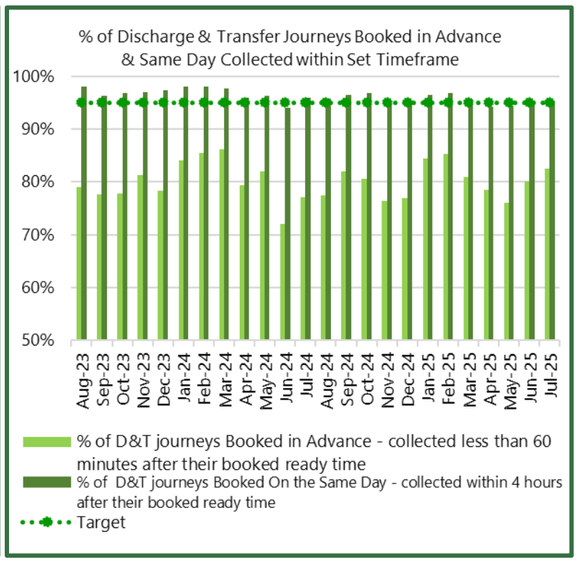
D&T	Oncology	Welsh Calls
R	G	G

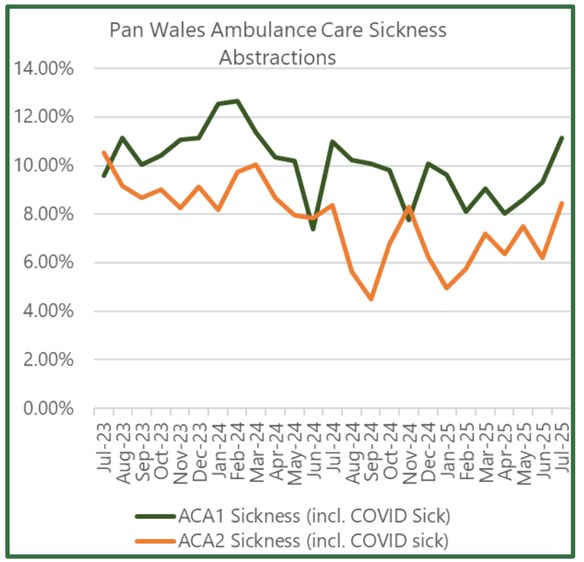
FPC

CI









Analysis

75.55% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in July 2025, once again achieving the 70% target.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment improved in July 2025 to 83% but remains below the 95% target. Discharge and Transfer journeys booked on the same day achieved the 95% target in July 2025.

Renal journeys decreased from 72.57% in June 2025 to 70.72% in July 2025 but marginally achieves the agreed performance standard of 70% for only the eighth time since September 2024.

Call volumes answered increased to 16,088 calls during July 2025, from 14,851 in June 2025; but the average speed of call answering decreased from 13 minutes 4 seconds to 10 minutes.

ACA1 sickness remains above the 5.99% target, at 11.15% and ACA2 sickness also remains above the 5.99% target at 8.45% in July 2025.

Remedial Plans and Actions

Oncology performance continues to be in excess of the service standards nationally, however there is some regional variation to this. Work is underway in the areas where performance is lower to address the underlying reasons for this. However, it is unlikely that significant inroads will be made until the completion of the NEPTS roster review.

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

Sickness levels have seen an increase during the quarter, with long term sickness within ACA1 cohort being a feature. Actions have been put in place across the service areas to increase focus on this area.

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

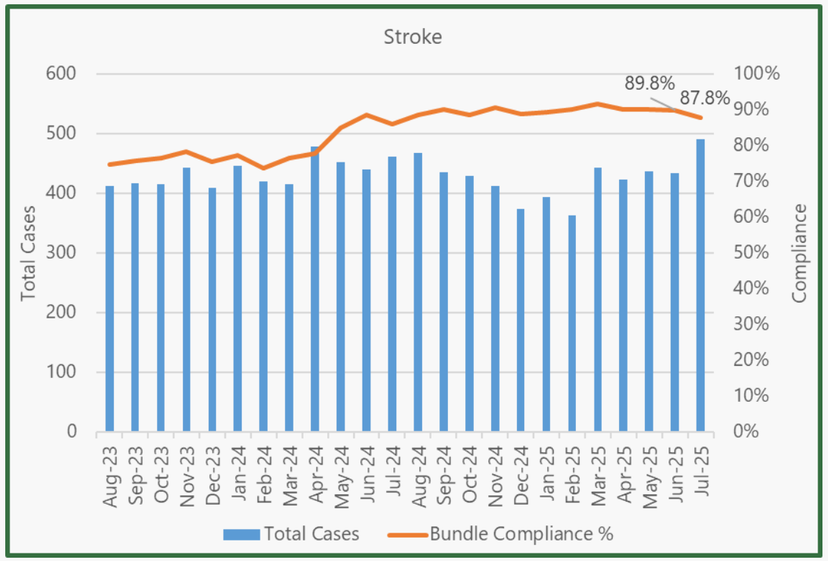
Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care and Time-Based metrics.

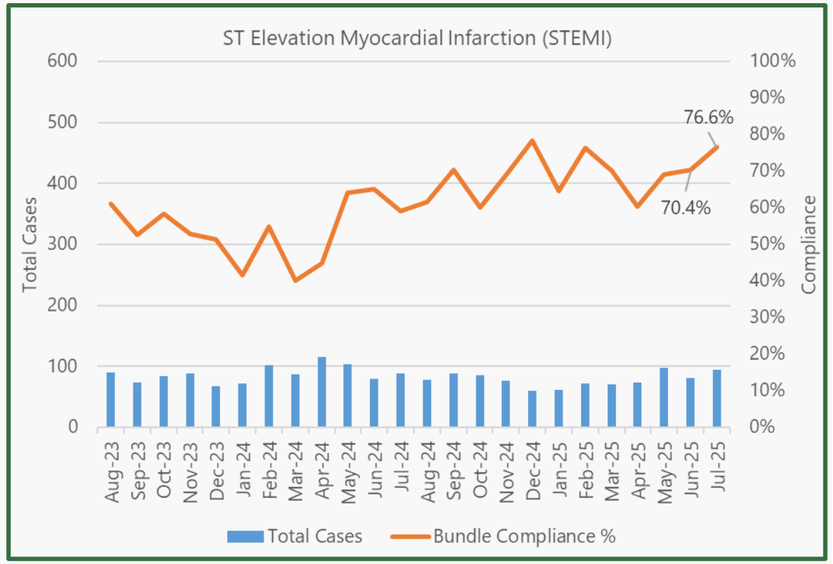
Stroke	Stroke Call to Door	STEMI
A	R	R

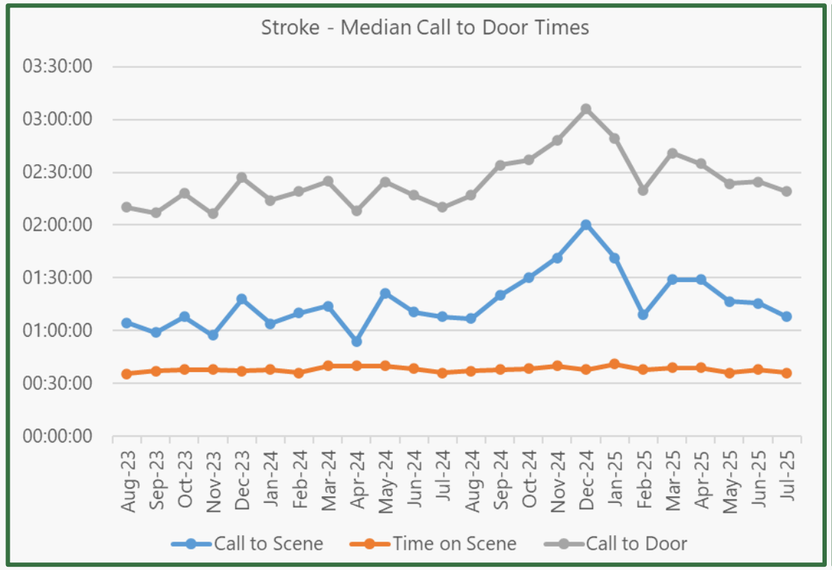
Self-Assessment: Strength of Internal Control: Moderate

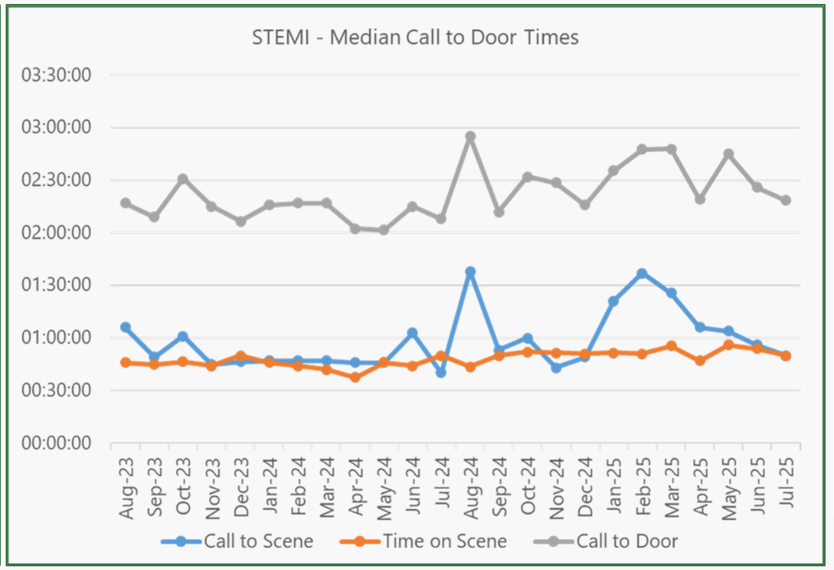
QUEST

(Responsible Officer: Andy Swinburn)









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

Stroke – 87.5% - performance has consistently remained at or above 85% since May 2024. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

STEMI (heart attack) – 76.6%, a significant improvement from 70.4% in June 2025. There has been an increase in compliance across all elements of the care bundle. The number of cases remained low (94) therefore, increasing the volatility of the compliance data so this could be natural variance.

Call to door times for Stroke – call to door times minimally decreased for stroke in July (02:19:00). All three elements of the bundle have seen consistency on time.

Call to door times for STEMI – Call to door time has decreased since last month (02:18:30).

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

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

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

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

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

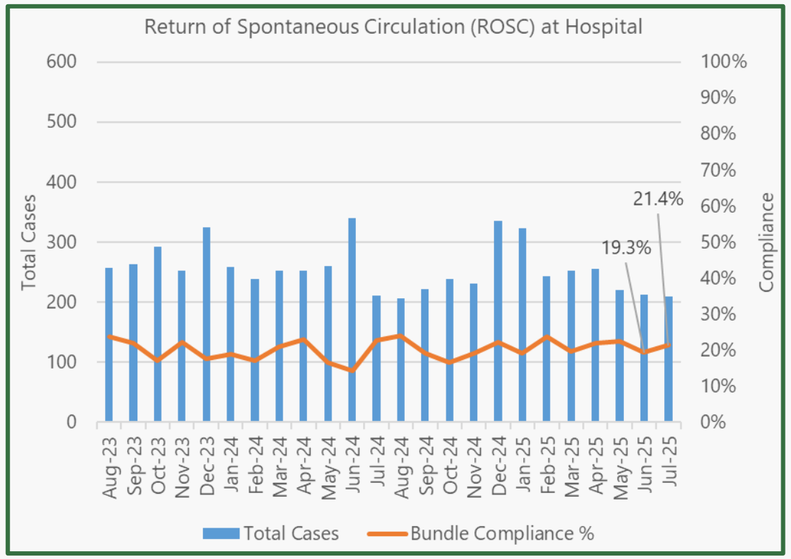
Return of Spontaneous Circulation, Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (#NOF)

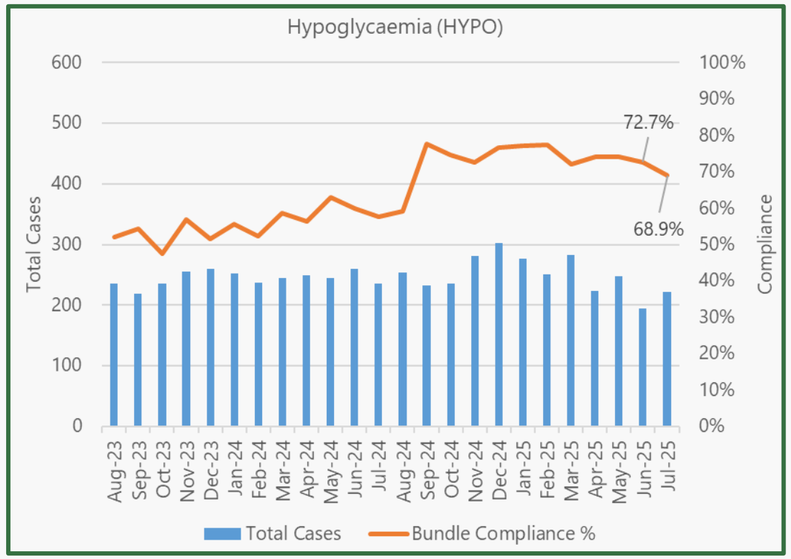
(Responsible Officer: Andy Swinburn)

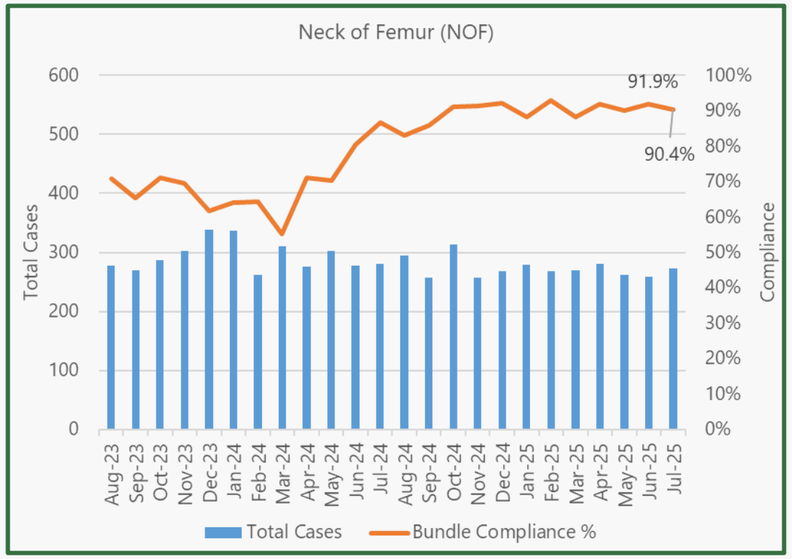
ROSC
A

Self-Assessment: Strength of Internal Control: Moderate

QUEST







#NOF Call 2 Door in development

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

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 21.4%, an increase from 19.3% in June. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024. Low case numbers means a volatile percentage dataset.

Hypoglycaemia (diabetic patients with low blood glucose) – 68.9%, a slight decrease from last month (72.7%). Compliance has remained quite static through Q1, although there has been a slight drop in compliance across the bundle.

Fractured Neck of Femur (hip fracture) – 90.4%, maintaining consistent performance from June. Only a slight decrease in compliance which is evident across the care bundle.

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

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

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

(Responsible Officer: Liam Williams)

Concerns.

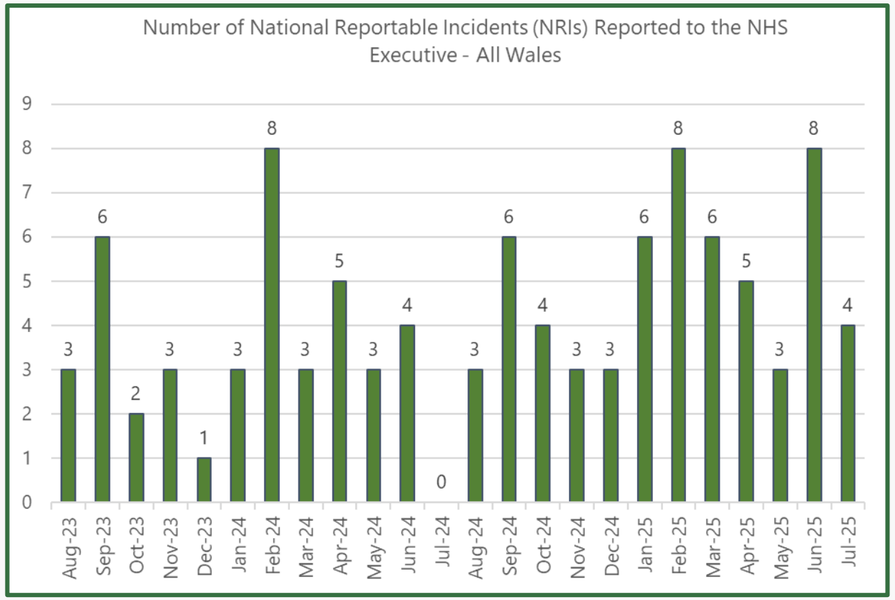
G

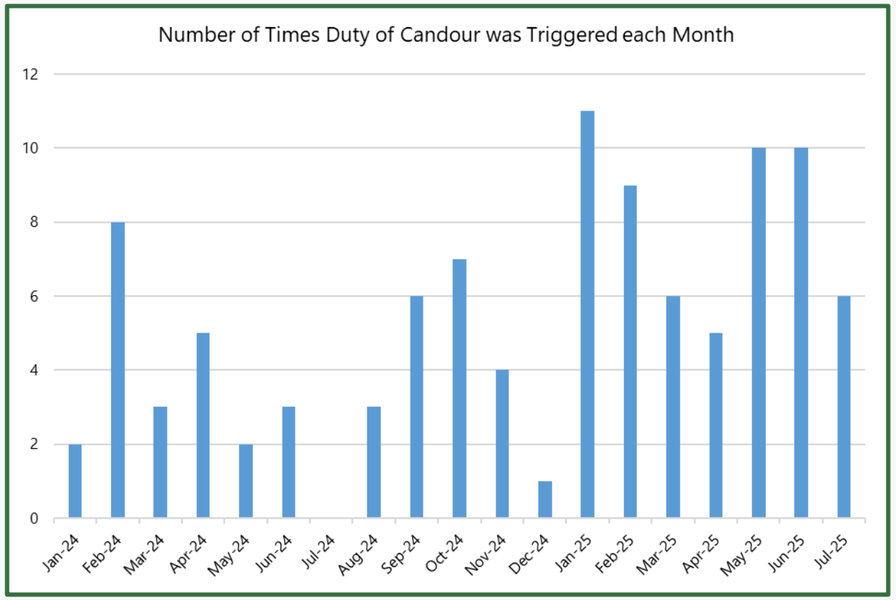
Self-Assessment: Strength of Internal Control: Moderate

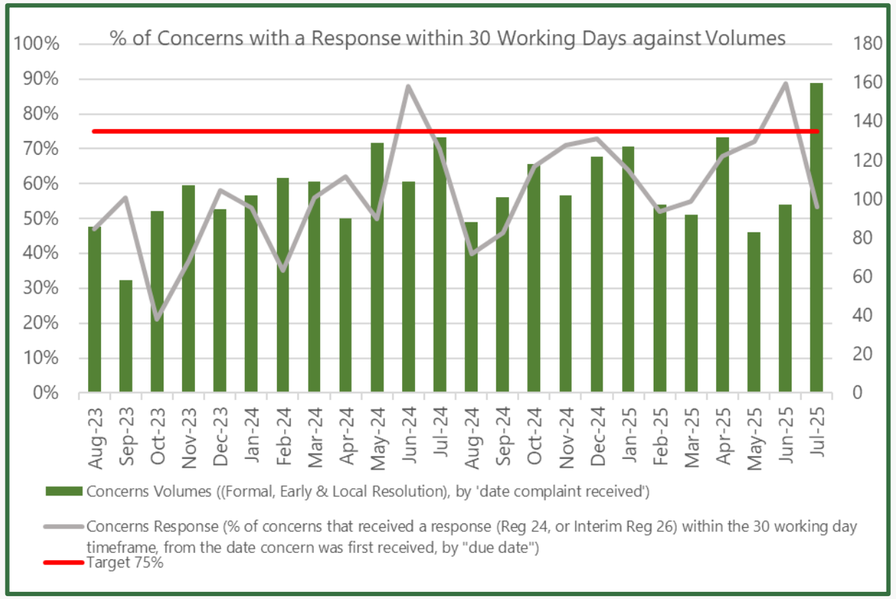
QUEST

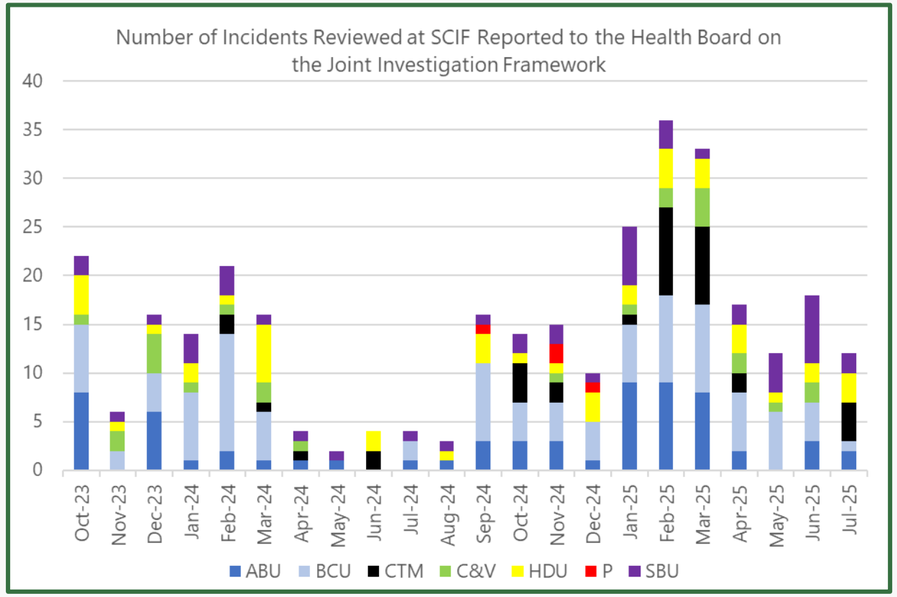
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis
Compliance with the 30 working day complaints target is decreasing as service areas begin to work on the PTR Recovery Plan and finalise overdue complaints. The compliance percentage is expected to drop in an increasing way as overdue complaints begin to be tackled. The Trust has been ordered to pay fines to some affected patients by the PSOW.

The Trust also received its highest volume of complaints in a month for the past 2 years during July. This high volume has been driven by the number of cancellations under the Ambulance Care Service Capacity Management Plan.

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

Remedial Plans and Actions
A Putting Things Right and Legal Services Recovery Plan has been developed to address the number of overdue concerns (complaints and incidents). This is being monitored through our internal governance structure and reported on in QuESt Committee.

Expected Performance Trajectory
As service areas focus on reducing the number of open overdue complaints, it is expected that the 30-working day performance will decrease. This is predicted to last until the number of open in-date complaints makes up the majority of open cases and, depending on the success of Recovery Plan actions, may take many months before it picks up again.

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

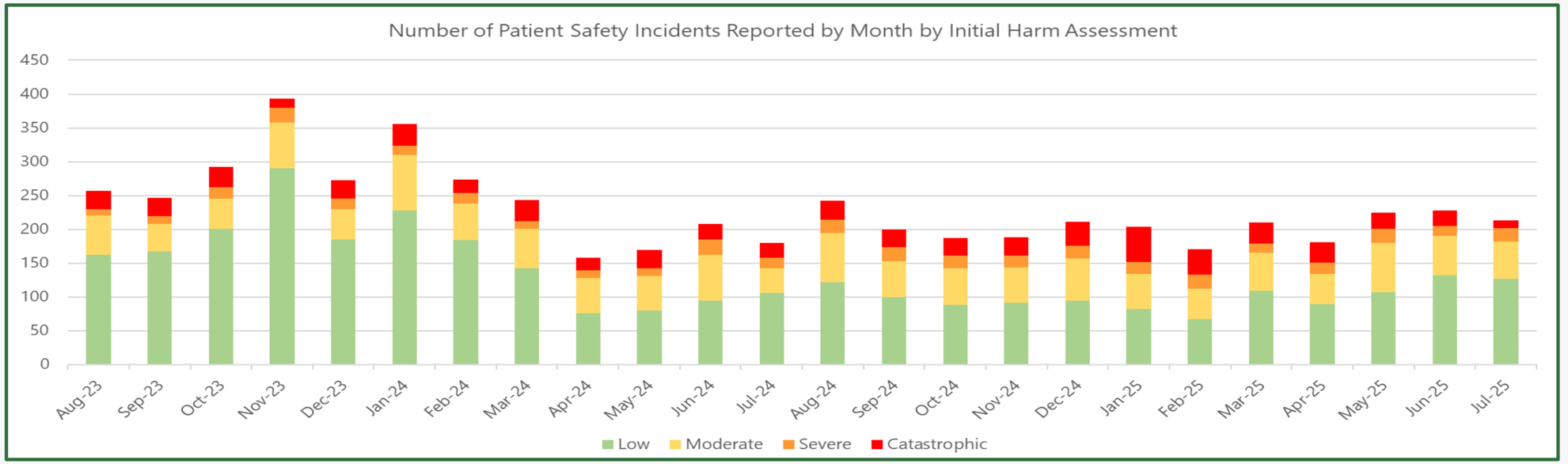
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

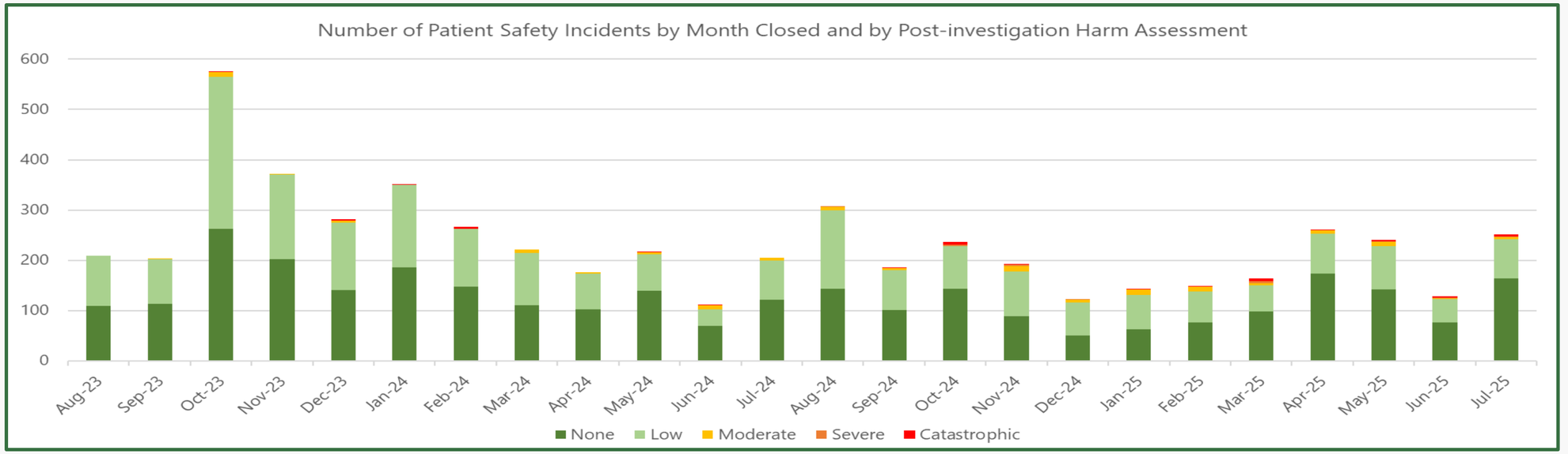
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care





Analysis
Incident reporting volumes remain stable and incident closure rate has increased again. The volume of closed incidents, does however, remain lower than the volume of reported incident search month, meaning the overall total of open records continues to increase.

Near miss reporting is being encouraged during daily operational meetings to ensure we learn from all opportunities. Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low.

NRI's that have been closed with the NHS Executive Wales have improved during the last month

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

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

Data source: Datix

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

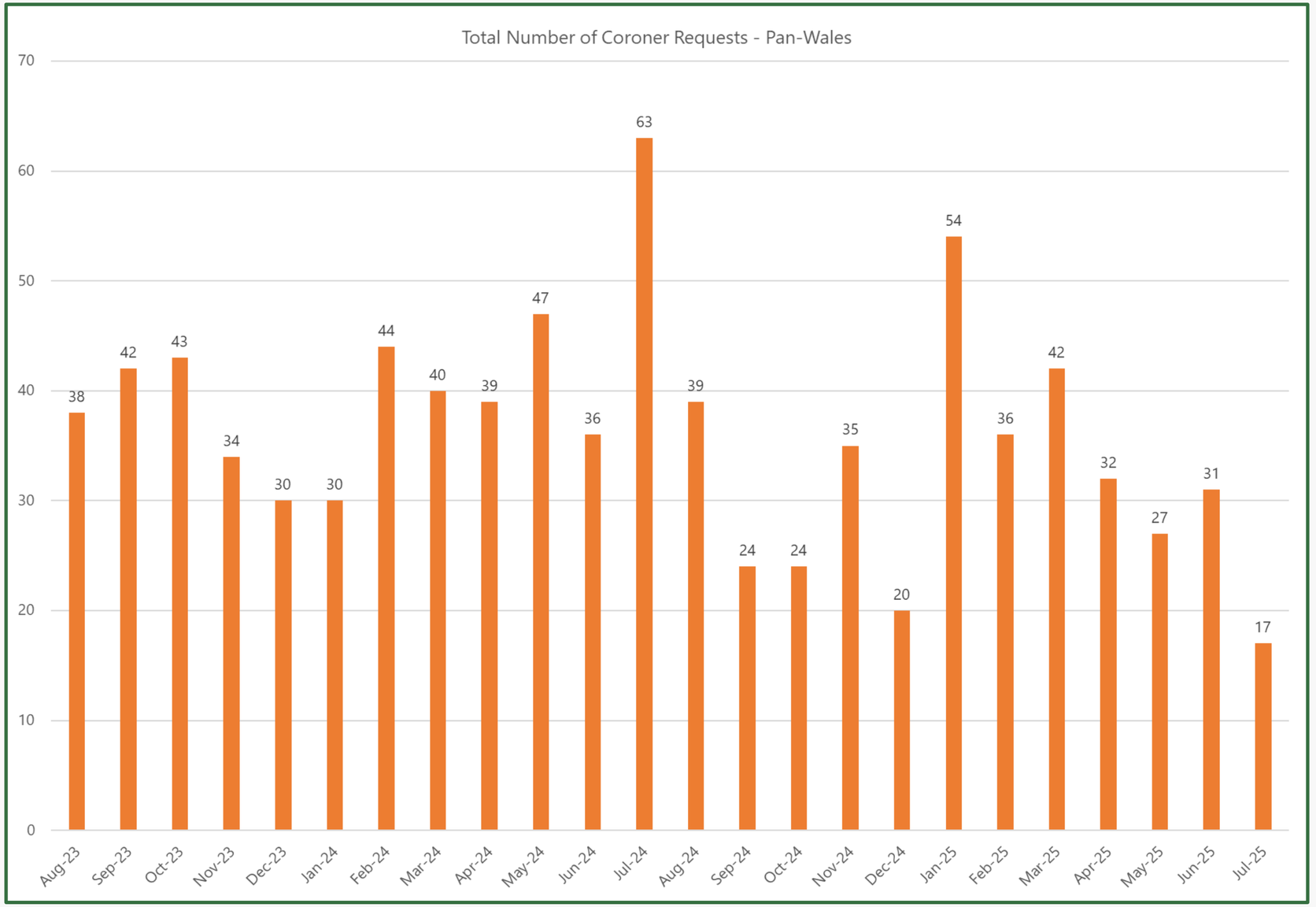
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



Analysis

The number of coroner approaches decreased in the last month, allowing opportunity to continue focusing on overdue statement requests.

Inquest cases continue to present with increased complexity and large numbers of statements and witnesses being called. These factors combined makes this an area of continued pressure across Trust services and for the individual staff involved in representing the organisation.

Medical Examiner Level 1 triage occurs regularly, ensuring prompt recognition of cases where learning and/or potential harm are identified.

The Level 2 Medical Examiner Learning Panel is now effectively reviewing the management and learning from cases although continues to operate retrospectively, reflecting the competing operational demands on senior clinical capacity.

Remedial Plans and Actions

A Putting Things Right and Legal Services Recovery Plan has been developed to address the number of overdue concerns (complaints and incidents). This is being monitored through our internal governance structure and reported on in QuESt Committee.

Expected Performance Trajectory

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

Mortality Reviews Data source: Internal Web Application

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

(Responsible Officers: Jonny Sammut & Liam Williams)

Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong

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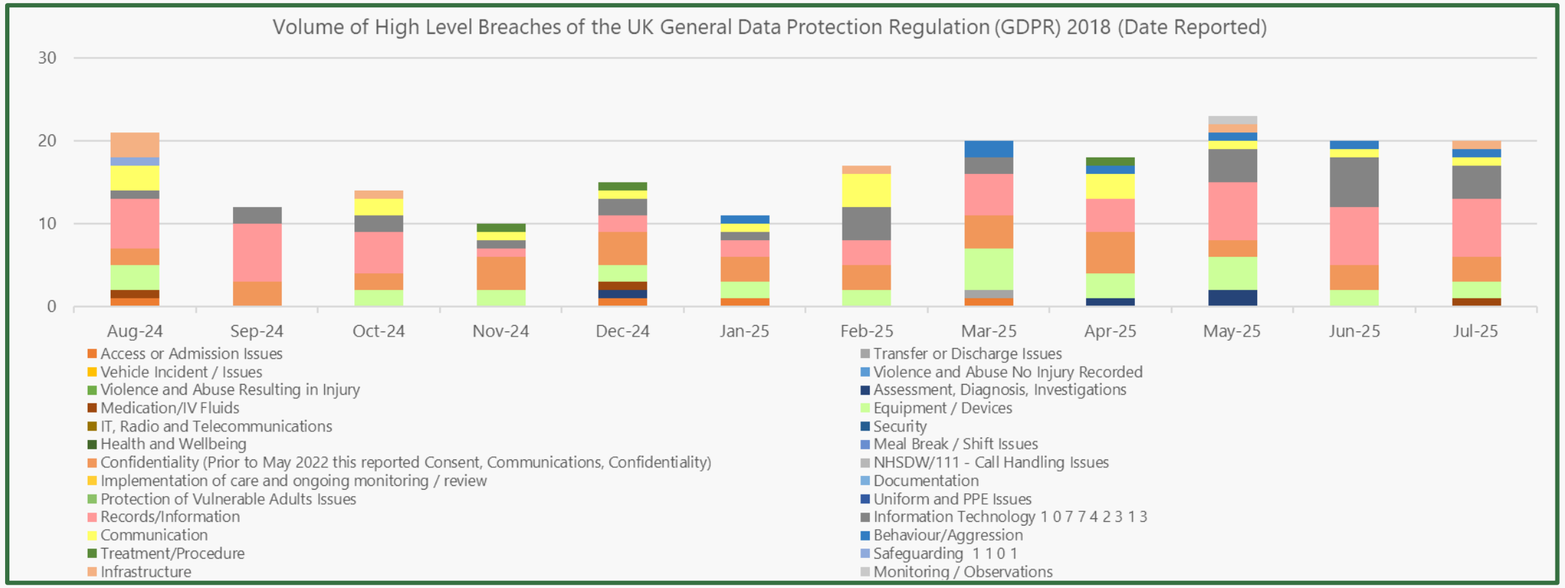

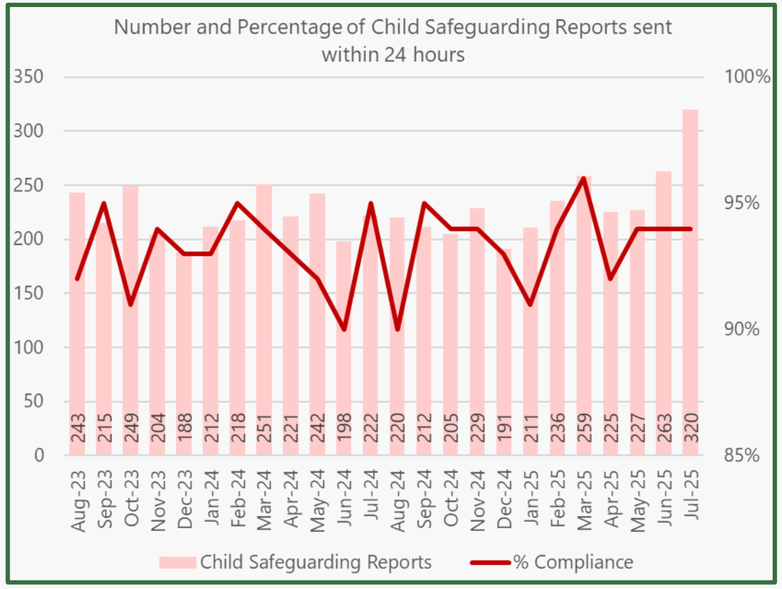

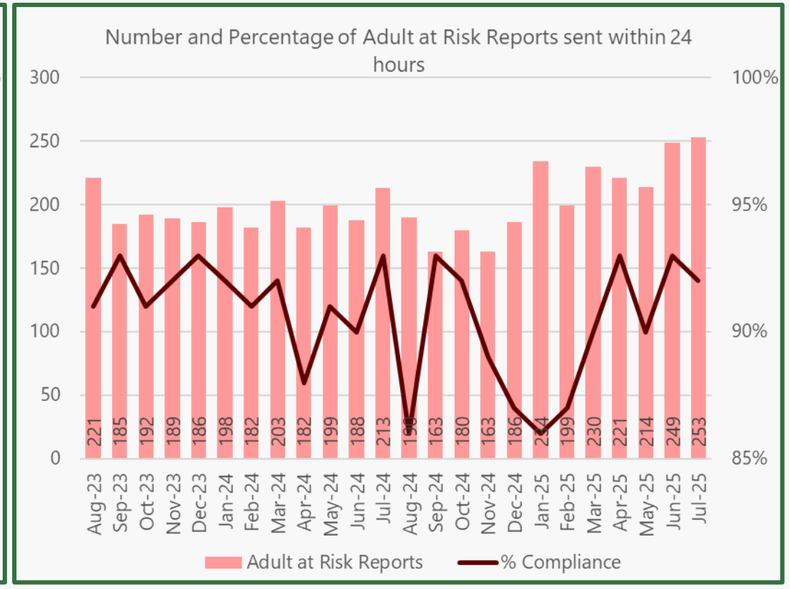

Analysis

Safeguarding: In July 2025 WAST colleagues submitted a total of 253 Adult at Risk Reports, 92% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 790 reports were shared with local authorities across Wales during this reporting period. There have been 320 Child Safeguarding Reports submitted in July 2025, 94% of these were processed within 24 hours.

Data Governance: In July 2025, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 7 related to Records/Information, 3 IG/Confidentiality, 1 Communication, 2 Equipment, 1 Behaviour, 4 Information Technology, 1 Infrastructure, and 1 Medication.

Remedial Plans and Actions

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

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

Expected Performance Trajectory

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

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

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

Safeguarding Data source: Doc Works

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

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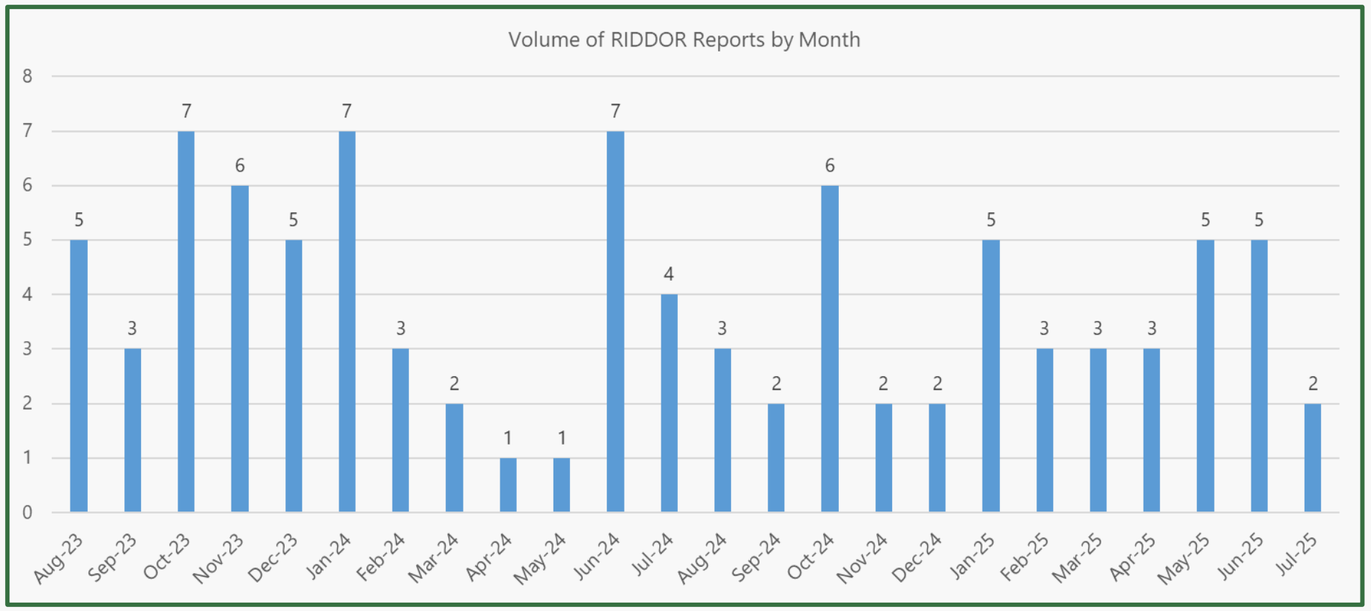
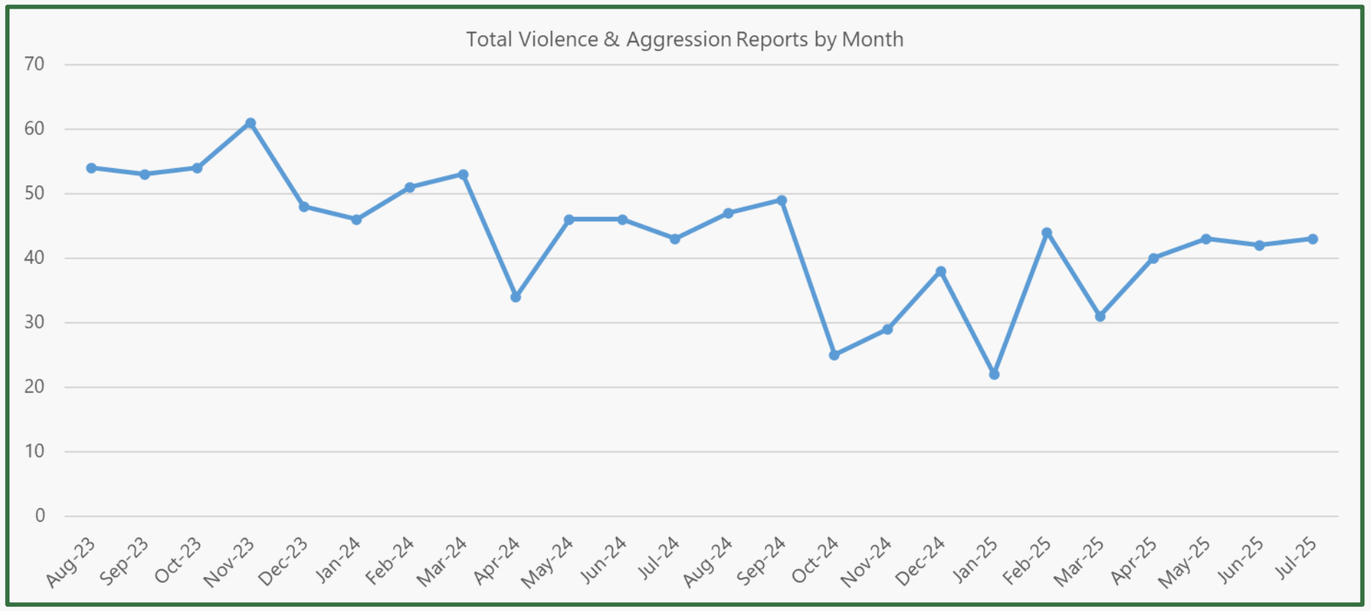
Health & Care Standard
Health – Safe Care





Analysis

RIDDOR: There were 2 incidents requiring reporting under RIDDOR during July 2025 all were for an injuries requiring over 7 days off work.

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

Violence and Aggression:

- A total of 43 incidents have been reported of V&A in July.
- 7 Physical Assault on staff was reported during the month with 4 incidents of verbal abuse all of which were incidents of swearing
- 7 incidents were reported as moderate in harm and 17 cases being noted as causing no harm.
- There were 4 incidents reported as Severe 2 involved the threat of knife use and one was because of Police refusing to attend a patient with a history of violent and aggressive behaviour.

Remedial Plans and Actions

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

Violence and Aggression:

The challenges of the Right Care Right Person approach by Polices Services is highlighted with the incident recorded where Police refused to attend. This is being taken up and managed via the Risk Management process in partnership with the WAST Mental Health Team.

V&A Deep dive is to be presented to the People and Culture Committee to provide assurance for the Trust's response to V&A incidents across Wales.

Expected Performance Trajectory

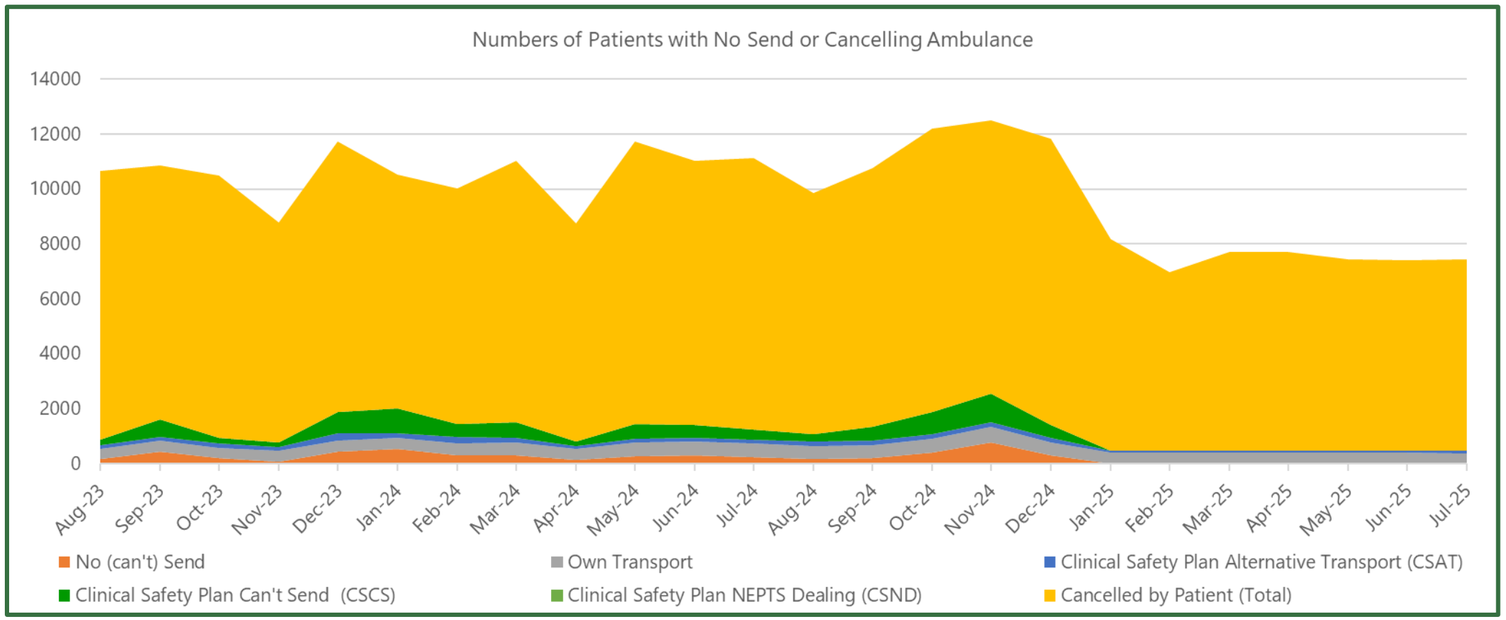
RIDDOR: The actions arising out of the recent deep dive into manual handling incidents aim to address the issues identified in the manual handling incidents this month.

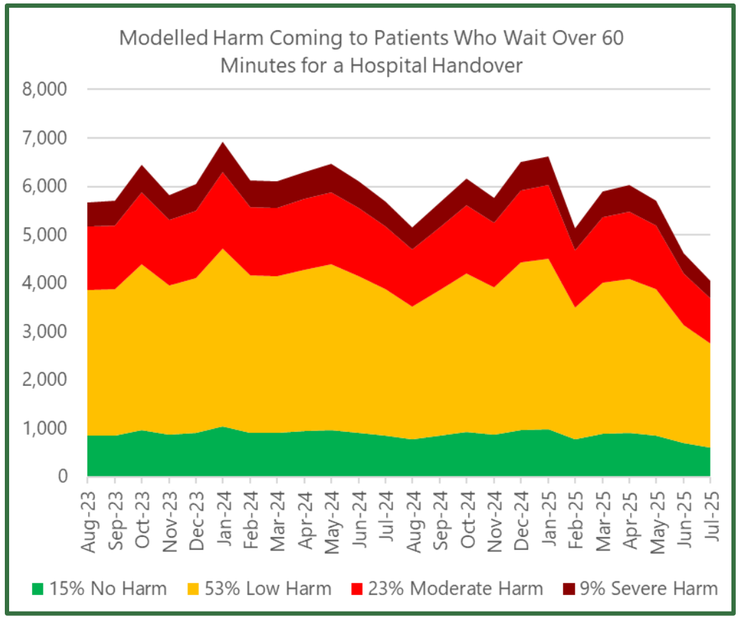
Violence and Aggression: It is expected that the number of verbal V&A incidents will increase over the next few months as a result of increased awareness of reporting mechanisms within the call centre teams.

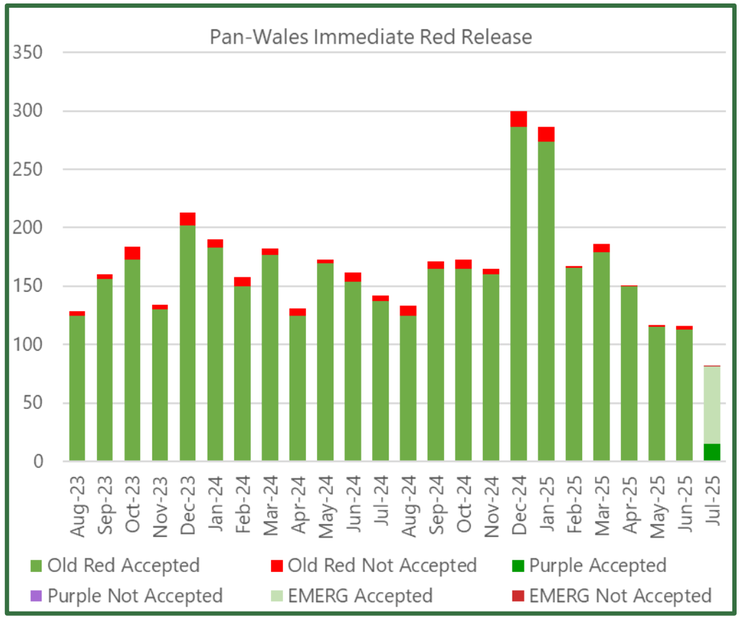
Data source: Datix

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

(Responsible Officer: Andy Swinburn) G QUEST







Analysis

In July 2025, 91 ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 6,996 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from the 6,926 in June 2025. There has been a downward trend in patient cancellations since December 2024 which the Trust believes is connected to the implementation of Rapid Clinical Screening.

There were 332 requests made to Health Board EDs for immediate release of Arrest, Emerg or Amber 1 calls in July 2025. Of these 15 were accepted and released in the Arrest category, with none not being accepted, 66 were accepted in the Emerg category, with 1 not accepted and 128 ambulances were released to respond to Amber 1 calls, but 122 were not.

The graph in the bottom left shows the estimated level of patient harm during July 2025. Of the 4,052 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (608 patients) would experience no harm, 53% (2,148 patients) would experience low harm, 23% (932 patients) would experience moderate harm and 9% (365 patients) would experience severe harm.

In July 2025 CSP levels for the Trust were:

Remedial Plans and Actions

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

Expected Performance Trajectory

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

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

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

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Health & Care Standard
Health – Safe Care

July 2025		
NEPTS (250 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	84
Were you happy with the transport you received?	85	92
999 (6 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	70
The 999-call taker who answered your call explained what was going to happen next.	85	100
The length of time I waited for an ambulance to arrive was acceptable.	85	75
111 (10 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	87
Did you follow the advice given to you by NHS 111 Wales?	85	83
Would you consider using NHS 111 Wales again?	85	80
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	85.64% Good	12.31% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	80.00% Good	0.00% Poor
o EMS (including CSD)	80.00% Good	0.00% Poor
o NHS 111 Wales Online	37.50% Good	18.75% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis

During July 2025, PECI attended 10 community engagement opportunities, engaging with approximately 322 people. Engagement this month was focused on attending Food Fun Wales school summer holiday enrichment programme.

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

111 callers have told us that they experienced long waits for call backs.

NEPTS users told us that overall, they continue to be happy with the transport they receive but experience delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

The PECI Team are still waiting the progression of an OCP which will see the Team restructured and re-aligned to meet the Trust's ongoing strategic objectives. The team will continue to engage in an ongoing dialogue with the public about their experiences and expectations of using our services, though it is as yet unclear how this will change.

The PECI Team are also carrying several vacancies which we are unable to back fill due to the impending OCP. As a result, its ability to engage with the community is severely impeded and engagement figures reported will be much lower than previously. The remaining PECI Team is switching it's focus to its core function of Patient Experience.

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

Expected Performance Trajectory

The vacancies are currently impacting on our ability to support community engagement opportunities, and the Team is re-focusing its day-to-day efforts onto our core function of patient experience.

Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production
A

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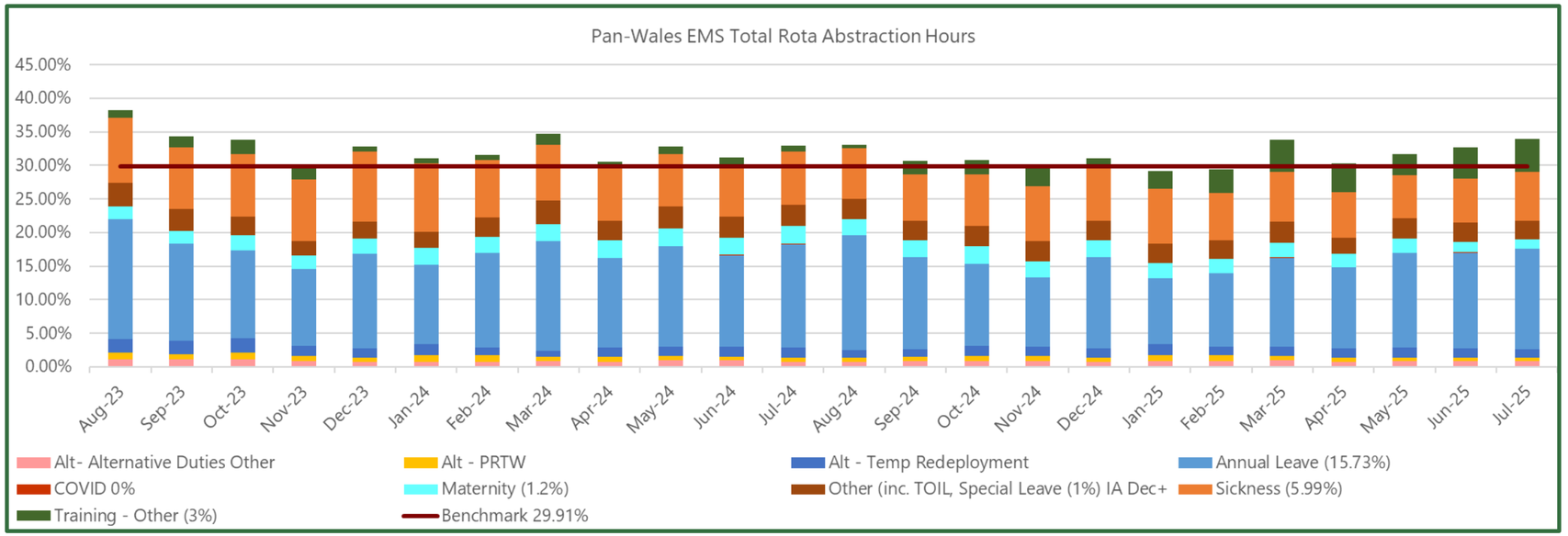

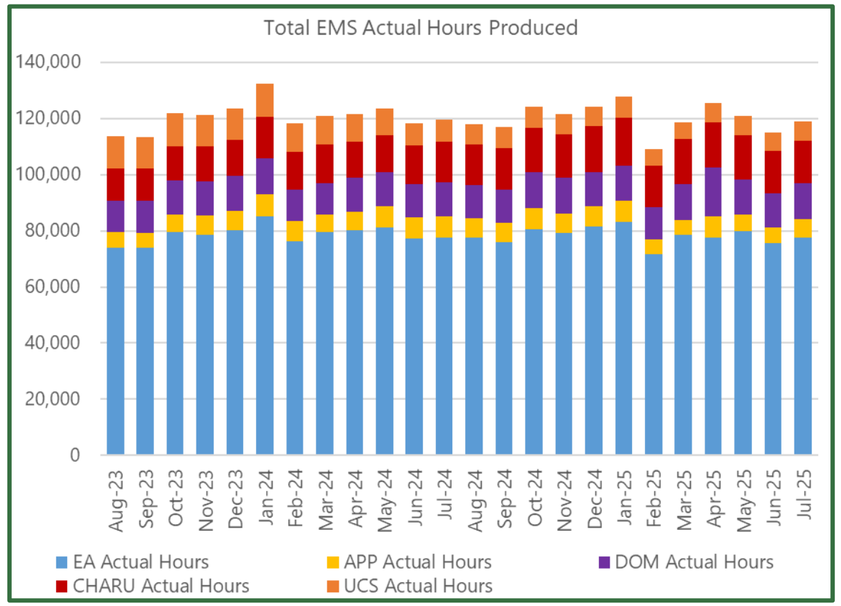

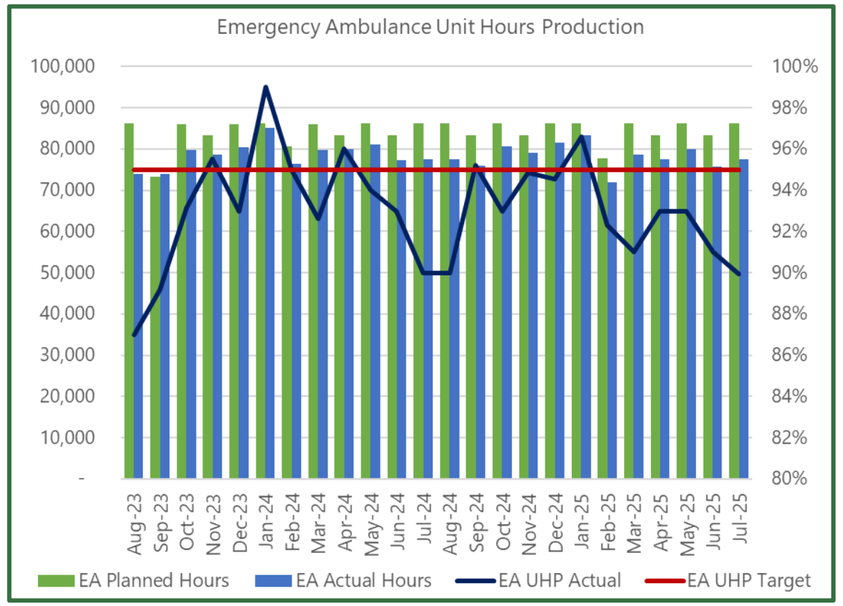

Analysis

Monthly abstractions from the rosters are key to managing the number of hours the Trust produces, as are the total number of staff in post. July 2025, saw total EMS abstractions (excluding Induction Training) of 33.98%. This was a minimal increase on the 32.63% recorded in June 2025 and remains above the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 15.03% followed by sickness at 7.30%.

The total EMS hours produced is a key metric for patient safety. The Trust produced 119,098 hours during July 2025; a slight decrease compared to the 119,710 hours produced during July 2024. The Trust is delivering good levels of production.

Emergency Ambulance Unit Hours Production (UHP) achieved 90% in July 2025 which equated to 77,528 Actual Hours.

In July 2025 CHARU UHP was 82% against the full roll out requirement. A slight drop compared to the past eight months.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Sickness	Mental Health
R	R

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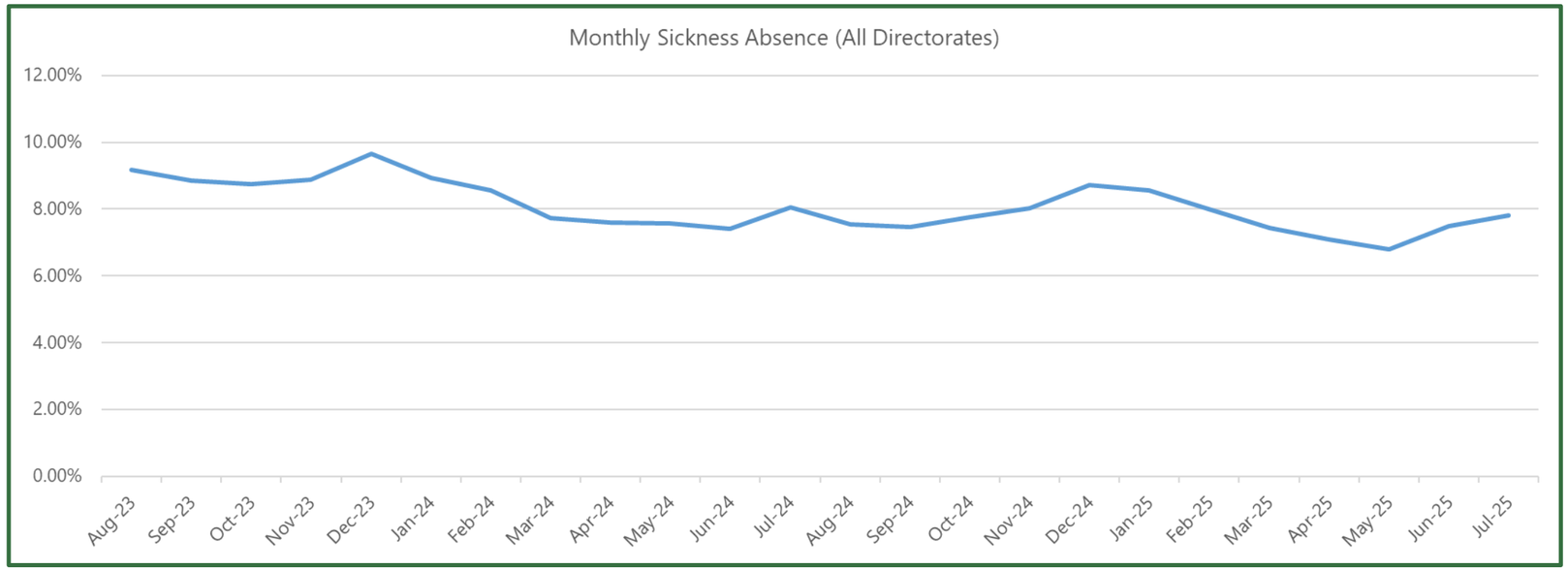
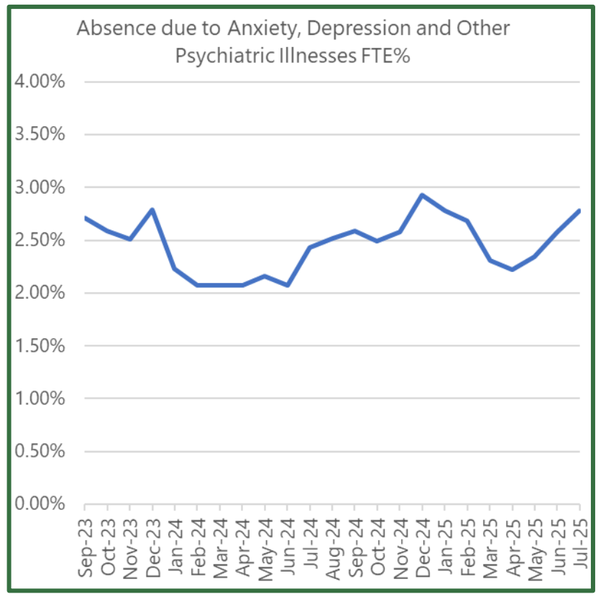
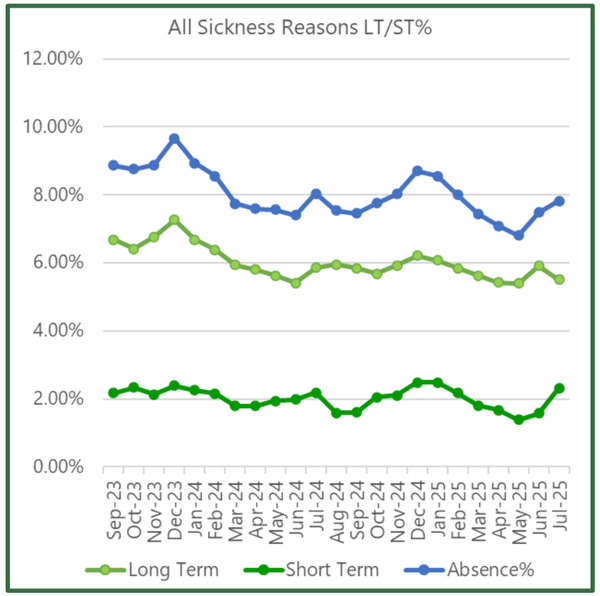




Jul-25	
Average working days lost per FTE (Annual)	
17.62 days	
Single month Absence %	
7.82%	
Long Term	**Short Term**
5.50%	2.32%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.78%	0.74%

July 2025



Analysis

There was a slight increase in overall sickness absence rates between June 2025 and July 2025, rising from 7.49% to 7.82%. Long term absence decreased from 5.91% in June 2025 to 5.50 % in July 2025, while short-term absence increased slightly to 2.32% (June 2025 - 1.58%).

The highest reasons for absence in July 2025 were Anxiety/ Stress/ Depression, other musculoskeletal problems, injury fracture and gastrointestinal problems. Absence due to Mental Health increased slightly from 2.58% in June 2025 to 2.78% in July 2025.

WAST Occupational Health continue to meet national KPIs set by the All-Wales Occupational Health standards and scope of practice, which states the 1st offered appointment date will be within 29 calendar days of the date referral received. The waiting time for a management referral in July was 11.2 days.

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

Remedial Plans and Actions

- The Health and Wellbeing Plan for 2025-29 has been developed and implemented. The focus of the plan is to improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges increasingly on a systemic level, in addition to providing support on an individual level.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits and drop-in clinics. We regularly give presentations to newly recruited staff to highlight and promote the Occupational Health & Wellbeing service.
- The programme plan for the pilot Health Check Programme, Health Diagnostics, (HD), has now started, and the team are scheduling clinics inviting staff to book screening appointments.

Expected Performance Trajectory

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

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

Our People
Capacity – Staff Turnover

(Responsible Officer: Angela Lewis)

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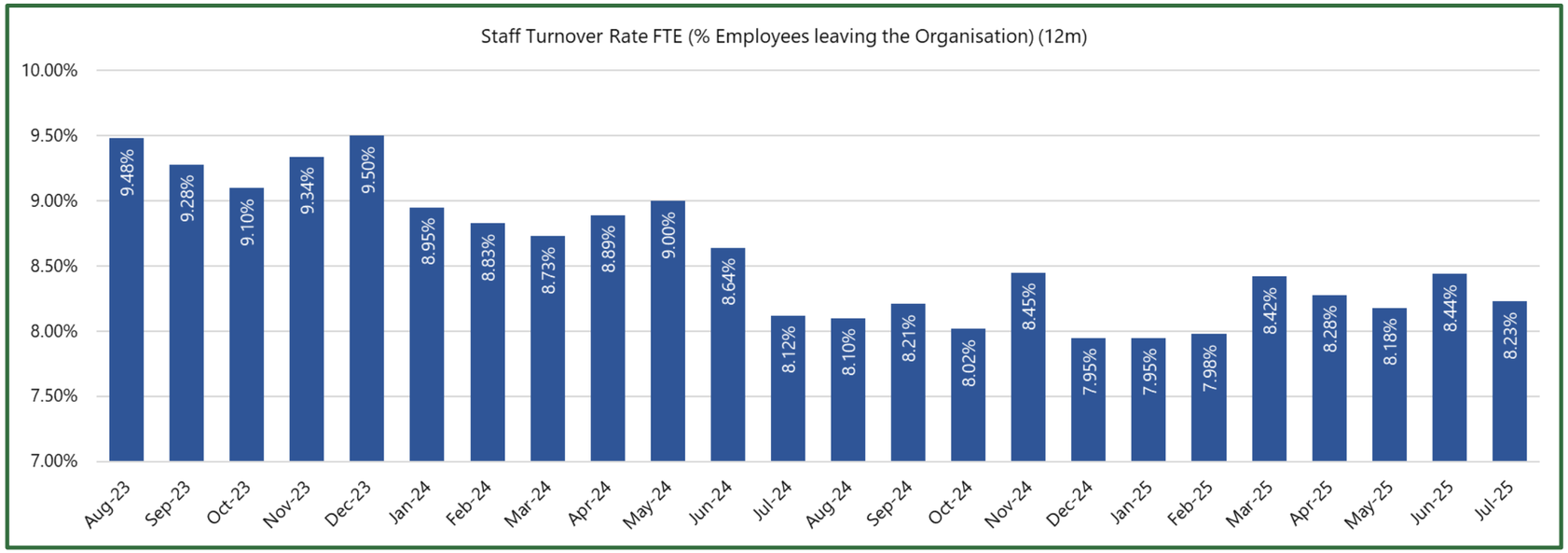

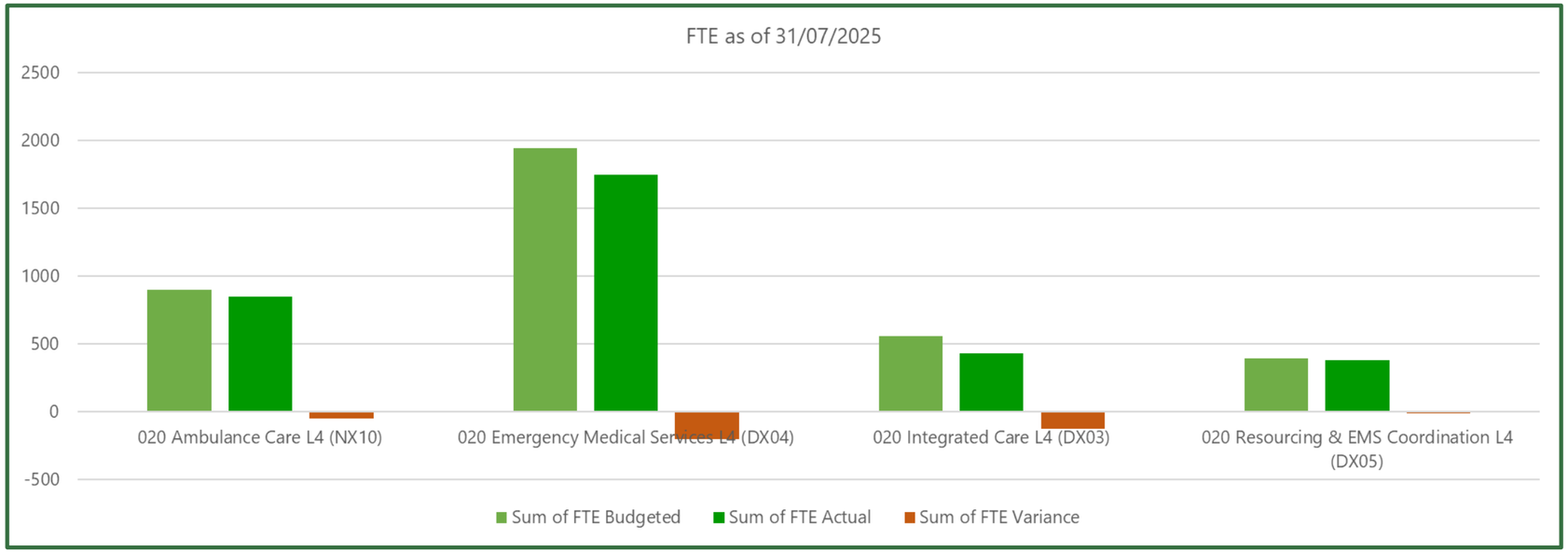

Analysis

The staff turnover rate in July 2025 was 8.23%, minimally decreasing from 8.44% in June 2025. July saw 26 leavers (21.60 FTE). Of those leaving, the greatest number were Operational and included;

- Ambulance Care Assistants/Patient Transport Drivers (6 people)
- Paramedics (3 people)
- Staff Nurses (3 people)
- Emergency Call Handlers (3 people)

Current trends are being monitored via the leaver's questionnaires; however, these are not mandatory. Of the information shown for July, most leavers mention changes in order to progress their career. However, burnout/stress, finding a role which aligns better with personal views or goals, new challenge career changes and better work life balance were also highly mentioned.

In July, this was partially compensated by 16 joiners (21.39 FTE). A headcount of 9 people into Corporate roles and 7 people into Operational roles, the top including:

- Managers (4 people)
- Clerical Worker (3 people)
- Call Operators (2 people)
- Staff nurse (2 people)

Remedial Plans and Actions

- The Trust is looking at longer term models to grow our APP cohort to support our future ambitions, which will include the recruitment of additional NQPs to support our B6 paramedics movement into APP roles.
- Discussions around the future skill mix of our EMS workforce are ongoing, this could have considerable impact on the EMS workforce going forward. However, sufficient training capacity has been planned during 2025-26 to enable the trust to recruit any staff into the organisation, regardless of what grade that may be.

Expected Performance Trajectory

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

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR: A

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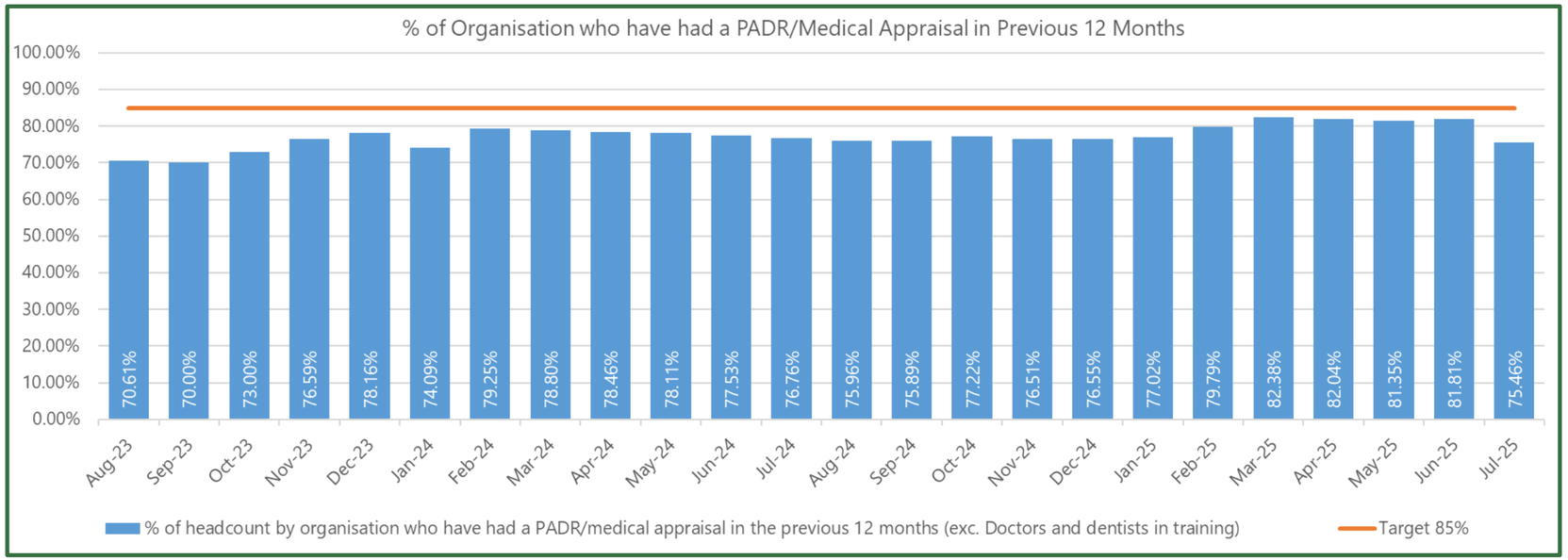
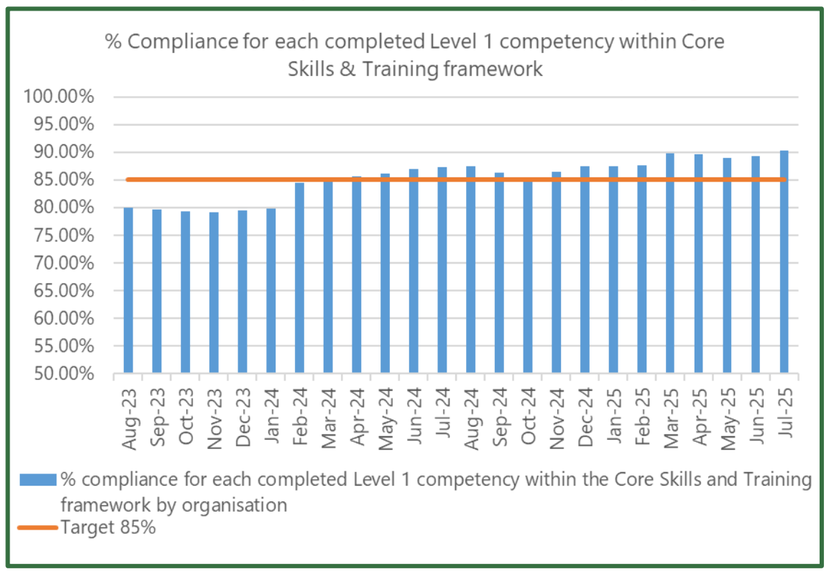
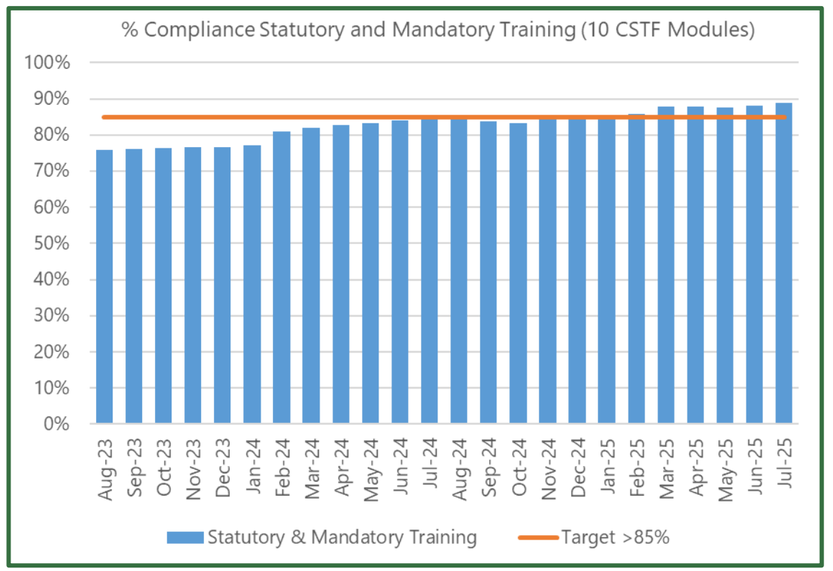
Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong



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





Analysis

PADR rates (excluding pay progression meetings) minimally decreased minimally from 81.81% in June 2025 to 75.46% in July 2025 and remains close the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In July 2025 Statutory & Mandatory Training rates reported a combined compliance of 88.98% exceeding the 85% target for the eighth consecutive month. With Dementia Awareness (98.70%), Moving & Handling (96.21%), Safeguarding Adults (96.15%), Information Governance (89.97%), Equality & Diversity (86.56%), Fire Safety (80.97%) and Fraud Awareness (80.91%), achieving the 85% target. Paul Ridd (79.27%), Violence Against Women, Domestic Abuse & Sexual Violence (76.42%) and Welsh Language Awareness (74.67%) all remain below this target.

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

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

Remedial Plans and Actions

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

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

Expected Performance Trajectory

Performance is improving as compliance has risen.

Data source: ESR

Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
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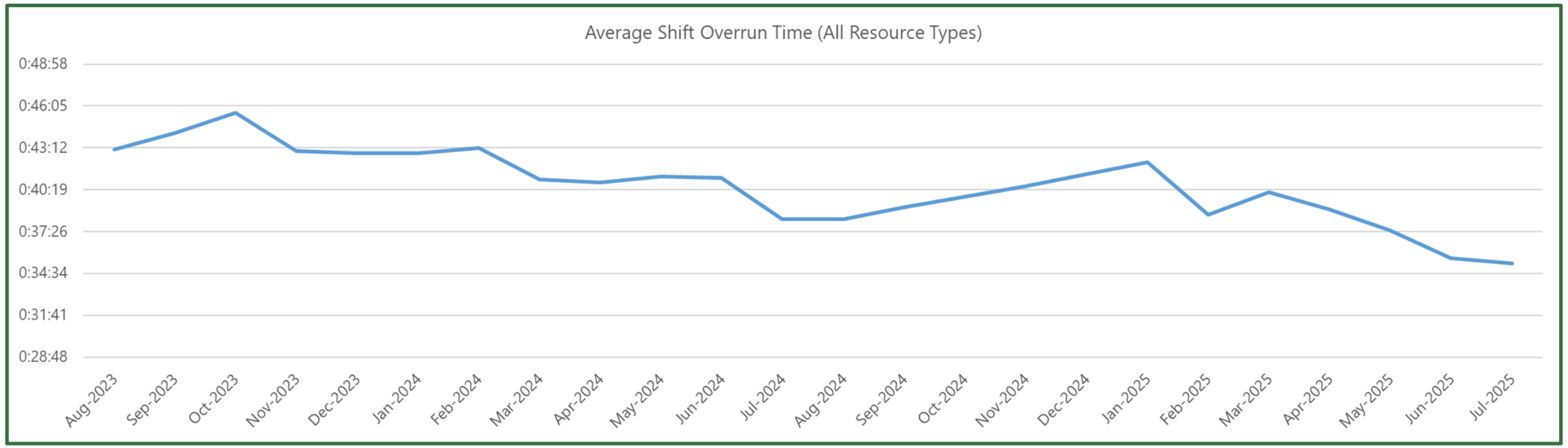
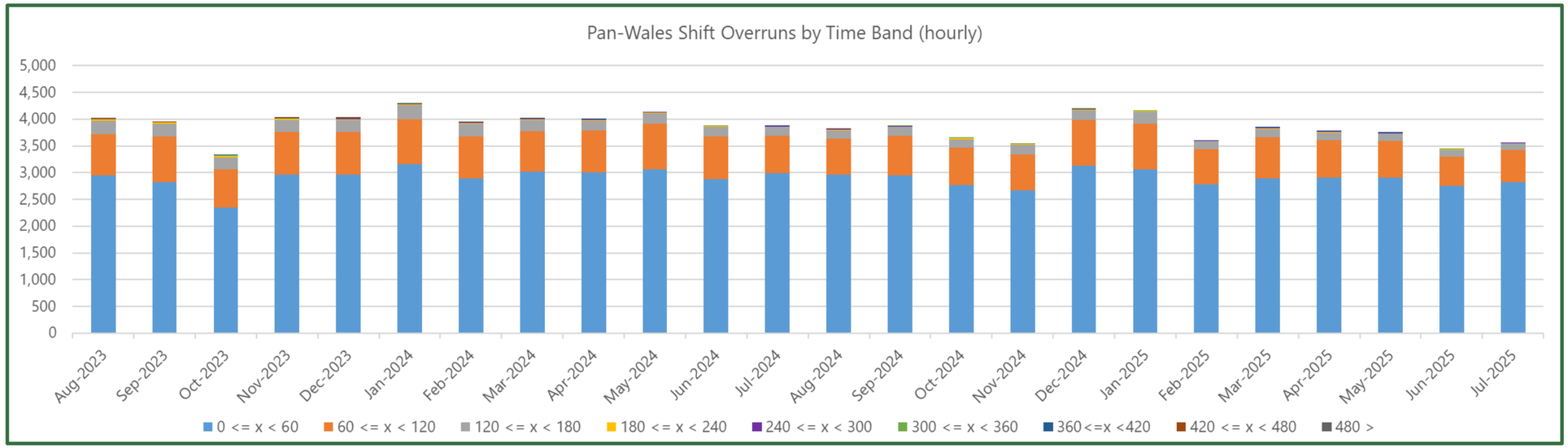




Analysis

There were 3,551 shift overruns during July 2025.

The average overrun figure for July 2025 was 35 minutes and 14 seconds, a minimal decrease from June 2025 (35 minutes 38 seconds). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 76.1% of the total. 18.6% fall within the 61 to 120-minute category, 4.1% in the 121 to 180-minute category, 0.4% in the 181 to 240-minute category and 0.1% in the 241 minutes and over category.

Remedial Plans and Actions

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

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

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

Expected Performance Trajectory

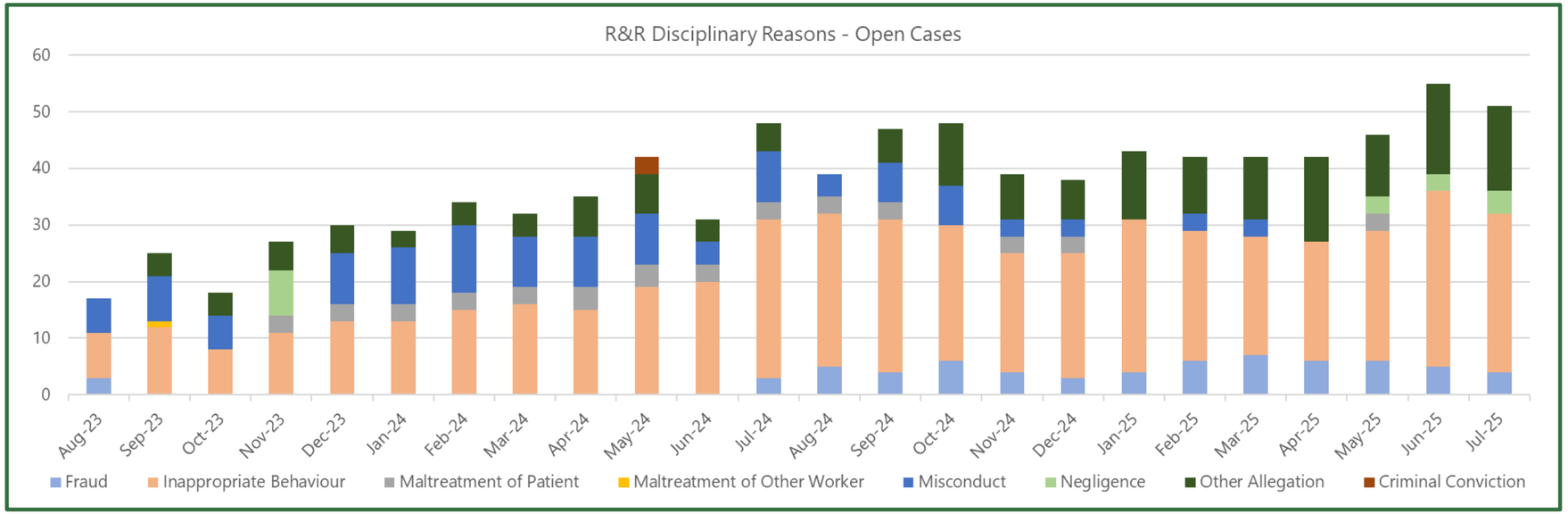
Overruns correlate with handover lost hours and may begin to decrease in handover times continue to reduce.

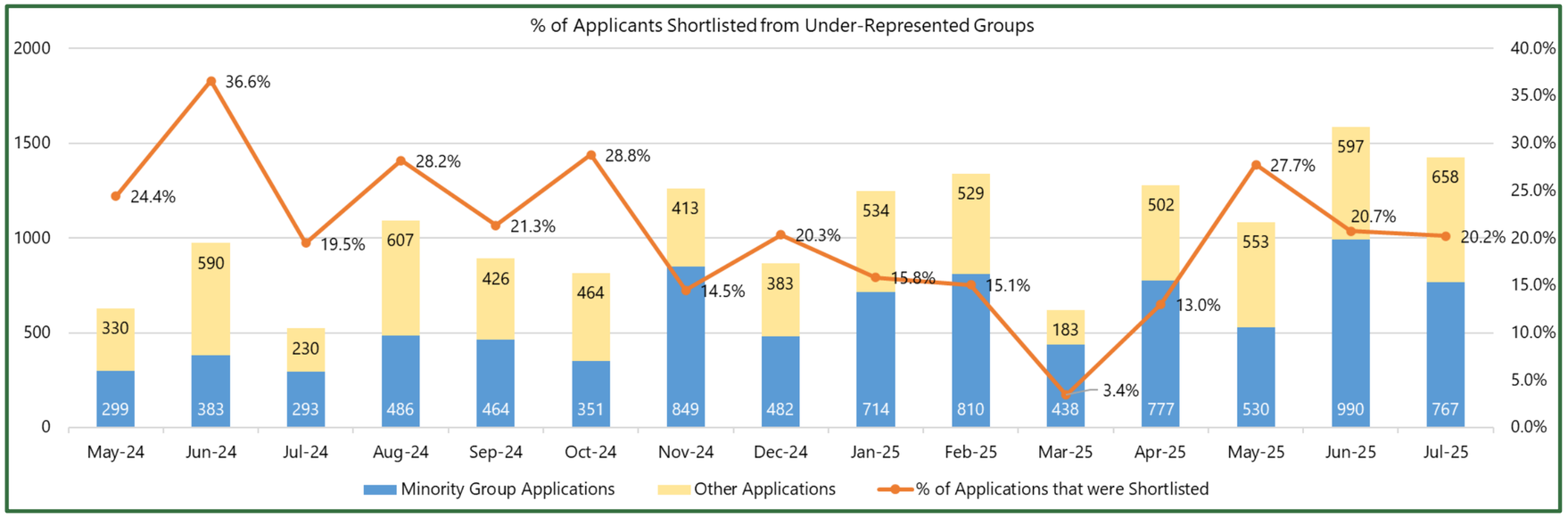
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 51 open formal disciplinary cases recorded at the end of July 2025, compared to 55 in June 2025. Of these Disciplinary cases, 55% are due to allegations of inappropriate behaviour.

There were 22 open formal Respect and Resolution cases in July 2025, a slight decrease from 27 reported in June 2025. (Previous increase due to R&Rs in relation to Roster Reviews).

The bottom graph shows that in July 2025, 1,425 job applications were processed, and 426 interviews planned.

Of the 1,425 applications, a total of 767 were from under-represented groups with 451 in the category of Ethnicity, 183 within Disability and 133 identifying within Sexual Orientation.

In July 2025, 20.2% (n=155) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a minimal decrease from the 20.7% in June 2025.

Remedial Plans and Actions

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

Applications: Work continues with the digital directorate and the ED&I team to host recruitment workshops for Black, Asian and Ethnically diverse applicants and unconscious bias training for the managers as well as interviewers for our annual Graduate Paramedic recruitment. Support workshops for applicants that have a protected characteristic that have been invited to interview for the Graduate Paramedic position have been established, with a plan to role out to other recruitment areas across the Trust.

Expected Performance Trajectory

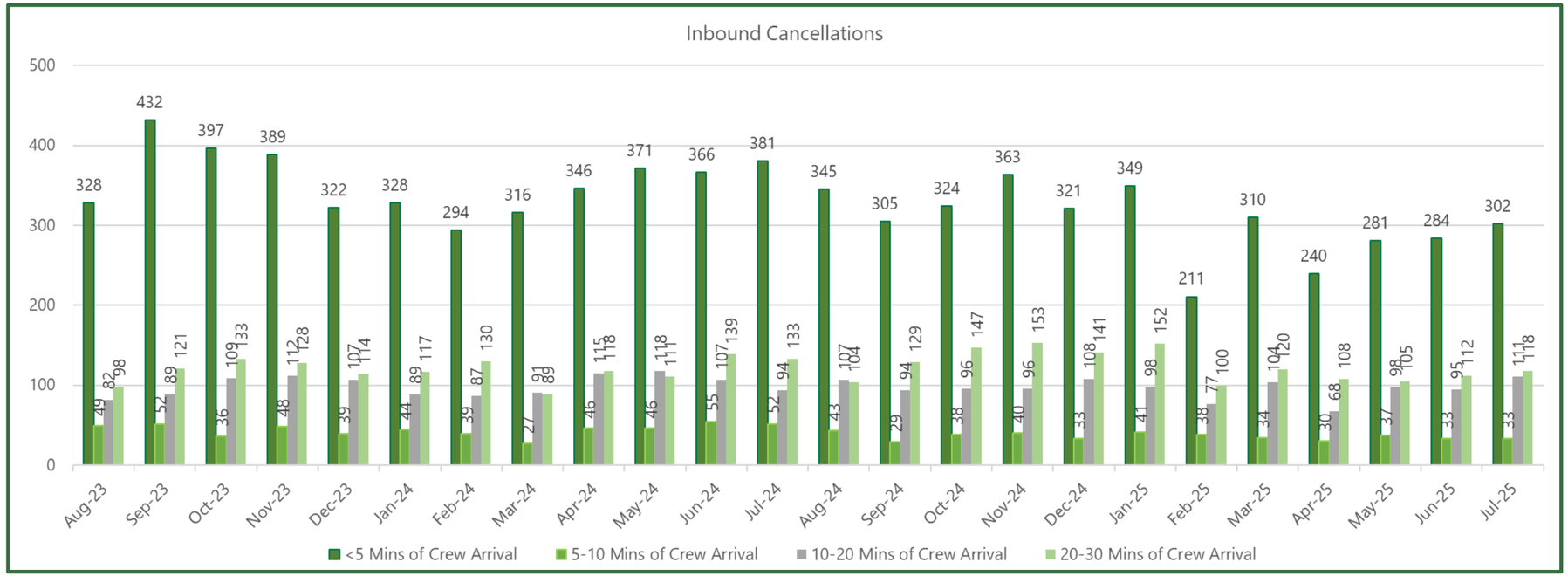
Continue to monitor levels, no trajectory for this measure.

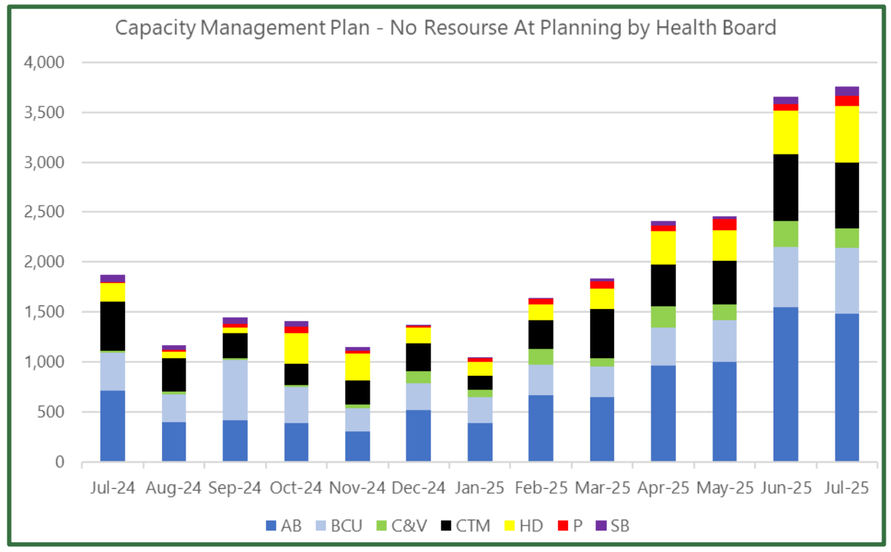
Finance, Resources and Value
Value: Ambulance Care Indicators

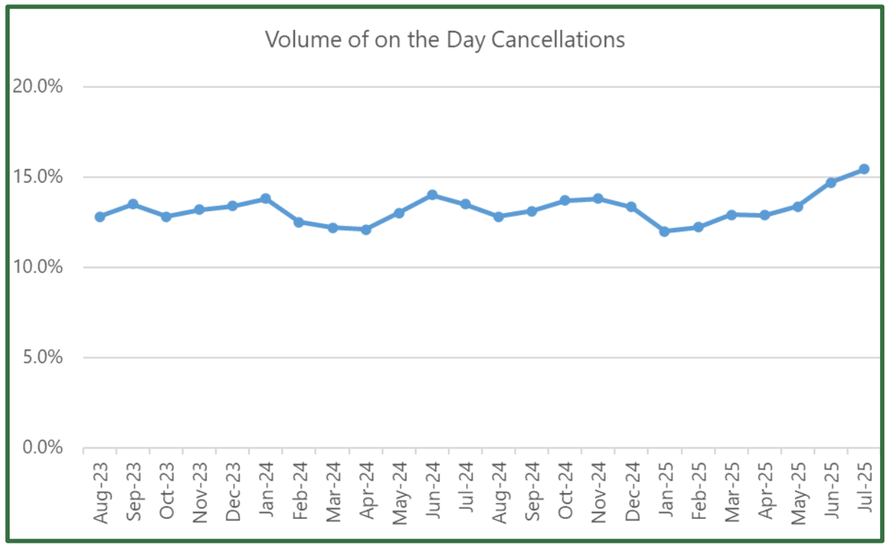
(Responsible Officer: Lee Brooks)

Cancellations
R

FPC







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a minimal increase in July 2025 to 302, compared to 284 in June 2025. The total number of cancellations within 30 minutes also marginally increased from 524 in June 2025 to 564 in July 2025.

In July 2025 there were 84 travel bookings cancelled by patients (including via SMS), one less than June 2025. Further SMS improvements went live in July that should continue the improving trend observed. The other top reasons for less than 5-minute cancellations included: 27 patients not located, 11 unwell/too ill to travel and 9 no appointment.

Same day cancellations increased slightly in July 2025 to 15.4% compared to June 2025 (14.7%).

Remedial Plans and Actions

The work with Hywel Dda to connect patient management systems went live in August. The process is still in live testing but expected to roll out as BAU in September. Although still in its infancy, a very small reduction in cancellations has been observed.

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

Expected Performance Trajectory

It is anticipated that CMP cancellations will reduce in August and September.

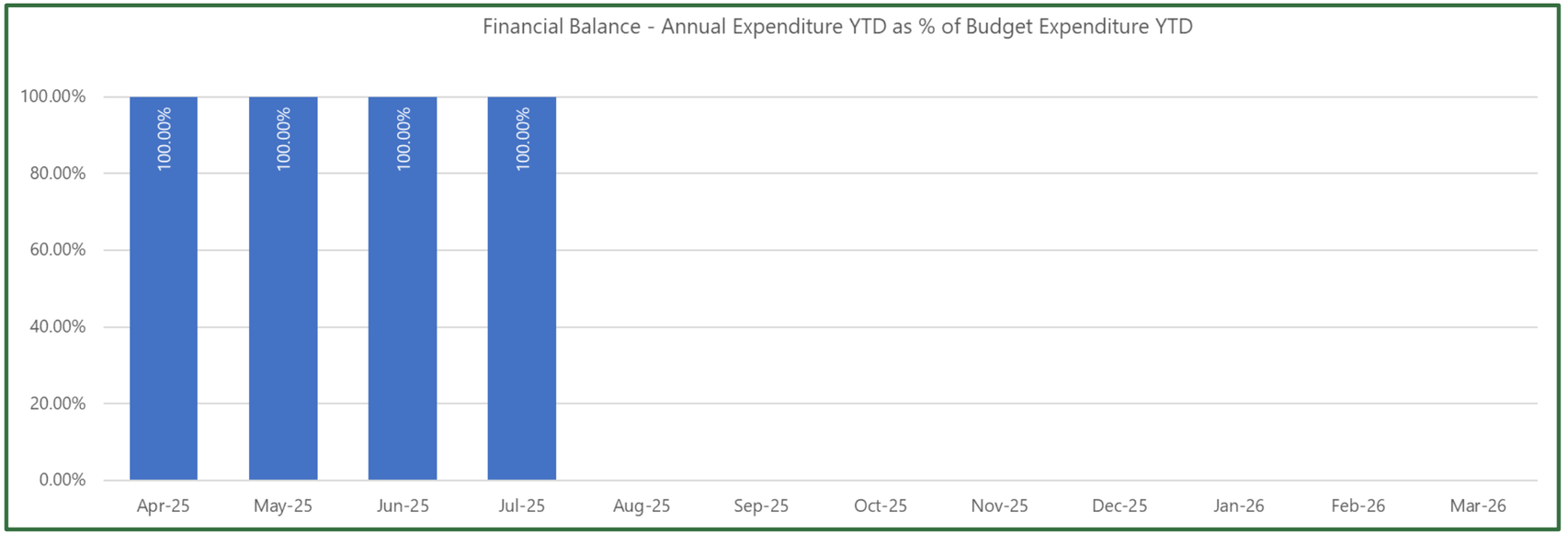
Please note that that figures may be lower than overall totals due to some records having no cancellation date.

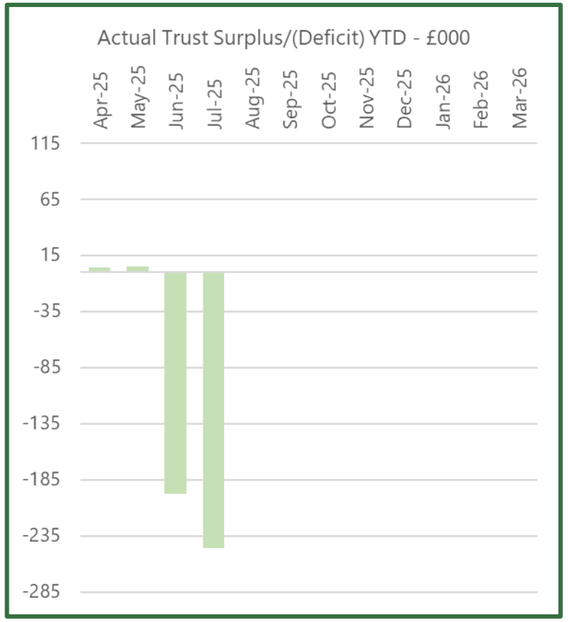
Finance, Resources and Value
Value - Finance Indicators

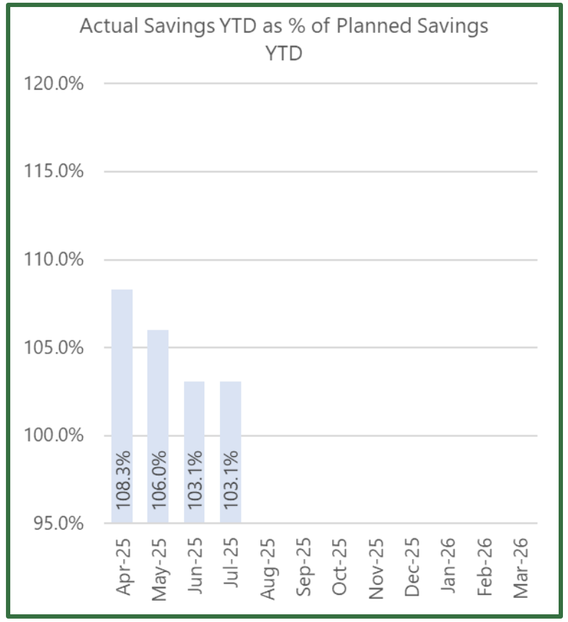
(Responsible Officer: Chris Turley)

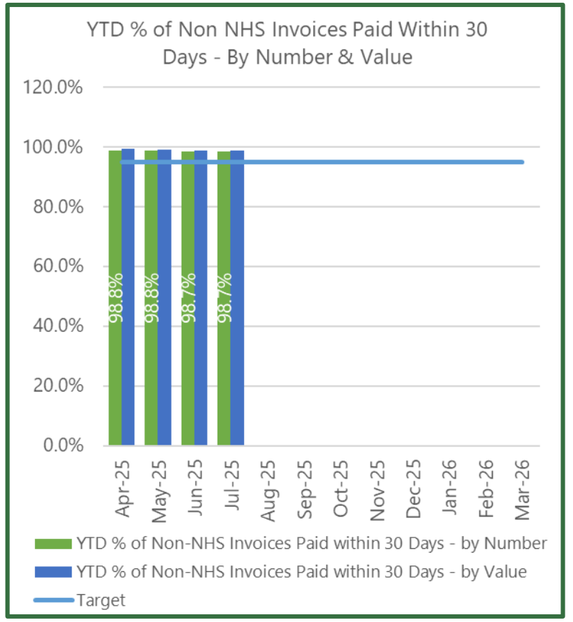
G

FPC









Analysis

The reported outturn performance at Month 4 is a deficit of £0.246m, with a forecast to the yearend of breakeven.

For Month 4 the Trust is reporting planned savings of £2.796m and actual savings of £2.884m (an achievement rate of 103.1%).

The Trust's cumulative performance against PSPP as at Month 4 is 98.7% against a target of 95%.

At Month 4 the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

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

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

Expected Performance Trajectory

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

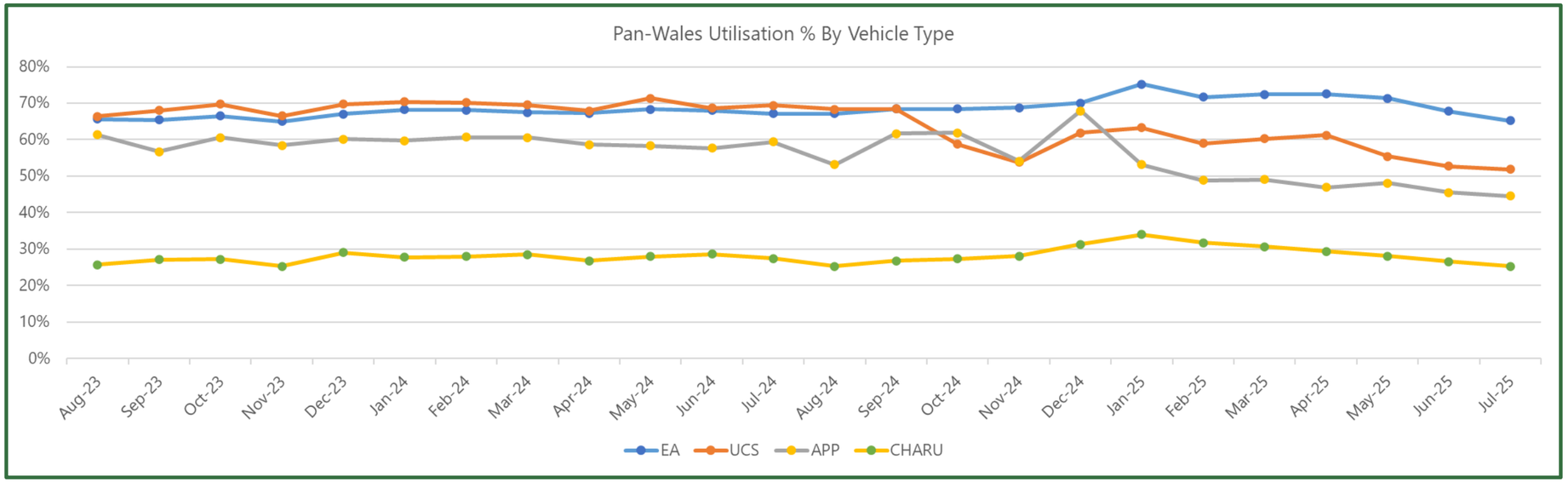
Finance, Resources and Value
EMS Utilisation

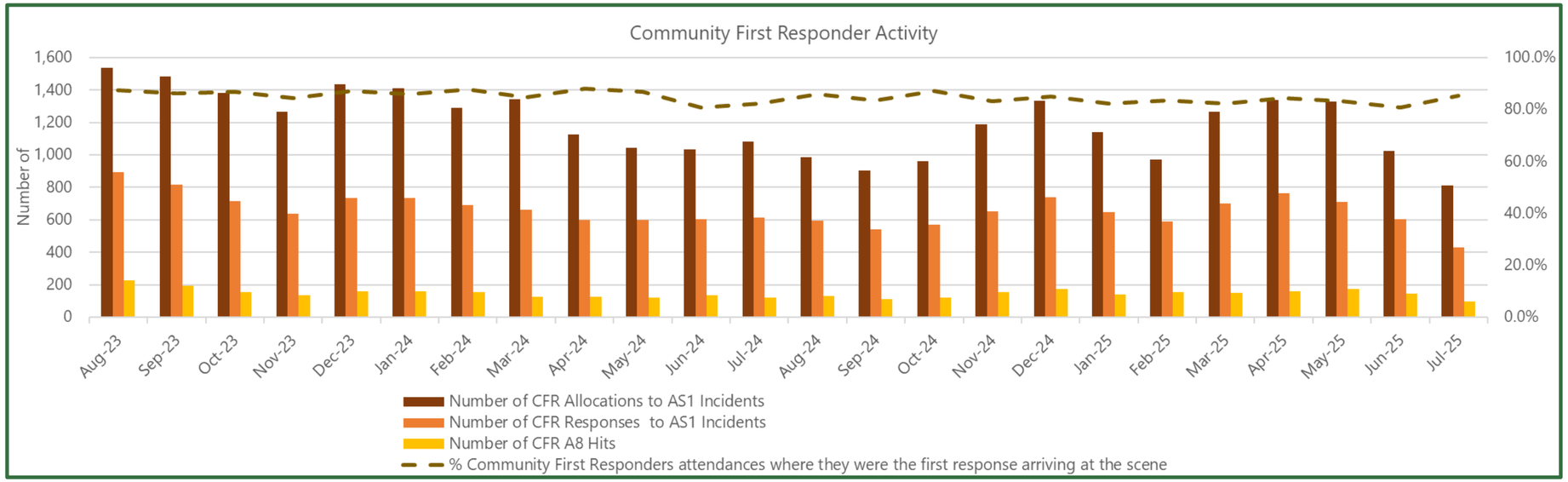
(Responsible Officer: Lee Brooks)

CHARU Utilisation A

FPC

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





Analysis

Pan Wales Utilisation metrics in July 2025 were 51% for all vehicles types, a decrease from 53.6% in June 2025. EA saw the highest rate during the month at 65.2%, a decrease compared to the upward trend over the previous months. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

CFR data collation is under review due to the new Assemble system going live in June 2025. At present hours for which a CFR volunteers are entered manually by the individual, however, there is work ongoing to connect this to the current CAD system from which they are dispatched to appropriate call codes. From the data available, in July we can see that CFRs were allocated to 810 EMS incidents and responded to 430. In July 2025 85.2% Community First Responders attendances where they were the first response arriving at the scene.

Remedial Plans and Actions

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

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

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

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

Expected Performance Trajectory

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

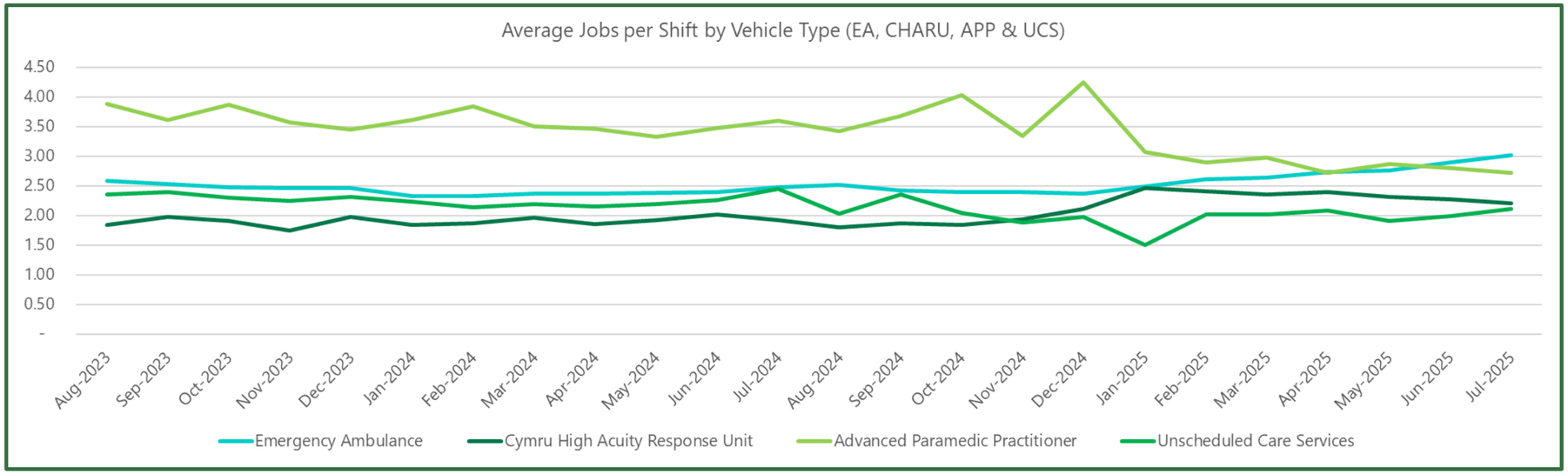
Finance, Resources and Value
Average Job/Shift Times

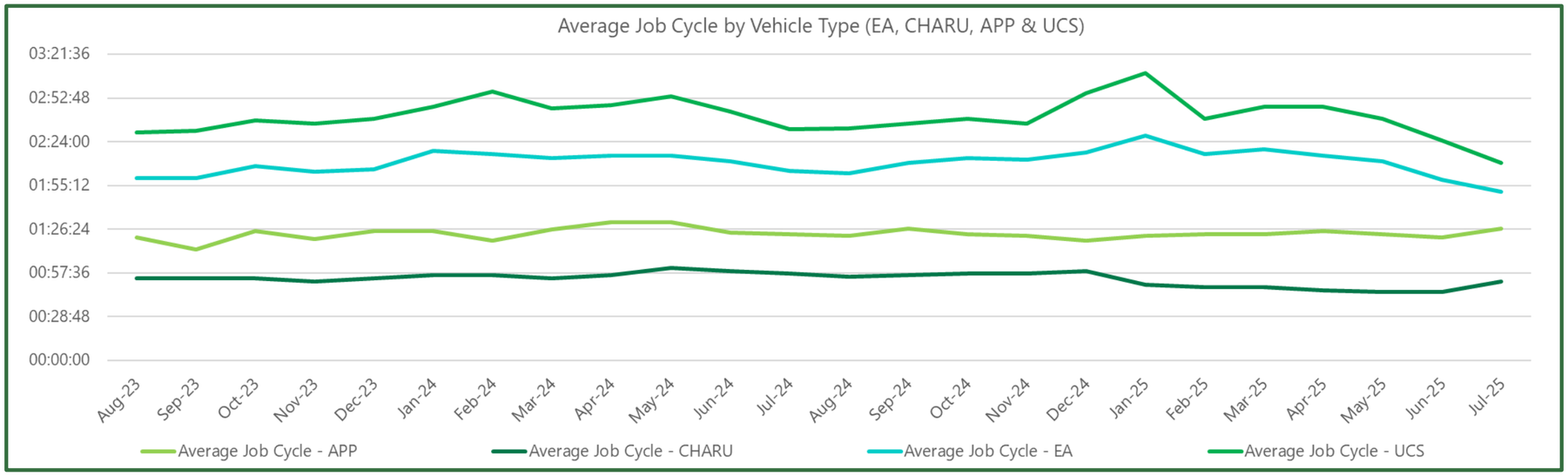
(Responsible Officer: Lee Brooks)

Jobs Per Shift
G

FPC

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





Analysis

Overall average jobs per shift was 2.83 in July 2025, an increase from June 2025 (2.74). EAs averaged 3.02 jobs per shift and UCS crews 2.11. Discussions with ORH indicate that 3.02 jobs per shift for EAs is higher than might be expected with the current levels of handover, with a definite upward trend as handover lost hours have come down.

APPs attended on average 2.72 jobs per shift and CHARU's 2.21. However, both sets of data need to be reviewed. The current priority is phase 2 of the Ambulance Performance Framework, with further capacity being recruited into to support the Insight & Data Services function.

As demonstrated in the bottom graph, the average job cycle decreased slightly in July 2025 for EAs (1 hours 51 minutes) and UCS (2 hours 10 minutes).
APPs (1 hour 27 minutes) and CHARU(52 minutes).
Both increased from the previous month.

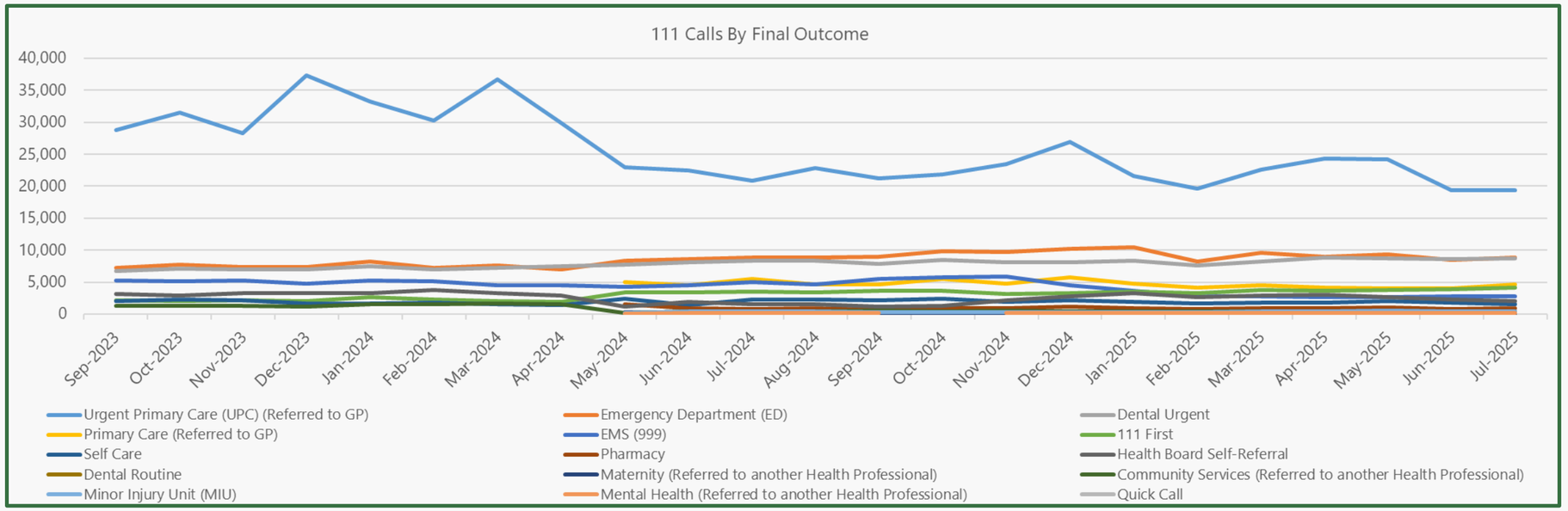
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

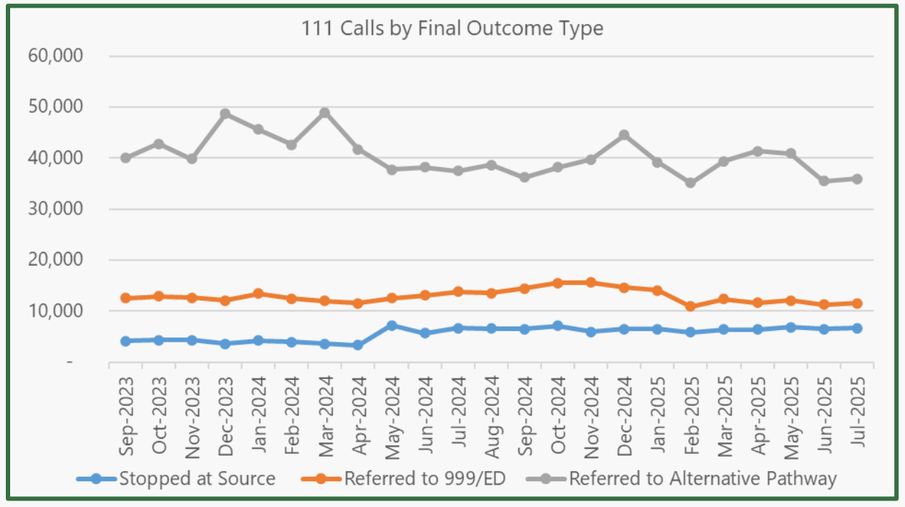
Dental G

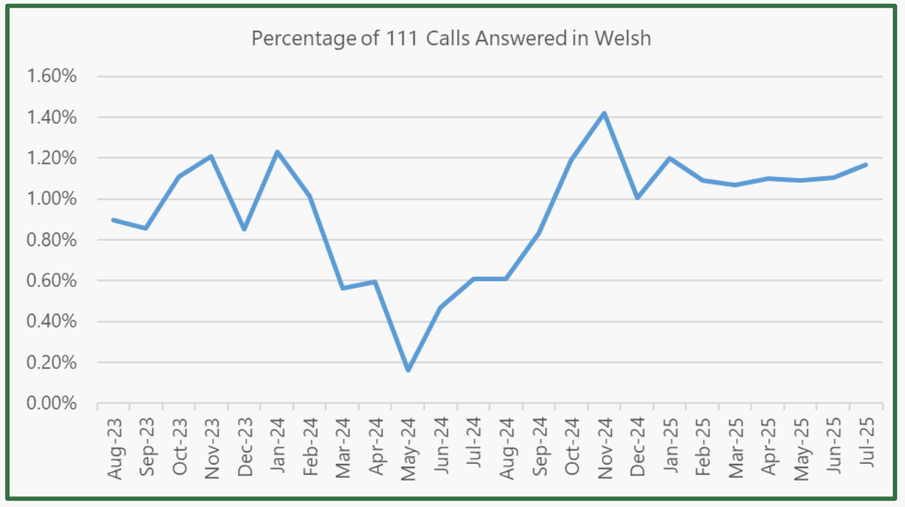
C&C Volumes G

FPC

(Responsible Officer: Lee Brooks)







Analysis

During July 2025, 54,060 calls were allocated into the 14 categories displayed in the graph opposite; an increase compared to the 53,175 seen during June 2025. However, data quality issues within 111 reporting have been addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 33.3% of all calls during July 2025, but there has been a material drop since the implementation of the new 111CAS system.

As the bottom left graph highlights, in July 2025, 6,624 calls were 'Stopped at Source', with no onward referral, a slight decrease from 6,439 in June 2025. 11,512 calls were referred to 999/ED in July 2025.

The percentage of 111 calls answered in Welsh increased slightly from 1.10% in June 2025 to 1.17% in July 2025. This equated to 67.8% of all 111 calls being offered in Welsh being answered.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

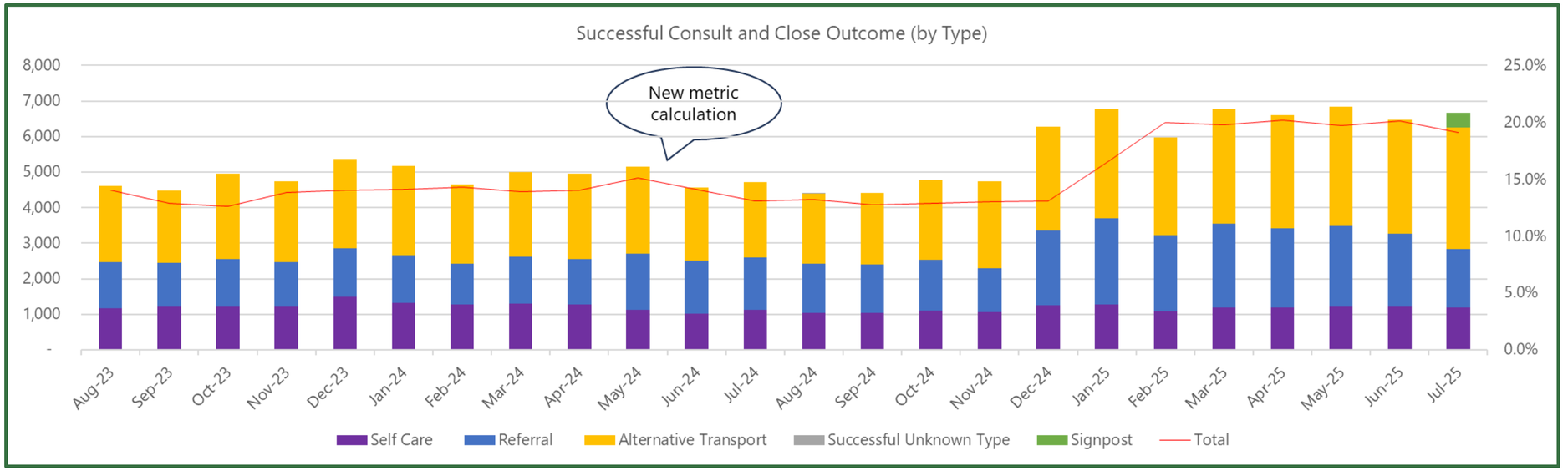
Partnerships / System Contribution
Consult & Close Indicators

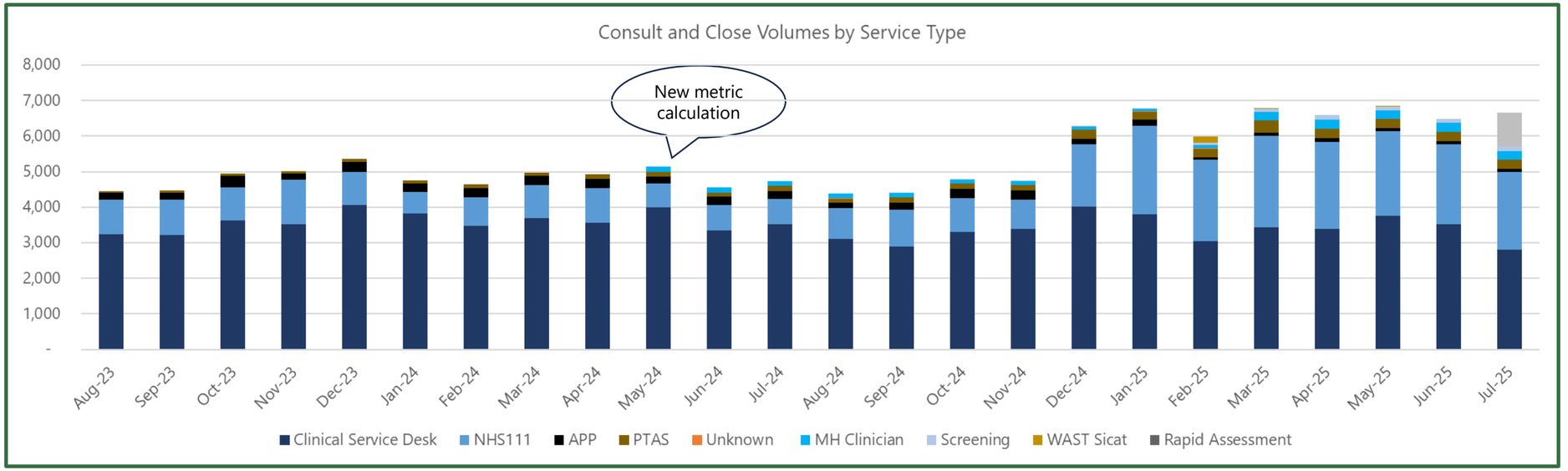
(Responsible Officer: Lee Brooks)

C&C Outcomes

G

FPC





Analysis

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

Contributions from Clinical Service Desk (CSD) (7.96%), NHS111 (6.16%), WAST APP (0.27%), Health Boards using Physician Triage and Streaming Service (PTAS) (0.70%), Mental Health Clinician (0.70%), Screening (0.33%) and Rapid Assessment (2.74%) achieved 18.9% in July 2025, a minimal decrease of 1.04% compared to June 2025, however achieving the 17% IMTP ambition for the seventh consecutive month. In July 2025, the number of 999 calls resulting in a Consult and Close outcome was 6,664, up from 4,725 in July 2024.

Of the calls successfully closed in July 2024, 77 patients received an outcome of self-care; 840 patients were referred to other services (including to Minor Injury Units and SDEC), 921 were advised to seek alternative transport services to acquire treatment and 337 were signposted.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Partnerships / System Contribution
Conveyance to ED Indicators

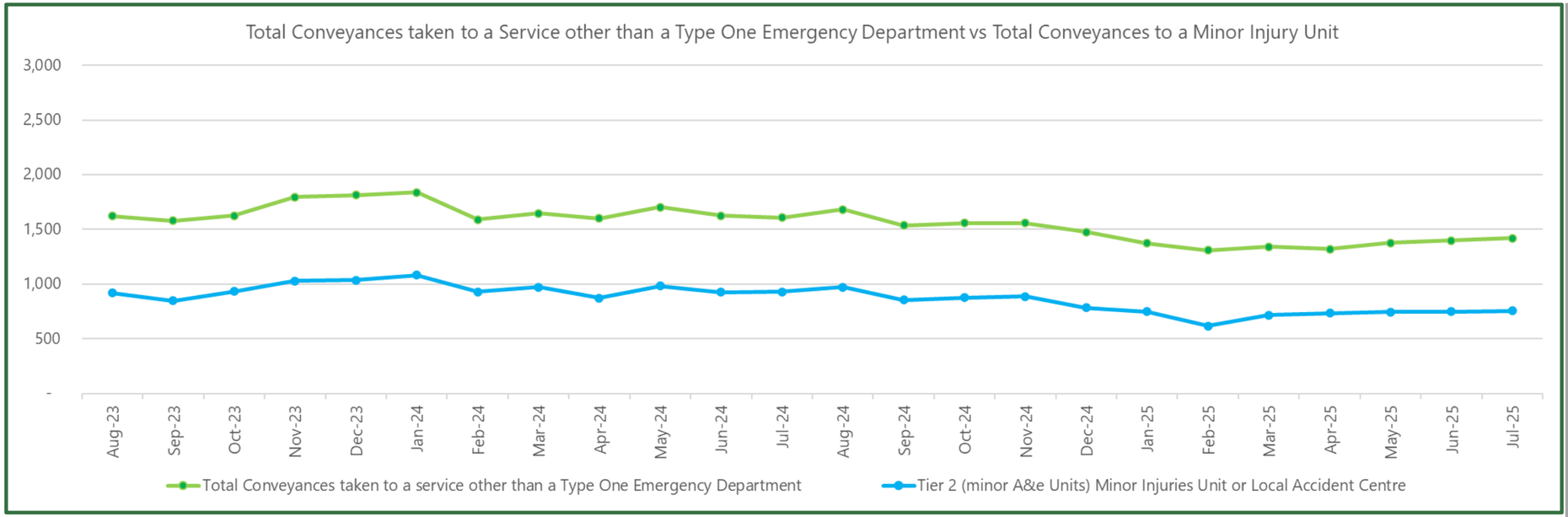
(Responsible Officer: Andy Swinburn)

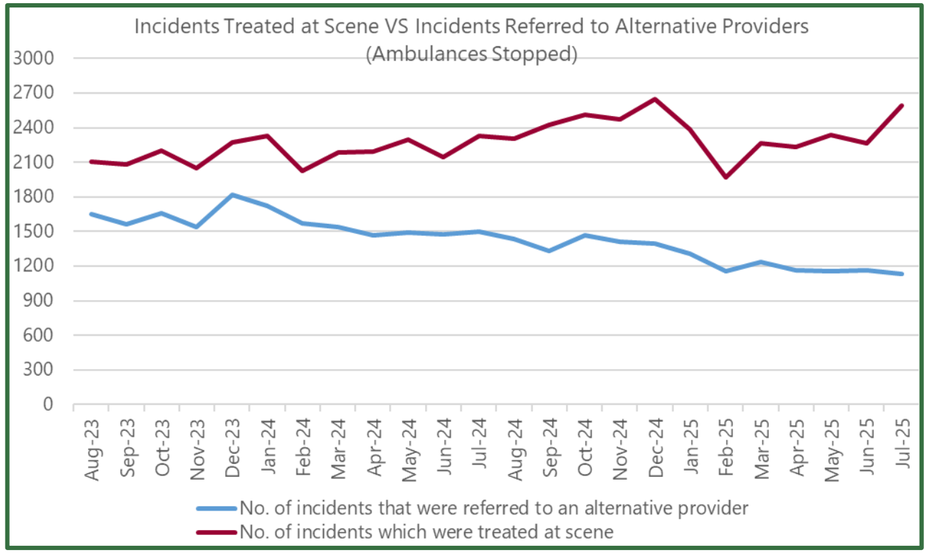
Conveyances
R

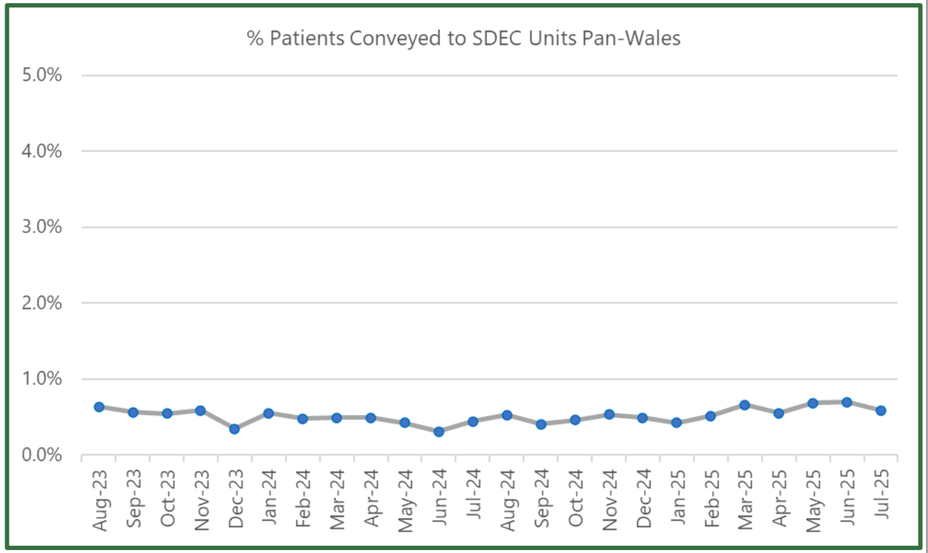
FPC

Ministerial Measure

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







Analysis

In July 2025 9.58% of patients (1,419) were conveyed to a service other than a Type One ED. 5.1% (757) were conveyed to a Tier two Minor Injuries Unit or Local Accident Centre while 37.94% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased, from 3,426 in June 2025 to 3,728 in July 2025.

Percentage of patients conveyed to SDEC units decreased minimally in July 2025 to 0.65% from 0.7% the previous month.

Taxi conveyance has remained consistent for the past 12 months, averaging 826 per month to hospitals.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

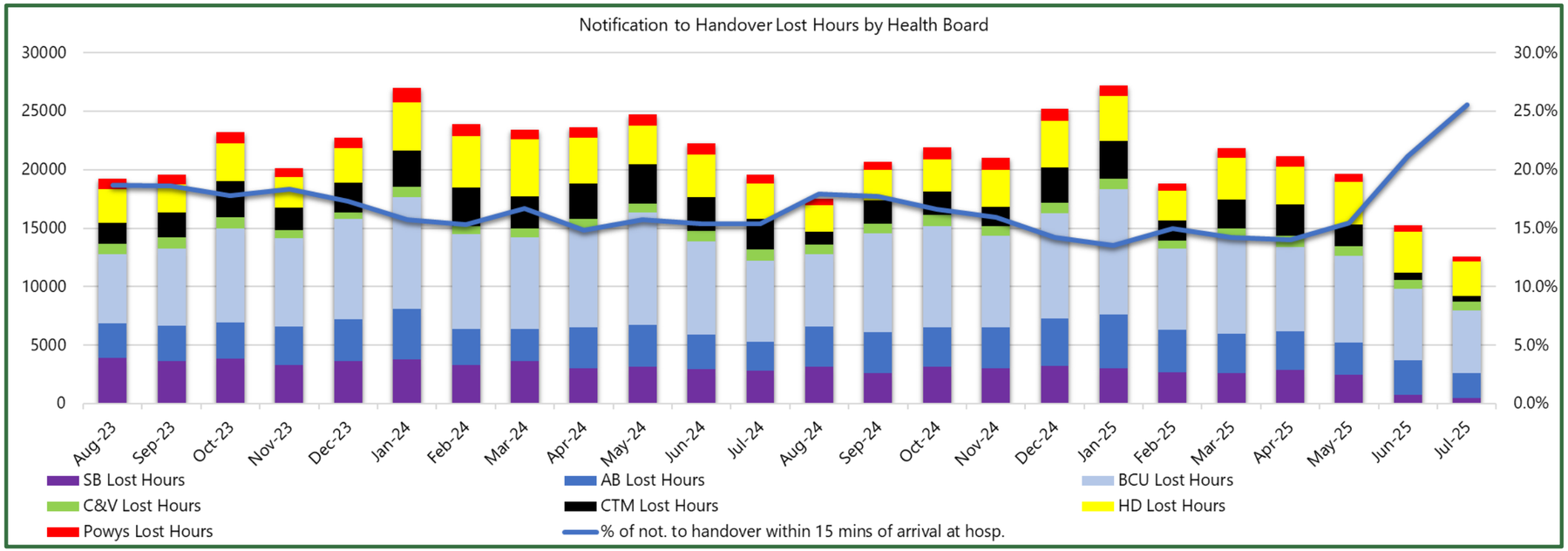
Partnerships / System Contribution
Handover Indicators

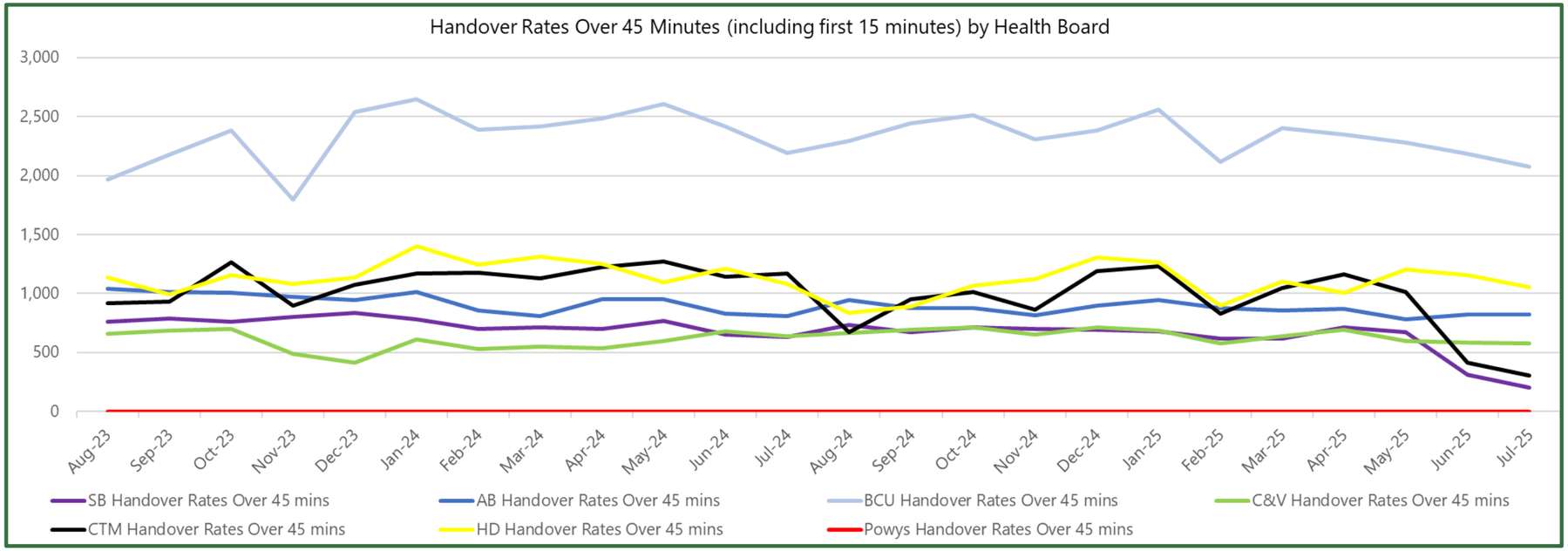
(Responsible Officer: Health Boards)

Lost Hours R

CI

QUEST





Analysis

242,880 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Aug-24 to Jul-25), compared to 269,434 hours over the same timeframe the previous year. There were 12,565 hours lost in July 2025, which is 35.87% lower than the 19,596 hours lost during July 2024 and is the lowest monthly figure since July 2021. All health boards have seen reductions, compared to last month, particularly Swansea Bay (35.7%) , Powys (32.4%) and Aneurin Bevan (29.2%).

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

- Ysbyty Gwynedd Hospital (BCUHB) at 2,109 lost hours
- Grange University Hospital (ABUHB) at 2,052 lost hours
- Ysbyty Glan Clwyd (BCUHB) at 1,921 lost hours
- Glangwilli Hospital (HDUHB) at 1,515 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 1,270 lost hours

Notification to handover lost hours averaged 405 hours per day during July 2025 (31 days) compared to 509 hours per day (30 days) in June 2025.

In July 2025, the Trust could have responded to approximately 3,964 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

Remedial Plans and Actions

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

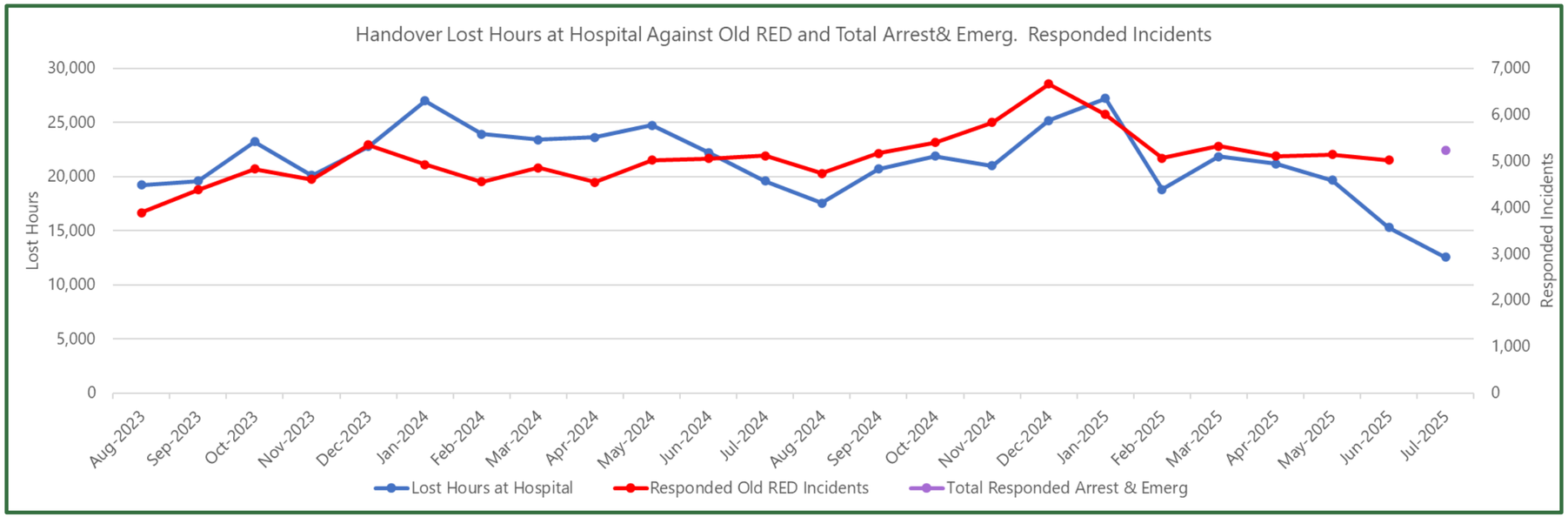
Expected Performance Trajectory

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

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

(Responsible Officer: Health Boards)

CI QUEST



Analysis

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

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

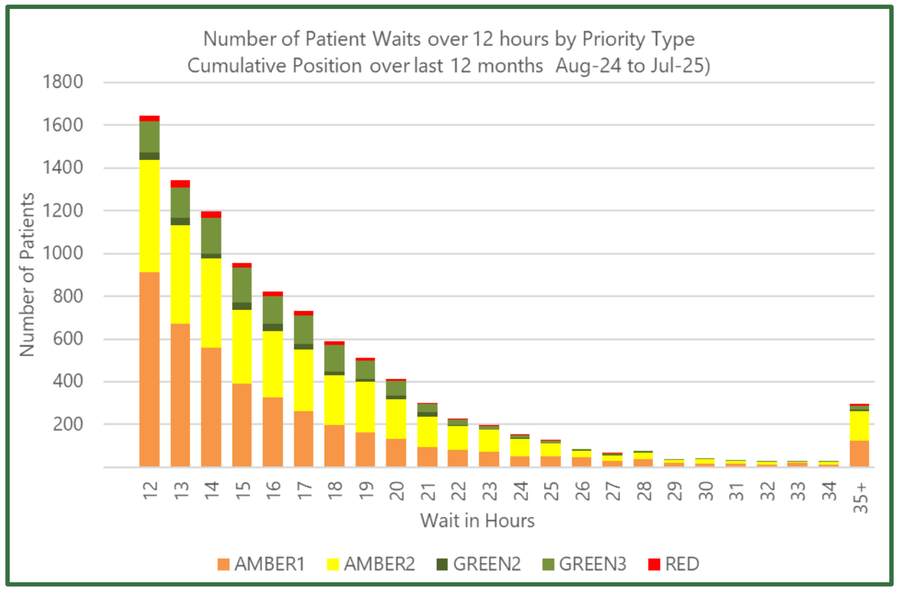
In July 2025, 294 patients waited over 12 hours for an ambulance response.

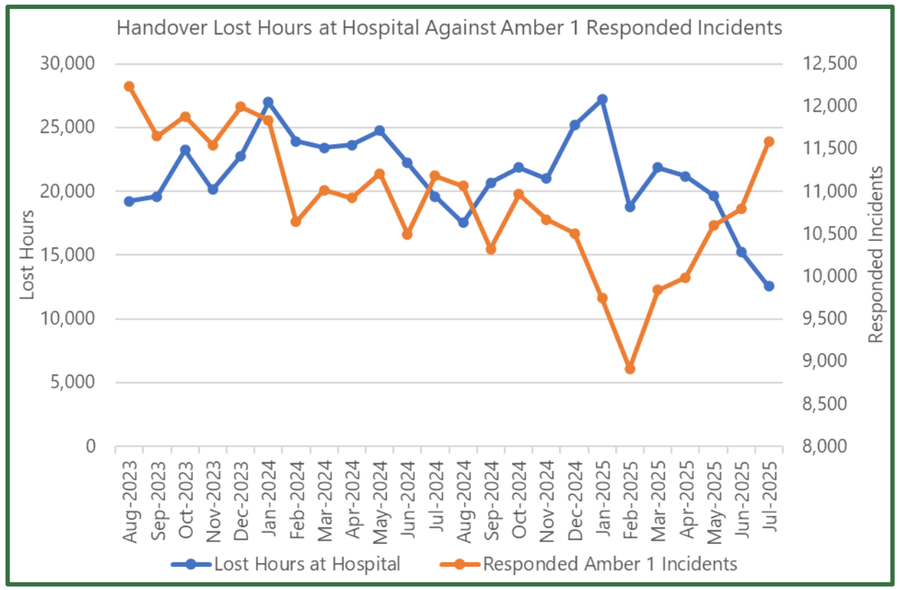
Remedial Plans and Actions

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

Expected Performance Trajectory

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





**NB: Data correct at time of abstraction*

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

Definition of Indicators

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

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

Agenda Item No.	8

REPORT TITLE

Ambulance Service Indicators

MEETING

Name of meeting	Finance & Performance Committee (FPC)
Date of meeting	16 September 2025
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

Executive sponsor	Estelle Hitchon - Interim Director of Strategy, Planning & Performance
Author(s) of report	Hugh Bennett – Interim Deputy Director, Commissioning & Performance

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. In line with this Committee's delegated responsibility to 'review performance against targets and standards set by Commissioners and/or Welsh Government for the Trust and, where appropriate, against national ambulance quality indicators', this report provides the Committee with an overview of the Ambulance Service Indicators (ASIs)**.**

2. The ASIs are published monthly by the Joint Commissioning Committee and set out the Trust's performance across the five step 999 patient pathway.

3. The ASIs were first produced when the original clinical response model (CRM) went live in October 2015. They were originally called the Ambulance Quality Indicators (AQIs) and were originally produced quarterly.

4. The ASIs are one of the main ways in which the Trust can be held to account on its performance and are therefore an important consideration for this Committee in line with its terms of reference.

5. The ASIs have not been reported separately to Committee previously, with key ASIs being used in the Monthly Integrated Quality & Performance Report (MIQPR), which is received by Committee and the Board at every meeting.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance & Performance Committee is requested to:

1. **Consider** the ASIs and their reporting to Committee via the MIQPR and whether his approach provides sufficient assurance.

ADDITIONAL PAPER(S)

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

Annex 1 - Ambulance Service Indicators - NHS Wales Joint Commissioning Committee

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
CRR 100: Failure to persuade Commissioners about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.

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
02.09.2025	Estelle Hitchon - Interim Director of Strategy, Planning & Performance

SITUATION

1. The purpose of this report is to provide Committee with an overview of the Ambulance Service Indicators (ASIs).

2. The ASIs are published monthly by the Joint Commissioning Committee (JCC) and set out the Trust's performance across the five step 999 patient pathway.

BACKGROUND

3. The AQIs were first produced when the original clinical response model (CRM) went live in October 2015. They were originally called the Ambulance Quality Indicators (AQIs) and were originally produced quarterly.

4. The AQIs were innovative in several ways. They measured performance across a patient pathway, the 999-emergency ambulance pathway:-

5. The AQIs measured performance across a distribution curve e.g. median, 65th and 95th percentile, rather than a hit/miss target, with no information about what happens to those patients for whom the target was not achieved.

6. The AQIs introduced clinical indicators e.g. ROSC rate, stroke care bundle, hip fracture bundle etc.

7. The ASIs are dynamic, changing over time to reflect changes and developments.

ASSESSMENT

8. The most recent ASIs were published on the 21 August 2025:-

Ambulance Service Indicators - NHS Wales Joint Commissioning Committee

9. These ASIs included the recent major change in incident categorisation, introducing Purple (Arrest), Red (Emergency) and Rapid Clinical Screening Zero (RCS0). Additional clinical indicators, in support of these changes are expected to go live in the Autumn and be included in the ASIs.

10. The ASIs are not formally reported to Committee, but many of them are incorporated into the MIQPR. There are 24 ASI indicators, of which 18 are contained in the MIQPR. The six that are not included in the MIQPR are:-

    - ASI2: Number of frequent callers;
    - ASI3: Number of HCP calls answered;
    - ASI14: Number of responded incidents where at least one resource arrived on scene;
    - ASI15: Number of community first responders (CFRs) attendance on scene;
    - ASI18: Ideal resource on scene (volumes and percentage); and
    - ASI22: Handover to clear (volumes and percentage).

11. Each year the MIQPR is formally reviewed, so the Trust reconsiders the metrics reported to Committee, including those ASIs currently not included and additional ASIs coming on stream. ASI18 is of particular note, as getting the ideal resource on scene is a critical component of the Yellow (Soon) category, so it is anticipated that a revised version of this metric will come into the MIQPR in Q4.

12. For ASIs not reported to Committee in the MIQPR, these are considered in other reports or are available on Power BI or Report Manager.

RECOMMENDATION

13. The Finance & Performance Committee is requested to **Consider** the ASIs and their reporting to Committee via the MIQPR and whether this approach provides sufficient assurance.

NEXT STEPS

14. As the ASIs change, the MIQPR will be reviewed and updated accordingly. The MIQPR will also be subject to its usual annual review in the second half of the year. Finally, it is anticipated that as part of the review of the MIQPR there will also be a discussion between the Executive Director of Strategy, Planning & Performance and committee chairs on the MIQPR.

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

DIGITAL REPORTING

MEETING	Finance & Performance Committee
DATE	16 September 2025
EXECUTIVE	Jonny Sammut, Director of Digital Services
AUTHOR	Aasha Cowey, Assistant Director of Digital Services Leanne Smith, Assistant Director of Digital Services Kimberly Abraham, Digital Directorate Support Administrator
CONTACT	Aasha.Cowey@wales.nhs.uk Leanne.Smith4@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report brings to the committee updates relating to Insight & Data Services (IDS), ICT, Digital Innovation and Transformation projects and programmes, and details progress against the Digital Plan (see **Appendix 1** for metrics and project status). This status report is updated regularly to offer an evolving picture of progress.

Highlights

2. **Recruitment** into Digital is progressing well. There are currently a total of 23 roles that Digital are actively recruiting into in 25/26 - made up of core baseline vacancies, posts from 24/25 investment, and new posts from 25/26 investment.
   - Four roles in the Innovation and Digital Transformation structure are currently out for advert, this comprises of the Head of Digital Business Change and Benefits, Digital Innovation Lead and 2 x Business Analysts. The Digital Adoption Lead is going through the job evaluation process. There is still an aim to complete all recruitment by the Autumn.
   - Within the Clinical Digital Unit, the Health Board Clinical Lead (ePCR) has started in their role as of July 2025. The Clinical Safety Officer role is currently out for advert.
   - Recruitment activity continues to across the ICT team into existing vacancies, with successful internal promotion to some new roles. There are several other roles with job descriptions under development.
   - Insight and Data Services (IDS) received 25/26 funding for 7 new posts: 2 of which have been recruited into (Information Analysts); 3 are at interview (Power BI Analysts) and 2 require Job Descriptions to be sourced / developed (Data

Science Lead and Data Translator); additionally 2 temporary contractors are working with the team to support with high-priority deliverables.

3. We continue to support the **Clinical Model Transformation (CMT)** with a significant contribution for 25/26. **Appendix 1** now contains an overview of our CMT contributions and alignment continues. Highlights from the current reporting period include:
    a. Metrics for Phase 1 of the new Performance Framework have been published for the first time (representing July 2025 data) by Welsh Government as part of the Official Statistics; and by JCC under the Ambulance Service Indicators (ASIs). These mark a significant change in the way WAST's emergency services will be measured with a more clinical and outcomes focus.
    b. An extensive suite of Data Definitions for Phase 2 Metrics has also been developed and signed off. These have now been shared with the supplier to inform further EMS CAD development ahead of the 1st December deadline agreed with Welsh Government for go-live. The Data & Analytics team will continue to collaborate with the supplier to ensure development of the system logic, data and reporting is high quality ahead of deployment.
    c. Signing of the Symptom Checker contract is now complete, which is a key milestone within the Digital Front End workstream.
    d. There has been good uptake of a Virtual Assistant, named 'Albot' following a competition for WAST staff, which integrates with NHS 111 Wales website content (i.e. Health A-Z). A review of evaluation metrics will follow alongside a formal launch.

4. In July, the Director of Digital Services gave a verbal update at this committee on the **Audit Wales Digital Transformation Review:** Board Self-Assessment (see **Appendix 2**). Since then, the WAST Trust Board were invited to share feedback, and the self-assessment has been submitted on behalf of the Trust. The Audit Wales team have requested further information to be submitted in September, and a suite of supporting evidence. Some interviews with key digital leaders and stakeholders within WAST have been arranged in coming weeks. Draft reports are expected to be released in the Autumn, with possible benchmarking intelligence across NHS Wales organisations.

5. A series of sprint meetings to design the **Digital Transformation Innovation Programme (DTIP)** group have continued and will conclude early Autumn. Work done to date includes front door mapping and identifying the routes in alongside key stakeholders, journey mapping to understand the user experience better, exploration of triage points and early scoping of prioritisation. This work will now pause until the new Head of Digital Business Change and Benefits has been recruited to ensure their ownership in implementing the new mechanisms. To recap, the purpose and strategic value of DTIP will be to:
    a. Ensure digital efforts are prioritised, visible and aligned to the Trust's broader objectives.
    b. Position Digital as a driver of transformation, not just a support service.

c. Enable the Trust to say "no" or "not yet" to non-priority work, with transparency and justification.

6. We have received 70 evaluation feedback forms as part of the **Copilot pilot** which have been developed into requirements for an ongoing education package. As our Business Analysts are recruited, deep dive work will commence in the Autumn. This will inform wider adoption, the development of meaningful and safe use-cases, and importantly our **AI policy,** as well as influence our **automation scale-up opportunities**. This work will bring efficiencies to WAST and free up time for higher value work. The Information Governance Steering Group (IGSG) also endorsed a proposal to establish an **AI Steering Group** to provide oversight and specialist guidance to the Trust on the approach to, and implementation of, Responsible AI.

7. Delivery for our **innovation labs** and **digital engagement** will be supported by the recruitment referenced above alongside learning from the copilot pilot. In addition a project with the aim of raising the profile is being shaped with support from Comms and Engagement colleagues. A kick off ideation meeting took place in August.

8. The **GRS cloud** pre-production environment became available on 8th August, with ongoing work involving stakeholders to establish initial test access and integrate systems. The 999 C3 system was upgraded between 19th and 20th August, followed by a revision update aligned to the Clinical Model Transformation programme requirements.

9. In the last Digital report, we reported that the **Video Compliance Project** had been delayed due to competing demands; however, the Trust's Data Protection Officer has since been able to prioritise this work and made good progress on reviewing the outdated CCTV Policy and creating supporting documentation and procedures. Video redaction software has also been procured for the Records team to allow them to compliantly fulfil appropriate subject access requests.

10. As part of the **National Data Resource (NDR) Programme**, an all-Wales Joint Controller Agreement was signed by WAST in August, the first step of a series of Information Governance assurances and requirements to enable compliant use of this DHCW managed platform. The national IG leads group (including representation from WAST) continue to support the next steps, and in parallel, WAST data engineers are testing connections between WAST data warehouse and DHCW NDR with non-identifiable data in readiness for future data sharing projects.

11. Following a previous data quality audit, and additional investment in 2024/25 to recruit a Data Quality team within IDS, several **Data Quality Key Performance Indicators** (KPIs) have been developed. This is an ongoing project, and further systems and datasets are being assessed for quality, and more metrics will be developed to surface ongoing visibility of these. However, the following metrics are now being reported through the Information Governance Steering Group representing two of the 6 Data Quality domains (timeliness and completeness) in relation to the EMS dataset (these are also included in Appendix 1):

a. Timeliness of submission of Ambulance Service Indicators to JCC against due date (one submission per month)
b. Timeliness of submission of Welsh Government Official Statistics against due date (one submission per month)
c. Number of data load failures from source to the WAST warehouse (total per month)
d. Percentage of incident records where patient NHS Number was verified (proportion per month – an important enabler for "data linkage" projects)

12. The refresh of the **Electronic Patient Care Record (ePCR)** application has been formally approved and is now in active development. This follows extensive engagement with users and stakeholders to identify opportunities to enhance the app's usability and improve the quality of data captured. The upcoming refresh will focus on optimising the application's core functions, aiming to reduce on-scene times for record completion without compromising the quality of information used for reporting. These improvements are intended to support staff in delivering efficient, high-quality care. We anticipate the updated ePCR application will be released in early 2026. Further updates on progress and rollout plans will continue to be shared.

13. The **ICT team** maintained strong **performance** throughout July and August 2025, effectively managing continued high demand. In July, 1,807 calls were logged, with 1,684 resolved and 123 remaining open at month end. August saw 1,582 calls raised, 1,360 resolved, and 222 still open. The rise in outstanding calls in August reflects both sustained activity levels and a number of complex issues still under active investigation. **Service level compliance** also remained strong, with only 8% of calls breaching SLA in July and no breaches recorded in August. Customer satisfaction was exceptional, with 100% of respondents in both months reporting complete satisfaction with the support provided.

Lowlights

14. All technical work for the **eTimesheets** project is complete and ready for deployment, however, alignment of contractual terms and conditions with the solution is required and is being progressed by the People team and Trade Union Partners.

15. Multiple, similar requests are being received from Health Boards and NHS Wales partners to **share WAST data**. These asks are a draw on the limited Insight & Data Services (IDS) resource, often requiring input from IG, Data Engineering and Data Analytics teams to serve. These requests are likely to be strategically aligned, but that is not always clear in the request, and it is likely there is duplication of effort occurring around the data community in Wales. The ambition of the **NDR** is ultimately to help serve these requests and ensure decision-makers across Wales have the intelligence they need – with pre-agreed, secure and compliant

arrangements for data-sharing across organisations – but it will be a while until the NDR programme reaches this stage.

16. The **Data Skills Enablement** project is on-hold, unable to progress due to limited capacity within the IDS team and competing priorities. There is a plan (supported by 25/26 funding) to recruit a "Data Translator" or "Enablement Lead" who will be able to bridge technical and non-technical stakeholders to drive adoption of data products, and be responsible for the improvement of workforce data skills and confidence; however, this role is dependent on the development of a Job Description and is not expected to be filled until late Q4.

17. Continued support of the **Clinical Model Transformation (CMT)** has led to re- and de- prioritisation of other workstreams / projects (see **Appendix 1).** Lowlights from the current reporting period include:
    a. Continued pressure on IDS team – particularly the data engineering and reporting teams who have been working in parallel on the new Call Flow Phase 1 reporting (for Welsh Government Official Stats publication, and the ASIs for JCC), the development of Clinical Indicators for the new Red Emergency category, and the development of 40+ data definitions for the Yellow Now, Orange Soon, Green Planned, and RICS categories of the Call Flow Phase 2 project.
    b. Nearly 200 hours of effort was spent by data analysts in August on the redevelopment of the Official Stats and ASIs alone, plus nearly another 100 hours on defining the Phase 2 metrics (not including time given by colleagues around WAST to support these activities).
    c. Approximately 185 hours was spent by the data engineers in July post go-live of Phase 1 on data logic refinement with the supplier and supporting internal reporting.
    d. Involvement of the Information Governance team in several high-priority projects, with competing timelines and reliance on a small group of data protection specialists.

18. The COMMITTEE are asked to NOTE the contents of the accompanying metrics report.

KEY ISSUES/IMPLICATIONS

19. The Clinical Model Transformation programme requires significant input from various Digital teams – including those supporting on changes to CAD or other systems, DOS updates, and data, reporting and analytics for the new call flow and categorisation process. Focus on Phase 2 of the Performance

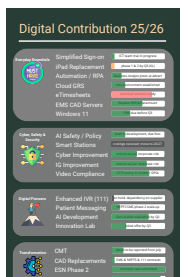
Framework is adding to the capacity risk within the directorate and means there is limited resource to work on any other CMT related workstreams. This has also lead to re- and de- prioritisation of other deliverables within the local Digital plan.

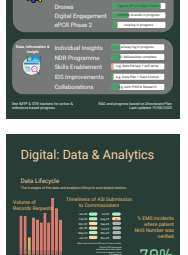
20. Progression on a number of areas of work, in particular the Digital Front End aspirations within CMT, are dependent on funding decisions and processes.

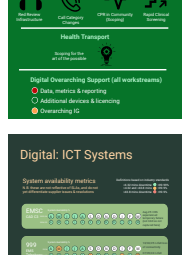
REPORT APPROVAL ROUTE
Reviewed by DLG 3rd September 2025

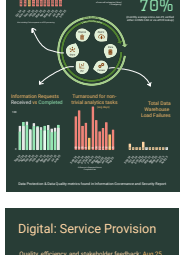
REPORT APPENDICES
Appendix 1 - Digital Reporting September 2025 – Metrics (pdf) Appendix 2 – WAST Review of Digital Transformation Board Self-Assessment

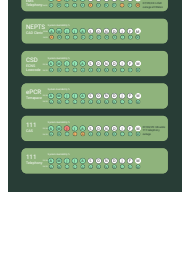
REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding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


Digital Contribution 25/26
Everyday Essentials
Simplified Sign-on
iPad Replacement
Automation / RPA
Cloud GRS
eTimesheets
EMS CAD Servers
Windows 11
Cyber, Safety & Security
AI Safety / Policy
Smart Stations
Cyber Improvement
IG Improvement
Video Compliance
Digital Planners
Enhanced IVR (111)
Patient Messaging
AI Development
Innovation Lab
Digital Records
CMT
CAD Replacements
ESN Phase 2
Drones
Digital Engagement
ePCR Phase 2
Data, Information & Insight
Individual Insights
NDR Programme
Skills Enablement
IDS Improvements
Collaborations
CMT Digital Contribution 25/26
Remote Integrated Care Service
RICS Integrated CAD
Remote Monitoring
Low-code Alignment
CPES in WMs (pilot)
Video Triage
Welsh Clinical Portal Integration
Digital Front End
Virtual Assistant
Clinical Management System
Symptom Clinicians
Service Development
Urgent Community Response
ePCR Review (e.g. falls responders)
Scheduling (APP to ambCare)
Emergency Response Service
Red Resolve Infrastructure
Call Category Changes
CPR in Community (Scouting)
Rapid Clinical Screening
Health Transport
Scoping for Go art of the possible
Digital Overarching Support (all workstreams)
Data, metrics & reporting
Additional devices & licencing
Overarching IG


Digital: Data & Analytics
Data Lifecycle
Volume of Records Requests
Timeliness of ASI Submission to Commissioners
% EMS incidents where patient NHS Number was verified
70%
Information Requests Received vs Completed
Turnaround for non-trivial analytics tasks
Total Data Warehouse Load Failures


Digital: ICT Systems
System availability metrics
EMSCC
999
NEPTS
CSD
ePCR
111
111


Digital: Service Provision
Quality, efficiency, and stakeholder feedback: Aug 25
ICT Service Desk
1807
1684
16
Top 5 Support Service Desk Requests
Records
10
IDS Inbox
ON TRACK
111 Website
47%
<1 MINUTE



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Audit Wales

Review of Digital Transformation: Board Self-assessment

Audit Wales is undertaking a review of digital transformation across NHS bodies in Wales. We are examining the arrangements NHS bodies have in place to use and embed digital solutions to improve the effectiveness and efficiency of their services. As part of this work, we are keen to understand the factors that either enable or impede digital transformation within each health body in Wales.

To support the delivery of our review, we are asking each NHS body in Wales to complete a self-assessment on their current position, which will help us understand how digital transformation is being taken forward in their organisation.

The aim of the self-assessment is to obtain a consolidated response on behalf of the Board of each NHS body. We would expect that the Chief Digital Officer (or equivalent) would be involved in the response to the self-assessment, but we would ask that it is completed in such a way that all board members have an opportunity to share their views, experiences and perceptions. We would also ask that the response is endorsed by the whole Board before it is submitted.

In undertaking the self-assessment, we are looking for NHS bodies to:

- use the exercise as an opportunity to evaluate the quality of its digital transformation arrangements and identify both strengths and weaknesses associated with its current approach.

- be open and honest in recognising where improvement is needed and to clearly differentiate between actions which have already been taken and those that are underway to address opportunities and / or weaknesses.

- refer to any relevant external assessments and reviews and describe progress made in addressing their recommendations.

- provide appropriate and relevant evidence (e.g., documents, data) to support your self-assessment responses (unless the evidence has already been provided separately). The documents should be clearly referenced in the narrative to enable us to triangulate the information.

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Please use the box below to briefly describe the steps the organisation took to complete this self-assessment:

To complete this self-assessment, we invited input from the full Board by opening a channel for all members to share their views, experiences, and reflections directly with the central Digital Services team. This ensured we could bring together a collective and representative response that reflects the breadth of perspectives across the Board.

We also worked through the self-assessment in detail with our Finance and Performance Committee to support appropriate oversight and alignment with our broader strategic priorities. The draft was reviewed on multiple occasions with our Digital Leadership Group (DLG), ensuring strong clinical, operational, and technical input. The DLG approved the final version ahead of submission.

Following submission, we will share the completed self-assessment and a summary of the themes raised with our full Board to ensure transparency and continued engagement.

Please provide the details of the individual we can contact if we have any questions / queries about the self-assessment:

Jonny Sammut – Jonny.sammut@wales.nhs.uk

Please complete and return the self-assessment by **5th August** to: **David Murphy (david.murphy@audit.wales) cc: Nathan Couch (nathan.couch@audit.wales) Tomos Jones (tomos.jones@audit.wales) and Darren Griffiths (darren.griffiths@audit.wales)**

We sincerely thank you for taking the time to complete this self-assessment.

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Audit Wales

1. Strategy and Planning

1.1 To what extent do you agree/disagree that the Board has articulated a clear vision for the organisation's digital transformation?

In assessing the Board's current position, please consider whether the vision:

- *Clearly outlines the organisation's ambition for digital transformation.*
- *Is based on an understanding of the organisation's current digital maturity.*
- *Is aligned with other key strategies and plans, supporting clinical, financial, workforce, estates and operational goals.*
- *Was developed with input from clinicians, staff, patients and service users.*
- *Aligns with national digital transformation priorities, including Welsh. Government's Once for Wales ambitions.*
- *Considers digital / IT workforce needs.*
- *Considers the business benefits expected from digital initiatives.*

Delete as appropriate:

○ Strongly disagree

○ Disagree

○ Neither agree nor disagree

○ Agree

✓ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

The Welsh Ambulance Services NHS Trust (WAST) has clearly articulated its vision for digital transformation, with strong Board-level ownership and alignment across corporate priorities. Our **Digital Plan**, launched in 2024, sets out a clear ambition to "create a connected, intelligent, and responsive ambulance service powered by digital innovation." This vision was co-designed with input from staff, clinical leaders, operational teams, and service users, and is reflected consistently across our **Integrated Medium Term Plan (IMTP)**, **Clinical Strategy**, and **Corporate Strategy**.

Our approach is grounded in a clear understanding of our digital maturity, informed by internal assessments, external reviews, and benchmarking activity. The digital vision is not standalone, it underpins key enabling elements across the IMTP, including:

- **Modernisation of clinical care delivery**
- **Operational efficiency and performance**
- **Workforce transformation**
- **Estate optimisation through smart technologies**
- **Enhanced patient experience through digital access and engagement**

We have ensured alignment with national priorities, including Welsh Government's *Once for Wales* digital ambition, the Digital Services for Patients and the Public (DSPP) programme, and the NHS Wales Digital Architecture principles. The digital workforce challenge is explicitly recognised, with clear actions around professionalisation, talent retention, and growing our internal capability, including the establishment of a new Inclusive **Digital Workforce Recruitment approach** and partnerships with national bodies like **BCS** and **FEDIP**.

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Strategy and Planning

1.2 To what extent do you agree/disagree that the Board has a clear plan to commit the resources required to deliver its digital transformation vision?

In assessing the Board's current position, please consider whether the Board's plan ensures that:

- *Digital investment requirements are clearly outlined for the short, medium, and long term.*
- *Resources are committed across the entire lifecycle of digital programmes and services (i.e. when they are operationalised and become 'business as usual').*
- *The benefits and potential cost efficiencies of digital transformation are highlighted.*
- *Strong Board support.*

Delete as appropriate:

○ Strongly disagree
○ Disagree
○ Neither agree nor disagree
✓ Agree
○ Strongly agree
○ Don't know

Please use the box below to explain or clarify your answer:

The Board has demonstrated a clear and sustained commitment to resourcing the delivery of our digital transformation vision. This is evidenced through successful bids for **additional recurrent digital funding in both 2024/25 and 2025/26**, which are now enabling us to significantly expand our digital capacity and capability.

This year, we are progressing the **recruitment of 26 new roles**, increasing the size of the Digital Services team by approximately **22%**. These roles span clinical safety, informatics, innovation, technical infrastructure, and service delivery, ensuring we have the breadth of skills required to support transformation across the Trust.

Our **Digital Plan 2024–2029**, aligned with our **IMTP**, outlines clear short-, medium- and long-term investment requirements. These are linked to priority transformation areas such as urgent care access, operational intelligence, digital front door, and digitally-enabled workforce. Crucially, we are planning not only for initial delivery but also for **long-term sustainability and business-as-usual ownership**, recognising that digital services must be continually supported to deliver enduring value.

This level of resourcing, backed by recurrent investment and Board endorsement, reflects a more mature and serious approach to delivering our digital ambitions in a sustainable and value-led way. **However, further work is required to establish longer-term funding mechanisms and future uplifts to meet increasing demand, noting that our ability to do so is constrained by the wider public sector financial context.** This level of resourcing, backed by recurrent investment and Board endorsement, reflects a mature and serious approach to delivering our digital ambitions in a sustainable and value-led way.

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Strategy and Planning

1.3 To what extent do you agree/disagree that the Board has a clear vision for how Artificial Intelligence (AI) will be used as part of its wider approach to digital transformation?

In assessing the Board's current position, please consider whether:

- *The Board's AI vision is explicitly integrated into the organisation's Digital Strategy, showing how AI supports long-term service, clinical, and operational objectives.*
- *The Digital Strategy identifies specific, relevant areas where AI will be applied.*
- *The Digital Strategy clearly articulates the intended benefits of AI, such as improving patient outcomes, enhancing decision-making, increasing efficiency, or reducing costs.*
- *The Board has considered the financial, technical, and human resources needed to support AI development and deployment, including infrastructure and staffing.*

Delete as appropriate:

○ Strongly disagree

○ Disagree

✓ Neither agree nor disagree

○ Agree

○ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

The Board recognises the significant potential of Artificial Intelligence (AI) as part of our wider approach to digital transformation. AI is clearly referenced within our **Digital Plan 2024–2029**, which sets out our intention to adopt AI tools that are safe, ethical, and add measurable value to our clinical, operational, and corporate functions.

We are currently **piloting two AI-driven solutions**: an **AI-powered co-pilot tool** to support internal productivity and efficiency, and an **AI virtual assistant** embedded within the NHS 111 Wales website, aimed at improving access and user experience. These early-stage initiatives are helping us build capability, understand risks, and begin to shape our organisational approach.

As our AI maturity evolves, we recognise the need to strengthen **ethical oversight and public trust**, including the development of formal mechanisms such as an **AI Ethics Panel** to ensure transparency, accountability, and responsible innovation. Broader awareness and engagement across the organisation will also be key to embedding AI in a way that is inclusive, safe, and aligned with our values.

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Strategy and Planning

1.4 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation has effective arrangements in place for identifying, managing, and mitigating the risks associated with its use of AI?

In assessing the Board's current position, please consider whether the Board receives sufficient assurance that:

- *The potential clinical, operational, ethical, legal, and reputational risks associated with AI use are identified and clearly documented in the organisation's BAF and / or Corporate Risk Register (or the Digital Strategy Risk Register, where one has been developed).*
- *The organisation has policies in place to ensure its use of AI complies with relevant laws, regulations, and ethical standards.*
- *The organisation has policies in place to ensure the quality, integrity, and security of data used in AI systems.*
- *The organisation has ensured that roles and responsibilities for AI oversight are clearly defined, including decision-making authority, and escalation procedures.*

Delete as appropriate:

○ Strongly disagree

○ Disagree

✓ Neither agree nor disagree

○ Agree

○ Strongly agree

Please use the box below to explain or clarify your answer:

The Board receives strong and appropriate assurance that the organisation has effective arrangements in place for identifying, managing, and mitigating risks associated with the use of AI.

AI initiatives are governed through established Trust mechanisms, with risks considered across **project, programme, and corporate levels**. These include risks relating to clinical safety, legal compliance, ethics, data integrity, and reputational impact. Risks are captured within the **Digital Services Risk Register** and escalated to the **Corporate Risk Register** as required. Oversight is provided via the **Finance and Performance Committee**, which in turn reports to the **Trust Board**, ensuring appropriate scrutiny and assurance.

While our current governance arrangements provide strong assurance, we recognise the need to **develop a dedicated AI risk entry within our Board Assurance Framework (BAF)** to ensure strategic oversight of AI-related risks at Board level. Additionally, we are exploring the establishment of an **AI Ethics Panel** to provide structured, independent guidance on the ethical implications of AI use, supporting safe and trusted deployment across the organisation.

While we recognise there is **further work to do to fully embed clinical safety standards** (e.g., DCB0129 and DCB0160) across all AI-related initiatives, we are actively building this capability into our governance approach as our AI adoption matures.

In terms of **data protection and information governance**, AI activity is supported through the Trust's **Information Governance Steering Group**, which ensures compliance with relevant legislation including the **UK GDPR** and the **Data Protection Act 2018**. This group provides oversight of lawful processing, data minimisation, transparency, and security measures associated with AI systems and the data they rely on.

Roles and responsibilities for AI oversight are defined within our digital programmes, and we are further strengthening this through our **AI Strategy and Governance Framework** (in development), which will set out clear accountabilities,

2.1 To what extent do you agree/disagree that the organisation's Digital Strategy is owned by the Board?

In assessing the Board's current position, please consider whether the strategy:

- *Stimulates Board development activities to build awareness and understanding of the opportunities and organisational requirements for delivering and achieving digital transformation.*

Delete as appropriate:

○ Strongly disagree
○ Disagree
○ Neither agree nor disagree
○ Agree
✓ Strongly agree
○ Don't know

Please use the box below to explain or clarify your answer:

The organisation's Digital Strategy is clearly owned by the Board, with digital transformation recognised as a strategic enabler that is fully embedded within our core business objectives, risks, and long-term planning.

A **Board-level Director of Digital** is a key member of the Executive Team, ensuring digital is consistently represented in strategic discussions and decision-making. Digital transformation is routinely considered at Board level alongside other core themes such as clinical quality, operational performance, finance, and workforce. Our **Digital Strategy** is directly aligned with the Trust's **Corporate Strategy** and **IMTP**, reinforcing its status as a fundamental component of organisational delivery.

The Board is actively engaged in digital leadership and capability development. This includes dedicated **Board development sessions**, such as our recent **enhanced cyber awareness training**, which supported collective understanding of risk, resilience, and digital maturity. Additional Board discussions are planned in 2025/26 to focus on the Trust's evolving position on artificial intelligence, data-driven decision-making, and emerging technologies.

This ongoing engagement ensures digital is not only well understood but meaningfully shaped by the Board as part of our commitment to safe, effective, and forward-looking healthcare delivery.

In addition to executive leadership, we have **Non-Executive Directors (NEDs) with a specific interest in digital**, as well as **Trade Union partners actively engaged** in shaping and supporting our Digital Strategy. Their involvement helps ensure digital transformation is inclusive, representative, and aligned with the values and priorities of our workforce and wider system.

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Audit Wales

Strategy Ownership and Oversight

2.2 To what extent do you agree/disagree that there is sufficient expertise at Board level to effectively guide the organisation's digital transformation agenda?

In assessing the Board's current position, please consider whether:

- *The CIO/Director of Digital is a Board member or regularly attends Board meetings to provide digital expertise; and / or*
- *An Independent Board Member is nominated to lead digital transformation.*

Delete as appropriate:

○ Strongly disagree

○ Disagree

○ Neither agree nor disagree

○ Agree

✓ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

There is strong and well-rounded digital expertise at Board level to effectively guide the organisation's digital transformation agenda.

The Trust benefits from a dedicated **Board-level Director of Digital Services**, who brings extensive professional experience and national influence, serving as **Chair of the BCS Wales Hub**, a **Fellow of BCS – The Chartered Institute for IT**, and a **Leading Practitioner with the Federation for Informatics Professionals (FEDIP)**. This ensures continuous alignment with national standards and industry best practice.

In addition, our **Non-Executive Directors (NEDs)** bring complementary digital expertise, including backgrounds in **data science and digital research**, as well as a designated **Digital NED** who provides additional challenge and strategic insight. We also have a **Trade Union partner dedicated to supporting the Digital Strategy**, ensuring that digital transformation is inclusive and reflective of the needs and concerns of our workforce.

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Audit Wales

Strategy Ownership and Oversight

2.3 To what extent do you agree/disagree that the Board has clear and effective oversight arrangements in place to support delivery of its Digital Strategy?

In assessing the Board's current position, please consider whether:

- *Progress on the Digital Strategy and implementation plans is routinely reported to the Board/relevant committee.*
- *Business benefits are monitored and reported to the and Board/relevant committee.*
- *Digital solutions are considered as enablers for operational and strategic decisions, featuring in business cases, service changes, and Board reports.*
- *Clear direction is provided by the Board, and/or relevant committee when digital plans do not meet milestones, targets, or business benefits.*
- *The Board, and/or relevant committee receives independent assurance on its digital arrangements from Internal Audit and other assurance providers.*

Delete as appropriate:

○ Strongly disagree

○ Disagree

○ Neither agree nor disagree

✓ Agree

○ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

The Board has established oversight arrangements in place to support delivery of its Digital Strategy, with digital transformation activity currently reported through multiple channels, including the **Finance and Performance Committee (FPC)** and **Academic Partnership Committee (APC)**. These structures provide a level of scrutiny and assurance across financial, operational, and risk dimensions.

However, we recognise there is an opportunity to **strengthen and clarify these oversight arrangements**, particularly by establishing a **Digital Transformation and Innovation Programme Board (DTIP)** as a clear focal point for strategic oversight and delivery assurance. The current multi-committee reporting model can at times dilute focus and consistency, and we have previously noted that some **alerts and digital issues do not always receive the level of discussion or visibility they require**.

In addition, while our reporting mechanisms are in place, we acknowledge that **key performance indicators (KPIs) and benefits realisation measures are still maturing** — particularly in terms of quantifying the broader business impact of digital initiatives. Improving this will form part of our ongoing digital governance development work in 2025/26.

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Strategy Ownership and Oversight

2.4 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation has effective arrangements in place for identifying, managing, and mitigating the risks to the successful delivery of its Digital Strategy?

In assessing the Board's current position, please consider whether the Board receives sufficient assurance that:

- *The organisation has an effective process for identifying, assessing, and recording key strategic and corporate risks related to the Digital Strategy.*
- *Risks are recorded, monitored, and managed by the relevant accountable owners.*

Delete as appropriate:

○ Strongly disagree
○ Disagree
○ Neither agree nor disagree
✓ Agree
○ Strongly agree
○ Don't know

Please use the box below to explain or clarify your answer:

The Board does receive assurance on the risks associated with delivering the Digital Strategy, but this assurance is largely driven by **direct escalation from the Digital Directorate**, rather than through fully embedded organisational mechanisms.

Currently, **risks to digital delivery are often managed at a local, project, or programme level**, and while they are escalated as needed, they are not always considered with the same weight or visibility as non-digital risks when strategic delivery decisions are made. This can lead to the need for escalation to **Executive Leadership Team (ELT)** or **Board** – not necessarily because of delegated authority gaps, but because **there are few formal structures where these cross-cutting risks can be appropriately explored** and balanced in the wider organisational context.

The introduction of a **Digital Transformation and Innovation Programme Board (DTIP)** is expected to significantly improve this by providing a dedicated forum for oversight of strategic digital risks, benefits, and interdependencies, strengthening governance and enabling more proactive assurance to the Board.

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3. Digital Skills, Capacity and Capability

3.1 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation has a clear plan in place to address gaps and enhance the digital skills, capacity, and capability of its workforce?

In assessing the Board's current position, please consider whether the Board receives sufficient assurance that:

- *The plan is based on a thorough understanding of current digital skills and what is needed for digital transformation.*
- *Resources are committed to delivering the plan for the short, medium, and long term.*
- *There is a clear vision of what a digitally enabled workforce looks like.*
- *The plan integrates with national digital workforce development programmes, such as: A Heathier Wales: Our Workforce Strategy for Health and Social Care, HEIW Digital Capability Framework and HEIW Digital and Data Strategy.*
- *Sufficient digital resources (online courses, e-learning platforms, webinars, virtual workshops, etc.) are available to enhance workforce skills.*
- *Risks to achieving the plan are well documented, with appropriate controls and mitigations in place.*
- *There are appropriate arrangements in place to attract, hire, and retain digital and data professionals with the necessary expertise required by the organisation.*

Delete as appropriate:

✓ Strongly disagree

○ Disagree

○ Neither agree nor disagree

○ Agree

○ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

At present, the Board does **not receive sufficient assurance** that the organisation has a clear and coordinated plan in place to address the digital skills, capacity, and capability gaps across the workforce.

While there is clear ambition around digital transformation, and the Trust holds **corporate membership with BCS – The Chartered Institute for IT**, we have **significant gaps in our approach to digital adoption, workforce development, and professionalisation**. There is **no structured or adequately resourced training programme** for digital skills across the organisation, and the available **training budget is limited**, particularly when compared to the scale of transformation required.

Efforts to embed digital thinking and capability are further constrained by **Agenda for Change (AfC) impacts** on recruitment and retention, especially in digital, data, and technical roles where we are competing with more flexible and better-remunerated markets. Additionally, operational pressures often leave **little protected time for staff to undertake digital training or engage with transformation initiatives**, further slowing adoption. Take up results on the HEIW digital capability framework is low, suggesting more can be done with this platform too.

Organisation	21/07/2025	Statistically relevant sample size
Aneurin Bevan UHB	289	375
Betsi Cadwaladr UHB	425	378
Cardiff and Vale UHB	310	376
Cwm Taf Morgannwg UHB	229	374
DHCW	33	287
HEIW	242	216
Hywel Dda UHB	209	360
NWSSP	64	360
Powys THB	73	336
Public Health Wales	17	329
Swansea Bay UHB	205	374
Velindre University NHS Trust	31	312
Welsh Ambulance Service NHS Trust	22	354

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4. Digital / Cyber Risk Management

4.1 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation has effective arrangements in place for identifying, managing and mitigating current and emerging cyber security risks?

In assessing the Board's current position, please consider whether:

- *There is a cyber security/resilience strategy defining current and future risks, threats, and opportunities.*
- *The Board understands the cyber security risks facing the organisation and has approved mitigation plans.*
- *The Board receives assurance that cyber security protocols are embedded through regular training and testing.*
- *There is a plan to respond to the Cyber Assessment Framework from the Cyber Resilience Unit.*
- *The Board receives assurance that cyber security risks are assessed in the development of new IT systems using risk assessment tools.*

Delete as appropriate:

- ○ Strongly disagree
- ○ Disagree
- ○ Neither agree nor disagree
- ○ Agree
- ✓ Strongly agree
- ○ Don't know

Please use the box below to explain or clarify your answer:

The Board receives **strong and regular assurance** that the organisation has effective arrangements in place for identifying, managing, and mitigating current and emerging cyber security risks.

Cyber risk is a standing item within our digital risk reporting, with **regular updates provided to the Board and its committees** on threat landscape, vulnerabilities, and progress against our **Cyber Security Improvement Plan**. These updates are supported by structured risk registers, mitigation plans, and investment cases aligned to national standards and expectations.

In addition, we deliver **dedicated Board development sessions** focused on cyber awareness, helping to strengthen organisational understanding of cyber resilience, governance, and accountability at the most senior level.

Cyber security is well embedded within our wider digital governance, with a clear link to operational continuity, data protection, and patient safety.

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Audit Wales

5. Digital Infrastructure

5.1 To what extent do you agree or disagree that the Board receives sufficient assurance that the organisation has effective arrangements in place to oversee and replace outdated, unsupported, and obsolete digital software and hardware?

In assessing the Board's current position, please consider whether the Board receives assurance that the organisation has:

- *A comprehensive inventory / service catalogue that details all digital software and hardware, including age, support status, condition, and owner / responsible officer.*
- *Up-to-date policies and procedures for replacing outdated technology, with evidence of staff awareness and compliance.*
- *Plans and budgets in place for IT upgrades and replacements.*
- *Robust risk assessments of outdated technology with plans to mitigate associated risks.*
- *Performance reports highlight issues caused by outdated technology.*

Delete as appropriate:

- ○ Strongly disagree
- ○ Disagree
- ○ Neither agree nor disagree
- ✓ Agree
- ○ Strongly agree
- ○ Don't know

Please use the box below to explain or clarify your answer:

The organisation has **effective arrangements in place** to oversee and replace outdated, unsupported, and obsolete digital software and hardware, and the Board receives appropriate assurance through regular reporting, risk assessments, and programme oversight.

We have established **Standard Operating Procedures (SOPs)**, a robust **service catalogue**, and a detailed **digital architecture document** that guide lifecycle management, procurement, and replacement planning. Risks associated with legacy systems are proactively managed through our **risk register and contract management processes**, and assurance is routinely provided via the **Finance and Performance Committee**.

That said, **longer-term strategic planning is limited by the nature of system-wide funding models**, which currently restrict forward financial planning beyond a single year. While we have had some success in securing investment and are beginning to build a **pipeline of future digital investment requirements**, the absence of multi-year digital capital funding across NHS Wales constrains our ability to fully move to a predictive and preventative model for infrastructure refresh.

With continued investment and a maturing pipeline, we expect to further strengthen assurance in this area over the coming year.

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Audit Wales

6. Digital Engagement

6.1 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation has a robust approach to engaging with staff, patients, and service users in shaping digital transformation?

In assessing the Board's current position, please consider whether the Board receives sufficient assurance that:

- *The organisation has a documented approach to engagement that is routinely followed.*
- *The organisation has clear evidence that engagement with staff, patients, and service users is used to shape digital requirements.*
- *Digital systems, tools, and developments are designed with the end-user in mind.*
- *These systems, tools, and developments meet the needs of both patients and healthcare professionals.*
- *There is positive feedback from staff, patients, and service users regarding their engagement in digital transformation.*

Delete as appropriate:

○ Strongly disagree

✓ Disagree

○ Neither agree nor disagree

○ Agree

○ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

While we do engage with staff, patients, and service users in shaping digital transformation — and have received **positive feedback** from specific initiatives, we acknowledge that our **approach is not yet systematic or visible enough to provide the Board with sufficient assurance**.

There are emerging mechanisms such as the **Digital Transformation and Innovation Programme Board (DTIP)**, our **Innovation Lab**, and efforts to embed **user-centred design** into product development, but these are still maturing. Additionally, while engagement activity is taking place at programme and project level, it is **not consistently surfaced to the Board**, and there is currently **no overarching engagement strategy or structured framework** that ensures voices are routinely captured, synthesised, and used to inform digital priorities at scale.

We recognise the opportunity to strengthen this area through clearer governance, structured reporting, and alignment with tools such as our **digital product catalogue**. This will help ensure engagement becomes a visible and embedded part of digital assurance at Board level going forward.

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Digital Engagement

6.2 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation is taking appropriate action to minimise digital exclusion during the roll-out and implementation of new digital and data projects and initiatives?

In assessing the Board's current position, please consider whether the Board receives sufficient that the organisation:

- *Has a designated lead for digital inclusion.*
- *Routinely assesses the potential impact of changes to digital systems or new systems on staff, patients, and service users.*
- *Has a good awareness of digital inclusion as a challenge.*
- *Ensures it is meeting the needs of people experiencing digital exclusion while digitising.*
- *Accesses appropriate support from other public bodies or third sector organisations such as Digital Communities Wales, Centre for Digital Public Services or Newid to help address digital exclusion.*
- *Has a good understanding how risks in its external environment i.e. rising cost of living, may impact on those who are disadvantaged and digitally excluded.*
- *Has a good understanding of the opportunities from future advances in digital.*

Delete as appropriate:

○ Strongly disagree

○ Disagree

✓ Neither agree nor disagree

○ Agree

○ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

While there is a good level of **awareness around digital inclusion and accessibility**, and these principles are **explicitly referenced in our Digital Plan**, the Board does **not yet receive sufficient assurance** that this is being consistently embedded into the delivery of new digital and data projects.

Currently, there is **no dedicated lead** for digital inclusion within the organisation, and we do **not routinely assess systems or services for accessibility and inclusion impacts** as part of our digital design or procurement processes, although these do get captured in a broader EQIA. As a result, assurance to the Board in this area is limited and lacks a structured framework or reporting mechanism.

We recognise this as a gap and a priority for development. Work is underway to explore how digital inclusion can be better embedded into our governance and delivery processes — including the potential for assigning clear ownership, integrating assessments into standard project documentation, and strengthening reporting to both DTIP and the Board.

Archwilio Cymru
Audit Wales

7. Partnership Working

7.1 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation maintains effective relationships with key digital and data partners, such as Digital Health and Care Wales (DHCW), Health Education and Improvement Wales (HEIW), and Welsh Government?

In assessing the Board's current position, please consider whether the Board receives sufficient assurance that the organisation:

- *Regularly engages with partners and other stakeholders to support delivery of its digital strategy and maximise innovation opportunities and stay updated on digital industry advancements.*
- *Has a clear understanding of the role and responsibilities of other partners in delivering its own digital strategy.*
- *Has appropriate monitoring and oversight arrangements for the aspects of its digital strategy that are delivered by its partners.*
- *Relationships with key digital and data partners are proactive and built on trust and openness.*
- *There is a clear understanding of the roles and responsibilities of key digital and data partners, including Welsh Government and DHCW.*
- *Routine dialogue occurs with key partners about national digital programs and products that the organisation is expected to deliver, manage, or administer locally.*

Delete as appropriate:

- ○ Strongly disagree
- ✓ Disagree
- ○ Neither agree nor disagree
- ○ Agree
- ○ Strongly agree
- ○ Don't know

Please use the box below to explain or clarify your answer:

While the organisation does maintain a range of relationships with key digital and data partners, the **Board does not currently receive sufficient assurance** that these partnerships — particularly at a **system level with Digital Health and Care Wales (DHCW)** and **Welsh Government** — are strategic, coordinated, or delivering maximum value.

Engagement with DHCW and Welsh Government is often **ad hoc, reactive, and programme-specific**, rather than part of a clearly defined strategic partnership. There is no formal framework in place for evaluating the effectiveness or maturity of these relationships, and updates to the Board are limited to occasional references in reports or programme-level briefings. This limits the Board's ability to gain a full picture of how these system-level relationships influence or enable delivery of our Digital Strategy.

In contrast, our **external collaboration with organisations such as LUSCII, SBRI, Tec Cymru, and the Life Sciences Hub Wales is much stronger**, with clear alignment around innovation, capability-building, and shared outcomes. These partnerships have been productive and better aligned with our digital transformation ambitions.

We recognise this imbalance and are exploring how mechanisms such as the **Digital Transformation and Innovation Programme (DTIP)** and IMTP delivery oversight can be used to formalise and strengthen system-level engagement and assurance.

8. Digital Health Transformation

8.1 To what extent do you agree or disagree that the Board receives sufficient assurance that the organisation has a clear, coordinated, and resourced programme of local and regional digital and data projects?

In assessing the Board's current position, please consider whether the Board receives sufficient assurance that projects are:

- *Prioritised based on their impact on service accessibility, quality, efficiency, and productivity.*
- *Coordinated and overseen centrally.*
- *Underpinned by clear milestones and measures in place to show how investments in digital and data projects benefit service users, improve care pathways, and enhance efficiency and productivity.*

Delete as appropriate:

○ Strongly disagree
○ Disagree
✓ Neither agree nor disagree
○ Agree
○ Strongly agree
○ Don't know

Please use the box below to explain or clarify your answer:

The organisation has a growing and maturing portfolio of internal digital and data projects, and the Board receives **increasing assurance** in this space — particularly through programme updates and structured internal reporting. Our **local digital initiatives are strong and moving towards very strong**, with good alignment to our Digital Strategy and clear ownership within the organisation.

However, assurance becomes more limited when it comes to **regional and national programmes**. Key national programmes, such as the **National Data Resource (NDR)**, would benefit from clearer planning, delivery visibility, and local integration to enable more confident assurance to the Board. Additionally, in regional collaborations, particularly with multiple Health Boards, we are **not always seen as an equal strategic partner**, often drawn in as a delivery mechanism rather than a co-designer of solutions.

There also remains a **gap in access to centralised planning and programme information**, which would support a more coordinated and strategic view of regional and national initiatives. While our internal governance is maturing, we recognise the need for **better visibility and structured alignment across the broader digital ecosystem** to provide the Board with fuller assurance.

Archwilio Cymru
Audit Wales

Digital Health Transformation

8.2 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation is actively adopting and rolling out national digital solutions to improve the accessibility, quality, efficiency, and productivity of services?

In assessing the Board's current position, please consider whether the Board receives sufficient assurance that the organisation:

- *Actively adopts and implements national digital solutions that support a 'Once for Wales' approach to enhance service accessibility, quality, efficiency, and productivity.*
- *Engages constructively with DHCW and WG to ensure national solutions are fit for purpose.*

Delete as appropriate:

○ Strongly disagree

○ Disagree

✓ Neither agree nor disagree

○ Agree

○ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

At present, the Board does not receive sufficient assurance that the organisation is actively adopting and rolling out **all relevant** national digital solutions to improve accessibility, quality, efficiency, or productivity, largely because, as an ambulance service, we are not the primary consumer or core user of many **Digital Health and Care Wales (DHCW)**-led products, which are designed predominantly for health boards and secondary care settings.

That said, we **do adopt and use key national products developed for ambulance services,** for example, those delivered via the **Ambulance Radio Programme (ARP),** and our position as a single national ambulance service provides an opportunity to align strongly with other UK ambulance trusts on shared digital standards and platforms.

In some areas, such as national data standards, we are not yet in a position to adopt fully due to integration, workflow, or technical constraints. Similarly, our engagement with platforms like the **National Data Resource (NDR)** has so far been limited in terms of functionality and realised benefits.

While the Board is aware of our engagement with national programmes at a high level, there remains limited structured assurance on adoption, impact, or alignment, representing a significant gap when compared to wider system ambitions around a "Once for Wales" approach and the potential for stronger UK-wide ambulance service collaboration.

Archwilio Cymru
Audit Wales

Digital Health Transformation

8.3 To what extent do you agree/disagree that the Board receives sufficient assurance that the organisation has effective arrangements for evaluating digital solutions?

In assessing the Board's current position, please consider whether the Board receives sufficient assurance that digital solutions are evaluated to ensure they:

- *Are easy to use, intuitive, and user-friendly.*
- *Are accessible to all users, including those with disabilities.*
- *Streamline workflows and reducing task completion time.*
- *Offer necessary features to support the organisation and its partners.*
- *Seamlessly integrate with other systems and platforms used by NHS digital partners using national data and technical standards i.e. NHS Wales Data Dictionary, SNOMED CT, Health Level 7, Fast Healthcare Interoperability Resources etc.*
- *Facilitate smooth and secure data exchange between different systems.*
- *Comply with the Digital Service Standard for Wales.*

Delete as appropriate:

✓ Strongly disagree

○ Disagree

○ Neither agree nor disagree

○ Agree

○ Strongly agree

○ Don't know

Please use the box below to explain or clarify your answer:

The Board does **not currently receive sufficient assurance** that the organisation has effective arrangements in place for evaluating digital solutions.

We **do not have a dedicated evaluation manager or function**, and formal processes for **evaluating accessibility, impact, or return on investment** are not yet embedded. There are **no routine accessibility audits**, limited integration between some **legacy systems**, and a clear need to improve **data exchange and interoperability** across platforms.

Additionally, we continue to face challenges with **shadow IT**, where digital tools and systems are procured without the involvement (or early engagement) of the Digital Services team, reducing our ability to apply governance, assurance, or alignment with strategy. This is further compounded by **a lack of control or standardisation across NHS Wales**, which impacts our ability to evaluate, benchmark, or adopt consistent approaches to digital implementation and performance.

Archwilio Cymru
Audit Wales

Other relevant information / evidence

Please provide details of any further information / evidence not covered by the self-assessment.

AGENDA ITEM No	**10**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

INFORMATION GOVERNANCE REPORTING

MEETING	Finance & Performance Committee
DATE	16 September 2025
EXECUTIVE	Jonny Sammut, Director of Digital Services / Senior Information Risk Owner
AUTHOR	Leanne Smith, Assistant Director of Digital
CONTACT	leanne.smith4@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. This paper covers intelligence from the period of 1st June to 31st July 2025, and the topics discussed at the **July and August meetings of IGSG**.

ALERT

3. **Data Breaches:** a log of data breaches under investigation or with outstanding remedial actions was reviewed at the August meeting, highlighting recurring issues such as delayed reporting, social media misuse and inappropriate access to records which can be found to be criminal offences under the Data Protection Act and Computer Misue Act. There was a deeper dive into the recent trend in Social Media and Photography related breaches, with a draft notice presented ahead of publication to WAST staff. This notice will also be shared with the Senior Operations Team and with Clinical Quality and Governance Group for support from these forums given the responsibilities of all individuals with a professional registration.

4. **National Data Resource:** WAST has singed the all-Wales Joint Controller Agreement which supports the National Data Resource (NDR) Programme. This comes after successful resolution nationally of governance and legal concerns raised previously by WAST's Data Protection Officer and SIRO. DHCW's revisions to the agreement, and subsequent signatures, marks a significant milestone of progress; with further IG assurances to follow including public engagement and data sharing agreements, to more comprehensively address Data Protection and Confidentiality laws.

5. **AI Risk:** a corporate risk for the inappropriate use of Artificial Intelligence (AI) has been drafted and is currently progressing through the Trust's risk management cycles. The risk addresses behaviours and understanding / awareness of staff when using the tools, the security and control at the technology layer, and the expertise and procedures to effectively manage WAST's approach to AI. A Policy for Appropriate AI Use is also in development and due to be received the Policy Group in November. Development also continues on an AI Cyber Security assurance process which will be used in conjunction with the AI Policy once available.

6. **ICO Response for 999 Surveys:** the ICO provided detailed advice with several recommendations to WAST to action *ahead* of the implementation of patient experience surveys in the 999 service. It was agreed that this advice would also be shared with IG leads across Wales and the Welsh Risk Pool for wider system understanding.

Highlights

7. **IG Training:** the overall Trust IG training compliance figure as of 01/07/25 reached 88.26%, the highest compliance rate achieved by the Trust, exceeding the 85% threshold. This was maintained throughout the month with the next report from 29/07/25 showing compliance of 89.61%.

8. **IG Toolkit:** actions to support the 2025/26 submission of the toolkit stand at 74% complete. A new section on Video Surveillance has been added to the Toolkit for 2025/26. To provide assurance against this new category, WAST's CCTV Policy is being reviewed, and is on-track to be received by the Policy Group in September.

9. **Cyber Improvement Programme (CIP):** the Trust's Cyber lead presented an update on the CIP to the July meeting of the IGSG, showing areas of the CIP that were on track – with closure of the Offline Immutable Backup solution (the last red-rated item from the previous NIS audit) and significant decrease

in vulnerabilities on EMS workstations in control rooms. Additionally, progress has been made to resolve the dormant account issues, with a significant reduction from 4300 accounts to ~700.

10. **Artificial Intelligence:** the creation of a new AI Steering Group (AISG) has been endorsed by IGSG given the pace of evolution with AI technologies, their wide availability and associated risk. A draft Terms of Reference was presented, for approval in principle, with the AISG taking responsibility for providing strategic and tactical guidance and advice related to AI, and oversight of the adoption of AI technologies within WAST.

11. **Records Management:** an issue with limited secure storage for paper records was highlighted, with current storage arrangements at Denbigh County Council and Vantage Point House being insufficient for the volume of Trust records. Ongoing reviews across EMS and NEPTS for records will likely identify the need for further storage space. Confirmation of the inventory and data processing agreement from Denbigh County Council is required. An options paper will also be developed to consider solutions to future records storage (e.g. internal, external and digitisation).

12. **St John Ambulance Breach – Clinical Records Audit:** following a previous breach related to patient records generated for WAST by St John Ambulance, a clinical audit was conducted into incidents where no patient record could be found. Most cases showed evidence of valid reason for missing records, and no evidence was found linking missing records to patient safety incidents or clinical risk. Recommendation will now be taken forward to alter procedures and ensure clear processes where external providers support WAST services, with plans to move St John Ambulance onto ePCR for better data capture in future. This closed the audit and concluded the action required following the breach.

13. **Data Quality Assurance:** the new Performance Framework metrics, implemented under the Phase 1 changes to call categories, were reported to Welsh Government and Commissioners for the first time in August, seeing WAST's July data for Purple Arrest and Red Emergency incidents published under the Official Statistics and Ambulance Service Indicators (ASIs). Additionally, the newly expanded Data Quality team continue to develop data quality metrics, with a current set of DQ metrics being reported to IGSG monthly, representing two of the six DQ domains (timeliness and completeness) for the EMS dataset:
    a. Timeliness of submission of Ambulance Service Indicators to JCC against due date (one submission per month)

b. Timeliness of submission of Welsh Government Official Statistics against due date (one submission per month)
c. Number of data load failures from source to the WAST warehouse (total per month)
d. Percentage of incident records where patient NHS Number was verified (proportion per month – a foundational enabler for dataset linkage)

14. **Freedom of Information (FOI) Requests:** June saw a total of 20 FOI requests received, although 4 were not applicable, and compliance to the response target was 67% (slightly lower than the previous two months which had seen compliance above 80%, although high variability is expected with small volumes). Work to automate management and reporting for FOIs has also progressed, with testing of the new platform undertaken and issues resolved. An FOI position paper is scheduled to be presented at the September meeting of IGSG.

Lowlights

15. **Letters to Staff regarding Mandatory Training:** a letter has been issued by the Trust's SIRO to 290 members of staff with overdue mandatory training explaining their non-compliance, and requesting training be completed by the end of August. IGSG will receive an update on this position at the September meeting.

16. **Ambulance Care 2-way SMS Process:** outstanding IG queries and remains in escalation, largely due to late changes in project scope, but is being managed with support from IGSG members.

17. **Body Worn Video:** Digital Services were made aware of a body-worn video project that lacked assurances around appropriate procurement and oversight. The project group were advised to return to the initiation stage to ensure proper governance, engagement and solution design, with support of the appropriate Digital specialists.

18. **Missing ECG file:** a number of historic digital ECG files have been corrupted and are believed to be "missing" Trust records. Work is underway with the supplier of the ECG technology to provide a fix for this going forward and to gain assurance that this issue will not be repeated. Standard Trust wording will be crafted and be provided to any requestors where historic ECG records cannot be obtained.

19. **Cyber Improvement Programme (CIP):** the Trust's Cyber lead presented an update on the CIP to the July meeting of the IGSG, describing a number of current cyber issues, in particular related to supplier access security.

20. The COMMITTEE are asked to NOTE the contents of paper.

KEY ISSUES/IMPLICATIONS

21. **NEW Risk of Inappropriate use of Artificial Intelligence:** a corporate risk has been developed around the inappropriate use of AI, and possible patient safety, service quality / accuracy, reputational and financial consequences that could materialise. This risk is now passing through the Trust's risk management process.

22. **Risk 623 Failure to comply with Data Protection Legislation:** A risk to Data Protection Compliance was initially logged on the Corporate Risk Register in April 2024 and has since been received by the Trust Board on several occasions as part of the Board Assurance Framework. Although some actions have been completed, and IG Training is now exceeding the compliance target, the score has not yet been reduced – this is due to low confidence in workforce understanding on IG and Data Protection, evidenced by several recent data breaches (including an increasing trend in social media breaches) and non-compliance with the Data Protection processes in several projects.

23. **Risk of Physical Security:** The group have been supporting the development of a new physical security risk. At the July meeting, the draft risk was received. It was also noted that a further physical security audit had been completed since previous discussions, and findings included in the risk assessment. This risk is now passing through the Trust's risk management process.

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

REPORT APPROVAL ROUTE

The points presented in this paper are taken from the Information Governance Highlight Reports presented at the July and August meetings of the Information Governance Steering Group (IGSG), and the resulting AAAs drafted for presentation to ELT.
Also reviewed by Digital Leadership Group w/c 01/09/2025.

REPORT APPENDICES

n/a

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

Agenda Item No.	11

REPORT TITLE

Internal Audit Report - Manchester Arena Inquiry:
Feedback from the Audit, Risk and Assurance Committee

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	16 September 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	n/a
Author(s) of report	Steve Owen, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The Audit, Risk and Assurance Committee (the ARAC) received and discussed the **Manchester Arena Inquiry (MAI) audit report** at its meeting on 02 September 2025. This report summarises the discussion from this meeting in reference to the receipt of this internal audit report by the Finance and Performance Committee.

2. The audit provided a *substantial assurance opinion* in relation to the audit purpose and focused on the progress made by the Trust to address and learn from the recommendations raised from the MAI; and to assess the governance and reporting arrangements established, including a validation exercise to support the closure of the actions.

3. The Committee welcomed the substantial assurance level noting that eighteen recommendations requiring financial investment have been referred to the Joint Commissioning Committee (JCC), with further discussions planned in the coming months. Members noted that the Trust remains at risk should a major incident occur before funding decisions are made; as some recommendations cannot be implemented without additional resources.

4. ARAC Members noted that additional funding for specific training and exercising for resilience and major incident response, as current resources and priorities limit internal delivery had been submitted to Commissioners. It was further noted that Welsh Government is setting up a national programme for joint testing and exercising among the tri-services (police, fire, ambulance), which would help staff practise these skills more frequently, especially in large-scale incidents.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to: -

note and take assurance from the discussion at the meeting of the ARAC on 02 September 2025.

ADDITIONAL PAPER(S)

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

The Committee is requested to receive the following:

1. Manchester Arena Inquiry – Internal Audit Report

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

- Risk ID 641 – The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident.
- 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.

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
02 September 2025	Audit, Risk and Assurance Committee
16 September 2025	Finance and Performance Committee

Manchester Arena Inquiry

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust

Substantial Assurance

Contents

Review Reference	WAST-2526-10
Fieldwork	June – July 2025
Executive Sign Off	7 August 2025
Audit Committee	2 September 2025
Executive Lead	Lee Brooks, Executive Director of Operations
Audit Team	Osian Lloyd, Head of Internal Audit
	Felicity Quance, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To review the progress made by the Welsh Ambulance Services University NHS Trust (the Trust) to address and learn from the recommendations raised from the Manchester Arena Inquiry; and to assess the governance and reporting arrangements established, including a validation exercise to support the closure of actions.

Overview

Following the events of the Manchester Arena bombings of May 2017, an inquiry was launched into the emergency response to the incident and examined the planning and preparation by the responders and their adequacy. The 'Manchester Arena Inquiry Volume 2: Emergency Response', report was issued in November 2022 and identified weaknesses and failings in the emergency response for which 149 recommendations have been determined. Our review focussed on the 68 findings and recommendations that more widely impacted the Trust, and the subsequent procedural changes required should a similar event occur in the future.

The Trust has taken a proactive approach to addressing the Manchester Arena Inquiry recommendations, with **substantial assurance** provided overall. An action plan has been developed and implemented, supported by robust internal reporting and governance arrangements. Evidence of meaningful change includes the introduction of new equipment, enhanced training programmes, and revised emergency response procedures. The Trust's engagement with national coordination efforts and its transparent approach to risk management further reinforce the positive direction of travel. One matter has been raised for management attention regarding the training delivered through the Mandatory In-Service Training (MIST) days. While the content was appropriately included, full delivery had not been achieved due to non-attendance by a number of staff; however, we note a satisfactory level of attendance was deemed achieved to allow the same to 'go live'.

Full details are included within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There is an approved action plan in place which reflects the recommendations raised and the lessons learned.	-	**Substantial**
2	Appropriate governance mechanisms are in place to monitor and manage progress against planned actions, the robustness of the evidence to support the action, and their continued sustainability	1	**Reasonable**
3	Periodic reports on the progress against implementation of the action plan are produced and submitted to appropriate management and Trust committees for oversight and escalation.	-	**Substantial**

Management Actions

0 High Priority

1 Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Manchester Arena Inquiry - At a Glance

As part of this audit, ten recommendations were selected for sampling. Evidence was reviewed to assess the robustness and sustainability of actions taken in response. The findings are summarised below:

Reference	Recommendation	Summary of Evidence Reviewed
1	The Greater Manchester Resilience Forum should oversee a biannual tri-service review of Major Incident plans to ensure mutual understanding and embed joint working.	Although not directly applicable to the Trust, an All-Wales emergency services group – the *Tri-Service Incident Plan Review Group (TriSIP RG)* – has been established.
27	North West Ambulance Service should improve its record-making practices during and after Major Incidents.	The Trust has updated its *Incident Response Plan (IRP)* to align record-keeping processes with best practice.
45	National bodies should review and update the Joint Doctrine and Joint Operating Principles for Marauding Terrorist Attacks.	Staff bulletins were issued via *Siren* outlining updated guidance. Section 7 of the IRP was also revised accordingly.
56	Police services should establish a hotline for emergency service commanders during Operation Plato.	While not directed at ambulance services, the Trust has implemented a *Major Incident Hotline* to support effective call handling.
105	Ambulance trusts should assess their capacity to respond to mass casualty incidents, including specialist personnel availability.	The Trust provided three key reports and supporting documentation, all approved by the Trust Board, identifying current gaps and outlining capability assessments.
111	Hazardous Area Response Team (HART) personnel should receive enhanced care training to ensure advanced interventions are available on every deployment.	The Trust developed and delivered an *Enhanced Skills Training Course* for HART paramedics, aligning with Cymru High Acuity Response Unit (CHARU) standards.
113	Emergency responders should be trained in the Ten Second Triage tool.	The Trust embedded *Ten Second Triage (TST)* and *Major Incident Triage Tool (MITT)* into practice, with training delivered via the annual *MIST Day* programme.
115	National bodies should review evacuation models to assess best practice globally.	While part of broader national research, the Trust has proactively introduced TST & MITT and updated the IRP.
123	Guidance should be issued on equipment for bridging interventions in warm zones.	Although awaiting national guidance, the Trust has implemented some bridging interventions in the interim.
148	A review should ensure appropriate stretchers are available in sufficient numbers and locations.	A bulletin was issued on the use of *PAX carry sheets* during major incidents, with training incorporated into the 2024/25 *MIST Day* programme.

Findings & Agreed Action Plan

Objective 1: There is an approved action plan in place which reflects the recommendations raised and the lessons learned.	**Substantial**

In August 2023, following review of the 149 recommendations outlined in the Manchester Arena Inquiry (MAI) report, an initial list was presented to the Senior Leadership Team (SLT). This detailed 71 recommendations that the Trust would take forward, and 78 recommendations that were deemed not applicable to the Trust as they related to external organisations such as the Home Office and Police Authorities. The SLT approved this categorisation at the same meeting.

The report also included the RAG (Red, Amber, Green) rating for each of the 71 applicable recommendations. Of these, nine were proposed for immediate closure, as existing arrangements within the Trust were deemed to already meet the expectation. A subsequent report, approved by SLT in December 2023, revised the number of recommendations the Trust would respond to from 71 to 68.

While a formal action plan was not produced in the traditional format, i.e. with defined timescales, responsible owners, and detailed actions, a spreadsheet was developed. This document included the text each recommendation, high-level progress updates, links to supporting evidence, and the corresponding RAG status. Further consideration of the action plan's management is considered under objective 2.

The Trust's response to the MAI recommendations demonstrates lessons learned, with evidence provided for 48 recommendations at the conclusion of audit fieldwork. These responses include a range of measures such as the introduction of new equipment, enhanced training for specialist roles, and revised procedures and arrangements for responding to similar incidents in the future.

Where the Trust has been unable to implement certain recommendations, these have been captured in the Corporate Risk Register (*#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; risk score 20*). This risk outlines the current gaps in controls, the capability shortfalls, and the assurance targets required to fully address the outstanding recommendations.

Objective 2: Appropriate governance mechanisms are in place to monitor and manage progress against planned actions, the robustness of the evidence to support the action, and their continued sustainability.	**Reasonable**

Under the leadership of the Executive Director of Operations, an Operations Support Manager was appointed to oversee the implementation of the MAI recommendations, supported by a Support Officer within the Emergency Preparedness, Resilience and Response (EPRR) team.

Internal monitoring arrangements were established within the EPRR team, including fortnightly highlight reports submitted to the Head of Service for EPPR, summarising progress against each recommendation. In addition, monthly highlight reports were prepared for the Assistant Director of Operations, and bi-monthly reports for the Executive Director of Operations. It is noted, however, that while regular meetings were held, the absence of formal outputs or minutes limits the ability to evidence oversight and decision-making. Further detail on internal reporting arrangements is provided under Objective 3 below.

At the commencement of audit fieldwork, 48 of the 68 recommendations had been marked as complete. To assess the appropriateness of the Trust's response, a sample of 10 closed recommendations was selected for detailed review (see page 2). Supporting evidence was provided for each, including relevant SBARs (Situation, Background, Assessment, and Recommendation reports) presented to the SLT for closure, along with the meeting minutes confirming their approval.

Three of the sampled recommendations (numbers 111, 115 and 148) related to the introduction of new equipment and the associated training requirements. It was noted that this training was scheduled to be delivered through the 2023/24 and 2024/25 Mandatory In-Service Training (MIST) days. While the training content was incorporated into the relevant sessions, a separate audit (as part of the 2025/26 Internal Audit plan - Mandatory In-Service Training) identified that approximately 300 staff members in 2023/24 and 230 in 2024/25 did not attend and therefore did not receive the required training. (**See Key Finding 1**). We note, however, that approval for 'go live' of the equipment, with effect from 1 April 2024, was provided at the Senior Operations Team meeting (March 2024) noting that an acceptable MIST compliance rate was deemed to have been achieved for EMS Response (81.4%) and arrangements for training made for the remaining staff.

At the conclusion of audit fieldwork, two of the 68 recommendations remained open, although we were advised that both are pending closure. The remaining 18 recommendations were identified as requiring further financial investment. These have been referred to the NHS Wales Joint Commissioning Committee (JCC) for consideration of funding to address the care gap and the Trust's current inability to fully implement the recommendations (refer to objective 3 for further details on the reporting arrangements in place). These 18 recommendations are also reflected in Corporate Risk #641 (see objective 1).

This transition brings the remaining unaddressed recommendations into a business-as-usual process, enabling the long-term management of associated risks, actions and the Trust's broader response.

Key Findings		Risk & Impact	Agreed Management Action
1	**Impact of MIST Day non-attendance** In relation to four recommendations from the MAI (including one not selected for sample testing), the Trust has developed and adopted specific measures to enhance its ability to respond effectively to a major incident. These measures were supported by face-to-face training sessions delivered through the Trust's MIST days. However, analysis of attendance data highlights potential gaps in training coverage: • Ten Second Triage Tool (TST)/Major Incident Triage Tool (MITT) – These tools represent improved triage arrangements adopted by multi-agency emergency services across Wales. Training was delivered via a 17-slide presentation during the 2023/24 MIST days. However, attendance records indicate that 194 Emergency Medical Services (EMS) staff and 112 Ambulance Care Services (ACS) staff did not attend (approximately 10% of the workforce). There is no evidence to confirm whether these staff received the training through alternative means. • Pax Carry Sheet –This lightweight, high-quality, and versatile rescue aid was procured for every emergency vehicle across the Trust. Training was delivered via a single slide within the broader 'Safer Handling' session during the 2024/25 MIST days. Attendance data shows that 168 EMS staff and 65 ACS staff did not attend (approximately 11% of the workforce), and again, there is no evidence of alternative training provision for these staff. Whilst we acknowledge that an acceptable MIST compliance was deemed to have been reached, to facilitate 'go live' of the equipment from 1 April 2024 (81.45% as at 12 March 2024), review of the Trust's current training arrangements did not identify any plans to provide further coverage of these specific training needs. While the financial submission to the NHS Wales Joint Commissioning Committee (JCC) highlights training gaps, these relate specifically to additional training for major incident Commanders, rather than the frontline training requirements associated with the MAI report recommendations.	Not all staff have received the required training to use new tools effectively, limiting the Trust's ability to deliver a fully effective major incident response.	**Agreed Action:** Following the feedback received, a multi-disciplinary team has identified solutions to address the issue. It was noted that the audit numbers (194 EMS and 112 ACAs) may have decreased as employees returned from absences like long-term illness or maternity leave. The ESR team is working to identify those who still need training. The Learning & Development team will then engage with these individuals to ensure compliance with the new triage tools and PAX carry sheets. An eLearning package by L&D has been recommended as the most efficient method for delivering remedial training. This package will be hosted on the Trust's LMS365 platform and made available to all staff, supporting ongoing CPD activities and new starters. We are consulting with neighbouring ambulance services for similar training materials to expedite this process. If unavailable, the Trust can develop its own materials using existing resources. Development of a new eLearning package may take until the end of Q3, but utilising existing packages could significantly reduce this timeline. The EMS Management Group (EMG) will monitor compliance and progress. Once available, the eLearning package will be a monthly agenda item for EMG to track progress and address any issues. Progress reports will be provided through standard assurance routes. We aim for completion by the end of the 2025/26 financial year, assuming all staff can undertake training. EMG will oversee this action until all necessary staff have completed the required training with approval for sign off to be sought from SOT.
			Expected Evidence of Implementation: Triple A reports from EMG into SOT on the monthly reporting of compliance.
		Medium Priority	**Officer:** Judith Bryce, Assistant Director of Operations **Target Implementation Date:** 28 February 2026
	Theme: Training & Development	Control Design	

Objective 3: Periodic reports on the progress against implementation of the action plan are produced and submitted to appropriate management and Trust committees for oversight and escalation.	**Substantial**

Internal Reporting

As outlined under objective 2, progress on implementing the MAI recommendations have been reported at various levels within the Trust:

- Operational Oversight: Fortnightly, monthly and bi-monthly updates were provided to management and executive leadership, including the Senior Leadership Team (SLT), following the approval of the initial list of recommendations.
- SLT Reporting: Periodic reporting to SLT (a total of 13 papers presented between August 2023 and March 2025) included lists of recommendations proposed for closure, narrative justifications for the Trust's response, supporting documentation, and evidence of scrutiny through meeting minutes. Where further work was required, recommendations were re-presented for approval.
- Committee Oversight: Due to the sensitive nature of the MAI response, detailed progress reporting was undertaken at closed sessions of the Finance and Performance (F&P) Committee (July 2024) and Trust Board (July 2025 and January 2025). Evidence of these sessions was provided, although the documentation was limited in scope.
- Open Committee Updates: High level updates were included in the Operations Directorate's quarterly reports, presented at open sessions of both Quality, Patient Experience and Safety (QuEST) and F&P Committees (noting that the same paper is presented at both). Some minutes included evidence of scrutiny and discussion from Committee Members.

Recognising the need to strengthen governance arrangements, the Trust has recently developed an integrated governance map, approved by the Audit, Risk and Assurance Committee in March 2025. This map outlines key principles to support effective oversight and accountability across meetings, clarify roles and responsibilities, and improve meeting administration. In relation to the Senior Operations Team (SOT) and SLT which sit under the Operations Directorate, the Integrated Governance Programme paper confirms that governance standards for directorates have not yet been developed.

External Reporting

- MAI report Monitoring: Of the 149 recommendations in the MAI report, 75 were subject to external monitoring and required feedback to the Chief Investigator. However, this applied only to named emergency services. As the Trust (WAST) was not named, no formal request for an update has been received to date.
- JCC: As part of the arrangements to secure additional funding to address the care gap identified in relation to the 18 recommendations (as noted under objectives 1 & 2), financial submissions have been made to the JCC setting out the funding required. Further, an update of the work being undertaken by the Trust and the Health Boards to respond to the findings of the inquiry was presented at the July meeting (15 July 2025), with specific reference to the three recommendations that the Joint Committee need to be aware of (namely recommendations 105, 106 and 107)
- Association of Ambulance Chief Executives (AACE) Coordination: The Association of Ambulance Chief Executives (AACE) identified 77 recommendations from the original MAI report as relevant to UK ambulance services. To coordinate a national response, AACE established the Manchester Arena Report Operations Group (MAROG). The Trust was required to document its progress against these recommendations in a quarterly submission to MAROG. This process enabled peer review across UK ambulance services to assess the consistency and appropriateness of response. Discussion with Trust officers confirmed that that nine of the MAROG recommendations were excluded from the Trust's response as they related to other emergency service organisations. These exclusions were clearly documented in the MAROG submissions.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

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

Agenda Item No. 12

REPORT TITLE

Integrated Medium Term Plan (IMTP) Progress Report

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	16 September 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Estelle Hitchon, Interim Executive Director of Strategy Planning & Performance
Author(s) of report	Alexander Crawford, Assistant Director of Planning & Performance Heather Holden, Head of Transformation Katherine Abbott, Planning & Performance Business Office

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 an interim Q2 position for IMTP delivery and assurance for the 2025/26 year of the 2025-28 IMTP.

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

3. Directorate led IMTP delivery end of Q1 position was reported into the July committee. An interim Q2 position has not yet been through the established governance route of Integrated Strategic Planning & Development Group and Strategic Transformation Board due to timing, and therefore the next update will be available at the November 2025 meeting as an end of Q2 position. However, included in this report are some updates on queries raised at the last Trust Board meeting on some of the Strategic Objective 5 deliverables.

4. This report will set out in detail how the Clinical Model Transformation programme continues to deliver significant evolution of our clinical response model, now in line with the new Ambulance Performance Framework announced in March.

5. The WAST IMTP for 2025-28 was approved by Trust Board on 27 March 2025 and submitted to Welsh Government on 31 March 2025. Welsh Government approved the IMTP on 30 June 2025, with accountability conditions following on 28 July 2025. The report will confirm the accountability conditions and how these are being addressed.

6. The key elements of the IMTP delivery are programme led delivery and directorate led delivery. Programme led delivery includes the Clinical Model Transformation Programme and the Financial Sustainability Programme (FSP). The FSP is re-establishing its governance mechanism with a new Steering Group established which will meet on 11 September 2025 to then report into Strategic Transformation Board and through this report into the Committee from November 2025.

7. The SBAR below sets out an update against the Clinical Model Transformation Programme. The programme remains YELLOW (cautionary) due to the pace and volume of work ongoing including Call Flow phase 2 CAD changes, governance arrangements for new workstreams and focus around the new Ambulance Performance Framework driving capacity challenges.

8. Appendix A is a detailed programme assurance report for CMT. Appendix B is the update against Q2 (interim position) milestones to meet Cabinet Secretary priorities.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. **Note** the CMT programme interim Q2 position;
2. **Note** the specific update on Directorate led deliverables for SO5
3. **Note** the interim Q2 position for the Cabinet Secretary's priorities
4. **Advise** of any further assurance needed for the Board.

ADDITIONAL PAPER(S)

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

The Committee is requested to receive the following:

1. Appendix A – 25076 - CMT Programme Highlight Report
2. Appendix B - Assurance against the Cabinet Secretary's priorities

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
424 - Directorate level risk on IMTP delivery

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
11 August 2025	Strategic Transformation Board

SITUATION

1. The purpose of this paper is to provide the Committee with an interim Q2 position for IMTP delivery and assurance for the 2025/26 year of the 2025-28 IMTP.

BACKGROUND

2. The WAST IMTP for 2025-28 was approved by Trust Board on 27 March 2025 and submitted to Welsh Government on 31 March 2025. Welsh Government approved the IMTP on 30 June 2025, with accountability conditions following on 28 July 2025.

3. The Trust's accountability conditions include:

2.1 Delivery of the objectives stated in the letter from Cabinet Secretary for Health and Social Care sent on 3rd July 2025, which include (where applicable):

Delivering the key Welsh Government priorities for the NHS:

a. Reducing waiting times (including Handover Delays)
b. Reducing Pathways of Care delays
c. Improving women's health services

Strengthening how we run the NHS:

a. Modernising leadership and culture
b. Getting better at regional working
c. Improving openness, accountability and collaboration

Getting services ready for the future:

a. More effective prevention of ill health
b. Putting more services into the community
c. Realising the potential of digital and innovation

2.2 Delivering the priorities and enabling actions set out the in the NHS Wales Planning Framework 2025-28.

2.3 Supporting Wales's ambition to become a Marmot nation, by embedding the principles of equity and social justice into actions and values.

2.4 Undertaking robust winter planning preparations with partners, which align to the key actions set by the Cabinet Secretary for Health and Social Care and clearly identify risks and mitigating actions ahead of winter 25/26.

2.5 Ensuring the workforce actions in your plan translate into delivery requirement. This should include a significant reduction in variable and agency pay.

2.6 Successfully launching and monitoring the Trust's clinical response model following the implementation of the new Welsh Government Emergency Ambulance Performance Framework, supported by the commissioning of a robust evaluation.

2.7 Providing further assurance on your plans to deliver effective community-based falls response services, in line with the national framework and Welsh Government key performance indicators (KPIs).

2.8 In addition to improvements made by health boards against the 45-minute ambulance patient handover target, contributing to improved outcomes for individuals in the purple and red categories, and delivering improved responsiveness for patients in the 'amber' / 'orange' category in particular.

2.9 Confirming, with supporting evidence, the strengthening of emergency planning during the year, reflecting a broad range of risks and planning contingencies.

2.10 Delivering and sustaining a financially balanced position, through:

a. Demonstrating delivery, in full, of the planned level of savings that underpin the trust's financially balanced plan
b. Demonstrating actions that are being taken to mitigate any in-year pressures that may arise
c. Ensuring delivery of the financially balanced plan that the organisation has approved
d. Identifying and delivering actions that positively improve the trust's recurrent position for 26/27 and beyond

2.11 We will address these conditions as set out in the following table:

No.	Accountability Condition	How being addressed
3.1	Delivering the key Welsh Government priorities for the NHS: a. Reducing waiting times (including Handover Delays) b. Reducing Pathways of Care delays c. Improving women's health services	• The Clinical Model Transformation programme includes key programmes of work to ensure WAST is playing its part in the reduction of handover delays and access to pathways of care. • WAST is a key partner in the Six Goals for Urgent & Emergency Care programme nationally and at Health Board level. • WAST is a key partner around the table of the clinically led Handover Task Force and playing its part in working with Health Boards to introduce the zero tolerance 45minute standard for ambulance handovers (known as W45). • Having permanently secured the lead midwife post in this year's IMTP we continue to be engaged with the WG MatNeo programme and developing the dedicated labour line as part of RICS subject to funding.
	Strengthening how we run the NHS: a. Modernising leadership and culture b. Getting better at regional working c. Improving openness, accountability and collaboration	• Our WAST Way has been launched focussed on leadership and culture. Further focus around culture expected through the next IMTP planning round. • WAST is engaged with all Health Board Strategic Service Change and regional planning groups. • WAST has responded to its own reputation audits and worked on improving how it collaborates across the system and through the Joint Commissioning Committee WAST is represented

No.	Accountability Condition	How being addressed
		on the Collaborative Commissioning Leadership Group.
	Getting services ready for the future: a. More effective prevention of ill health b. Putting more services into the community c. Realising the potential of digital and innovation	• Section 5.4 below sets out our position on Population Health. • Our Clinical Model Transformation Programme and Digital plan seek to both reduce conveyance, enabling more care at or close to home, and through accessing community pathways, and using digital technology as the forefront of how people are able to access our services and how we deliver and support our services.
3.2	Delivering the priorities and enabling actions set out the in the NHS Wales Planning Framework 2025-28.	• An update is provided in Appendix B
3.3	Supporting Wales's ambition to become a Marmot nation, by embedding the principles of equity and social justice into actions and values.	• WAST is committed to tackling health inequalities although there are difficulties in delivering our population health plan due to capacity, data linkage etc. There also remain challenges in rural areas due to recruitment and geography, but the Trust is unerring in its commitment to equity and social justice through its Wellbeing Objectives. • WAST uses both EQIAs and QIAs to focus its planning and programme delivery to ensure equity is taken into account in planning and strategic decision making.
3.4	Undertaking robust winter planning preparations with partners, which align to the key actions set by the	• Winter plans have been developed with a key focus around delivery of the

No.	Accountability Condition	How being addressed
	Cabinet Secretary for Health and Social Care and clearly identify risks and mitigating actions ahead of winter 25/26.	Ambulance Performance Framework.
3.5	Ensuring the workforce actions in your plan translate into delivery requirement. This should include a significant reduction in variable and agency pay.	• WAST has committed to no agency spend in frontline service delivery (albeit noting that the Plurality Model for NEPTS commissions 3rd party provision).
3.6	Successfully launching and monitoring the Trust's clinical response model following the implementation of the new Welsh Government Emergency Ambulance Performance Framework, supported by the commissioning of a robust evaluation.	• An update is provided in this report.
3.7	Providing further assurance on your plans to deliver effective community-based falls response services, in line with the national framework and Welsh Government key performance indicators (KPIs).	• Updates on Falls & Frailty are provided through the Clinical Model Transformation Programme reporting Appendix A and ministerial priorities at Appendix B.
3.8	In addition to improvements made by health boards against the 45-minute ambulance patient handover target, contributing to improved outcomes for individuals in the purple and red categories, and delivering improved responsiveness for patients in the 'amber' / 'orange' category in particular.	• Updates on this work is provided in Appendix A.
3.9	Confirming, with supporting evidence, the strengthening of emergency planning during the year, reflecting a broad range of risks and planning contingencies.	• WAST continues to develop its EPRR responses and working with commissioners on the recommendations of the Manchester Arena Inquiry. • The rollout of the Special Operations Response Teams (SORT) continues as part of our

No.	Accountability Condition	How being addressed
		major incident provision, and the Trust has funded and trained additional Communications Tactical Advisors (CTA) to support effective radio network utilisation.
3.10	Delivering and sustaining a financially balanced position, through: a. Demonstrating delivery, in full, of the planned level of savings that underpin the trust's financially balanced plan b. Demonstrating actions that are being taken to mitigate any in-year pressures that may arise c. Ensuring delivery of the financially balanced plan that the organisation has approved d. Identifying and delivering actions that positively improve the trust's recurrent position for 26/27 and beyond	• Forecast year end projections are an overall breakeven position based on current assumptions but with a under recovery on recurrent schemes and over recovery of non-recurrent schemes of £0.255m. • 33.9% of the 25/26 overall plan value of £8.5m has been achieved YTD • Section 6 below updates on the next steps for the Financial Sustainability Programme aimed at delivering sustainability over the course of the 2026-29 IMTP.

Ministerial priorities

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

ASSESSMENT

4. **Clinical Model Transformation (CMT) Programme Key Issues/Implications**

4.1 The interim Q2 position has been summarised within the main SBAR and the complete assurance report included as Appendix A.

4.2 The CMT programme continues to strengthen its approach to programme management using digital applications including SharePoint and MS Project/Planner. The transition from MS Excel to central programme control logs held in SharePoint (e.g. risks and issues) has enabled the **introduction of Power BI for risk and issue management at programme-level**. The proposed dashboard will be presented to CMT Board in September, and subject to approval, will be formally launched and rolled out across CMT workstreams.

4.3 Additionally, the transition to MS Project/Planner for all workstream plans will enable approved dependency mapping and the Transformation Support Office (TSO) have **initiated work to dependency map milestones across CMT workstreams including mapping inter-workstream, and wider dependencies**. Once mapped, MS Project/Planner functionality will enable these to be managed dynamically.

4.4 Progress on Quality Impact Assessments (QIAs) remains a priority. To date, **QIAs have been approved for four of the five core workstreams**, with the remaining QIA for Remote Integrated Care due for Clinical Quality Governance Group (CQGG) review imminently. Additionally, a QIA for the implementation of Phase 2 call flow changes aligned with the new Ambulance Performance Framework has been completed and will be considered by an exceptional Clinical Advisory Group on the 10th September, before onward submission to CQGG for formal approval.

4.5 A review of the Programme Definition Document (PDD) and the CMT Board's Terms of Reference has also been completed with significant updates to the PDD to reflect the evolving programme. **The PDD has been reviewed and updated collaboratively through the CMT Board and will be presented to Strategic Transformation Board in September for formal approval**.

4.6 A **dedicated session with Executive Sponsors and Senior Responsible Owners was completed in July to finalise Logic-Benefits Maps (LBMs) for each Workstream Scorecards**. Following revisions, Workstream Scorecards were presented to the CMT Board and formally approved as a first iteration (subject to minor revisions). The Insights and Data Services (IDS) team are currently

reviewing the scorecards to determine the availability of key metrics. The programme Benefits Realisation Plan will now be developed with the aim to submit to CMT Board in October.

4.7 The proposal to **Executive Finance Group (EFG) for a modest additional investment in the TSO was deferred.** This investment will facilitate adjustments to the current structure – expanding the skill mix and introducing senior project management capacity – **to align with the complexity and scale of the programme**. A decision is now anticipated by mid-September.

4.8 Finally, the programme team are currently preparing for an audit of the CMT programme (formal initiation anticipated in Q3). All programme documentation is being reviewed to ensure completeness with an action to prioritise any outstanding Workstream Definition Documents and Terms of Reference requiring review.

5. Directorate Led delivery

5.1. The assurance report in Appendix B sets out the end of Q1 position for the directorate led portfolio of IMTP deliverables.

5.2. During Quarter 1 the Planning Team has **developed a digitised system for Directorate Plans**, working with Directorate leads to transition to a live platform through MS365. This provides a dynamic single source of information that is more streamlined, user friendly and through greater visibility will support greater interdependency planning across the organisation. **This is now in place across most directorates**, giving clear line of sight to IMTP directorate led activity, CMT programme activity and directorate level plans and core business to enable resource, workforce and strategic planning. Power BI and further automations will enable reporting for end of Q2.

5.3. There were some specific queries raised about delivery confidence and changes to timelines in the IMTP for directorate led plans at the July committee and Trust Board. During Q2 a deliverable review and change process has been signed off by STB to ensure and changes to existing or development of new in year programme and directorate led deliverables are clearly sighted at Strategic Transformation Board.

5.4. For the specific queries raised in July Trust Board related to SO5 (Being quality driven and clinically led) the latest updates are provided in the table below.

Strategy Planning & Performance Team are meeting with Executive Director of Quality and Nursing to discuss remedial actions and the risk this poses in order to update the Board. A directorate planning session is also planned for 17 September 2025 to look at current and future priorities for the directorate as part of the IMTP planning process for next year.

Deliverable	Status	New delivery qtr	Original delivery qtr	Progress summary
Draft Population Health Plan, approved.	Red	Qtr 3	Qtr 1	Delayed due to lack of resource QuESt received assurance on the development of a Draft Population Health Plan and health inequalities maturity matrix. The draft plan supports delivery of the Trust's strategic objectives and compliance with the Health & Care Quality Standards 2023
Updated health inequalities maturity matrix for reducing impact	Red	Qtr 3	Qtr 1	Delays caused by lack of resource (dedicated post ended 31/3/25) QuESt received assurance on the development of a draft Population Health Plan and health inequalities maturity matrix, which align with the Trust's strategic objectives and the 2023 Health & Care Quality Standards.
Developing the data engineering & modelling around harm (patient harm)	Red	Qtr 4	Qtr 1	RED for Q1 delivery whilst scope and resource availability is reviewed.

Deliverable	Status	New delivery qtr	Original delivery qtr	Progress summary
Always On and Duty of Quality reporting	Red	Qtr 4	Qtr 4	Internal Always On project is continuing - impacted by IDS capacity and shifting priorities for CMT. Expected deadline for Datix reporting in Always On dashboard has been impacted by the failure to achieve reporting from CAD to meet CMT go live on 1st July. External Always on being explored by Quality Assurance Team this will include a narrative report in addition to access to the Always on Dashboard. MIQPR reports submitted to board are now translated and shared with comms for inclusion on the website for easy access. Consideration to translated Always On dashboards now being discussed at QPM steering group. IDS capacity to support either the development of the reporting or a semantic environment for QSPE intelligence leads to self serve report generation. Both of which are impacted by IDS capacity and conflicting Trust priorities. MIQPR development is a deliverable for the Commissioning and Performance team.

Deliverable	Status	New delivery qtr	Original delivery qtr	Progress summary
Develop WAST Health and Safety Plan incorporating further improvements to legislative compliance with existing and emerging legislation	Red	Qtr 3	Qtr 1	Due to capacity constraints, delivery has shifted from Q1 to Q3 2025, with the strategy being driven via NARSF in September. A Manual Handling Deep Dive has been completed, and its recommendations will be incorporated into the Health & Safety Strategy, which is now in draft. The strategy will also embed a culture change process and ensure legislative compliance through process reviews. Completion and approval are targeted for Q3.

6. **Financial Sustainability Programme (FSP)**

6.1. Following the last update to the Committee on the FSP in July 2025, a Senior Project Manager has been appointed to drive forward the growing programme of work to support ongoing financial sustainability and efficiency, and a Governance Steering Group has been stood up from 8th September 2025.

6.2. Progress has been made in the following areas:

- **Administrative Review:** ADLT has closed down a number of actions to meet the recommendations of the Administrative and Support Services Review
- **Service Review:** Implementation planning for the Services Review will be undertaken alongside IMTP and Directorate Planning to embed FSP in directorate plans to ensure ownership and delivery of agreed efficiency activity.
- **Commercial Development:** The trust new Head of Commercial Development is due to commence on Monday 6th October. Following the on boarding process we expect progress around this area.
- **Skills Mix:** An options paper has been presented to the Executive Leadership Team, detailing nine potential configurations for crew

composition. Each option was assessed against key criteria including clinical effectiveness, operational feasibility, cost implications, and strategic alignment.

6.3. A full update on FSP will be made at the next Committee meeting in November.

RECOMMENDATION

The Committee is requested to:

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

Advise of any further assurance needed for the Board.

NEXT STEPS

7. An update on the end of quarter position for all deliverables will be provided at the November Committee meeting together with available outcomes metrics.

Welsh Ambulance Services University NHS Trust

Clinical Model Transformation (CMT) Programme Highlight Report

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

Clinical Model Transformation (CMT) Programme Highlight Report
Released: 30th July 2025

Transformation Support Office

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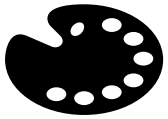
Programme Management Update

Programme Management Highlights



Developing our programme vision:

- Final revisions being made to our **Clinical Services Model Information Pack** before wider circulation, along with the updated **'Service Model Blueprint'**; due to be presented at CMT Board (Sep-25) for approval.

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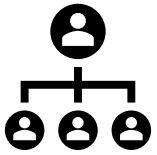
- ❑ **Patient personas in development**; agreement to reframe into condition specific profiles to better demonstrate the integration of services.



Establishing the CMT Programme Delivery & Assurance Arrangements:

Benefits realisation: Workstream Logic-Benefits Mapping complete and Workstream Scorecards reviewed with SROs at collaborative workshop on the 14/07. **Scorecards approved by CMT Board (Jul-25)** subject to minor revisions.

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- ❑ **Benefits realisation:** Final refinements to workstream scorecards and discussion with IDS team around development.
- ❑ **Digitising our assurance approach:** Development of Power BI dashboards for some elements of reporting (was delayed due to ICT capacity but will be revisited).
- ❑ Work to be initiated to **dependency map milestones across CMT workstreams including mapping inter-workstream, and wider dependencies**.

Developing formal programme documentation and audit readiness:

- **Workstream QIAs developed and timeline for CAG/CQGG submission confirmed**; see next slide.
- Programme Definition Document (V2) developed and circulated to CMT Board members for comments and feedback; due to be presented at CMT Board (Sep-25) for approval.

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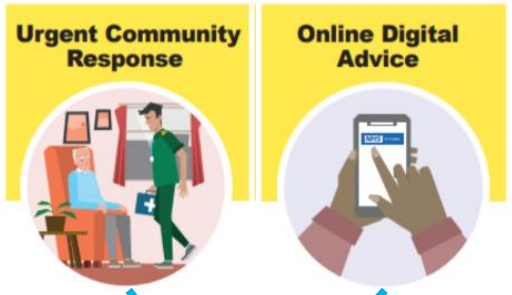
- ❑ **Benefits Realisation Plan** to be developed.
- ❑ **Audit readiness:** Outcome of the CMT programme 'health check' is being considered and incorporated into the CMT programme management plan.

QIA Update

April	May	June	July

Clinical Quality Governance Group Approval Group

APPROVED (14/04)



APPROVED (12/05)

APPROVED (24/07)

Revisions required and resubmission to CAG

Clinical Advisory Group Review Group

REVIEWED (23/05)

REVIEWED (27/06)

The Remote Integrated Care QIA was considered by CQGG on 24th July with a request for further review and refinement. The group asked for the QIA to be resubmitted to CAG for further consideration, prior to resubmission to CQGG for formal approval. Revised timescales TBC but aiming for CQGG resubmission on the 16th September.

Status	Description	Characteristics
Green	Project is on track and progressing well, meeting or exceeding expectations in terms of schedule, budget, quality, and objectives. **Action Required:** No immediate action is necessary, but ongoing monitoring and regular reporting are still required to ensure the project maintains its positive trajectory.	• Project milestones and deliverables are being achieved as planned. • Risks and issues are under control or adequately mitigated. • The project is progressing within the defined timeline and budget. • Key performance indicators are being met or surpassed.
Yellow	Provides an early warning that challenges or barriers are anticipated, but are not yet impacting on progress. **Action Required:** Close monitoring of factors anticipated to impact on progress, contingency planning, and reprioritisation if appropriate.	• Workload reprioritisation has been required to keep the project on track i.e. the impact has been transferred. • The project remains on track overall, however there are notable issues or risks or amber/red statuses recorded against key enablers, or interdependent projects that may impact over time. • The project remains on track overall but there may be moderate slippage against some tasks or actions.
Amber	An amber status signifies a cautionary state, indicating that the project is encountering challenges or potential risks that need attention to prevent further escalation. **Action Required:** Close monitoring of the project, proactive measures to mitigate risks, and corrective actions to address identified issues should be taken promptly to prevent further deterioration.	• Some project objectives are not being met as planned. • Certain milestones are at risk of being missed. • There are notable issues or risks that could impact project success if not addressed promptly. • Project performance or progress is below expectations but can be recovered with timely actions.
Red	A red status indicates a critical situation where the activity is significantly behind schedule, over budget, or facing major issues that jeopardize its success. **Action Required:** Immediate attention and intervention are necessary to address the issues and bring the project back on track.	• Major project objectives are not being met. • Critical milestones are consistently missed. • Key deliverables are incomplete or of poor quality. • Significant risks or issues are unresolved, and their impact on the project is severe.

RAG Status Definitions

CMT Programme Update

Report Date:	Programme RAG	Previous RAG	For Noting:	Senior Responsible Owner:	Lee Brooks *(interim)*
Jul-25	**Yellow**	**Yellow**	**Call Flow Phase 2:** 1-Dec go-live (Cab Sec expectation) is dependent on MIS (CAD supplier) delivering required changes, with definitions needed by mid-Aug. If delivery slips, the earliest alternative go-live date is likely to be Feb-25, presenting reputational and resource risks (escalated to the programme risk register). **Emergency Response Workstream Delivery and Assurance Arrangements:** Refreshed governance arrangements were agreed for the ERS workstream to recognise the inclusion of the Out-of-Hospital Cardiac Arrest (OHCA) improvement plan into the programme. **RICS CAD Options:** The Board endorsed the implementation of a single clinical queue across both CADs, providing greater operational flexibility. This option has capital and revenue cost implications and is unlikely to be delivered for winter (due to conflicting MIS priorities), with Q4 implementation more realistic. The paper will now be presented to Capital Management Board to consider funding.	**Programme Manager:**	Heather Holden

CORE CMT WORKSTREAM UPDATE

Workstream	RAG Status	RAG Trend	Summary Position
Digital Front-End	**Green**	↑	**Virtual Assistant Implementation:** A soft launch of the NHS111 Wales Virtual Assistant went live on 9 July. Metrics from the soft launch will be analysed using the supplier's GPT model to categorise public queries, informing future website and service development. **Symptom Checker (CPSS) Funding and Procurement:** Funding has been approved by Trust Board for the web-based Call Prioritisation Streaming System (CPSS). The single tender procurement process is progressing as planned. Monitoring and notification to Welsh Government is required before full implementation. Initial planning meetings are being arranged, and supplier impact assessments (DPIA and Cloud Security Assessment) are pending issue. **Business Case Development:** The workstream is awaiting a Welsh Government funding decision for broader website development.
Remote Integrated Care	**Amber**	↓	**Care Planning Function:** A priorities paper was presented to the RICS Board (17 July), focusing on training refresh and potential recruitment. Discussions continue on the future of the Remote Monitoring Solution, particularly funding for its use in urgent and emergency care. Next steps include communications, training refreshers to strengthen clinician confidence, and shaping future recruitment. **New Call Flows & Categories:** RCS0 implementation (1 July) was successfully delivered with supporting communications, training, and SOPs completed. **CPSS Strengthening and Evaluation:** The RICS Board endorsed a proposal to expand the CPSS Winter Desk function, focusing on integration with call handling, infrastructure, training, and data. Delivery is paused due to resource and governance constraints but remains a priority for review in Q4. **Alignment of CSD and 111:** Amber status reflects risks relating to CAD options. A final proposal for clinician terms and conditions is with Trade Union Partners for review (decision expected by Sep-25). Option 3 for CAD development has been agreed, with a paper to define resource and timeframes. A telephony migration plan is in place with a projected go-live of 27 August, following training. Work continues to produce SOPs for a centralised Remote Integrated Care Team. **CMT Board Notes:** The Board endorsed the implementation of a single clinical queue across both CADs, providing greater operational flexibility. This option has capital and revenue cost implications and is unlikely to be delivered for winter (due to conflicting MIS priorities), with Q4 implementation more realistic. The paper will now be presented to Capital Management Board to test the ability for funding. Executive Finance Group is also considering a potential +12FTE in integrated care to support Care Planning functions alleviating some of the prioritisation requirements; further update expected towards the end of August.

CMT Programme Update

Workstream	RAG Status	RAG Trend	Summary Position
Urgent Community Response	**Yellow**	↔	**UCR Scheduling:** Implementation options have been finalised and were presented to the CMT Board (Jul-25); further operational discussion required. **Falls & Frailty Response Model:** Emergency Ambulance Practitioners can now undertake community falls referrals, and proposals have been submitted to optimise resources for urgent falls response and explore winter collaboration opportunities. A SOP for volunteers and falls responders has been drafted, but the lack of device funding and delays in updating the Falls Dashboard continue to impact national reporting, with escalation requested. **Tasking Optimisation:** Recruitment of a third Mental Health Practitioner is underway. The v2 Mental Health Response Vehicle (MHRV) Power BI dashboard is operational, but v3 development is paused, impacting performance metric reporting. A pilot evaluation report has been completed, and RCDM Train the Trainer courses are planned. Work continues to review Single Point of Access (SPoA) and to establish a CTAS Task & Finish group by late August. **Advanced Practice Delivery Group:** Recruitment targets have been met (130.7 FTE) with expansion focused on Betsi Cadwaladr, Powys, and Hywel Dda areas. Palliative care phase 3 recruitment is progressing, and interest from Aneurin Bevan and Hywel Dda APPs is strong. Workforce modelling is underway to define optimal APP numbers. The RCDM education package has been approved, and dashboard development is under review with IDS. **CMT Board Notes:** The UCR Scheduling Options paper was presented to the Board with an action for further operational discussion outside the meeting.
Emergency Response	**Green**	↔	**Metrics and Reporting:** AQM reporting has now been delivered and is being reviewed by the project team. **Call Flow Prioritisation – CAD Developments:** New call categories went live on 1 July with a smooth transition and positive early feedback. An issue log has been established to track and resolve minor teething issues, and a further CAD update is planned to enhance reporting and address residual issues (19/08 aim). **Data Definitions and Monitoring:** Initial priority reports and logic are operational, supporting the new call flow framework. Further refinement of definitions is ongoing to ensure accuracy, with an external reporting deadline to Welsh Government on 11 August. **Communications and Training:** Extensive training was delivered ahead of go-live, and stakeholder communications, including the Ambulance Performance Framework explainer, were well received. Stakeholder feedback is being collated to inform any future updates. **CMT Board Notes:** Revised governance arrangements were agreed for the Emergency Response Workstream that recognise the incorporation of the Out-of-Hospital Cardiac Arrest (OHCA) improvement plan. The ERS workstream will recognise two distinct elements: 1) Operationally-led changes and 2) Clinically-led changes. Lee Brooks and Ceri Griffiths will lead the operational elements, which include Rapid Clinical Screening, Call Flow Implementation (Phase 2), and HCP Call Flows, whilst Andy Swinburn and Greg Lloyd will lead the OHCA elements. Progress will be reported to the CMT Board via two highlight reports aligned to the Emergency Response Workstream. Call Flow Implementation (Phase 1) and Rapid Clinical Screening will be transitioning to business-as-usual over the next reporting period, with the ongoing management of the Call Flow Issue Log transitioning to the Call Flow Implementation (Phase 2) group. These changes will be reflected in future ERS workstream reporting.
Health Transport	**Green**	↔	**Access to Planned Transport:** the project is progressing, with manual processes for patient transfers being formalised and a Cleric software update awaited (expected October). An interim workaround is in development, subject to DPIA approval. **Transfer & Discharge:** agreement between workstream and programme SRO that this project is out of scope of 'Health Transport' and will be managed through the Ops IMTP Assurance route, supported by Integrated Strategic Planning & Development Group (ISPD).

CMT Programme Update

ENABLING GROUP UPDATES			
Group	**RAG Status**	**RAG Trend**	**Summary Position**
Quality & Performance Metrics	**Green**	↔	• Board was advised that no issues required escalation. • Revised definitions for Arrest/Emergency/RCS0 have been approved, and the first week of data reporting is complete. Associated monitoring and assurance plans are in place, including development of local authority-level reporting. • Board was assured that CMT Scorecards are progressing and will be shared at the next Board *(approved 28/07)*. The CMT evaluation supplier has been shortlisted, with resource implications now factored into IDS priorities. Data reporting following the 1 July go-live is delivering outputs as planned, with strong progress against the Monitoring and Assurance Plan.
Change Management	**Yellow**	↔	• Board was alerted to the continuing risk of **change saturation** in parts of the organisation, creating potential staff disengagement and capacity challenges. • Board was advised of positive engagement activity following the recent Hive Survey, with staff reporting improved involvement in decision-making. Further focus will be placed on communicating when influence is limited. • Board was assured that change leads are now embedded across all workstreams and that external change management training is scheduled for the Autumn to strengthen capability.
Partnerships & Engagement	**Green**	↔	• Board was advised of the successful delivery of a comprehensive communications campaign supporting the Welsh Government changes to the Ambulance Performance Framework effective from 1 July. This included external stakeholder briefings, public-facing materials, media engagement, and internal communications resources tailored to different staff groups. • Following the transfer of the internal communications portfolio to the workstream in June, integration work is progressing, and the internal communications plan is under review. • Board was assured that engagement with Llais continues to be positive, with support expressed for both the communications approach and Clinical Services Model proposals. No new risks were identified this period.

APPENDICES

Workstream Highlight Reports (HLR2s)

Produced for the CMT Board on the
28th July 2025

Navigation


Working in collaboration with the wider health and social care system
Online Digital Advice
Remote Integrated Care
Urgent Community Response
Emergency Response
Health Transport
Non-Urgent Health Query
Urgent Health Care Need
Life-Threatening Illness Or Injury
Health Related Transport Need
Service Offer
Health Need
Health Need
Service Offer

Digital Front-End Workstream

Executive Sponsor: Jonny Sammut

Senior Responsible Owner: Jonathan Turnbull-Ross

Digital Front-End Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Jonny Sammut
Jul-25	Green	Amber	Soft launch of Virtual Assistant deployed on the NHS111 Wales Website. Funding agreed for the development of the new web-based symptom checkers.	SRO:	Ceri Griffiths

Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View
Virtual Assistant Implementation	Green	↑	• A soft launch for the Virtual Assistant was deployed on the NHS111 Wales website on the 9th July. • Internal Communications are live on Siren, including a poll to name the Virtual Assistant featuring the top 5 options.	• Metrics from the soft launch to be reviewed, using the supplier's existing GPT model to thematically categorise the questions being asked by the public. This thematic analysis will give a richer understanding of the concerns/queries that patients are directing to the Virtual Assistant, assisting in conversations around further web and service development.
Symptom Checker Funding Decision	Green	↑	• Funding agreed at Trust Board to proceed **with the purchase of a web-based version of Call Prioritisation Streaming Service (CPSS).** • **Procurement Pathway for Single Tender Procurement** is progressing as expected. • **Paused** - Quotes requested **for external independent commercial advice** on CPSS Intellectual Property expectation that this will cost up to £15,000. • Monitoring and Return Notification will be required to Welsh Government to proceed; to be completed.	• Initial Implementation meeting to be arranged to initiate work. • Impact Assessments (DPIA and Cloud Security Assessment) to be sent out to Supplier.
Business Case Development	Yellow	↔	• Outstanding the Welsh Government decision for website funding based on the business case.	-
Project Management	Green	↔	-	**Project Group to be initiated and Project Plan developed** for Symptom Checker Implementation. This will formally report into the Digital Front End Workstream.

Digital Front-End Workstream – Programme-level Risk

Risk Ref:	RISK-137	Responsible Group:	CMT Board	Risk Category:	Technological	Risk Owner:	Jonny Sammut

Risk Title:	**Lack of early and structured engagement with Digital leading to unclear requirements and unrealistic delivery expectations**
Risk Description:	**IF** there is a lack of clarity around digital requirements, or Digital colleagues are not proactively engaged in programme design. **THEN** there will be a lack of strategic coordination of digital requirements. **RESULTING IN** 1 - Digital requirements not clearly defined at the right time, leading to misaligned stakeholder expectations. 2 - Inadequate time built in for technical discovery, solution design, development, testing, and deployment. 3 - Project plans assuming Digital capacity without formal agreement, increasing risk to delivery timelines and quality. 4 - Poor coordination of user needs, technical requirements, and third-party supplier input, resulting in fragmented delivery. 5 - Unreasonable and unplanned expectations placed on ICT, IDS, Information Governance, and Cyber Security teams. 6 - The 'delivery clock' starting before all digital, system, and process requirements are confirmed, compressing timelines and increasing risk of failure or rework. 7 - Lack of capacity within digital to move from Minimum Viable Product (MVP) to product development and optimisation.
Existing Controls:	1 - Prioritisation of IDS and digital delivery requests through the DTIP group (when created), ad-hoc until then in various groups ensuring alignment with organisational priorities, (including via the CMT metrics group although this is predominately IDS). 2 - Early engagement of Digital Services via representation in programme governance and workstream planning discussions. 3 - Digital requirements mapping led by the Assistant Director of Digital Services: Digital Transformation & Innovation, providing a baseline and tracking evolving needs. 4 - Clear change control process in place for introducing or modifying digital elements to avoid uncontrolled scope creep. 5 - Workstream-level plans developed and maintained in MS Project, shared with all stakeholders to ensure visibility of interdependencies and resource impact. 6 - Third-party digital supplier dependencies identified and logged to support proactive coordination and avoid last-minute requests.
Planned Mitigation:	1 - Ongoing review process to be embedded to review digital requirements emerging across the programme (Head of Transformation to be included in SPP Digital Plan touchpoints). 2 - MS Project plans to be reviewed regularly with "Digital Dependency" tag used to flag key activities. 3 - Risk to be presented to CMT Board with an ask for all Board members to commit to early engagement with Digital Services, including in third party supplier discussions. 4 - Information Governance training and awareness session planned with the Transformation Support Office to raise the profile of IG/DPIA requirements to support early consideration in project design.

Risk Approach	Opening Score			Current Score		
	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score
Mitigate	5	3	**15**	5	3	**15**

Actions Required:	1. Review the risk and consider the current risk score

Remote Integrated Care Service Workstream

Executive Sponsor: Liam Williams

Senior Responsible Owner: Pete Brown

Remote Integrated Care Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Liam Williams
July-25	Amber	Yellow	RAG Status to escalated to Amber due to raised risk around the feasibility of implementing CAD options by November. Groups to move into delivery of the proposed options specifically around Care Planning and CPSS Expansion decision to endorse direction of travel but not progress yet. Will review proposal in Q4 to determine feasibility.	SRO:	Pete Brown
Scope:	Phase 2 of Remote Integrated Care Service developments which fall under the Clinical Model Transformation (CMT) Programme Board.				

Task / Milestone	Status	RAG Trend	Current Position	Forward View
Care Planning Function	Yellow	↑	• Priorities paper presented to RICS Board (17.07) outlining the focus and next steps for the Care Planning function. • Ongoing discussions underway to formulate a refresh in training and potential recruitment. • **Decision required:** future for Remote Monitoring Solution, especially around funding element in utilising RMS in Urgent/Emergency Care.	• Following approval of Priorities paper, begin discussions and communications around the focus for Care Planning Clinicians, plan and deploy training refreshers to strengthen confidence in Care Planning Clinicians and shape future intakes.
New Call Flows & Categories	Green	↔	• RCS0 implementation (01.07) successful and operational within Integrated Care. Development of communications, training, and SOPs completed and distributed with a seamless implementation.	• Representatives to be present at the Emergency Response Workstream meetings for **Phase 2.** Exploration into workflows, requirements, etc.
Strengthening, Application, and Evaluation of CPSS	Yellow	↔	• Proposal brought to the RICS Board (17.07) recommending that there is an expansion of the CPSS ***Winter Desk*** Function focusing on integration with the 999 Call Handling System, Technical and Operational Infrastructure, Training Programmes, and Data elements. Board have noted and received the proposal, endorsed the principles outlined as a direction of travel, noting no delivery path yet required due to restrictions relating to resource capacity and governance, licensing, etc.	• Continue to shape and implement the RICS Support Desk to further support the Winter Desk initiative. • CPSS Expansion paper to be revisited when resource capacity is in a better position to deliver. Will be reviewed in Q4 to understand operationalisation.
Alignment of CSD and 111	Amber	↓	• **Amber status due to risk raised around the CAD Options.** • Final proposal for Terms and Conditions for all Clinicians across IC is currently with Trade Union Partners for review, with an aim to reach agreement by September 2025. • CAD Options paper to shared and this will be used to shape the development of the SOPs. Board have agreed Option 3 (preferred option) for CAD and will be developing a paper outlining resource required and timeframes and how this work aligns with the Phase 2 of Emergency Response Workstream. • Telephony migration plan devised in conjunction with Trade Union Partners with a projected Go Live date of **27th August** following two weeks of training.	• Process Project Group to undertake a helicopter view to produce SOPs for one centralised Remote Integrated Care Team. • Paper to be drafted and shared outlining the next steps of CAD Options.

RICS Workstream Board – What was covered?

- CAD Options & Risk
- Care Planning Priorities
- Respiratory Offer
- Mental Health Offer
- Care Traffic Controller Day
- RICS Support Desk
- SPOA Position
- West Wales Project
- WCP Funding Paper
- CPSS Expansion Proposal
- SCW Review Response
- Priorities
- Integrated Care Structures
- Audit & Education Structures
- Advancing Clinical Practice
- Clinical Supervision
- Telephony Migration
- Appointment Scheduling
- SOP Development
- Call Categories: Phase 2
- Remote Monitoring Solutions
- Project Interdependencies
- RICS Project Group Delivery

RICS Enabling Deliverables

Report Date:	Remote Integrated Care **Enabling Deliverables**	For Noting:
July-25		The following key milestones and deliverables, while not directly reporting into the CMT governance structure, are critical enablers for broader transformational outcomes and are therefore important to highlight
Scope:	Phase 2 of Remote Integrated Care Service developments which **do not** fall under the Clinical Model Transformation (CMT) Programme Board however are key enablers for delivering objectives relating to Remote Integrated Care.	

Task / Milestone	RAG	Update
Integrated Care Structures	**Amber**	• **Amber:** delivery delay relating to **Audit and Education OCP** specifically. Education OCP now moving into consultation phase and original plan was to have this completed in Summer 25. • The Senior and Middle Management structure is now entering a transition phase. • The First Line Management Co-Design sessions provided valuable insights into evolving roles and upcoming consultation phase. • Progress is underway in relation to Audit Structures with recent advertisement for CPSS Quality Auditors under the Operations Quality Team marks another step forward in strengthening our quality assurance and creating the structures required.
Video Functionality across Integrated Care	**Complete**	• **Tuesday 8th July 2025** saw Video Functionality introduced across NHS 111 Wales to ensure all Integrated Care Clinicians have access to Video Functionality to strengthen clinical decision making. • Monitoring and evaluation of usage will be embedded into Operational performance monitoring.
Appointment Scheduling in Integrated Care	**Green**	• Establishing links with **Urgent Community Response Workstream** to cohesively bring together interdependencies across Workstreams with representatives from each Workstream present in various project groups/boards. • Collaborative shaping of scope, workflows, and resourcing, to explore sustainable solutions of utilising Urgent Community Response services deployed from Integrated Care.
Mental Health Offer	**Yellow**	• **Yellow:** Early Warning status due to original plan to deliver offer to CMT in July Board however this will not be achieved. Principles outlined however further refinement and consultation required. • Paper to be presented at upcoming RICS Board (17th July) outlining next steps in the Remote Mental Health space. • Pending approval, the next steps would include progression with the proposed recommendations.
Respiratory Offer	**Green**	• Overview paper presented to the CMT Fortnightly Executive Catch Up outlining proposed respiratory offer aims to better manage and address this seasonal surge, ensuring that patients receive timely and effective care. • Plan and implemented the proposed recommendations and offers within the paper.
Single Points of Access (SPoA)	**Amber**	• **Amber:** due to the pace of change from External factors. • An overview of the current position of SPoAs across Wales was drafted following Clinical Model Transformation Board (CMT) agreeing that oversight for delivery would be placed within the Remote integrated Care Service (RICS) project but recognised this work would require contributions from a range of areas. • A centralised TEAMS Channel has been created to support a collaborative approach to manoeuvring through SPoA development.

RICS Workstream Board Next Steps

The following points are the areas of focus for the next **4 weeks** and the planned outputs to be presented at the next Remote Integrated Care Board.
Note this does not include the reporting of progress of deliverables underway.

Area of Focus	Deliverable Outputs Presented at Next Board
Single CAD	Solutions and next steps following escalation of the risk into CMT Board
Telephony Migration	Complete telephony migration by the scheduled go-live date, providing reflections on implementation to the Board.
Care Planning	Focus on resetting and reprioritising care planning, including completing CAD infrastructure with three queues, conducting a training gap analysis, and starting staff training. Full 'go-live' may not occur within the sprint, but foundational work will be completed.
	Remote Monitoring: Develop a plan for remote monitoring, including scoping, how it is used across Wales, procurement options, and timelines, aiming to present a paper at next board.
SOPs	Ongoing review and development of SOPs for both transformation initiatives and the broader set of SOPs, with nominated leads reviewing and updating as needed. A prioritisation to be completed.
Clinical Offers	Firm up offers for paediatrics, respiratory, and mental health, and progress the Clinical Supervision Workshop.
Care Traffic Control Day	Delivery and evaluation of the Care Traffic Control Day (6th August)
Structures	Implementation of Senior and Middle Management Structures
	Consultation phase with 1st Line Management Structure
	Consultation phase with Education Teams in current CSD and 111
SCW	Review reports and comments on response

Remote Integrated Care Service (RICS) Risk Escalation

Risk Ref:	RISK-139	Responsible Group:	Remote Integrated Care Board	Oversight Group:	CMT Programme Board

Risk Title:	**Feasibility of CAD Options Delivery Pre-Winter**
Risk Description:	**IF** the focus for MIS (supplier) is to deliver Phase 2 of Call Categories by October. **THEN** there will be insufficient capacity to deliver proposed options for CAD to bring CSD and 111 into RICS by November. The single Integrated Care Team will need to operate with the current systems. **RESULTING IN** clinical safety concerns and issues, operational productivity impact, and a poor culture across Integrated Care. Patients will not be effectively prioritised, ineffectual manual processes will be required to move patients across CADs, leading to patient data becoming lost and poor reporting.
Mitigations:	1. A formal paper is required to outline the preferred option development, timing and the shape of the work. 2. External supplier discussions to map feasibility. 3. Organisational prioritisation of objective delivery.

Risk Approach	Current Score			Target Score		
	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score
Mitigate	5	4	**20**			

Recommendation / Actions Required (from Oversight Group):	1. Due to the high score, the Workstream Board has reported the risk to the CMT Board to agree that this will be transferred to the CMT Board. 2. Risk Score ≥20 (high impact/high likelihood) 3. Need for Additional Resources or Authority

Urgent Community Response Service Workstream

Executive Sponsor: Andy Swinburn

Senior Responsible Owner: Sonia Thompson

Urgent Community Response Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Andy Swinburn
Jul-25	Yellow	Yellow	Scheduling - Implementation Options Paper to be presented at CMT Board in July Falls & Frailty - **Delays in updating the Falls Dashboard with the requested additional data continue to impact WAST's ability to deliver the required national reporting.** Tasking Optimisation - MHRV dashboard work paused, which could delay getting accurate data for the evaluation. RCDM Course scheduled for Q2/3. Looking to set up CTAS T & F group. ACPDG - Full APP establishment has been achieved, totalling 130.7 FTE. Organisational approval received for (RCDM) education package.	SRO:	Sonia Thompson

Project/Working Group	RAG Status	RAG Trend	Summary Position
UCR Scheduling	Green	↔	• Implementation Options Paper to be presented at CMT Board in July.
Falls & Frailty Response Model	Yellow	↔	• Confirmation received from Learning & Development that Emergency Ambulance Practitioner can undertake a community falls referral. • Paper submitted to the UCR Board proposing optimisation of existing resources to enhance urgent falls response and explore additional provisions or winter collaboration opportunities. • ePCR SOP drafted for volunteers and falls responders. **No funding currently available for devices.** • **Delays in updating the Falls Dashboard with the requested additional data continue to impact WAST's ability to deliver the required national reporting. Requested this issue is escalated to UCR Work Stream Board.**
Tasking Optimisation	Yellow	↓	• Approval given to recruit 3rd MHP, recruitment process ongoing. • MHRV Power BI dashboard v2 now operational via Launchpad. Development work on v3 currently paused following decision at CMT Metrics Group. Noted as issue and escalated to Tasking Optimisation and workstream SRO. Will impact collation of performance-related metrics. • MHRV Pilot Evaluation Document and CMT Executive Summary written, to be discussed at Tasking Optimisation meeting. • RCDM Train the Trainer course scheduled for July, with courses planned for Q2/3 • Reviewing the SPoA (Single Point of Access) framework and aligning the expectations with our current workstream. • Discussed setting up a CTAS T&F group; plan to bring ToR to next Tasking Optimisation meeting with a provisional start date of 22 August.
Advanced Practice Delivery Group	Green	↑	• Recent recruitment has enabled the achievement of the full establishment for this year, set at 130.7 FTE. This year's recruitment was focussed in the Betsi Cadwaladr, Powys and Hywel Dda Health Board areas. • Palliative phase 3 recruitment (focused on expanding into new areas); interest currently from Hywel Dda and Aneurin Bevan Health Board areas. Significant interest from qualified APPs to join this specialism. • Initial APP Roster Review Governance Group meeting held on 19 June, with subsequent meetings scheduled for 18 July. Workforce modelling currently being undertaken to determine the desired no of APPs in each specialism across all areas. TU rep requested yet to be confirmed. • APP Remote Clinical Decision-Making (RCDM) education package endorsed by the CPAS and approved by both CQGG and SOT. • Luke Watkins (Clinical Development Lead) has written a paper on UCR Dashboard, which was discussed at Tasking Optimisation. Further discussions to be held with IDS.

Emergency Response Service Workstream

Executive Sponsor: Lee Brooks

Senior Responsible Owner: Greg Lloyd

Emergency Response Workstream Update

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

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

Health Transport Workstream

Executive Sponsor: Lee Brooks

Senior Responsible Owner: Mark Harris

Health Transport Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Lee Brooks
Jul-25	Green	Green	• QIA for Health Transport approved with positive feedback at CQGG • ToR for ATPC approved by HT Board • Board acknowledged the realignment of Transfer & Discharge project from Health Transport to BAU IMTP • Two issues raised: - Cleric patch-fix to include holding area for white calls. Options paper for interim process being drafted. - Additional development request for MIS (electronic Passover of WHITE calls) will require funding to be identified	SRO:	Mark Harris

Project/Working Group	In Scope	RAG Status	RAG Trend	Summary Position
Access to Planned Transport	Develop a pathway process from RICs	Green	N/A	• Terms of Reference approved at Board for the project • Formalising the process of manually transferring a patient from the call stack to Ambulance Care for taxi transport to be arranged by the NEPTS team has started, along with identifying the quality checks that will be needed for reporting. • Awaiting software update from Cleric for bookings to go into a Health Transport 'holding area'. Advised October but date TBC by Cleric. Options paper being drafted for interim process . DPIA to be signed off prior to a 'workaround' going live. • Two new issues raised • Opportunities for inclusion within Health Transport to be identified
	Identify additional routes of call origin	Green	N/A	
Transfer & Discharge	Board acknowledged the realignment of the Transfer & Discharge project from Health Transport to operationally-led IMTP delivery.			There will be no future reports to CMT for Transfer and Discharge. This will be monitored through Ops IMTP Assurance Meetings, with onward reporting into Strategic Transformation Board (STB) via the Integrated Strategic Planning and Development Group (ISPD).

Appendix B

Assurance against the Cabinet Secretary's priorities 2025/26

BACKGROUND

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

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

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

ASSESSMENT

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

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	RAG (Delivery)	Progress
Timely Access to Care	**Ambulance Target Review & Call Categorisation** Respond to the outcome of the Welsh Government-led Task & Finish group to determine the appropriateness of the current Red 8-minute target.	• Ambulance Target Review complete with a formal mandate from Welsh Government • MIS configuration of Arrest category • Dual reporting for Ambulance Target Review go-live (subject to confirmed recommendation)	• Implementation of Purple ARREST category • Development and roll-out of revised performance reporting in line with agreed KPIs		• Completed and gone live 01 July 25.
	Rapid Clinical Screening Transition to a clinically prioritised emergency response model with early clinical input to improve the accuracy of prioritisation, providing more timely response to the most critically unwell patients	• Implement RCS0 call category	• Post implementation evaluation / lessons learnt • Adoption of High Risk Markers data (Q2/Q3) (dependent upon high risk marker work)		• AQM reporting remains outstanding (currently an IDS team priority) presenting a barrier to effective evaluation of Rapid Clinical Screening (RCS).
	RICS Strengthen and expand the use of the Call Prioritisation Streaming System (CPSS) enabling call handlers to provide safe, effective advice and referrals to a broader range of calls Design and implement processes and policies to deliver an effective integrated care clinical team including revisions to SOPs, alignment of terms and conditions, strengthened quality and safety governance arrangements, and implementation of a Home and Remote Working Model to enhance service delivery and support seamless collaboration	• Complete evaluation of Winter Desk • Implement a sustainable solution to the Winter Desk Test of Change • Strengthen Quality and Safety Governance arrangements • Define processes for single Integrated Care Clinical team and replace 52 SOPs • Align terms and conditions for clinical teams	• Implement a sustainable solution to the Winter Desk Test of Change • Complete formal evaluation of CPSS • Strengthen Quality and Safety Governance arrangements		• Review of winter desk completed with proposals for establishment of a permanent desk presented. • Continue to shape and implement the RICS Support Desk to further support the Winter Desk initiative. • CPSS Expansion paper to be revisited when resource capacity is in a better position to deliver. Will be reviewed in Q4 to understand operationalisation. • Progress is underway in relation to Audit Structures with recent advertisement for CPSS Quality Auditors under the Operations Quality Team marks another step forward in strengthening our quality assurance and creating the structures required.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	RAG (Delivery)	Progress
	Transfer & Discharge Service Model Engage with commissioners to develop a Transfer & Discharge service model appropriate to Health Board & strategic service development needs - including opportunities to implement a Transfer Clinical Hub (subject to external funding)	• Agree the internal vision for Transfer & Discharge aligned with the national direction of travel • Work with six goals team to integrate NEPTS processes into system wide discharge planning •	• Develop a proposal for the WAST Transfer & Discharge model for internal agreement • Engage via JCC with Health Boards on options for future model, aligned to EMS, NEPTS and ACCTS commissioning intentions • Work with six goals team to integrate NEPTS processes into system wide discharge planning		• Currently paused – moved from CMT to own workstream. New SRO and Project lead required due to staff moving on.
	Non-Emergency Patient Transport Service (NEPTS) Continued development of the service to ensure the right capacity is in place to meet demand to support planned care and cancer services.	• Data and insights to improve co-ordination and decision making with health boards throughout 25/26.	• Roster review completed		• Initial modelling on 3 options from ORH. Total mobile looking at roster patterns. Next steps planning against resources.
Population Health and Prevention	**NHS 111 Wales website**: the website will provide information and advice to support people to access the right part of the health system or self-care, preventing escalation of care unnecessarily.	• Deliver and evaluate the initial proof of concept for the Virtual Assistant (navigation of the A-Z Directory (funded).	• Scoping and feasibility (further development would require additional investment)		• Yellow Outline Business Case submission provided to Welsh Government. Decision pending.
	NHS111.Wales Improvement Deploy a Virtual Assistant integrated with Robotics AI to empower patients with the tools and information needed to manage their health needs more autonomously, enhancing accessibility and supporting self-care.		• Virtual assistant deployed		• Green A soft launch for the Virtual Assistant was deployed on the NHS111 Wales website on the 9th July.
	Online Symptom Checker (OSC) Identify and implement an effective Online Symptom Checker tool to		• Online symptom checkers secured		• Online symptom checker -Trust Board approved direct award, enabling us to move forward on

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	RAG (Delivery)	Progress
	enhance patient access to timely, accurate advice				the single tender action process. Pending funding agreement.
	Falls services: Objectives are to lift patients at the earliest opportunity to prevent deterioration and avoid hospital conveyance where safe and appropriate to do so. Where hospital conveyance is required the aim is to convey in a timely manner to prevent further deterioration. By the end of FY25/26: Optimise the current Falls Level One Service in line with Health Board specifications and remit, National Falls Framework, and WAST Falls Response to provide an effective and safe Falls Service across Wales. We will also develop the subsequent transformational amendments to Falls incident management and deployment (including RICS, RCS, Care Planning, and UCR Hubs) to ensure patient safety. By the end of FY27/28: Deploy and optimise a Falls Level Two Service in collaboration with Health Boards, and in line with the National Falls Framework and Trust Level Two Specification including subsequent transformational amendments to Falls incident management and deployment (including RICS, RCS, Care Planning, and UCR Hubs) to ensure patient safety.	• L1 - Identify data availability regarding National Falls Framework Metrics (conveyance, response, community, resource, and HB data) • L2 - Continue assessing developing Level One service to begin drafting Level Two specification	Presentation of L1 options and benefits Present evaluation and options for sustainability of L2 services going forward		• Delays in updating the Falls Dashboard with the requested additional data continue to impact WAST's ability to deliver the required national reporting. • Paper submitted to the UCR Board proposing optimisation of existing resources to enhance urgent falls response and explore additional provisions or winter collaboration opportunities. • Ongoing discussions through W45 Health Board workshops about the Falls and Frailty resources required to support the W45 initiative pre-hospital and the offer available in WAST.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	RAG (Delivery)	Progress
Building Community Capacity	**APP Navigators** By the end of FY26/27: Deliver an APP Navigator in every Health Board, fully integrated into Health Board MDT hubs to enhance collaboration, optimise resource allocation, and ensure a consistent, equitable service offer across all seven Health Boards. To deliver this, a roster review will also be conducted to support efficient deployment and service consistency.	• Engagement with HBs to identify opportunities to co-locate APP Navigators in MDT hubs	• APP Navigator operating in every Health Board • Integration with Health Board MDT Hubs		• APP Navigators embedded in all health boards, ongoing collaborative work. • APP Remote Clinical Decision-Making (RCDM) education package endorsed by the CPAS and approved by both CQGG and SOT.
	Care Planning Explore opportunities to schedule care through the planned deployment of internal responders including Community Welfare Responders, Falls, Mental Health, and Advanced Paramedic Practitioners etc, including expanding volunteer and community response resource i.e. Community Welfare Responders (CWRs) as required.	• Implement Care Planning capability • Expand volunteer and community resource numbers including CWRs	• Implement Appointment Scheduling and Deployment of CWRs / Falls / MHRVs / APP / etc. • Expand volunteer and community resource numbers including CWRs		• Implementation Options Paper to be presented at CMT Board in July (outcome to be confirmed in end of Quarter 2 update) • Priorities paper presented to RICS Board (17.07) outlining the focus and next steps for the Care Planning function. • Ongoing discussions underway to formulate a refresh in training and potential recruitment. • Funding requirement.
	End of Life Care By the end of FY27/28: In collaboration with Health Board Specialist Palliative Care Teams, integrate Palliative Care Paramedics (PCPs) into the Advanced Practice portfolio and deploy a PCP in every Health Board, fully operationalising PCPs within our commissioned service offer to deliver an equitable, patient-centred, and specialised palliative care service	• Secure funding pathway with Marie Curie (3-5 year funding) and establish shared vision, and baseline metrics for performance monitoring and evaluation • Secure palliative care training pathway with Swansea and Cardiff SPCT • First cohort of Trainee Advanced Paramedic Practitioners (TAPPs) to complete palliative care training pathway (Swansea and Cardiff)	• Second cohort of Trainee Advanced Paramedic Practitioners (TAPPs) to complete palliative care training pathway (Swansea and Cardiff)Engage with further HB Specialist Palliative Care Teams to establish additional training pathways • Agree a Fleet model for PCPs (currently operating in unmarked vehicles, however alternative models need to be explored)		• Phase 1 and 2 of Marie Curie funding bid complete. • Ongoing work with Swansea University regards palliative care training and APP recruitment • Palliative phase 3 recruitment (focused on expanding into new areas); interest currently from Hywel Dda and Aneurin Bevan Health Board areas. Significant interest from qualified APPs to join this specialism.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	RAG (Delivery)	Progress
					• Fleet programme incorporates plans for single responder vehicles.
	CTAS (formerly PTAS) By the end of FY26/27: Deliver a Clinical Triage Assessment Service (CTAS) in every Health Board to facilitate direct patient access to remote specialist clinical care (e.g. physiotherapists). Collaborate with Health Boards to implement an integrated model that enhances patient access and delivers a consistent, equitable service across all seven Health Boards.	• Development of MoUs with Health Boards • System integration / interoperability to enable the dynamic transfer of patients • Development if inclusion/exclusion criteria and ability to identify suitable patients	• TBC based on further development of model		• Ongoing collaboration with Health Boards seeking sign off for governance documentation to enable CTAS further. • Reviewing the SPoA (Single Point of Access) framework and aligning the expectations with our current workstream. • Discussed setting up a CTAS T&F group; plan to bring ToR to next Tasking Optimisation meeting with a provisional start date of 22 August.
Mental Health Access	As part of our remote integrated care offer we will explore opportunities to schedule care through the planned deployment of internal responders including Mental Health By the end of FY26/27: we aim to evaluate and optimise the Mental Health Response Vehicle (MHRV) blended model and expand across Wales as part of a wider developing mental health service offer.	• Implement care planning capability • Quality measures confirmed • Performance metrics, and service offer defined - MHRV Logic Model approved	• Implement appointment scheduling and deployment of MHRVs		• Paper on MH offer to be presented at upcoming RICS Board (17th July) outlining next steps in the Remote Mental Health space. • Pending approval, the next steps would include progression with the proposed recommendations. • Approval given to recruit 3rd MHP, recruitment process ongoing. • MHRV Power BI dashboard v2 now operational via Launchpad. Development work on v3 currently paused following decision at CMT Metrics Group. Noted as issue and escalated to Tasking Optimisation and workstream SRO. Will impact collation of performance-related metrics.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	RAG (Delivery)	Progress
					• MHRV Pilot Evaluation Document and CMT Executive Summary written, to be discussed at Tasking Optimisation meeting.

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

AGENDA ITEM No	**13**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**0**

Environment, Decarbonisation and Sustainability Update - AUGUST 2025

MEETING	Finance and Performance Committee
DATE	16 September 2025
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Jo Williams – Head of Capital Development
CONTACT	Joanne.williams10@wales.nhs.uk

EXECUTIVE SUMMARY

To provide an update on:

- Welsh Government SDP refresh
- Capital Investment – TEF Funding
- Single Response Vehicle locations and EV charging
- EV rapid charging infrastructure
- EV and infrastructure resources
- ISO14001 reaccreditation

RECOMMENDATION: The Finance & Performance Committee is asked to NOTE this update.

KEY ISSUES/IMPLICATIONS

N/A

REPORT APPROVAL ROUTE

Capital Management Board – 10th July 2025 – to note
Finance and Performance Committee – 16th September – to note

REPORT APPENDICES

N/A

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST
Finance and Performance Committee
Environment, Decarbonisation & Sustainability Update
August 2025

SITUATION

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

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

BACKGROUND

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

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

5. It is noted that the Welsh Government, supported by Welsh Government Energy Services (WGES) are currently refreshing the Strategic Delivery Plan (SDP) and this will have a bearing on a DAP refresh in due course. Initial comments were requested on the draft initiatives by the end of August, and the team has responded with comments. This follows on from informal WAST feedback provided during numerous stakeholder engagement sessions and the team continues to engage with the WGES team. While timescales are still subject to some potential change, it is currently anticipated that the NHS Wales Leadership Board on 21st October 2025 will be asked to approve the revised SDP.

6. The Decarbonisation Programme Board will meet again in late September (date to be confirmed) to receive an update on the emerging refreshed SDP documentation and a further summary will be provided to Finance and Performance Committee in due course.

ASSESSMENT

Capital Investment – TEF Funding

7. The Trust was successful in obtaining funding for schemes in Abergavenny (£850k) and HART (£156k) this year. Both schemes are progressing well.

8. At the time of writing, the HART scheme is currently out to tender and the Abergavenny scheme is scheduled to go out to tender by August 2025.

9. The second reporting submission was submitted to NWSSP on 7th August and presented both schemes on track.

Single Response Vehicle specification design

10. Work is ongoing to consider the implementation requirements for the 10 x Maxus BEVs, procured as a pilot as part of the 2024/25 vehicle replacement programme and which are now nearing completion.. A range of considerations are being worked through including training, evaluation and operational practice, including service lines the vehicles will be used for. Whilst this work is being led by FinCoR there is a need for several teams to be engaged, and there is a strong operational and training input into the roll-out.

EV rapid charging infrastructure

11. Further to the installation of 3 rapid chargers in 2024/25, a programme of works had been put in place to further install 10 rapid chargers held in stock with BP Chargemaster, and to maximise the number of 7kw and 22kw chargers which could be installed from Pod Point stock.

12. However, in May 2025 BP Chargemaster confirmed that they would be withdrawing from the rapid charge fleet market, instead focussing on commercial aspects. Therefore, the company will refund the cost of the 10 rapid chargers, and the Trust does not now currently have a supplier. Given that this is the second time in 12months this situation has happened (the first with Pod Point), the team is exploring options to progress this further, being conscious of risks in entering a situation where this could happen for a third time.

13. Appropriate assurances have been sought from BP Chargemaster regarding the longer-term functionality of the chargers and back-office systems, and risks are noted after the three-year contract period, and the potential for this support to switch to an alternative supplier. This will be managed through the ongoing contractual support arrangements with the company.

14. Whilst options are being considered, the team continues to progress with the slower charger installations, with 10 sites identified for capacity scoping work.

15. It should be noted that limitations and challenges still exist with the Distribution Network Operator (DNO) in both timescales for installations (capacity of the network and infrastructure) and the costs of upgrades required to support further EV charging.

EV and infrastructure resources

16. As noted in a previous update, resources to support the roll out of EVs and supporting infrastructure remain a challenge. Consideration is being given to this within the Finance and Corporate Resources Directorate, recognising that any new resources or roles would straddle across teams.

ISO14001 Reaccreditation

17. Once again the Trust has successfully retained the internationally recognised ISO14001 certification. This achievement provides assurance that as an organisation we are effectively managing all aspects of environmental compliance. WAST continues to be the only UK ambulance Trust with this prestigious accreditation.

18. Audits are undertaken annually by an external assessor, focussing on one of our three regions. This year audits were completed at seven sites in the Central and West Region, with a system audit completed at Beacon House.

19. Two minor non-conformities (N/Cs) were raised during the audit and one opportunity for improvement (OFI) was highlighted:
    - Minor N/C – not all aspects of the Legal Register have been evaluated for compliance
    - Minor N/C – clinical waste consignment notes were not readily available at time of audit
    - Opportunity for improvement – review and enhance the scope of the Environmental Governance System to provide further clarity

    These items will be resolved prior to the next audit.

20. Although not raised as a Minor N/C there were some inconsistencies in the quality of COSHH registers and fire logbooks at stations. However, since the previous audit and COSHH non-conformities highlighted significant action has been taken by the Health and Safety Team.

21. There were no N/Cs raised regarding operational procedures at ambulance stations. The support of Operational staff during the audit was key to successfully retaining certification.

RECOMMENDATION: The Finance & Performance Committee is asked to NOTE this update.

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Estates Condition & Backlog Maintenance Update – September 2025

MEETING	Finance and Performance Committee
DATE	16 September 2025
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Richard Davies – Assistant Director Capital and Estates
CONTACT	Richard.davies16@wales.nhs.uk

EXECUTIVE SUMMARY

To provide the Committee with its annual update on:

- Estates and Facilities Performance Management System annual return (EFPMS)
- Backlog Maintenance values
- Backlog reduction plan.

Recommendation: The Finance and Performance Committee is asked to note this update.

KEY ISSUES/IMPLICATIONS

REPORT APPROVAL ROUTE

Finance and Performance Committee – 16th September 25

REPORT APPENDICES

Appendix 1: EFPMS return 2024-25 (iBabs reading room)

REPORT CHECKLIST

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

WELSH AMBULANCE SERVICES NHS TRUST
FINANCE & PERFORMACE COMMITTEE
Estates Condition & Backlog Maintenance Update
September 2025

SITUATION

1. This paper presents Finance and Performance Committee with the annual Estates and Facilities Performance Management System (EFPMS) report for 2024/25, for information.

2. It also provides an update on outstanding Backlog Maintenance.

BACKGROUND

3. The Trust is required to complete and return to NWSSP an annual review of the Trust' estate, its quality, compliance to statutory legislation and utilisation, called EFPMS.

4. This report also provides data on backlog maintenance costs for the Trust's estate portfolio, segregated by risk.

5. As the result of a previous internal audit (November 2023) a recommended action was to report backlog maintenance costs for high and significant risk to this Committee, to allow for Board level scrutiny, challenge, trend analysis and assurance.

ASSESSMENT

Internal Audit: Estate Condition

6. As was reported previously in November 2023, an Estate Condition Internal Audit was undertaken by NWSSP. The resulting assurance rating was limited assurance as this was an all-Wales audit of backlog maintenance across all NHS Wales, with a classification of medium priority and nine recommendations.

7. Five of these recommendations have been fully completed, with two addressing the need to update the Estates Strategic Outline Plan (ESOP), this has been re-scheduled to fall in line with quinquennial condition surveys, these are planned by the end of this financial year, once complete this data will assist to develop an updated Estates Strategic Outline Plan (ESOP). Other factors including likely capital availability and agreed timelines with Welsh Government over the receipt of such an updated document also feature here.

8. The remaining recommendation related to Board level oversight of backlog maintenance within the Trusts estate, which it was agreed would be undertaken in the first instance through an annual report such as this to the F&PC. Last year's update effectively therefore provided closure to this recommendation; however, an annual update will continue to be provided now to this Committee to seek to provide assurance where possible that the estates backlog maintenance is reducing, and monies are initially focused on higher levels of risk.

The NHS Wales Estates and Facilities Performance Management System (EFPMS)

9. The NHS Wales Estates and Facilities Performance Management System (EFPMS) encourages a disciplined approach to data collection, dissemination and review and supports strategic decision making at both a local and national level.

10. 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.

11. 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 uses a risk-based methodology for establishing and managing backlog maintenance, with condition rankings based on those given in 'Estatecode' (NHS Estates, 2002).

12. Physical condition surveys are completed every 5 years (quinquennial), and updated annually after completion of essential works, or as a result of disposal. These surveys determine building condition, including compliance with fire safety requirements and statutory safety legislation, and present those finding in condition ranking, A-DX, and produce risk rankings of Low, Moderate, Significant and High.

13. Backlog maintenance cost (backlog) is the cost to maintain assets in condition B or bring them up to condition B.

14. 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.

15. The 2024-2025 EFPMS report data has been collected (appendix A – see ibabs reading room). From inception 2002-2003 until 2023-24, the EFPMS report data has been compiled in regions and requested by NWSSP at the time of inception and has continued in this format ever since.

16. 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, in 2024-25 high has reduced by 7% and significant reduced by 39%. *See Table 1.*

Table 1: Backlog Maintenance Figures 2023-24 & 2024-25: EFPMS Returns

Cost to eradicate	2024-25	2023-24	Difference
High Risk Backlog	£230,077	£246,810	-£16,733
Significant Risk Backlog	£1,772,123	£2,919,040	-£1,146,917
Moderate Risk Backlog	£3,065,803	£3,853,246	-£787,443
Low Risk Backlog	£2,252,733	£2,737,305	-£484,572

17. This has been achieved by targeting the high and significant risks within the Estates strategy to include capital to replace several roofs as well as upgrading fire alarm systems and electrical system improvements.

18. Various Estates Facilities Advisory Board (EFAB) funded works have also helped improve the estate and target the funding appropriately. The funding for 2024-2025 has resulted in the former building on the Bryntirion site in Llanfairfechan becoming surplus and will be handed back to BCUHB.

19. The cost to bring all the estate up to condition B has slightly reduced, even despite inflation and the additional floor space. The percentage of the occupied floor area in physical condition A&B, plus Health & Safety compliance has increased, another reassuring indicator that our focus is showing some positive results.

Backlog Reduction Plan

20. As stated last year, the EFAB funding for 2024/25 has addressed and provided improvements to fire safety and gas storage facilities as well as the introduction of renewable technology to reduce carbon emissions across Wales.

21. As noted last year the monies secured to reduce some specific backlog issues have now been completed, namely;
    - Ty Elwy (atrium glazing replacement)
    - Merthyr Tydfil Ambulance Station (roof replacement)
    - Decarbonisation & backlog maintenance issues across the estate.

22. The Estates team also continue to use any and all available revenue funding to improve the working environments such as new kitchen facilities, decoration, flooring replacement, improved infrastructure (cabling and connectivity). For 2024/25 some 30 sites benefited from varying levels of investment.

23. As stated previously the estate is due its quinquennial surveys in 2025/26; at present a working group established to support this work has finalised the specification and plan to procure the services of surveyors for a 3 facet survey to gather condition data for the estate.

24. This data will be required to sense check current backlog data and to provide a baseline for a further 5 year cycle and develop an updated estates strategy (ESOP) for business cases for future capital investment, whether this be via all Wales or discretionary capital funding.

25. Backlog maintenance continues to reduce, all large sites posing major backlog maintenance issues and costs have been disposed of or were handed back to landlords, once this year's capital projects for Dolgellau, Bangor workshops and Monmouth are completed, backlog maintenance costs will be reduced further from the backlog maintenance figures above (table1).

RECOMMENDATION: The Finance & Performance Committee is asked to NOTE this update and the 2024/25 Estates Condition and Backlog Maintenance Report.

Agenda Item No.	15

REPORT TITLE

Risk Management and Board Assurance Framework

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	16 September 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of 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 seven risks that are relevant to Committee's remit.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF). All updates are highlighted in blue and show changes to the narrative, mitigating actions, controls, and assurances.

3. The more detailed description contained within the BAF (Annex 4) provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the scoring matrix (Annex 2).

4. Members can take assurance that each of the principal risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

5. The Executive Leadership Team (ELT) approved the principal risk activity on 27 August 2025 having considered the review of each risk undertaken throughout July and August 2025 by Risk Owners. There have been no material changes to the principal risks during this period.

6. **Risk 260** *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems* remains static at a score of 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations. The specific detail and planned mitigations of this risk will be considered in closed session of committee today due to the sensitive and security based nature of these and is not included in Annex 4.

7. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in open session in full transparency. However, members will note that the actions to address individual recommendations are not included in detail in the BAF extract. This is for reasons of sensitivity and security.

8. **Risks 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* at a score of 16 (4x4). Work is underway to consider repositioning the risk and a new approach to the way this is presented. The new approach separates controls, assurances and gaps into internal and external themes and categories; those that the Trust manages and those that it monitors. Each of the assurances against the controls will be described over three lines of assurance.

9. **Risk 623** *Failure to comply with Data Protection Legislation* remains unchanged at a score of 15 (3x5) and continues to be reviewed.

10. **Risk 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* remains unchanged this period and static at a score of 15 (3x5).

11. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* and **Risk 139** *Failure to Deliver our Statutory Financial Duties in accordance with legislation* remain unchanged at a score of 12 (3x4) during this period; however, the Executive Director of Finance and Corporate Services has foreshadowed that this risk is likely to increase in the near future given the financial position.

12. A **new Artificial Intelligence (AI) Risk** has been developed and approved for inclusion on the Corporate Risk Register, by the ELT, at a score of 16 (4x4) with a target of 8 (2x4). The full detail of the risk will be included in the Trust Board Risk Report for the next meeting on 25 September 2025 and for the November 2025 meeting of committee.

13. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the Risk Owner to describe the rationale for each of the risk ratings which is particularly important where ratings have remained static or increased.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance & Performance Committee is requested to:

1. Consider contents of the report including:

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

ADDITIONAL PAPER(S)

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

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

1. Annex 1 - Summary table
2. Annex 2 – Scoring Matrix
3. Annex 3 – Frequency of Risk review
4. Annex 4 - Board Assurance Framework

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
As detailed in the report.

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
27 August 2025	Executive Leadership Team

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	**IF** the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared **THEN** there is a RISK that the Trust's Incident Response will be suboptimal **RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	**20 (4x4)** →
NEW	Unauthorised or Inappropriate use of AI technologies	**IF** staff use Gen-AI tools such as ChatGPT, Co-Pilot or other AI enable platforms outside of approved organisational channels or without appropriate governance **THEN** information passed into, accessed by, or returned by the AI tools may breach information security and data protection controls, and use of the output may breach transparency, medical device, equality, Welsh Language and ethical requirements **RESULTING IN** potential breach of confidentiality and data protection law, data, damage to Trust, and non-compliance with other legislation, regulation and standards.		**16 (4x4)**
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in	Executive Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage		
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)** →
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	**IF** WAST fails to persuade JCC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Executive Director of Strategy Planning & Performance	**12 (3x4)** →
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Executive Director of Finance & Corporate Resources	**8 (2x4)** →

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ocal media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Risk ID 641	**The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident**	**Date of Review:**	**08/07/2025**	**TREND**	**20 (4x5)**
		Date of Next Review:	**08/08/2025**	➡	

IF the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	**THEN** there is a RISK that the Trust's Incident Response will be suboptimal	**RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.

	Likelihood	**Consequence**	**Score**
Inherent	**5**	**5**	**25**
Current	**4**	**5**	**20**
Target	**2**	**3**	**6**

IMTP Deliverable Numbers:

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Operations	**ASSURANCE COMMITTEE**	Finance & Performance Committee

Risk Commentary

Following the Manchester Arena Incident in May 2017, whereby twenty-two (22) innocent people were sadly killed, and the subsequent Public Inquiry (MAI), ambulance services across the UK have reviewed their ability to respond to a Major Incident. WAST has undertaken its own review and has identified sixty-eight (68) of the MAI recommendations as being pertinent to the ambulance service and/or multi-agency preparedness and response. Once these recommendations have been implemented then the risk will be mitigated to target; however, additional financial resources are required to do this.

As part of the Trust's ongoing commitment to deliver the necessary change against the MAI recommendations, a dedicated team was established in June 2023 to investigate and assure the Board that all necessary organisational processes were in place should an incident occur in Wales. Since the beginning of this project, significant progress has been made in addressing the recommendations (as identified in the 'Controls' section below) and the Trust is better prepared because of the work undertaken to date.

As part of the ongoing work, the Trust has completed a series of investigations and developed a series of 'Capability Reports' to demonstrate and explain where remaining challenges to an anticipated Major Incident could occur. The capability gaps identified are detailed in the below reports, which were shared with the Board, and are supported by a significant base of evidence produced as part of the 'R105' self-review process. The reports are:

- **R106 Capability Report**
- **Capability to Prepare**
- **Capability to Respond**
- **Capability of Specialist Assets**

The reports identify that a significant proportion of the MAI recommendations remain outstanding, and the Trust is unable to progress these further or fully implement the identified learning without financial support. The reports highlighted what is needed to complete or significantly progress twenty (20) MAI recommendations and forms the basis of the 'Gaps in Controls' and 'Actions' sections. Transitioning these gaps and actions across into the 'Controls' section when achieved will act as a longitudinal method of tracking progress of completion against the MAI recommendations, and the associated risk reduction as this occurs. If the Trust is unable to implement the MAI recommendations fully, there remains a risk to the public, the organisation, and commissioners in the event of a mass casualty incident.

This Board Assurance Framework (BAF) extract is supported by a more detailed appendix of itemised actions required to permit greater scrutiny of remaining gaps and actions, as well as a detailed repository of control measures that have been successfully implemented.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Forty-eight (48) of the pertinent MAI Recommendations have been implemented into WAST practice through the work undertaken to date.	1. MAI recommendations that have been marked as implemented by the EPRR MAI Project are authorised and ratified by Operations Senior Leadership Team and cascaded via the approved governance route (AAA) to ELT and Trust Board. This forms a documented governance route for rationale for completion and details of this are recorded in the EPRR share drive alongside evidence of compliance. Additional details of assurance are provided in the annex to this Corporate Risk. Ongoing monitoring and assurance of lessons learned is captured through BAU processes and the established debriefing/lessons learned process such as the Organisational Learning Spreadsheet.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Two (2) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated	1. Work is progressing against these recommendations as part of the ongoing MAI project. It is anticipated that these recommendations can be implemented without additional financial support. Regular updates on these four recommendations are provided through the regular 'touch point'

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	08/07/2025	TREND	20 (4x5)
		Date of Next Review:	08/08/2025	➡	

learning **(REF: MAI recommendations 26, 88).** These are not included in the R106 funding request.	meetings with EPRR HoS, ADO for National Operations & ED of Ops, with periodic updates to SLT that are then cascaded via the approved governance route.
2. Eighteen (18) outstanding MAI Recommendations that have been submitted to Trust commissioners via the 'R106' process as requiring financial support to implement the learning **(REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 108, 109, 117, 124).**	2. The outstanding recommendations are not able to be implemented independently by WAST and may remain unresolved until such time that additional financial resources and practical arrangements are in place to support this work. Trust commissioners have been notified of this via the formal R106 submission completed in August 2024.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implement the learning relating to forty-eight (48) recommendations identified in the MAI report as pertinent for WAST **(REF: Outstanding MAI recommendations 1, 26, 88, 111).**	Assistant Director of Operations, National Operations & Support	CLOSED	This programme of work is underway, with nearly all recommendations completed. 4 recommendations remain outstanding, with a plan in place to implement all these recommendations. May 25 – Progress report has been submitted to SLT and outstanding actions are now monitored through the risk register (Ref: 641). Submission to commissioners and further scrutiny sessions completed and awaiting commissioner outcome expected in August 2025.
2. Submit evidence to Commissioners demonstrating that additional funding is required to implement a further twenty (20) recommendations identified in the MAI report **(REF: MAI recommendation R106).**	Assistant Director of Operations, National Operations & Support	CLOSED	March 25- During March and April the Trust has engaged with commissioners on a series of scrutiny sessions to review content of submission for the MAI; following these scrutiny sessions it will be for the commissioners to formally respond to the Trust, determining next steps and any subsequent course of action. A formal submission of requirements has been submitted to commissioners for consideration and approval. Commissioners have been engaged with since early 2024 to raise awareness and facilitate early discussion. The Trust is awaiting a formal response to the submission. May 25 – Progress report has been submitted to SLT and outstanding actions are now monitored through the risk register (Ref: 641). Submission to commissioners completed and awaiting commissioner outcome expected August 2025.
3. Implement the necessary amendments to Trust infrastructure, resourcing level and equipment required to address the remaining recommendations once funding has been made available. (**REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 108, 109, 117, 124).**	Assistant Director of Operations, National Operations & Support	March 2029	An assortment of 20 proposals rests with commissioners at present. As these proposals are funded, capabilities gaps will be addressed and an associated reduction in the risk score can be expected. Some of these proposals may take several years to implement (e.g. a North Wales HART Unit) which is reflected in the target date. Other proposals could be accomplished in a much shorter timeframe if funded. Once the implementation of infrastructure, resourcing and equipment has occurred, WAST will either be compliant with the MAI recommendations, or, in some circumstances, may need to undertake further work to integrate the MAI learning into practice (e.g. once the EPRR Training & Exercising Team have established, they will then need to provide sufficient levels of exercising to comply with the exercising-related MAI recs).

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	11/08/2025	TREND	16 (4x4)
		Date of Next Review:	11/09/2025	➡	

IF	THEN	RESULTING IN
there is a lack of resources and available technology and infrastructure	there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	negative environmental and social impacts causing reputational damage

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers: 17, 18, 33

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary
Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board continue to meet. Noting some progress on positive movement to actions within the DAP. Recent progress is focussing on implementation of PHEV and BEV SRVs.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board	1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board. Next update will be **September** FPC meeting
2. Capital and Estates directorate lead support – Director of Finance (DOF)	2. Regular briefings to DOF
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.	3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps	4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. Next survey round to take place in 2025/26 which will inform the update of the Estates SOP. (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions	5. Fleet SOP shows move to ULEV vehicles. BJC 2025/26 details intention for move to EV for smaller and support vehicles**. Ambitions for futher decarbonisation of fleet to be included in 2026/27 Business Justification Case (currently in development)**
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
14. **Full engagement in Strategic Development Plan (SDP) refresh process undertaken by Welsh Government**	15. **WAST specific comments provided. Full engagement in support of influencing future SDP (and therefore DAP) actions.**
	External - Independent Assurance:

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	11/08/2025	TREND	16 (4x4)
		Date of Next Review:	11/09/2025	➡	

	• Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)	
4. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establishment of potential further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	Not needed. Action closed.	Workstreams were set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	March 2025 Ongoing programme of investment. Next phase to be complete by March 2026	Actions taken in line with investment provided to implement rapid charging by end of March 2025 at a small number of sites. Confirmed adequate charging provision for the replacement of 20 x PHEV and 10 x BEV in March/April 2025. This action is ongoing. Further consideration of the increasing resource requirements will be highlighted at the Transport Project Board, Decarbonisation Programme Board and through the Capital Management Board. Specific action in relation to development of investment plan was closed on the Audit Tracker in March 2025, given that this has been absorbed within other strategic investment plans.
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	March 2025 Ongoing programme of investment. Next phase to be completed by March 2026	Position remains that only vans can currently be purchased. This will be delivered by March/April 2025. Further PHEV SRVs and full BEV small NEPTS vehicles to be procured in 2025/26 for implementation by end March 2026.
4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level	Director of Corporate Governance / Board Secretary	Not being progressed	To be further discussed with relevant Directors. It is unlikely that a NED Champion role will be allocated in the near future.
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25 March 2026	Discussions ongoing regarding enhanced resource requirements to implement low carbon emission vehicles. Targeted Estate Fund (TEF) bids were submitted, and it has been confirmed that 3 of the 6 submitted projects have been supported. Work **is well underway on delivery of the** 2025/26 schemes.

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	07/08/2025	TREND	15 (3x5)
		Date of Next Review:	08/08/2025	➡	

IF a major incident or mass casualty incident is declared	THEN there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

IMTP Deliverable Numbers: 1, 5, 6, 7,14, 15, 24

Strategic Objective:

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q1 2024/2025

The challenges across the unscheduled care system**.** Handover lost hours in **June** were **15,278** and **July** were **12,561.** There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

After a thorough review and assessment of Risk 594 within the Corporate Risk Register at SLT on 02/10/2024, we propose reducing the risk score from 20 to 15 (likelihood from 4 to 3) due to the following reasons:

· Mitigation/Controls have been Implemented: We have several controls measures that directly address the identified risk and are content we have exhausted all opportunities for additional controls. These controls are embedded within the corporate risk register.

· Immediate Release Protocol: The revised version of the IR protocol v1.3 has been agreed and shared at COO group and published which has included the release schedule for ambulances at the declaration of an incident as set out below:

·50% of vehicles released within 10 minutes

· 75% of vehicles released within 20 minutes

· 100% of vehicles released within 30 minutes

· Monitoring and Review: We will continue to monitor the risk within the normal governance channels (SOT/SLT/ADLT etc) to ensure that mitigations are still in place and any emerging risks are promptly identified and addressed.

22/01/25 - In light of the critical incident declared earlier this month, a review of the risk scoring is scheduled for this at SLT on 11th February in the first instance and this will be updated following conversations.

March 25 – following review at SLT, it has been agreed to maintain the score as it stands currently.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services. V1.3 has been reviewed, updated and released (August 2024).
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v5.1 released in January 2025
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU. New version 3.3 released in December 2024.
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	07/08/2025	TREND	15 (3x5)
		Date of Next Review:	08/08/2025		

8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A
11. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans.	11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.	12. All Health Boards responded with assurance of plans except BCU.
13. Multi Agency Exercise to be arranged.	13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	07/08/2025	TREND	15 (3x5)
		Date of Next Review:	08/08/2025		

1. Review of Manchester Arena Inquiry	Assistant Director of Operations	**CLOSED**	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and JCC during Jan and Feb 2024, with the final outline case to ELT in March 2024. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024. 01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed, and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes. Jan 2025 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust, continues. We expect to complete all recommendations that do not rely on financial investment by the end of this financial year. To ensure the continued progression and completion of the recommendations with financial dependency (18 recommendations), a corporate risk has been developed for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework. As the risk progresses through the internal governance route, culminating in final approval at Trust Board in January 2025, there is an alignment of the outstanding MAI recommendations with a clearly defined business-as-usual framework, which will support the governance of capability gaps whilst awaiting financial decisions from commissioners and the implementation of necessary changes. Mar25 – Progress of MAI will now be reviewed within CRR 641. During March and April the Trust has engaged with commissioners on a series of scrutiny sessions to review content of submission for the MAI, following these scrutiny sessions it will be the commissioners to determine next steps and any subsequent course of action. May 25 – Actions complete subject to closure report to SLT with outstanding actions monitored through the risk register (Ref: 641). Submission to commissioners completed and awaiting commissioner outcome expected August 2025.
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	**CLOSED**	Immediate Release Protocol Developed and Released August 2024. Correspondence with Welsh Government remains ongoing. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th Feb 2024). Further follow up will be provided as MAI progresses. Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC. May25 – Further correspondence submitted to the NHS Executive dated 28 April 2025, highlights that plans remain untested in the context of a continued deterioration on handover delays.
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	**Q1 CLOSED**	May24 – LB will follow up with COO network on the sharing of their action cards to WAST. March 24 – This risk was discussed at both JCC management and in the COO meeting. May25 – The Trust has now exhausted its influence on this risk, and with further correspondence to NHS Executive in April 2025 highlighting the outstanding risk and untested plans, the Trust considers all actions closed.

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	11/08/2025	TREND	15 (3x5)
		Date of Next Review:	16/09/2025	➡	

				Likelihood	Consequence	Score
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	**THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	**RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: 1, 13, 14, 18, 19

Strategic Objective:

EXECUTIVE OWNER	Director of Digital Services	**ASSURANCE COMMITTEE**	Finance & Performance Committee

Risk Commentary

The consequences of this risk depend on the worst-case scenario which crosses of a number Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk, and should we demonstrate meeting Statutory Requirements even if a serious incident/event/failure arises evidence provided would reduce / mitigate against the consequences.

In March 2025 the Trust submitted a self-assessment under the Welsh IG Toolkit, and met or exceeded expectations in all areas, except for the Training & Awareness category (for which minimum expectations were not met.) **Last m**easured on the **29/07**/25, WAST had achieved **89.61**% compliance against an 85% target for statutory IG training. The Confidentiality Advisory Group (CAG), an independent body advising the UK's Health Research Authority on the use of confidential patient information in research projects, and the Secretary of State for Health for non-research uses, **require** organisations across NHS Wales to demonstrate compliance with legislation via the IG Toolkit, or risk requests for using sensitive patient information being rejected – **this compliance achievement helps protects** WAST's academic partnerships and reputation, strategic research endeavours, and patient data linkage initiatives should CAG support be pursued**, but must now be maintained until the Toolkit is submitted in March 2026**

If the Trust fails to meet the Minimum Expectations of the IG Toolkit, this highlights that the organisation may not be meeting its obligations under the accountability principle. The accountability principle places a responsibility on organisations to not only comply with the UK GDPR, but that they must also to be able to demonstrate compliance. If an organisation cannot show good data protection practices, it may leave them open to administrative fines (irrespective of a data breach), reputational damage and affect patients' trust in the organisation handling their data.

Recently, several projects have seen delays due to outstanding IG queries, late engagement with the IG team, and project scope change impacting data protection. These have been escalated and are being managed but demonstrate some risk still in the understanding and awareness of IG and data protection requirements and responsibilities of staff, despite the increase in training compliance. Several incidents remain under investigation, and there has been an increase in inappropriate use of social media.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Expertise: Data Protection Expertise: 2 x FTE Data Protection and Compliance Managers (DPCM); 1 FTE Information Governance Officer, 4 x FTE in the Cyber Security team	1. Two new permanent Data Protection and Compliance Managers have been in post since November 2024, bringing capacity of this skillset up to 3 x FTE.
2. Expertise: Permanent Data Protection Officer	2. Temporary Data Protection Officer responsibilities held by Head of ICT up to December 2024. A full-time, permanent DPO has been recruited, and the position has been filled since December 2024.
3. Documentation: Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments)	3. Procedure for auditing Welsh Clinical Portal usage (by WAST staff) updated (Jun24). Monthly Information Governance Steering Group which includes progress updates on: - DPC, DSA and DPIA reviews (I) IG Training IG Toolkit (System for providing a level of assurance of compliance (I)

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	11/08/2025	TREND	15 (3x5)
		Date of Next Review:	16/09/2025		

	Incident Reporting Accountability to ELT Development of reporting (dashboard) which supports IGSG, ELT and Finance & Performance Board Committee for scrutiny.
4. Documentation: Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy	4. Add: Template Model Data Processor Agreements and Data Sharing Agreements which are able to be produced when IG are engaged.
5. Ownership: Register of information assets and data flows (outdated)	5.
6. Awareness: Staff training on updated training module (Apr 2023)	6. Training compliance monitored monthly via IGSG (captured on ESR and LMS365)
7. Monitoring: Incident Reporting and management (DATIX)	7. Summary statistics reported monthly via IGSG and MIQPR
8. Monitoring: NIIAS (national intelligent integrated audit solution) for auditing access to personal information on national systems such as WCP and WDS.	8.
9. Awareness: Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	9. Regular publication of IG related comms: Lock screen image issued 04/24 in relation to WhatsApp and training. Lock screen image in relation to physical security as ongoing recurring screen. Digital Notice on Whatsapp issued 04/25. AI Guidance issued 01/25. Cyber & IG procurement guidance drafted and available on SharePoint and shared to ADLT. Information Governance Factsheet produced and shared to new users of WCP, WDS, and Secure File Share Portal (and as and when needed to other groups). Presentations on Data Breaches and DPIAs are provided to groups.
10. Collaboration: Proactive engagement outbound (not inbound to team)	10a. Regular comms issued across WAST in Q3 and Q4 of 2024/25, explaining the importance and encouraging uptake of IG Training – this included targeted messages to non-compliant individuals, and their line managers, and escalations to Executive level as required. 10b. Requests made for IG representatives to sit on project boards of critical workstreams and other Directorate forums, helping improve understanding, and collaboration, reducing risk of non-compliant go-lives or deliverables.
11. **Compliance: Trust meeting mandatory IG training compliance threshold of 85%**	**11. The Trust has seen increasing compliance for the past several months – this must now be maintained**
12. **Ownership: documented risk for physical security with mitigating action plan**	**12. This risk was approved by IGSG in June 2025 and will now pass through usual Trust risk management cycles.**
GAPS IN CONTROLS	GAPS IN ASSURANCE
1. **Succession Planning and appropriate capacity within the team to manage the incoming demand from across the Trust and wider NHS Wales system (particularly in respect to national data sharing)**	2. Expertise: Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan
2. Documentation: Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements, policies or procedures.	3. Documentation: Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could engage third parties and/or purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.
3. Documentation: Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.	4.
4. Ownership: New data, or new data processes which have either bypassed the controls or there are no information asset owners identified and therefore asset doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)	4. Ownership: Data Protection and Compliance Risks not fully realised. IGSG have approved the establishment of a sub-group to manage activities related to Information Asset Register and Ownership, however, due to vacancies and limited capacity in the IG team, this action will not be able to be progressed until January-25.
5. Awareness: Currently not meeting levels of IG staff training.	5. Awareness: Some data errors in ESR reporting for IG mandatory training has been identified, requiring manual effort to calculate Trust-wide compliance percentages.
6. Documentation & Awareness: Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase non-compliant IT systems.	

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	11/08/2025	TREND	15 (3x5)
		Date of Next Review:	16/09/2025		

7. Awareness: The Confidentiality Advisory Group (CAG) notified WAST (via DHCW) in June 24 that for organisations with a 23-24 IG Toolkit outcome of "standards not met", any CAG approvals for research & non-research requests are likely to be rejected unless the organisations' IG Toolkit Improvement Action Plan can be met and evidenced by Nov 24 (instead of the original target date for this plan of Mar 25).	7. Awareness: The Confidentiality Advisory Group (CAG) required WAST to submit an IG Toolkit Improvement Action Plan (via DHCW) with adjusted timelines to show a path to a "minimum standards met" position by Nov 24. The Improvement Action Plan has been adjusted and shared, and internal stakeholders notified. This will be managed by ADLT and monitored via IGSG. The Improvement Plan Actions were met by the Nov 24 deadline, satisfying the requirements of the CAG up to March 2025. However, with the IG Toolkit submission in March-25 this view will be reset, and WAST failed to meet the minimum expectations for Training and Awareness.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Ensure compliance with the appropriate IG level training across all Directorate and Departments a. Demonstrate a regular series of comms on IG and DP - complete b. Regular monitoring of training compliance through IGSG – evidence of ongoing c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached by March 2025. - **achieved in July 2025. This must now be maintained, and will be monitored for the next few months to ensure progress does not slip.** d. BAU on Siren training notices and specific guidance or advice – evidence of ongoing e. IG checklist to be complete for all projects, and DPIAs ahead of project design / development, and critically all go-lives to have IG approval	Leanne Smith	Q4 2024/25 Q2 2025/26	**IG training compliance required to meet 85% target. An Action Plan for training has been created, and a training needs analysis being progressed with L&D team.** **3d. Procedures, such as audit of Welsh Clinical Portal usage, has been updated.** **Previous actions: April 2024** - Lock screen issued in relation to WhatsApp and training, refreshed 06/24. **May 2024** - Siren notice drafted for ELT. Jan 2025 - AI guidance issued. **Mar 2025** - Cyber & IG procurement guidance in development. Evidence that regular comms is being published, and so action complete, and assurances added to Controls. **May 2025** - Ongoing comms on the importance of early engagement with IG to ensure legal required documents and risk assessment are completed will continue to be raised across forums. **Jun 2024 -** Paper to ADLT seeking support for increased awareness & training compliance **Mar 2025 -** Direct contact to individuals who have been non-compliant for a significant period of time, with escalation through their line management structures as required. **Latest actions: July 2025 - Letters have been issued to individuals and training is requested to be completed by end of August 2025.** **Several potential data breach incidents remain under investigation, and there has been an increase in inappropriate use of social media by staff – further work is required to give confidence in Trust compliance beyond threshold met.**
2. Report on physical security to IGSG – working with fleet and estates team	Leanne Smith and Aled Williams	Q2 2024/25 Q1 2025/26 **Complete**	Reporting to IGSG and FPC. A risk has been drafted by members of IGSG, and agreed, but action plan now to be developed in collaboration with Fleet & Estates. **The draft risk was approved by IGSG in July 2025 and will now progress through risk management cycles.**
3. Assurance of "standards met" for all IG Toolkit requirements: gain support of all Directorates' leadership to complete the IG Toolkit Improvement Action Plan and ensure compliance for the **2025/26** IG Toolkit submission	Leanne Smith	Nov24 for IG Toolkit Improvement Action Plan (with evidence to CAG) - complete March 2025 for 24/25 submission complete	Paper to ADLT Jun24 seeking support for completion of the IG Toolkit improvement action plan. To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov24. The improvement plan actions resulting from the "standards not met" results of the 23/24 IG Toolkit submission were met ahead of the Nov24 deadline to

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	11/08/2025	TREND	15 (3x5)
		Date of Next Review:	16/09/2025		

		March 2026 for 25/26 submission **– ahead of plan**	assure CAG, however, to meet the requirements of the 24/25 IG Toolkit submission, further improvement work was required before the Mar25 deadline. All other improvement work was complete, and the submission of the IG Toolkit in March 2025 saw standards either met or exceeded in all categories except for Training & Awareness, where standards were not met due to the IG Training compliance being below the 85% target. **Progress on the 2025/26 improvement plan, to support the IG Toolkit submission in March 2026 is approximately 74% complete.**

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	19/08/25	TREND	12 (3x4)
		Date of Next Review:	14/11/2025	➡	

IF	THEN	RESULTING IN
IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Strategy, Planning & Performance	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

From the 01 April 2024 111, emergency ambulance and Ambulance Care are all commissioned by the Joint Commissioning Committee (JCC). This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.

The ambition is appropriate levels of patient safety and good working conditions for our staff across the 111 pathway, emergency ambulance care pathway and Ambulance Care pathway. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at **12,560 (Jul**-25). The **extant WG policy is 15 minute handover i.e. no lost hours, with the current WG focus on W45 i.e. 45 minute handover, which equates to approximately 6,000 hours. There is evidence of some material handover lost reduction in some health boards in recent months.** The Trust had almost recruited up to the modelled 153 CHARU FTEs and connected to this focus on CHARU productivity. CHARU UHP in January 2025 was 94%, which is the highest it has achieved, and it is now seeking to close the remaining gap through the recruitment of fully qualified paramedics **(current levels are staff in post to establishment for CHARUs at 85%).** The Trust delivered on its ambition to switch on key aspects of its clinical model transformation programme in 2024/25, in particular, rapid clinical screening, which included the recruitment of 28 FTES to EMSC (clinical navigators) and increasing the APP establishment to APPs. The 111-call abandonment rate has stabilised post 111 CAS go live, as the Trust has recovered it call handler staff in post to establishment**, but the commissioned levels are not sufficient to achieve the 5% abandonment rate**. Ambulance Care performance is stable**, but the level of capacity management plan cancellations are running at c20,000 per annum**. For 2025/26 the Trust's ambitions are set out its IMTP, with a particular focus on delivering further aspects of the clinical model transformation programme: the re-categorisation of 999 demand (purple, red and RCS0 etc), remote clinical care and further see & treat capability. The EA skills mix (no funding from JCC) and Manchester Area Inquiry (MIA) submission are also important considerations.

The JCC is now becoming more established. Current areas of focus for the JCC (in relation to WAST) include: a scrutiny exercise on the Trust's MAI submission, consideration of the Future Vision for NEPTS, the Emergency Ambulance Measures Review Task Group and Ambulance Patient Handover Improvement Implementation (APHID) Group. The Trust has received the JCC commissioning intentions 25/26 for 111, 999 and NEPTS, which are reflected in the Trust's IMTP. These are broadly supportive of the Trust's ambitions, but the financial pressures within NHS Wales means that there's limited financial support of the Trust's ambitions.

CONTROLS	ASSURANCES
	Internal & External Management (1st Line of Assurance)
1. JCC/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC meetings	1. Minutes of meetings and a standard agenda item
2. JCC and its 2 sub-committees established as a forum to discuss WAST's strategy (sub-committees currently under review as part of move into JCC).	2. Minutes of meetings and a standard agenda item**. Sub-committees now established, with report on commissioning arrangements to July Finance & Performance Committee.**
3. Weekly catch up between Interim Director of 111 & Ambulance Commissioning /CEO	3. Meetings are diarised every week
4. Collaboration between JCC and WAST on specific projects e.g.	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
~~5. Monthly CASC Quality and Delivery Meeting established (currently paused as part of move into JCC).~~	5. Note: this meeting has stopped and needs to be restarted, probably in a slightly different form. **It is anticipated that this meeting will restart in its new form in the second half of 2025/26.**
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly
7. Commissioning intentions.	1. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111 Wales and expected to be approved by Mar-24 JCC (approved).

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	19/08/25	TREND	12 (3x4)
		Date of Next Review:	14/11/2025	➡	

8. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	2. Minutes of meetings and a standard agenda item
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.	1. A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees. **There is no provider brief going at this time, but the Trust does produce extensive slides for the bi-monthly WG Integrated Quality, Planning & Delivery accountability meeting, with the Director of Commissioning for Ambulance & 111 Services in attendance.**
2. Governance coordination between the JCC and WAST to be improved.	2. Identified need for a governance meeting between JCC and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. This will be further reviewed as the JCC goes live in April-24 (period of transition likely to extend through Q1). This has lapsed at this time, but request to re-establish it sent to commissioners. This meeting has now been restarted **and continues to function**
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	3. Ministerial direction on handover reduction with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements. The Welsh Government target is no waits > one hour, which equates to 7,000 lost hours. WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition. **This has led to the W45 initiative i.e. 45 minute handover, with handover lost hours in July 2025 being their lowest since July 2021. A continued focus by health boards is required to achieve the ambition and sustain it.**
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	4. Strategic demand and capacity review completed and reported to Finance & Performance Committee. Whilst the Director of 111 & Ambulance Commissioning is sighted on the findings, it has not yet been formally reported to the JCC, in agreement with WAST. **This remains the case.**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence JCC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	As part of 25/26 budget setting process in Q4 this year (18/03/25 F&P Committee). IMTP now with WG awaiting approval, timeframe dependent on WG.	26.06.24 Funding for a 32 FTE APPs secured for 2024/25 and 23.2 FTEs into Integrated Care. 06/08/24 WAST briefing on evolved CRM and 2023 EMS Demand & Capacity Review to JCC Board Development session in Aug-24. 21/01/25 ELT has considered the draft commissioning intentions and responded to the Director of Commissioning. 14/04/25 Commissioning intentions built into the Trust's 2025-28 IMTP with FTE additionality planned in the remote care and see & treat space. MAI scrutiny exercise on-going. Skills Mix Task & Finish on-going, due to report into ELT end of April 2025, no funding from JCC expected. **19/08/25 Q1 commissioning intentions reported to JCC sub-committee. EA Skills Mix paper went to ELT in June 2025 with further paper on 27/08/25.**
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	IQPD 12/02/25 The APHID is a WG led group, so timeframe is dependent on WG.	26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour. 26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust. 21/01/25 The Trust experienced 26,000 ambulance unit hours lost to hospital handover in December 2025, in line with its prediction, but significantly above the WG target of no waits over one hour, which equates to approximately 7,500 hours.

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	19/08/25	TREND	12 (3x4)
		Date of Next Review:	14/11/2025	➡	

			14/04/25 WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition. **19/08/25 This has led to the W45 initiative i.e. 45 minute handover, with handover lost hours in July 2025 being their lowest since July 2021. A continued focus by health boards is required to achieve the ambition and sustain it.**
3. Increased understanding of NEPTS by JCC	Executive Director of Strategy Planning and Performance	02/08/23 30/06/24 20/08/24 21/02/25 Timeframe tbc, subject to current discussion with JCC.	16/04/24 Workshop arranged for April 2024 (completed). 26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee. 06/08/24 The WAST briefing to the JCC Board Development session in Aug-24 includes coverage of five workstreams, one of which is Health Transport, which includes NEPTS and UCS. 21/01/25 Consideration of Future Vision for NEPTS at JCC meeting on 21/02/25. 14/04/25 On-going discussions with JCC on the Future Vision, in particular, next steps, with possible development of a service blueprint connected to the Vision. **18/08/25 The Director of Commissioning for Ambulance & 111 Services has raised a concern about the level of capacity management cancellations and asked for options for mitigating these, which the Trust is currently exploring.**
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date Timeframe for establishing a replacement for CASC Assurance is a JCC responsibility.	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the development of the IMTP. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control. 16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment. 26/06/24 Request to commissioners to re-establish this meeting. 06/08/24 Meeting now re-established. 21/01/25 Meeting continues to operate. 14/04/25 Meeting continues, but the monthly CASC Assurance meeting has lapsed and needs to be restarted. This is anticipated by the Trust but is dependent on the Director of 111 & Ambulance Commissioning discussion with JCC colleagues. **19/08/25 As above, the WG IQPD meeting operates bi-monthly and provides an accountability mechanism, but the Trust is anticipating the resumption of a JCC mechanism in the second half of the year.**
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	**Q2 24/25 onwards**	15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2. 14/04/25 The CMT Programme Engagement Plan (PEP) is live. During Q4 the programme has undertaken a series of priority engagement sessions with key clinical groups and stakeholders on the Clinical Services Model proposals. The next steps are to undertake wider system engagement. **19/08/25 System wider engagement was undertaken as part of the phase one Ambulance Performance Framework go live on 01 July, with further communications planned as part of the phase 2 go live on 01 December 2025.**

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	13/08/2025	TREND	8 (2x4)
		Date of Next Review:	13/11/2025	➡	

IF the Trust does:	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
• 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		

	Likelihood	Consequence	Score
Inherent	3	4	12
Current	2	4	8
Target	2	4	8

IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary: **To End of July 2025 of the** 2025/26 **financial year.** The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG year to date to Month **4** of the 2025/26 Financial Year. The score is consistent with that of Qtr. **1 2025/26** due to presenting an opening balanced financial plan for 2025/26, full allocation of the £8.5m savings delivery target **and YTD overachievement**. **Reported Financial position is currently in deficit (£0.246m) but revised year end forecast is one of balance.** It must be noted though that clear monitoring of the savings target for 25/26 will be needed as this is £2m increase from the 24/25 delivered position and also the **recovery of the current deficit albeit in a** challenging financial climate for all public sector organisations. .

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings **and delegation of budgets**
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place	4. Diarised dates for ADLT, FPC and Trust Board and monthly reports with budget managers**. EFG meeting held late July with another planned for August 25**
5. Welsh government reporting	5.
6. Monthly review of savings targets	6. ADLT updated via core reporting. Reporting included in finance reports to committees and boards
7. Regular review monitoring and challenge via WAST and JCC / CASC quality and delivery meeting with commissioners.	
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	a) Monthly monitoring returns to ADLT, ELT **(EFG)** and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, ELT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. JCC management meetings and at bi-monthly meeting with JCC Finance teams
	8. Capital meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	13/08/2025	TREND	8 (2x4)
		Date of Next Review:	13/11/2025		

	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Lack of formalised service contracts between Commissioner and WAST as a commissioned body	1. None identified.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/25 31/03/26	Supported financial plan included in IMTP for 25/26. At least bi-monthly meetings with WAST finance and JCC in relation to contract payments.
2. Embed a transformative savings plan and ensure organisational buy in	Savings subgroup / FSP	31/03/25 31/03/26	The Financial Sustainability Program (FSP) will continue to be a key vehicle for the Trust to monitor and develop its savings program. Over delivery was achieved for the 24/25 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 25/26 £8.5m savings plan before the start of the financial year.
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/25 31/03/26	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/25 31/03/26	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales. Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.

AGENDA ITEM No	**16**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER – June 2025 (2025/26 Q1)

MEETING	Finance and Performance Committee (FPC)
DATE	16 September 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Lisa Trounce, Head of Compliance & Assurance
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the 2025/26 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 2025/26. In an attempt to manage volume of papers, the tracker has been added to the Ibabs reading room filtered to the actions assigned to this committee for oversight. This digital reading room hosts documents for additional information, not essential for scrutiny or decision-making. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided to those without access to Ibabs upon request.

Internal Audit

4. At the beginning of 2025/26 Quarter 1, there were a total of 26 open internal audit recommendations relevant to the Committee: four from 2023/24 (one of which is reported in the committee's private session), and 22 from 2024/25.

5. Of the 26 open audit recommendations, nine were due for closure in quarter, and 17 not yet due.

6. By end of quarter, four of the nine (44%) audit recommendations due for closure during Quarter 1 were confirmed as completed, plus one other that was not due for completion until quarter 2. Of these five closed recommendations, three met their original deadlines, and two after one deadline revision.

7. New revised deadlines have been proposed for five recommendations which remain open: two from 2023/24 both on their second and therefore last revision date: one relating to a recommendation reported in the private session, and the other relating to 111 Commissioning (advisory review only). Due to unavoidable absences the Audit, Risk and Assurance Committee were unable to discuss these revised dates with the Director of Digital or Assistant Director. Members are therefore requested to seek assurance that these final revised dates are appropriate and realistic.

8. New revised deadlines have been proposed for two recommendations from 2024/25, one on its first revision relating to Estates Assurance Energy Management, and the other on its second and therefore last revision date relating to Data Quality. Members are referred to paragraph 11 below regarding this audit.

External Audit

9. There were two external audit recommendations (both relating to the 2023/24 '*Review of Cost Saving Arrangements*' audit) relevant to the Committee that remained open at the start of 2025/26 Quarter 1. One was due for closure in quarter, and the other due for closure during Quarter 2.

10. By the end of quarter, the audit recommendation due for closure in quarter was confirmed as completed, and the other on track for closure during Quarter 2.

Commission Note: 2024/25 Data Quality Internal Audit Monitoring

11. In line with a commission note from the previous meeting, the Committee agreed to proactively monitor the actions generated from the **2024/25 Data Quality Internal Audit** over the coming year, via the future Audit Tracker report. As such these recommendations have been drawn out within this report:

11.1 Position at the start of 2025/26 Quarter 1

There were five open recommendations related to the 2024/25 Data Quality Internal Audit, all of which were on first revised dates.

11.2 Closed in Quarter

Of these five open recommendations: two were due to be completed in quarter, and the remaining three due in Quarter 2. Two of the five open recommendations were closed during Quarter 1: one that was due in quarter (005-24/25), and the other (010-24/25) that was not due until Quarter 2.

11.3 New Revised Dates

A new revised date of October 2025 has been applied to recommendation 003-24/25 – one of the two audit recommendations that were due in quarter.

11.4 Action 03-24/25 ~ Assessing and Improving Digital Literacy

This recommendation was originally due for completion in December 2024. A review of available data quality training has been undertaken and found suitable. Instead the team were collaborating with the Education Team to develop awareness raising materials. These materials were likely to include: a process flow map highlighting areas where data plays a crucial role in WAST services. This work was anticipated to be completed in July 2025, and would be presented to the Information Governance Steering Group in August 2025. However, a second and therefore final revised date of October 2025 has been applied to afford time for full deployment. **This recommendation remains open (due for closure in Quarter 3).**

11.5 Action 04-24/25 ~ Information Asset Register

During July 2025, Information Asset Ownership (IAO) was actively progressed by the Information Governance Team, this work included: finalising the terms of reference for the IAO Group (owners identified), updating the IAO handbook, and adopting/adapting an NHS England IAO e-Learning module. **This recommendation remains open (on track for closure in Quarter 2).**

11.6 Action 05-24/25 ~ Automated Data Quality Tool

The recommendation was for management to consider implementing an automated data quality tool to support automated audit processes, reduce manual effort and enhance data accuracy and consistency.

A review of available tooling was conducted resulting in recommendations being made by the Data Quality Team to install an available module (DQS) onto existing SQL Server. This had been passed to ICT to deploy to the test environment at a non-critical time for the Trust (i.e. post the July 2025 Clinical Model Transformation 'go live') for Data Quality to then fully test and deploy. **This recommendation was closed in quarter.**

11.7 Action 09-24/25 ~ Development and Reporting of Data Quality KPIs

It was recommended that data quality KPIs be developed and reported. A monthly KPI report, which includes a placeholder for data quality metrics, is submitted routinely to the IGSG. Progress on this action was delayed due to extended recruitment timelines for the two Data Quality posts. Both new

appointees joined the organisation in March 2025, and a revised date of July 2025 was applied in Quarter 4 to allow sufficient time for development of appropriate metrics.

A first iteration of metrics was now available for some aspects of WAST Data Quality. These have been produced for Information Governance Steering Group, and were scheduled to appear in the report at the July 2025 meeting. **This recommendation remains open (on track for closure in Quarter 2).**

11.8 Action 10-24/25 ~ Development of a Standard Reporting Template

The recommendation was for a standardised reporting template for data quality matters. With recent investment in the Digital Directorate and the appointment of two new Data Quality experts, work had been progressing toward building a more resilient Data Quality Team. Development of the reporting template has been assigned to the new Data Quality Assurance Manager and was expected to be completed by the first revised date of May 2025.

A new Data Quality Issues form had been developed, used at the Insight and Data Services (IDS) Change Advisory Board (CAB) in June 2025. Feedback has been received from group members, and further iterations of the form were expected. However, this demonstrated progress towards a more resilient data quality function and practice within WAST. **This recommendation was closed in quarter.**

12. The current version of the tracker is now open for Directorate review for actions due in July, August and September 2025. These updates will then be reported to the Committee at its meeting in November 2025.

RECOMMENDATION

13. The Committee is requested to:

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

(b) Note the progress reported against the remaining 2024/25 Data Quality Internal Audit recommendations.

KEY ISSUES/IMPLICATIONS
As set out above.

REPORT APPROVAL ROUTE

2025/26 Q1 Audit Tracker updates presented to the Assistant Directors Leadership Team: shared via email on 100725 and in the meeting held on 040825.

REPORT APPENDICIES
Tracker 2.0 25-26 Q1 (April - June 2025) – FPC 160925 [in reading room] • Annex 1 – Audit Tracker 2.0 – 25-26 Q1 Internal Audit Actions (Up to 2023/24) • Annex 2 – Audit Tracker 2.0 – 25-26 Q1 Internal Audit Actions (2024/25) • Annex 3 – Audit Tracker 2.0 – 25-26 Q1 External Audit Actions (2023/24)

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

Agenda Item No. 17

REPORT TITLE

Committee Cycle of Business Monitoring and Priorities Report 2025/26

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	16 September 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Steve Owen, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report updates the Committee on progress against the priorities it set for 2025/26 and progress against the agreed cycle of business for the Committee.

2. During the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2025 and will be tracked quarterly.

3. The Committee's cycle of business was approved by the Committee in May 2025. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

4. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports.

5. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

6. The Committee is to note that the Waste Management update report, scheduled for this meeting, has been deferred to the meeting of the committee in January 2026. There is no time critically to its receipt in September 2025. Finally, the committee's priorities and progress against them is as follows:

Priority	Progress
A focus on financial sustainability	• It has been agreed that an update on the Financial Sustainability Programme will be received at every other meeting of the Committee, and as such has been programmed for July 2025, November 2025 and March 2026 (on the Committee Cycle of Business).

A focus on Clinical Model Transformation performance	• Updates on the progress will be included as part of the Integrated Medium Term Plan (IMTP) Progress Report which is received at every meeting of the Committee. An update regarding progress of the 'Phase 2 Ambulance Performance Framework and Wait 45 Assurance Update will be provided prior to go live.
A focus on resilience including information security	• The Information Governance (IG) Report received at every meeting highlight ongoing efforts to enhance information governance and data protection within the Trust, addressing both compliance requirements and operational challenges. • As part of the additional funding secured for the Digital Directorate in 2024/25 and 2025/26, a significant recruitment programme is underway to strengthen capacity.
A focus on the progress of the Manchester Arena Inquiry recommendations	• The Committee will continue to receive progress updates against the Manchester Arena Inquiry (MAI) with regards to the recommendations required via the Operations Directorate report received at each meeting. • The feedback of the discussion from the MAI Internal Audit report received at the Audit, Risk and Assurance Committee on 02 September 2025 is included at this meeting. • An update on the progress of recommendations is given in the closed session of this meeting.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Committee is requested to NOTE the update.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
The Committee is requested to receive the following: 1. FPC Cycle of Business Monitoring Report – September 2025

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
16 September 2025	Finance and Performance Committee

PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2025-26											
TERMS OF REFERENCE NOTED IN RED TEXT											
Refreshes of 2030 Delivering Excellence	STB	Ad Hoc							EDSPP	Endorsement	
Refreshes of long term plans	STB	Ad Hoc							EDSPP	Endorsement	
Long term plans organogram	STB	Annually							EDSPP	Assurance	
IMTP for following year	STB/ELT/Board	Annually							EDSPP	Endorsement	Earmarked for potential preliminary discussions n November/January
IMTP Progress Report	STB/Board	Each meeting							EDSPP	Endorsement	
Annual revenue budget	ELT	Annually							EDOF	Endorsement	SFI 4.2.2 - Boards must approve balanced revenue and capital plans before the start of the year
Annual capital budget (closed)	Capital M'ment Board	Annually							EDOF	Endorsement	
Financial report	ELT	Each meeting							EDOF	Assurance	Financial sustainability report may be included in this report or separately throughout the year; year end report May
Year end M12 report (same time as M1 in new year)	ELT	May meeting							EDOF	Assurance	
IMTP financial plan	STB/ELT	Annually							EDOF	Endorsement	
Financial Sustainability Report	TBC	Every other meeting							DPC	Assurance	Agreed at 18.09.23 FPC to include quarterly updates on the Financial Sustainability Programme (FSP) for future meetings.
Business cases over £500K	TBC	As required							EDOF	Endorsement	FPC to consider if individual business cases should return for PIR, and if so at what time, Bangor Workshop at July meeting.
Reporting to be developed in 2025/26	TBC	TBC							EDSPP	Assurance	Head of Commercial being appointed in 2025. Reporting to be confirmed following appointment.
Value Based Healthcare Report	TBC	Every other meeting							EDQN	Assurance	May: VBH deferred to future meeting, in line with update from LW, EDON. Note, this item will now be presented at a BDD
Review of Ambulance Service Indicators	**TBC**	**Bi-annually**							EDSPP	Assurance	**Added in 20062025; reporting placement to be agreed.**
Report on commissioning	TBC	TBC							EDSPP	Assurance	Scope of this element to be developed - see Note 1
QPMF update report	QPMF Steering Group	Bi-annually							EDSPP	Assurance	QPMF Benefits map went to July meeting
Monthly Integrated Quality Performance report	ELT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	ELT/Board Committees	Annually							EDSPP	Endorsement	May: review of metrics not taken, discussions held at BDD.
Annual HART KPI report (Open Session)	TBC	Annually							EDO	Assurance	HART Internal Audit Nov 22 recommended annual reporting of HART KPIs which was accepted. See July FPC on HART KPIs
Metrics for digital systems infrastructure	TBC	Three times a year							DD	Assurance	
Commissioning arrangements	ELT	Consider annually							EDSPP	Endorsement	Consider potential annual report to be developed
Demand and capacity reviews	ELT	Ad Hoc							EDSPP	Endorsement	
Estates Condition and Backlog Maintenance Update [EFPMS Data/Report]	TBC	Annually							EDOF	Assurance	This was added in as a future requirement (following initial receipt in September 2024) by CorGov.
Decarbonisation Update	Decarb Programme Board	Every other meeting							EDOF		Progress also against WG action plan and Trust Plan; metrics in development. Annually to include update on waste management.
Waste Management Update	Decarb Programme Board	Annually							EDOF	Assurance	Annual update aligned with Internal Audit recommendations. First report in September 2023.
Sustainability Report	Decarb Programme Board	Annually							EDOF	Assurance/Endorse	Annual update - as per Manual for Accounts.
Fire safety annual report	ELT/Board	Annually							EDOF	Assurance	Timing of annual report TBC (annual compliance report was presented in Jan 24). By exception reporting outside cycle.
Fire safety exception report	TBC	Periodically as required							EDOF	Assurance	By exception outside of annual report
WG Annual Emergency Planning Report (Open session)	ELT/Board	Annually							EDO	Assurance	Report provides for compliance with Civil Contingencies Act 2004; exercises carried out; learning from incidents/exercises/debriefs.
Incident Response Plan Report [closed session]	ELT	Annually							EDO	Assurance	Externally reported - See Note 2
Business Continuity Annual Report (Open Session)	ELT	Annually							EDO	Assurance	See Note 2
Cyber Resilience and Cyber Security Reporting	TBC	TBC							DD	Assurance	Reporting developing in 23/24 - start off at 3 times a year reporting; intention to bring to every meeting if possible.
Information Governance Toolkit	IGSC	Annually							DD	Assurance	
Information Governance Report	IGSC	Each meeting							DD	Assurance	
Policies for review and approval	Policy Group	Ad Hoc							BS	Approval	
Board Assurance Framework	Board	Each meeting							BS	Assurance	
Corporate Risk Register	Board	Each meeting							BS	Assurance	
Audit Recommendation Tracker	ADLT	Each meeting							BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc							Relevant Director	Assurance	
STANDARD ITEMS											
Quarterly operations update	TBC	Each meeting							EDO	Information/Discussion	Only received in quarter, not at every FPC meeting (if it would otherwise be a duplicate from previous meeting)
GOVERNANCE											
Committee effectiveness review and annual report	Audit/Board	Annually							Board Sec.	Approval	
Review of Terms of Reference	Audit/Board	Annually							Board Sec.	Approval	
Committee cycle of business refresh	N/A	Annually							Board Sec.	Approval	
Committee Cycle of Business review	Audit/Board	Each meeting							Board Sec.	Approval	
Committee Review of Annual Priorities	None	Every other meeting							Chair	Review	
SUB-GROUPS											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
PROMPTS											
External Reports	N/A	Ad Hoc							TBC	TBC	UEC report presented 21 July 2025

EDOF - Exec Director of Finance and Corporate Resources
EDO - Exec Director of Operations
EDSPP - Exec Director of Strategy, Planning and Performance
DD - Digital Director
BS - Board Secretary
EDQN - Exec Director of Quality and Nursing
DP - Director of People

Key: Pre-agenda setting
Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing

Key: Post-agenda setting
Presented as cycled
Ah hoc / item considered - not programmed
Item deferred
Reporting developing

1	**Commissioning**	Review of commissioning standards is the commissioning intentions met as part of IMTP. AQIs published monthly to EASC. Key AQIs included in the 28 KPIs.
2	**Emergency Preparedness**	The Trust is classed as a category one responder under the Civil Contingencies Act (2004) and as a result there is a legislative obligation for us to address 6 key responsibilities, which are - Assess local risks and use this to inform emergency planning - Put in place emergency plans - Put in place Business Continuity Management arrangements - Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency - Share information with other local responders to enhance co-ordination - Co-operate with other local responders to enhance co-ordination and efficiency CCA Part one devolved to Wales. WAST is a category 1 responder under the Civil Contingencies Act (2004) and Regulations (2005). Category 1 responders are required to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies in both the response and recovery phases, and has a duty to ensure business continuity plans are in place. Trust is working towards ISO22301 accreditation. Internal Audit on Major Incidents - September 2022 AC - raised F&P review of incident response plan when reviewed next. NHS Emergency Planning Annual Report: return that is signed by JK. Comes to FPC for assurance. One element is assurance the board has received the IRP which FPC does on behalf of the board. WG compile into an All Wales return and in September 2024 the first meeting of the Health Executives for EPRR has been called by WG and likely they will be the primary reviewer of these. Incident Response Plan Report: WG report accompanied by assurance that Incident Response Plan (IRP) in place and approved by ELT. SBAR includes detail of staff training in place, compliance levels, and resourcing for assurance; list of plans that underpin IRP are in date and regularly reviewed. IRP provides guidance and support to commanders on a range of incidents. Taken in closed session due to sensitivities. Business Continuity Annual Report: SBAR to include compliance with CCA 2004 if not included in WG annual report and compliance under policy; list of plans that underpin BCP are in date and regularly reviewed; staff training in place, compliance levels and resourcing for assurance if not included in IRP report above; exercises carried our and planned; learning from incidents/exercises/debriefs.