

Bundle Trust Board (Open Session) 31 July 2025

Agenda attachments

- ITEM 00 Agenda
- ITEM 0 Open Trust Board Agenda 31 July 2025-en-cy-C
- 0 11:00 – OPENING ITEMS
- 1 Chair's Welcome, Apologies and Quorum
- 2 Declarations of Interest
 - ITEM 02 Board Member Register of Interests as at 13 July 2025
- 3 Minutes of the Last Meeting:
 - 3.1 29 May 2025
 - 3.2 26 June 2025
 - ITEM 03 2025-05-29 Draft Trust Board Minutes
 - ITEM 03.1 2025-06-26 Draft Trust Board Minutes 1
- 4 Action Log & Matters Arising
 - ITEM 04 Action Log
- 5 11:05 – Chair and Vice Chair's Report
 - ITEM 05 Chair's and Vice-Chair's Report to Board – July 2025
- 6 11:15 – Chief Executive's Report
 - ITEM 06 CEO REPORT TO TRUST BOARD JULY 2025
- 7 11:35 – Staff Story – Mark Horrigan (Clinical Navigator), Experience on the Clinical Model Transformation
 - Follow up on previous staff/patient story – Dylan's story*
- 8 12:05 – Actions to Mitigate Avoidable Patient Harm
 - ITEM 08 Patient Harm Realtime Mitigations July 2025
 - ITEM 08.1 Patient Harm MoC 0250715(1)
- 9 12:25 – Risk Management and Board Assurance Framework
 - ITEM 09 Executive Summary Risk Management Report Trust Board 310725
- 10 12:35 – Monthly Integrated Quality and Performance Report (MIQPR), June 2025
 - ITEM 10 MIQPR June 2025, TB July 2025
 - ITEM 10.1 Appendix 1, MIQPR TB June 2025
- 10.1 12:50 – LUNCH
- 11 13:30 – Integrated Medium Term Plan (IMTP) Delivery/Assurance – Update
 - ITEM 11 Executive Summary – IMTP Delivery & Assurance Q1 2526
 - ITEM 11a Appendix A – 2506 – CMT Programme Highlight Report
 - ITEM 11b Appendix B – IMTP Delivery & Assurance Report Q1 Jun 25
- 12 13:40 – Finance Update Month 3, 2025/26
 - ITEM 12 Finance Report Month 3 25-26 Final
 - ITEM 12.1 Month 03 2025-26 – Welsh Ambulance Services NHS Trust – Monitoring Return – FINAL
- 13 14:00 – WAST Urgent and Emergency Care – Arrangements for Managing Demand Report
 - ITEM 13 UEC Arrangements for Managing Demand – WAST
- 14 14:20 – Governance Report
 - 14.1 *WASPT Terms of Reference 2025/26*
 - ITEM 14 Governance Report – July 2025
 - ITEM 14.1 Final WASPT Terms of Reference 2025-26 for approval 30052025 – clean
- 15 14:30 – Board Committee Reports
 - 15.1 03 June 2025 and 15.1a 11 July 2025 – Remuneration Committee
 - 15.2 13 June 2025 Quality, Patient and Experience Committee
 - 15.3 24 June 2025 – Audit, Risk and Assurance Committee (To include HOIA opinion)
 - 15.4 21 July 2025 – Finance and Performance Committee (The BC Annual report and the EPRR annual report are both available in the reading room)
 - ITEM 15.1a Remuneration Committee AAA Report 3 June 2025 Public Board
 - ITEM 15.1b Remuneration Committee AAA Report 11 July 2025 Public Board
 - ITEM 15.2 Quest Committee Highlight Report June 2025 – Extraordinary
 - ITEM 15.3 Audit Committee AAA Report 24 June 2025

ITEM 15.3a WAST_Fin05.2 WAST_ Final HOIA Opinion and Annual Report_2024-25 v1_for Trust Issue

ITEM 15.4 Finance and Performance Committee Highlight Report July 2025

15.1 CONSENT ITEMS

16 Minutes of Board Committee

1 May 2025 – Audit, Risk and Assurance Committee

20 May 2025 – Finance and Performance Committee

ITEM 16.1 2025-05-01 ARAC OPEN Minutes

ITEM 16.2 2025-05-20 OPEN F and P Minutes

17 20 May 2025 JCC Highlight Report

ITEM 17 2025.07.15 PUBLIC APPROVED JCC

17.1 14:50 – CLOSING ITEMS

18 Reflections and Summary of Decisions/Actions

19 Any Other Business

20 Exclusion of the press and members of the public.

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

22 Acronyms

ITEM 22 Acronyms 2025

Length of Meeting: 03:55		Agenda Status:		OPEN TRUST BOARD - 31 July 2025					Deadline for papers: 22 July 2025	
Time	Mins allotted	Agendum	Title	Item for	Item requested by	Format	Paper prepared by	Item presented by	Colleagues to cc	
OPENING ITEMS										
		1	Chair's Welcome, Apologies and Quorum	Information	Standing	Verbal	n/a	Chair		
		2	Declarations of Interest	To State Conflicts	Standing	Verbal	n/a	Chair		
11:00	00:05	3	Minutes of the Last Meeting: 3.1 29 May 2025 3.2 26 June 2025	Approval	Standing	Paper	n/a	Chair		
		4	Action Log & Matters Arising	Discussion	Standing	Paper	n/a	Chair		
11:05	00:10	5	Chair and Vice Chair's Report	Information	Standing	Paper	CorGov	Chair, Vice Chair	Alex Payne	
11:15	00:20	6	Chief Executive's Report	Assurance	Standing	Paper	CEO Office	CEO	Keith Ellingham	
11:35	00:30	7	Staff Story - Mark Horrigan (Clinical Navigator), Experience on the Clinical Model Transformation	Assurance	Standing	Verbal	Ops	Mark Horrigan		
		7.1	Follow up on previous staff/patient story - Dylan's story	Assurance	Standing	Verbal	QPSE	Liam Williams	Leanne Hawker	
FOR APPROVAL, ASSURANCE AND DISCUSSION										
12:05	00:20	8	Actions to Mitigate Avoidable Patient Harm	Assurance	Standing	Paper	SPP	Rachel Marsh	Rachel Marsh, Hugh Bennett	
12:25	00:10	9	Risk Management and Board Assurance Framework	Assurance	Standing	Paper	CorGov	Trish Mills	Julie Boalch	
12:35	00:15	10	Monthly Integrated Quality and Performance Report (MIQPR)	Assurance	Standing	Paper	SPP	Estelle Hitchon	Hugh Bennett, Mark Thomas, Georgia Tizzard, Melanie O'Connor	
12:50	00:40	LUNCH								
13:30	00:10	11	Integrated Medium Term Plan (IMTP) Delivery/Assurance - Update	Assurance	CoB	Paper	SPP	Estelle Hitchon	Alex Crawford	
13:40	00:20	12	Finance Update Month 3 , 2025/26	Assurance	Standing	Paper	FinCor	Chris Turley	Edward Roberts	
14:00	00:20	13	WAST Urgent and Emergency Care – Arrangements for Managing Demand Report	Assurance	CoB	Paper	CorGov	Fflur Jones	n/a	
14:20	00:10	14	Governance Report 14.1 WASPT Terms of Reference 2025/26	Approval	As required.	Paper	CorGov	Trish Mills	Alex Payne, Steve Owen	
		15	Board Committee Reports:	Assurance	Standing	Paper	CorGov			
14:30	00:20	15.1	3 June 2025 and 11 July 2025 - Remuneration Committee	Assurance	Standing	Paper	CorGov	Colin Dennis		
		15.2	13 June 2025 - Quality, Patient Safety and Experience Committee	Assurance	Standing	Paper	CorGov	Bethan Evans		
		15.3	24 June 2025 - Audit, Risk and Assurance Committee (To include HOIA opinion)	Assurance	Standing	Paper	CorGov	Peter Curran		
		15.4	21 July 2025 - Finance and Performance Committee	Assurance	Standing	Paper	CorGov	Jayne Beeslee		
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.										
14:50	00:00	16	Minutes of Board Committees: 1 May 2025 - Audit, Risk and Assurance Committee 20 May 2025- Finance and Performance Committee	Information	Standing	Paper	CorGov	Chair		
		17	20 May 2025 JCC Highlight Report	Information	Standing	Paper	CorGov	Chair		
CLOSING ITEMS										
		18	Reflections and Summary of Decisions/Actions	Discussion	Standing	Verbal	n/a	Chair		
		19	Any Other Business	Discussion	Standing	Verbal	n/a	Chair		
14:50	00:05	20	Exclusion of the press and members of the public. To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).	Approval	Standing	Verbal	n/a	Chair		
		21	Date & Time of the Next Meeting: 25 September 2025	Information	Standing	Verbal	n/a	Chair		
		22	Acronyms	Information	Standing	Paper	n/a	Chair		
14:55	03:55	CLOSE								

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Non-Executive Director, Chair of Finance and Performance Committee
Peter Curran	Non - Executive Director, and Chair of ARAC
Colin Dennis	Chair of the Trust Board
Bethan Evans	Non-Executive Director, Chair of QuEST
Estelle Hitchon	Director of Partnerships
Ceri Jackson	Non - Executive Director, Vice Chair and Chair of PCC
Rachel Marsh	Interim Chief Executive
Trish Mills	Director of Corporate Governance/Board Secretary
Chris Turley	Executive Director of Finance and Corporate Resources
Fflur Jones	Audit Wales

Hyd y cyfarfod: 03:55		Statws yr agenda:		BWRDD ADORED YR YMDDIRIEDOLAETH - 31 Gorffennaf 2025					Dyddiad cau ar gyfer papurau: 22 Gorffennaf 2025	
Amser	Munudau a neilltuwyd	Agendum	Teitl	Eitem ar gyfer	Cais am eitem gan	Fformat	Papur a baratowyd gan	Eitem wedi'i chyflwyno gan	Cydweithwyr i'w cynnwys	
EITEMAU AGORIADOL										
		1	Croeso gan y Cadeirydd, Ymddiheuriadau a Chworwm	Gwybodaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd		
		2	Datganiadau o Fuddiant	I ddatgan gwrthdaro	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd		
11:00	00:05	3	Cofnodion y Cyfarfod Diwethaf: 3.1 29 Mai 2025 3.2 26 Mehefin 2025	Cymeradwyaeth	Sefydlog	Papur	Ddim yn berthnasol	Cadeirydd		
		4	Cofnodion Gweithredu a Materion sy'n Codi Cam gweithredu 16- Adroddiad Partneriaethau ac Ymgysylltu Mai 2025. Estelle Hitchon i gynnwys mapio rhanddeiliaid a nodi bylchau dylanwad strategol yn yr adroddiad nesaf.	Trafodaeth	Sefydlog	Papur	Ddim yn berthnasol	Cadeirydd		
11:05	00:10	5	Adroddiad y Cadeirydd a'r Is-gadeirydd	Gwybodaeth	Sefydlog	Papur	CorGov	Cadeirydd, Is-gadeirydd	Alex Payne	
		6	Adroddiad y Prif Swyddog Gweithredol Camau Gweithredu - 6.1 Rachel Marsh i rannu'r personâu gyda Rhiannon Beaumont-Wood i gael adborth a barn. Cam Gweithredu 6.2 Jason Killens i rannu deialog o'r cyfarfod sydd ar ddod gyda'r Ysgrifennydd Cabinet ynghylch Trais ac Ymosoddedd yn erbyn staff	Sicrwydd	Sefydlog	Papur	Swyddfa'r CEO	PRIF SWYDDOG GWEITHREDOL	Keith Ellingham	
11:35	00:30	7	Stori Staff - Mark Horrigan, Trawsnewid y Model Clinigol	Sicrwydd	Sefydlog	Ar lafar	Ops	Peter Brown		
		7.1	Dilyn i fyny ar stori staff/claf flaenorol - stori Dylan	Sicrwydd	Sefydlog	Ar lafar	QPSE	Liam Williams	Leanne Hawker	
EITEMAU AT GYFER CYMERADWYAETH, SICRWYDD A THRAFODAETH										
12:05	00:20	8	Camau i Liniaru Niwed Cleifion y Gellir ei Osgoi Cam Gweithredu 9 - Cydymffurfedd â Rhyddhau ar unwaith: Awgrymwyd cynnwys y pwnc hwn yn yr Agenda ar gyfer cyfarfod nesaf Grŵp Gorchwyl a Gorffen Ysgrifennydd y Cabinet i fynd i'r afael â'r heriau sy'n gysylltiedig â Cheisiadau i rhyddhau ar unwaith a'u heffaith ar niwed i gleifion, a'i fod yn cael sylw dyledus a'i integreiddio i'r ymdrechion gwella ehangach.	Sicrwydd	Sefydlog	Papur	SPP	I'W GADARNHAU	Rachel Marsh, Hugh Bennett	
12:25	00:10	9	Rheoli Risg a Fframwaith Sicrwydd y Bwrdd	Sicrwydd	Sefydlog	Papur	CorGov	Trish Mills	Julie Boalch	
12:35	00:15	10	Adroddiad Ansawdd a Pherfformiad Integredig Misol (MIQPR)	Sicrwydd Cymeradwyaeth	Sefydlog	Papur	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Georgia Tizzard, Melanie O'Connor	
12:50	00:40	CINIO								
13:30	00:10	11	Cyflawni/Sicrwydd y Cynllun Tymor Canolig Integredig - Diweddariad	Sicrwydd	CoB	Papur	SPP	Rachel Marsh	Alex Crawford	
13:40	00:20	12	Diweddariad Cyllid Mis 3 , 2025/26	Sicrwydd	Sefydlog	Papur	FinCor	Chris Turley	Edward Roberts	
14:00	00:20	13	Gofal Brys a Gofal Mewn Argyfwng WAST – Adroddiad Trefniadau ar gyfer Rheoli'r Galw	Sicrwydd	CoB	Papur	CorGov	Fflur Jones		
14:20	00:10	14	Adroddiad Llywodraethu 15.1 Cylch Gorchwyl WASPT 2025/26	Cymeradwyaeth	Yn ôl y gofyn.	Papur	CorGov	Trish Mills	Alex Payne, Steve Owen	
		15	Adroddiadau Pwyllgorau'r Bwrdd:	Sicrwydd	Sefydlog	Papur	CorGov			
		15.1	3 Mehefin 2025 - Y Pwyllgor Tâl Cydnabyddiaeth	Sicrwydd	Sefydlog	Papur	CorGov	Colin Dennis		
14:30	00:20	15.2	13 Mehefin 2025 Y Pwyllgor Ansawdd, Cleifion a Phrofiad	Sicrwydd	Sefydlog	Papur	CorGov	Bethan Evans		
		15.3	24 Mehefin 2025 - Pwyllgor Archwilio, Risg a Sicrwydd (I gynnwys barn HOIA)	Sicrwydd	Sefydlog	Papur	CorGov	Peter Curran		
		15.4	21 Gorffennaf 2025 - Y Pwyllgor Cyllid a Pherfformiad	Sicrwydd	Sefydlog	Papur	CorGov	Jayne Beeslee		
EITEMAU CYDSYNIAD										
Mae'r eitemau sy'n dilyn er gwybodaeth yn unig. Os bydd aelod yn dymuno trafod unrhyw rai o'r eitemau hyn gofynnir iddo hysbysu'r Cadeirydd fel y gellir neilltuo amser i wneud hynny.										
14:50	00:00	16	Cofnodion Pwyllgorau'r Bwrdd: 1 Mai 2025 - Y Pwyllgor Archwilio, Risg a Sicrwydd 20 Mai 2025 - Y Pwyllgor Cyllid a Pherfformiad	Gwybodaeth	Sefydlog	Papur	CorGov	Cadeirydd		
		17	20 Mai 2025 Adroddiad Uchafbwyntiau'r Cyd-bwyllgor Comisiynu	Gwybodaeth	Sefydlog	Papur	CorGov	Cadeirydd		
EITEMAU CAU										
		18	Myfyrdodau a Chrynodeb o Benderfyniadau/Camau Gweithredu	Trafodaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd		
		19	Unrhyw Fater Arall	Trafodaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd		
14:50	00:05	20	Gwahardd y wasg ac aelodau'r cyhoedd. Gwahodd y wasg a'r cyhoedd i adael y cyfarfod oherwydd natur gyfrinachol y busnes sydd ar fin cael ei drafod (yn unol ag Adran 1(2) o Ddeddf Cyfrff Cyhoeddus (Mynediad i Gyfarfodydd) 1960).	Cymeradwyaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd		

	21	Dyddiad ac Amser y Cyfarfod Nesaf: 25 Medi 2025	Gwybodaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd
	23	Acronymau	Gwybodaeth	Sefydlog	Papur	Ddim yn berthnasol	Cadeirydd
14:55	03:55	CLOI					

PRIF GYFLWYNWYR

Enw	Swydd
Jayne Beeslee	Cyfarwyddwr Anweithredol; Cadeirydd y Pwyllgor Cyllid a Pherfformiad
Peter Curran	Cyfarwyddwr Anweithredol a Chadeirydd ARAC
Colin Dennis	Cadeirydd Bwrdd yr Ymddiriedolaeth
Bethan Evans	Cyfarwyddwr Anweithredol, Cadeirydd QuEST
Estelle Hitchon	Cyfarwyddwr Partneriaethau
Ceri Jackson	Cyfarwyddwr Anweithredol, Is-gadeirydd y Bwrdd a Chadeirydd PCC
Rachel Marsh	Cyfarwyddwr Gweithredol Strategaeth, Cynllunio a Pherfformiad
Trish Mills	Cyfarwyddwr Llywodraethu Corfforaethol/Ysgrifennydd y Bwrdd
Chris Turley	Cyfarwyddwr Gweithredol Cyllid ac Adnoddau Corfforaethol

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				
BEESLEE, Jayne	Non-Executive Director * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Member of the Royal College of Nursing	Non-Financial Professional	2007				
		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				
BROOKS, Lee	Executive Director of Operations	Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006				
		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				
		Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021				
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	Company Director - Action for Children [04764232]	Directorships	01 February 2021				
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022				
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021				
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021				
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022				
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024			
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024				
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024			
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303]	Directorships	01 March 2024				
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024				
		DENNIS, Colin	Chair of Trust Board and Non-Executive Director * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015	January 2025	
				Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
Company Director - Citizen Treasury Vehicle Ltd	Directorships			04 September 2017				
Chair - North Devon Homes	Position in Charity or Voluntary Organisation			01 October 2021	January 2025			
Company Director - North Devon Homes	Directorships			01 April 2022				
Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation			26 March 2024				
Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships			26 March 2024				
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	Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024				
		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 - Glynconel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
Company Director - The Mountains Property Ltd	Directorships	09 December 2024				
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 Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Position in Charity or Voluntary Organisation Non-Financial Personal	15 July 2024 01 January 2025		
JACKSON, Ceri	Non-Executive Director & Vice Chair of the Trust Board * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	Chief Executive	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019	31 May 2025	
		Emeritus Professor - Swansea University	Non-Financial Professional	31 May 2025		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	Director of People	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	Director of Culture Change	Nil Declaration				
MARSH, Rachel	Executive Director of Strategy, Planning and Performance	Nil Declaration				
MILLS, Patricia (Trish)	Director of Corporate Governance/ Board Secretary	Nil Declaration				
PARRY, Hugh	Trade Union Partner	Nil Declaration				
ROWAN, Hannah	Non-Executive Director * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	Director of Digital Services [appointed 26.09.2023]	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
		Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	Executive Director of Finance and Corporate Resources	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	Trade Union Partner	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
WILLIAMS, Liam	Executive Director of Quality and Nursing [from 01 August 2022]	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		



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Welsh Ambulance Services
University NHS Trust

**MINUTES OF THE OPEN MEETING OF THE WELSH AMBULANCE SERVICES
UNIVERSITY NHS TRUST BOARD, HELD on THURSDAY 29 MAY 2025
MEETING HELD AT THE CARDIFF MAKE READY DEPOT AND VIA TEAMS**

Meeting started at 09:30

PRESENT:

Colin Dennis	Non-Executive Director and Chair of the Board
Jason Killens	Chief Executive
Rhiannon Beaumont-Wood	Non-Executive Director
Lee Brooks	Executive Director of Operations
Peter Curran	Non-Executive Director
Professor Hutchings	Non-Executive Director
Estelle Hitchon	Director of Partnerships and Engagement
Ceri Jackson	Vice Chair and Non-Executive Director
Carl Kneeshaw	Director of People
Angela Lewis	Director of Culture Change
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Hannah Rowan	Non-Executive Director (Virtual)
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Marcus Viggers	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

ATTENDEES:

Sarah Harland	Corporate Governance Officer
Alex Payne	Corporate Governance Manager

APOLOGIES:

Jayne Beeslee	Non-Executive Director
Bethan Evans	Non-Executive Director
Angela Mutlow	Llais
Hugh Parry	Trade Union Partner
Damon Turner	Trade Union Partner

44/25

WELCOME AND APOLOGIES FOR ABSENCE

The Chair reiterated that the Board meeting was part of the overall scrutiny and assurance process with much of the detailed work undertaken in the Committees, that met prior to the Trust Board, and that Committee AAA highlight reports, which featured later in the agenda, together with committee minutes, all added to the overall assurance and scrutiny process.

Welcome and Apologies:

The Chair welcomed all to the meeting, apologies were received from Jayne Beeslee, Bethan Evans, Hugh Parry and Damon Turner.

Declarations of Interest:

The Board noted that all declarations of interest were formally recorded on the Trust's Register of Interests and no new declarations were declared.

Minutes

The minutes of the Board meetings held on 27 March 2025 and 7 May 2025 were confirmed as correct record.

Action Log

Action 24/25 - *The Chair asked that future reports include a narrative on the progress of and feedback from the Cabinet Secretary's Ambulance Patient Handover Improvement Implementation (APHID) Group which was addressing handover delays.* Details were contained in the Actions to mitigate avoidable harm report – Action closed.

The Board RESOLVED TO:

- (1) Note the declarations of interest on the Trust's Register of Interests.**
- (2) Note the apologies of Jayne Beeslee, Bethan Evans, Hugh Parry and Damon Turner.**
- (3) Approve the minutes of 27 March 2025 and 7 May 2025.**
- (4) Note the closure of the action as described.**

45/25

CHAIR AND VICE CHAIR'S REPORT

The report was presented as read.

The Chair congratulated the Chief Executive Jason Killens on his appointment as CEO of the London Ambulance Service.

The Board RESOLVED TO note the update.

Jason Killens presented the report and drew attention to the following areas:

1. The WAST way, a leadership management development programme, has launched, and the NHS Wales Compassionate Leadership pledge was signed.
2. Violence and Aggression Against Staff: Media coverage highlighted a 15% increase in violence and aggression against staff. Meetings with health secretaries were planned to seek support in this matter going forward. Jason Killens agreed to share dialogue from the upcoming meeting with the Cabinet Secretary regarding Violence and Aggression against staff.
3. A national roster review for Non-Emergency Patient Transport Services (NEPTS) was underway to modernise working patterns.
4. Refurbishments for clinical contact centres in Central and West and North Wales were completed.
5. Clinical Transformation Model (CMT): There was ongoing work on the CMT which included task and finish group meetings.
6. Digital Front End: Introduction of a virtual agent (Chatbot) on the 111 website was expected to go live by the end of June 2025. Jonny Sammut elaborated on further detail.
7. There had been a very successful stroke study day for pre-registration students at Swansea. Andy Swinburn added that feedback from staff had been positive.
8. HSJ Digital Awards: The team has been shortlisted for HSJ Digital Awards, with results expected on 26 June.
9. There has been a significant impact on maternity care led by the team, including updates to triage protocols. Liam Williams added that the Trust has seen continual improvement in this area a result of the investment made.
10. Supreme Court Ruling on Definition of a Woman: The CEO recently issued a statement to reassure staff and service users, emphasising respect for differences and was awaiting national guidance on the court ruling.

Rhiannon Beaumont-Wood sought clarification on the target audience for personas and the Trust's involvement with Public Service Boards (PSB). Rachel Marsh explained that the personas were used to describe the model to patients, making complex changes easier to understand and agreed to share them for further feedback. In terms of PSB membership, which the Trust was a member of one, Estelle Hitchon

outlined further details of the PSB and advised the Trust does not have the capacity to service the current 19 PSB.

The Chair commended all those involved in the seamless move of the contact centres from Bryn Tirion to Ty Elwy.

Members held a discussion on the use of drones for situational awareness and research on delivering defibrillators to remote communities.

The Chair referred to the introduction of the new Head of Research and the importance of strengthening the research team. Andy Swinburn provided further information on the successful applicant.

Lee Brooks addressed the Manchester Arena Inquiry question by explaining the rationale behind the four actions that have slipped.

The Board RESOLVED TO note the update.

47/25 QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions received from the public.

48/25 PATIENT STORY

Lucie Jones presented the distressing story given by Dylan's parents, Mr and Mrs Cope. Dylan was a nine-year-old boy who tragically died in December 2022 from sepsis. An investigation led by Aneurin Bevan University Health Board examined Dylan's care leading up to his death, involving NHS 111 Wales. In December 2022, Mr Cope contacted 111 when call volumes were at their highest recorded level.

Dylan had experienced severe abdominal pain, initially suspected to be appendicitis, but later diagnosed as having flu, following a hospital assessment. Dylan was subsequently discharged from hospital but when his condition worsened, his parents contacted NHS 111 Wales (111) for advice. They experienced a significant delay for their call to be answered, with an incorrect estimated call answer time being provided. A call handler assessed Dylan's call, which resulted in the outcome for a clinician call back. While waiting for a call back from a clinician Dylan's condition rapidly deteriorated. Dylan became critically unwell and following emergency surgery at the University Hospital of Wales in Cardiff, Dylan tragically died several days later from a ruptured appendix and sepsis.

There were multiple failings and missed opportunities which may have prevented Dylan's death, and Members were moved both by the circumstances that led to his death, and the drive that Mr and Mrs Cope have to ensure that his legacy has meaningful change at all levels.

Members noted that the Trust has implemented a new call handling system that ensures sepsis indicators were flagged and prioritised appropriately. This included additional checks and balances to prevent similar failures which were important evidence based system change that the Trust has made. Liam Williams added that the Trust was collaborating with Mr and Mrs Cope, the Sepsis Trust, and Aneurin Bevan Health Board to increase sepsis awareness and understanding.

Liam Williams noted new Putting Things Right (PTR) regulations and updates were underway by the Welsh Government. This tragedy has guided the Trust on necessary adjustments and potential flexibility.

Lucie Jones explained that the main message conveyed today was that we need to hear Dylan's voice. Mr and Mrs Cope have reiterated that Dylan's voice can no longer be heard directly, so this must be shared as if through his own words.

Liam Williams mentioned that whenever there was a significant incident, processes were immediately initiated to support staff, be they call takers, dispatchers, or clinicians. In this instance, the primary individual was a call taker who received strong support.

Jason Killens thanked Dylan's parents for bringing this story to the meeting. He deeply appreciated their courage and commitment, acknowledging the challenges faced after the loss of Dylan.

Follow up on previous staff/patient story - Volunteer Car Service

Lee Brooks updated on the Volunteer Driver Programme. There were 168 drivers, with 25 involved in the oncology pilot. The operations assistant coordinates with control teams and cancer centres to match patients with volunteers. A funding proposal to extend this role will be presented to senior leadership in early June.

The Board RESOLVED TO note the story and the follow up from the previous staff/patient story.

49/25

ACTIONS TO MITIGATE AVOIDABLE PATIENT HARM IN THE CONTEXT OF EXTREME AND SUSTAINED PRESSURE ACROSS URGENT AND EMERGENCY CARE

Jason Killens updated members on the following areas:

1. Approximately 500 patients per month were estimated to have come to harm due to delays in the community or while waiting to enter emergency departments.

2. There has been a significant reduction in the number of patients with no send or cancelled ambulance calls, indicating better management of these cases within the Trust.
3. The number of cases successfully managed remotely has increased to 22%, up from 5% a few years ago. This improvement was attributed to changes in the Clinical Transformation Model.
4. Despite a 16% increase in red call activity over the last financial year, performance has remained relatively static, suggesting improved efficiency and effectiveness in managing the increased demand.
5. Sickness absence rates have decreased, with EMS field operations at around 6%, down from 14% post-pandemic. This improvement has positively impacted the capacity to respond to patients.
6. A reduction in emergency ambulance hours lost to handover delays has led to improved response times, with the amber median response time decreasing by 48 minutes in a recent week.

Rhiannon Beaumont-Wood sought further information on the palliative care expertise and how it was integrated into the broader palliative care approach. Andy Swinburn explained that palliative care paramedics rotate, spending half their time with health boards. They work closely with palliative care teams, enhancing multidisciplinary efforts with their unique expertise.

Following a discussion on Immediate Release Directive compliance, it was suggested to request to include this topic in the agenda for the next meeting of the Cabinet Secretary's Task and Finish Group to address the challenges related to Immediate Release Directive requests and their impact on patient harm.

Ceri Jackson inquired about the reasoning behind the decrease in no send calls and the proactive strategy for handling identified risks. Rachel Marsh clarified that the decision was made in partnership with health boards to more effectively manage patient risk and enhance outcomes.

Peter Curran questioned the green RAG rating for the average jobs per shift metric, given its correlation with handover delays and avoidable harm. Rachel Marsh clarified that the rating was based on the metric being higher than the two-year average but acknowledged the need for further improvement.

The Board RESOLVED TO:

- (1) **NOTE that the Trust's clinical model transformation is beginning to take effect.**
- (2) **NOTE the continued level of avoidable patient harm in the 999-emergency care pathway.**

- (3) NOTE the strategic imperative to continue delivering the clinical model transformation programme at pace, supported by early tactical planning for winter 2025/26.**

50/25

RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Trish Mills provided an overview of the risk management report, highlighting the following points:

1. The full risk management document was placed in the iBabs reading room to reduce the volume of papers for the meeting. It was also available as supplementary material on the website.
2. There were no changes in risk scores for this reporting period, and all risks were reviewed. The changes were marked in blue type in the document.
3. The internal audit on risk management focused on the Board Assurance Framework (BAF) and resulted in a reasonable assurance rating with only one recommendation.
4. In terms of internal governance, several deep dives were taking place, including a review of the Trade Union relationship risk and the staff welfare risk both of which would be presented to the Welsh Ambulance Services Partnership Team Committee.
5. The Executive Leadership Team (ELT) reviewed the first draft of the updated risk 223 (*the Trust's inability to reach patients in the community causing patient harm and death*), which focused on what can be managed and monitored.

The Board RESOLVED TO:

Consider and discuss the contents of the report and:

- (1) Receive assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees.**
- (2) Note the ratings and mitigating actions for each principal risk.**

51/25

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – MARCH 2025 / APRIL 2025

Rachel Marsh drew the Board's attention to the following areas:

1. In terms of the data quality issues, the revised data definitions have been confirmed by the Commissioners, and internal reports will start using these definitions from mid-June.
2. There was a significant increase in the level of consult and close cases, which was a positive development.
3. The 111 service was not currently performing at the desired level and there was an increased focus on improving this service.

4. Currently there were challenges faced by the NEPTS (Non-Emergency Patient Transport Service), including increased demand, inefficiencies, and rising costs.

Ceri Jackson noted that the Trust received 1279 job applications during this period, with 777 from underrepresented groups, which seemed unusually high.

Carl Kneeshaw stated it was found that the numbers recorded in the system were accurate as per the method of recording and self-declaration. However, he had observed an increase in the number of overseas applicants submitting multiple applications across various jobs and organisations, which inflated the figures for job postings. This trend was consistent with other organisations, particularly in the public sector. Consequently, this increase impacted the data related to diversity and inclusion backgrounds, which showed in the statistics.

The Board RESOLVED TO:

Consider the March 2025/April 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 was required, or**
- c) **Further remedial actions were to be undertaken through Executives.**

52/25

**INTEGRATED MEDIUM TERM PLAN (IMTP) DELIVERY/ASSURANCE
END OF YEAR REPORT**

Rachel Marsh provided an overview of the IMTP assurance report, highlighting the scale of achievements from the previous year. Rachel added that the assurance report sets out the end of Q4 position. A number of deliverables at directorate level remain AMBER (in progress, off track) with some deliverables having rolled over into the 2025/28 IMTP. However, there were a number of key pieces of work COMPLETE and progress on track (GREEN) in a number of areas where delivery is across multiple years of the plan.

Peter Curran mentioned two specific issues discussed at the Finance and Performance Committee: The Head of Commercial post, which was out for advert again and the Clinical Model Transformation (CMT) programme, which were rated Amber due to documentation and workload pressures. Rachel Marsh advised that the Head of Commercial post had been readvertised. Rachel added that work was ongoing to improve the CMT programmes documentation.

Rhiannon Beaumont-Wood sought further clarity on the Trust's investment in mental health response and an update on the recent evaluation. Liam Williams advised that Welsh Government have recently published their mental health strategy, and he updated members on the role of the Trust in supporting this strategy. Liam noted

the recent evaluation that had been undertaken by the Trust to consider what was required from the Trust's resources.

The Board RESOLVED TO:

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

53/25

FINANCIAL PERFORMANCE MONTH ONE AND MONTH TWELVE

Month One

Chris Turley explained that the update presented to the Board was the first Financial Performance Report of the 2025/26 financial year. A summarised presentation of the position was presented to the Finance and Performance Committee on 20 May 2025.

Chris Turley highlighted that the financial performance continued to be on track, reflecting the Trust's strong track record of delivering balanced budgets. He stressed that while the month one position was positive, there were still risks and challenges ahead for the year.

The Board RESOLVED TO:

- 1. Note and gain assurance in relation to the Month 1 revenue financial position and performance of the Trust as at 30 April 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 initial capital programme for 2025/26, and**
- 4. Note the Month 1 Welsh Government monitoring returns submission included within *Appendices 1 – 2* (as required by WG).**

Month Twelve

This paper presents to members the Financial Performance Report of the 2024/25 financial year, the reported position as at Month 12 (March 2025) / year end for 2024/25.

Chris Turley noted that the year-end financial position was in line with the forecast presented throughout the year. The financial performance for the year was reflected in the draft set of annual accounts submitted to the Welsh Government (WG) and Audit Wales on 02 May 2025. The audit was currently ongoing, and the final audit completion was expected by the end of June.

Peter Curran, on behalf of the Board and in his capacity as the Chair of the Audit, Risk and Assurance Committee (ARAC), congratulated colleagues on the collaborative effort across the Trust to ensure that budgets were well managed, avoiding both surpluses and deficits.

The Board RESOLVED TO:

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

54/25

**2024/25 ANNUAL BOARD AND COMMITTEE EFFECTIVENESS REVIEW
COMMITTEE TERMS OF REFERENCE**

Trish Mills explained that the update was in two parts, part one was an overview of the effectiveness of the Trust and part two focused on the effectiveness of the seven committees of the board. Of note, this report was accompanied by a significant pack of papers for approval, however much of it has been reviewed by members through their attendance at relevant committees and the ARAC.

Trish Mills provided an overview of the Board's effectiveness for 2024/2025, reflecting on member feedback and the Board's own assessment. She noted that the Board met as scheduled throughout the year with strong attendance and participation across both public and private sessions. Decisions taken in private were subsequently brought into public to maintain transparency.

Trish highlighted the value of board development sessions for in-depth informal discussions and long-term views. Trish noted that while the Board has delegated detailed work to its committees, allowing for a focus on strategic direction, there was still some duplication in meeting agendas that requirement refinement.

She acknowledged that the Trust does not yet adequately reflect the communities it serves and outlined steps to address this, including participation in the Aspiring Board Members Programme with WG, and considering holding board meetings at other Trust locations.

Externally, Trish cited the positive opinion from the 2024 Audit Wales Structured Assessment and the final annual opinion from the Head of Internal Audit for 2024/25 which was of reasonable assurance.

Peter Curran expressed gratitude to Trish and the team for their work, emphasising the importance of the continuous improvement. He acknowledged the board's effectiveness but stressed the need to avoid complacency and continue seeking improvements.

The Board received and approved the terms of reference.

The Board RESOLVED TO:

- 1. Receive assurance on the effectiveness of the board and its committees as set out in this paper and the committee annual reports.**
- 2. Approve the terms of reference (as endorsed by ARAC) for:**
 - a) Audit, Risk and Assurance Committee**
 - b) Finance and Performance Committee**
 - c) People and Culture Committee**
 - d) Quality, Patient Experience and Safety Committee**
 - e) Remuneration Committee**
- 3. Note the changes to the operating arrangements for the board and committees**
- 4. Note the future work to be carried out on streamlining committees in Q1 and Q2**
- 5. Note the progress against the changes to operating arrangements agreed following the 2023/24 effectiveness reviews and further work on conducting board visits pan-Wales.**

55/25

AUDIT WALES DETAILED ANNUAL AUDIT PLAN 2025

The Audit Wales Annual Audit Plan sets out details of the planned work for the forthcoming year in respect of Audit Wales. This included performance audit work and a structured assessment.

Peter Curran outlined several details within the Audit Wales report, noting that Audit Wales had brought forward their timeline by two weeks compared to the 2023/24 reporting period. He emphasised the importance of the Board approving the accounts on 26 June 2025, with the ARAC meeting two days prior for scrutiny and endorsement.

Chris Turley mentioned that the audit of the annual accounts was progressing well, with the team being halfway through the audit period. He noted that the accounts were submitted to Welsh Government and Audit Wales on 02 May 2025. Chris expressed confidence that the audit would be completed in good time, with a closure meeting scheduled in less than two weeks' time.

The Board RESOLVED TO approve the plan.

56/25

PARTNERSHIPS AND ENGAGEMENT REPORT MAY 2025

Estelle Hitchon explained that this initial paper to Board provided a broad outline of current key priorities within the partnership and engagement arena. It was anticipated that a report will be provided biannually, with additional reporting as required and appropriate. Estelle highlighted several key points:

1. Political Engagement: the importance of continuing political engagement, especially with the upcoming election year and changes in the Senate. She noted that Jason Killens has been strong in this area, and it was crucial to maintain this activity.
2. Manifestos: these will be reviewed over the coming months, which will be interesting for the Trust to analyse.
3. Format and Frequency: this was the first report in the new format, coming back to the board for assurance. these reports should ideally be twice a year.
4. Scope of Report: the report covered areas firmly rooted within Estelle's purview and invited board members to provide feedback on areas they would like to see explored in future reports.
5. Broader Partnerships Activity: much of the partnerships activity does not sit within her portfolio and happened across various portfolios within the Trust.
6. Public Service Boards (PSB) and Regional Partnership Boards (RPB) Membership: the challenges and benefits of engaging with PSBs and RPBs, noting the recent success in securing membership in the Gwent RPB was highlighted.
7. Reputational Risk: the discrepancy in reputational risk between formal stakeholders and public perception was recognised.

Rhiannon Beaumont-Wood suggested exploring opportunities to engage with PSB chairs at a national level, as they likely meet regularly, like RPB chairs.

Rhiannon Beaumont-Wood proposed a matrix approach to reflect the full breadth of engagement activities across different portfolios, not just Estelle's purview. Estelle acknowledged the challenge of mapping partnership activities and stressed the importance of highlighting key areas to influence or address gaps.

Hannah Rowan highlighted the need for a centralised database to capture all partnership activities, which would help in identifying gaps and ensuring comprehensive coverage. Estelle mentioned that work had been undertaken to understand where the interfaces within the Academic Partnership Committee purview were. She agreed to include this information in the next report.

The Board RESOLVED TO note the content of this report and provide feedback on areas of particular interest for future reports.

57/25

GOVERNANCE REPORT

Trish Mills outlined the report which asked the Board to ratify a chair's action made on 08 April regarding the St. John's Ambulance Cymru (SJAC) award of the Level 1 falls contract.

The board was asked to approve the application of the Trust seal.

Public Session Confirmation: It was confirmed that the extraordinary meeting on 07 May, which discussed the new ambulance performance framework and the EqIA, was a public session.

The Board RESOLVED TO;

- 1. RATIFY the decision made by Chair's Action on 08 April 2025 in regard to SJAC and the award of the Level 1 Falls Contract.**
- 2. APPROVE the application of the Trust Seal to documents in relation to the surrender and grant of a new lease between Dyfed Powys Police & Crime Commissioner (Landlord) and the Welsh Ambulance Services University NHS Trust (the tenant).**
- 3. NOTE the use of the Trust Seal and the receipt of business on 07 May 2025 and the associated documents, and the outcome of the meeting as now presented in public.**

58/25

BOARD COMMITTEE REPORTS

Peter Curran provided the following updates in relation to the Audit and Risk Assurance Committee (ARAC) report dated 1 May 2025:

1. The committee focused on the annual effectiveness review, the outcome of which was discussed in the meeting.
2. The committee scrutinised and considered the Audit Wales plan.
3. Three internal audit reports were received, all of which had reasonable assurance:
 1. Risk Management and Board Assurance Framework
 2. Occupational Health and Well-being Supports
 3. Speaking Up Safely
4. The committee received assurance that the Trust was complying with all elements of the Corporate Governance 2017 code.
5. The committee reviewed the board members' interests, and the gifts hospitality register to ensure transparency and proper disclosure.

Ceri Jackson provided the following updates in relation to the Quality, Patient Experience, and Safety Committee (QuEST) report dated 9 May 2025:

There were several alerts from this meeting. One matter was brought to the Board for approval: The Strategic Quality Plan 2025-27, which was received and endorsed at QuEST on the 09 May, ahead of Trust Board. The plan, with the required Equality Impact Assessment has been presented for approval.

1. The committee discussed Dylan's story, which was also presented to the board, highlighting the importance of learning from patient experiences.
2. Risk 223 and 224: Extensive discussion on risks related to handover delays and patient safety, emphasising the ongoing challenges and the need for continuous monitoring.
3. The committee reviewed the 30-day target for complaints and the backlog of overdue investigations, noting the impact of the challenging winter and the recovery plan in place.
4. The committee endorsed the Strategic Quality Plan, recognising the significant work involved.
5. Two Section 23 public interest reports were received, focusing on missed opportunities for technical review and poor standard of complaint investigation. The committee was assured that recommendations were largely completed.
6. Learning from Death Mortality Reviews: The committee discussed the disproportionate impact on older people and the importance of equitable services across communities.
7. A presentation on the clinical indicator related to return of spontaneous circulation was received, emphasising continuous improvement in ROSC rates.
8. The committee reviewed efforts to increase feedback from service users, focusing on outcome measures and not just experience.
9. The committee received the health inequalities maturity metrics and population plan, recognising the efforts to address disparities.

Ceri Jackson provided the following updates in relation to the People and Culture Committee report dated 15 May 2025:

1. Feedback from the 2024 NHS Staff Survey was received and it was summarised at Annex 1. Additionally, the Annual Health and Safety Report for the Trust was received and approved and was presented at Annex 2 for the board's assurance.
2. Lived Experience Representative: Mandy shared her experience with menopause, highlighting the challenges and resilience she demonstrated. Mandy's journey emphasised the need for broader understanding and support within the Trust.
3. The committee welcomed the launch of Our WAST Way, recognising its pivotal role in leadership, transformation, and culture within the Trust.
4. The committee discussed the priority areas identified in the NHS staff survey, noting improvements in several indicators.

5. A presentation on the volunteer strategy was received, highlighting the progress and impact of volunteer development. The committee endorsed the inclusion of volunteer development in the People and Culture Plan.
6. The committee received and approved the annual health and safety report.
7. The committee reviewed the six-monthly progress update on strategic equality objectives, engaging in a good conversation about the challenges and achievements.
8. The committee discussed the audit on speaking up safely, recognising the challenges around confidentiality and the assurance provided by the audit.

Colin Dennis advised there were no alerts from the Remuneration Committee report dated 15 May 2025.

Peter Curran provided an update on the Finance and Performance Committee report dated 20 May 2025.

While not an alert for escalation, the Energy Management Internal Audit was presented which received substantial assurance and included three medium rated recommendations.

The Trust maintained an ISO accreditation in this area, which likely contributed to the positive audit outcome. The report highlighted that energy management involves a national contract for energy, meaning the Trust does not contract directly with energy suppliers which adds a layer of complexity to implementing some recommendations.

59/25

MINUTES OF BOARD AND OTHER COMMITTEES

The Board received the following minutes:

1. 4 February 2025 - Quality, Patient Experience and Safety Committee
2. 18 February 2025- People and Culture Committee
3. 6 March 2025 - Audit, Risk and Assurance Committee
4. 18 March 2025- Finance and Performance Committee
5. JCC Highlight Report 18 March 2025

The Board RESOLVED TO Receive the following minutes:

- 1. 4 February 2025 - Quality, Patient Experience and Safety Committee**
- 2. 18 February 2025- People and Culture Committee**
- 3. 6 March 2025 - Audit, Risk and Assurance Committee**
- 4. 18 March 2025- Finance and Performance Committee**
- 5. JCC Highlight Report 18 March 2025**

60/25 ANY OTHER BUSINESS

None

61/25 EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC – 27 MARCH 2025

Members of the Press and Public were invited to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).

Date of next meeting: 31 July 2025



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**MINUTES OF THE EXTRAORDINARY OPEN MEETING OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST BOARD, HELD on THURSDAY 26 JUNE 2025
MEETING HELD AT THE MERTHYR TYDFILL WORKSHOP AND VIA TEAMS**

Meeting started at 11:30

PRESENT:

Colin Dennis	Non-Executive Director and Chair of the Board
Jason Killens	Chief Executive
Jayne Beeslee	Non-Executive Director
Peter Curran	Non-Executive Director
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Professor Hayley Hutchings	Non-Executive Director
Ceri Jackson	Vice Chair and Non-Executive Director
Carl Kneeshaw	Director of People
Angela Lewis	Director of Culture Change
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Trade Union Partner
Hugh Parry	Director of Corporate Governance/Board Secretary
Hannah Rowan	Non-Executive Director
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine
Sonia Thompson	Assistant Director of Operations
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner

ATTENDEES:

Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager

APOLOGIES:

Rhiannon Beaumont-Wood	Non-Executive Director
Lee Brooks	Executive Director of Operations
Bethan Evans	Non-Executive Director
Estelle Hitchon	Director of Partnerships and Engagement
Liam Williams	Executive Director of Quality and Nursing

62/25

WELCOME AND APOLOGIES FOR ABSENCE

Welcome and Apologies:

The Chair welcomed all to the meeting, apologies were received from Rhiannon Beaumont-Wood, Lee Brooks, Bethan Evans, Estelle Hitchon, and Liam Williams.

Declarations of Interest:

The Board noted that all declarations of interest were formally recorded on the Trust's Register of Interests and no new declarations were declared.

The Board RESOLVED TO:

- (1) Note the declarations of interest on the Trust's Register of Interests.**
- (2) Note the apologies of Rhiannon Beaumont-Wood, Lee Brooks, Bethan Evans, Estelle Hitchon and Liam Williams.**

63/25

2024-25 ANNUAL ACCOUNTS AND ANNUAL REPORT

2024-25 Annual Audited Accounts Audit Report, 2024-25 Accounts (Inc. Letter of Representation

Chris Turley gave a presentation on the 2024-25 Welsh Ambulance Services University NHS Trust final accounts advising Members that the accounts had been fully endorsed for approval at the Audit, Risk and Assurance Committee (ARAC) meeting on 24 June 2025.

The accounts for the year ended 31 March 2025 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's Financial Reporting Manual by the Welsh Ambulance Services University NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed. The final audited accounts as presented demonstrated that the Trust had:

- a) A retained surplus of £0.070m for the 2024/25 financial year.
- b) Met its financial duty to break even over the 3 years 2022/23 to 2024/25.
- c) Expended Capital Investment funds of £20.321 million (including IFRS16 leases funding), thereby utilising 100% of the Trust's Welsh Government set Capital Expenditure Limit.
- d) Achieved Public Sector Payments Policy (PSPP) of 97.7% within 30 days against the 95% target.

Total income for the Trust was £325.4m, an increase of £22.3m from the previous year, which consisted of £314.4m from patient care activities, £9.2m from other operating income and £1.8m from investment and other gains. The total net

expenditure for the Trust was £325.2m an increase of circa £18.5m from the previous year.

Chris Turley added that Audit Wales (AW) have advised that the Auditor General for Wales will issue an unqualified certificate and report on the 2024-25 financial statements, citing that they provided a true and fair view of the Trust's finances in the 2024-25 financial year. AW acknowledged the improvements in the quality of the draft accounts for 2024/25 leading to a reduction in the number of issues and misstatements reported via the International Standard on Auditing (ISA) 260.

The final approved and audited Annual Accounts were due to be submitted to Welsh Government by 30 June 2025 together with the Trust's Annual Report, as a single unified document in line with the agreed timetable.

Peter Curran, as Chair of ARAC, reiterated the Committee's endorsement and acknowledged the achievement and dedication of the staff involved as outlined in the AW report.

Members considered and approved the 2024/25 Annual Audit of Accounts and the Final Letter of representation from Management.

2024-25 Annual Report

Trish Mills explained that the Annual Report was part of a suite of documents that provided information about the Trust and were completed in accordance with the NHS Wales 2024-25 Manual for Accounts and HM Treasury's Financial Reporting Manual, the Annual Report for 2024-25.

Trish Mills acknowledged the extensive work involved in preparing the report. She praised members of Rachel Marsh's team for part 1 and Alex Payne for part 2 for ensuring consistency and avoiding duplication. The report was prepared and sent to Audit Wales and the Welsh Government, who raised a few minor points that were addressed. Trish Mills added that Jason Killens and Chris Turley will sign the statement of directors' responsibilities on behalf of the board.

Trish suggested starting work on next year's report earlier to streamline it and avoid duplication with other reports.

The Chair, on behalf of the Board added his thanks to all those in the production of both reports.

The Board RESOLVED To: Adopt and approve the Trust's Annual Report and Annual Accounts for 2024/25 and Approve the Trust's Letter of Representation for 2024-25.

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2024-25 DUTY OF QUALITY ANNUAL REPORT

Penny Durrant presented the report, which had been endorsed for Board approval by the Quality, Patient Experience and Safety Committee (QuEST) on 13 June 2025.

Penny Durrant explained that the report outlined the steps taken to meet statutory responsibilities under The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This Act required the Trust to report on how safe, effective, and person-centered care was delivered. It also demonstrated what the Trust was doing to drive improvements across all functions of the organisation, both clinical and non-clinical.

The report provided an opportunity to reflect on the progress made as a Trust and assess its quality journey. The contributions from all staff have led to a more mature and embedded quality management system and report. Examples highlighted in the report include the strengthening of clinical leadership in control rooms, implementing more digitally integrated systems, and advancing new models of remote and community care.

Overall, the report conveyed a level of assurance that quality was a shared endeavour within the Trust, supported by structures, systems, and a culture focused on continuous improvement. The Board welcomed the report, thanked those for their contribution and approved it for publication.

The Board RESOLVED To approve the Duty of Quality Annual Report 2024/25 for publication.

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ANY OTHER BUSINESS

None

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EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC – 26 JUNE 2025

Members of the Press and Public were invited to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).

Meeting closed at 12:00

Date of next meeting: 31 July 2025

ACTION LOG
WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST BOARD

Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
29 May 2025	Chief Executive's Report	Rachel Marsh to share the personas with Rhiannon Beaumont-Wood for feedback and views.	Rachel Marsh	21 July 2025	<u>Update for 31 July meeting</u> Verbal Update	Open
29 May 2025	Chief Executive's Report	Jason Killens to share dialogue from the upcoming meeting with the Cabinet Secretary regarding Violence and Aggression against staff.	Jason Killens	21 July 2025	<u>Update for 31 July meeting</u> On 25 June I met the Cabinet Secretary for Health and Social Care in my role as Chair of the Association of Ambulance Chief Executives (AACE) to discuss recent data that AACE had released relating to the increasing violence and aggression ambulance workers across the UK are subject to. Similar meetings are scheduled with the Health Ministers of the other UK nations. We discussed what more can be done to prevent assaults from occurring and the role Welsh Government can play in that regard. The Cabinet Secretary was very sympathetic to the challenge WAST and the wider sector faces and pledged his support and assistance.	Complete
29 May 2025	Actions to Mitigate Avoidable Patient Harm in the context of extreme and sustained pressure across Urgent and Emergency Care	<u>Immediate Release Compliance</u> : It was suggested to include this topic in the Agenda for the next meeting of the Cabinet Secretary's Task and Finish Group to address the challenges related to Immediate Release Requests and their impact on patient harm, and that it is given due attention and integrated into the broader improvement efforts.	Rachel Marsh/ Corporate Governance	21 July 2025	<u>Update for 31 July meeting</u> Verbal Update	Open
29 May 2025	Partnerships and Engagement Report May 2025	Estelle Hitchon to include stakeholder mapping and identification of strategic influence gaps in the next report.	Estelle Hitchon	13 November 2025		Not Due

AGENDA ITEM No	5
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	0

CHAIR AND VICE-CHAIR'S REPORT

MEETING	Trust Board
DATE	31 July 2025
EXECUTIVE	Colin Dennis, Chair of the Trust Board Ceri Jackson, Vice Chair of the Trust Board
AUTHOR	Alex Payne, Corporate Governance Manager
CONTACT	Alex.Payne2@wales.nhs.uk

EXECUTIVE SUMMARY

CHAIR'S REPORT

1. I am very pleased to report that the recruitment exercise for the Chief Executive vacancy has been successful, with an external appointment having been made after the conclusion of the stakeholder and interview panels in early July. As the start date is yet to be agreed, I have confirmed interim arrangements with the Cabinet Secretary for Health and Social Care and welcome Rachel Marsh as Interim Chief Executive (effective 19 July 2025). Rachel's substantive position in the Trust is that of Executive Director of Strategy, Planning and Performance. I wish to express my sincere congratulations to Rachel on this interim appointment and will provide details of the substantively appointed candidate in due course.
2. I am very pleased to welcome Meshack Ezeadim to the Trust Board as the first Trust 'Aspiring Board Member' on the Welsh Government scheme of the same name. Meshack will join the Trust Board at all of its open meetings and all board development activity and will be supported by Angela Lewis, Director of Culture Change who is his scheme 'sponsor'. In relation to this scheme, I attended an all-day induction session on the 12 June where I met with Meshack and the other scheme members. Meshack has joined the Trust Board for a period of 12 months, which will therefore run until Summer 2026.

3. Since our last meeting I have been busy, with the following activity: -
- Regular meetings and briefings with Jason Killens, Chief Executive, and other Executives and more recently meetings with Rachel Marsh, Interim Chief Executive;
 - Regular meetings with Ceri Jackson, Vice-Chair;
 - Panel membership of the WAST Live events on the 16 June and 29 July
 - Chaired a meeting of the Remuneration Committee on the 03 June and the 11 July;
 - Attended a meeting of the Public Body Chairs (in Wales) on the 11 June;
 - Attended a meeting of the NHS Wales body Chairs Peer Group on the 24 June;
 - Visited staff at the Llangunnor Clinical Contact Centre on the 25 June;
 - Facilitated the Merthyr Workshop opening event on the 26 June where members of the Trust Board and Executive Team met with the Cabinet Secretary;
 - Chaired an extraordinary meeting of the Trust Board on the 26 June to approve the Trust's 2024/25 Annual Report and Accounts, and 2024/25 Duty of Quality Annual Report;
 - Attended the NHS Wales Chairs meeting with Llais, on 30 June;
 - Chaired an extraordinary meeting of closed Trust Board on the 03 July;
 - Joined a webinar regarding Reducing Health Inequalities on the 11 July;
 - Attended the AACE Chairs meeting on the 14 July;
 - Attended the AACE Council meeting on the 15 July;
 - Attended the meeting of the Finance and Performance Committee on the 21 July;
 - Attended the Trust's Long Service Awards on the 23 and 29 July;
 - Visited staff at the Ty Elwy Clinical Contact Centre on 24 July;
 - Attended a WASPT Joint Chairs Working Group on the 14 July;
 - Routine meetings with Internal Audit;
 - Routine monthly meetings with Non-Executive Director colleagues;

VICE-CHAIR'S REPORT

4. Since our last meeting I have been busy with the following activity: -
- I have been a Panel Member for the Chief Executive recruitment and attended the stakeholder Panel;
 - Visited colleagues at Morriston Emergency Department on the 04 June;
 - Attended a meeting of the Remuneration Committee on the 06 June and 11 July;
 - Visited Vantage Point House on the 07 June;
 - Attended the Audit, Risk and Assurance Committee members' meeting on the 11 June;
 - Attended the Quality, Patient Experience and Safety Committee meeting on the 13 June;
 - Attended the Trust's Leadership Symposium on the 18 June;

- Attended the Audit, Risk and Assurance Committee on the 24 June;
- Attended the Merthyr Workshop opening event on the 26 June where members of the Trust Board and Executive Team met with the Cabinet Secretary;
- Attended the extraordinary meeting of the Trust Board on the 26 June to approve the Trust’s 2024/25 Annual Report and Accounts, and 2024/25 Duty of Quality Annual Report;
- Attended the meeting of the Charity Committee on the 03 July;
- Attended the extraordinary meeting of closed Trust Board on the 03 July;
- Attended Vice-Chair’s Peer Group on the 09 July;
- Joined a webinar regarding Reducing Health Inequalities on the 11 July.
- Attended the Trust’s Long Service Awards on the 23 July;
- Held routine meetings with people and culture colleagues;
- Held routine meetings with the Trust’s Mental Health Lead;
- Routine monthly meetings with non-executive director colleagues.

KEY ISSUES/IMPLICATIONS

Not applicable.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Not applicable.

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	6
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	One

CHIEF EXECUTIVE REPORT: JULY 2025

MEETING	Trust Board
DATE	31 st July 2025
EXECUTIVE	Jason Killens, Chief Executive Rachel Marsh, Interim Chief Executive (effective 19 July 2025)
AUTHOR	Jason Killens, Chief Executive
CONTACT	Jason.Killens@wales.nhs.uk

EXECUTIVE SUMMARY

This report is presented to the Trust Board to provide awareness of the Chief Executive’s activities up to Friday 18 July 2025 and key service issues since the last Trust Board meeting held on the 29th of May 2025. It is intended that this report will provide a useful briefing on current issues and is structured by directorate function.

RECOMMENDATION

That Trust Board note the contents of this report.

KEY ISSUES/IMPLICATIONS

This report is for information only to ensure the Trust Board are aware of the Chief Executive’s activities and key service issues.

REPORT APPROVAL ROUTE

The Trust Board meeting held on 31st July 2025.

REPORT APPENDICES

An SBAR is attached.

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

SITUATION

1. This report provides an update to the Trust Board on recent key activities, matters of interest and material issues since my last report dated 29th of May 2025. It covers the period up to and including Friday 18 July 2025 as this was my last day of service with WAST.

BACKGROUND

2. This report is presented to the Trust Board to provide awareness of the Chief Executive's activities and key service issues. It is intended that this report will provide a useful briefing on current issues and is structured by directorate function.

ASSESSMENT

3. CHIEF EXECUTIVE

Since the last Trust Board meeting, examples of items of note include:

- Attending frequent meetings with key stakeholders such as NHS Wales CEOs, the Director General of NHS Wales, Blue Light Service Leaders, Trade Union Partners, Commissioners, AACE, EASC, JCC and senior elected representatives.
- I presented at EMS Europe 2025 in Stockholm on the topic "*How Safe is Safe Enough*" and the ongoing changes to measuring ambulance response. The presentation was well received and sparked meaningful dialogue on the evolution of performance metrics in emergency medical services. The event provided a valuable platform to share WAST's approach to safety and performance, and to engage with international colleagues on best practice and innovation in pre-hospital care.
- I was honoured to attend the St John Ambulance Service Investiture in Cardiff, recognising the outstanding contributions of volunteers and staff. The ceremony celebrated excellence in service and community impact, and I had the opportunity to meet with senior representatives from St John and other emergency services to discuss future collaboration.
- I gave an interview to BBC Wales, focusing on the Trust's response to increasing demand and our ongoing efforts to improve patient outcomes. The interview also addressed recent developments in ambulance performance metrics and our commitment to staff wellbeing and safety.

- I hosted the Trust's Leadership Symposium in Cardiff, bringing together senior leaders from across the organisation. The event focused on embedding "Our WAST Way" leadership framework, with workshops on essential conversations, inclusive leadership, and strategic alignment. Feedback was overwhelmingly positive, reinforcing our commitment to leadership development.
- I attended the funeral of Professor Douglas Chamberlain, a pioneer of modern paramedicine and a key figure in the development of pre-hospital emergency care. It was a moment to reflect on his legacy and reaffirm our commitment to clinical excellence and innovation in ambulance services.
- We welcomed Jeremy Miles MS, Cabinet Secretary for Health and Social Care, to our Merthyr site. The visit included a tour of facilities and discussions with frontline staff. I provided an overview of our operational priorities and highlighted the impact of recent investments in digital infrastructure and fleet modernisation.
- I represented the Trust at commemorative events in London, honouring the contributions of emergency services personnel. These events offered a platform to reflect on the sacrifices made by colleagues and to reaffirm our shared commitment to public service and community resilience.
- I joined colleagues at the Senedd to mark International Paramedics Day, celebrating the vital role of paramedics in the healthcare system. The event included recognition of clinical innovation, professional development, and the evolving scope of paramedic practice. It was a proud moment to showcase the achievements of WAST staff and advocate for continued investment in the profession.

OPERATIONS DIRECTORATE

Launch of Assemble

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

Volunteer Steering Group Refresh

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

EMS Coordination Estate

3. The refurbishment of Llangunnor estates has been completed. After consultation with colleagues working from the site, Ty Tywi was selected as the name for the newly renovated site.
4. Operational teams relocated from Bryn Tirion to Ty Elwy, finishing with EMSC on 8 May 2025. WAST became the first Trust to implement the *Life X* control room solution in new facilities. The Ty Elwy Coordination and Communications Centre was officially opened by High Sheriff Julie Gillbanks on 12 June 2025, with Lee Brooks and Andy Swinburn attending.

MAIT

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

Yorkshire Ambulance Services

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

Launch of New Emergency Ambulance Performance Framework

7. On the 1st July 2025, WAST went live with its new approach to high-priority incident responses. The current red category was replaced by three new classifications: Purple Arrest, Red Emergency, and RCS0.
8. Operations team have supported the planning approach, standing up an implementation structure integrated with other directorates for the duration of the Go Live period, leading to a seamless implementation of the new framework. Additional effort to incorporate the performance framework into numerous documents and data dashboards in the run up to Go Live has also

been undertaken. Ongoing mechanisms are in place to monitor and report on progress.

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

Staff Survey – Quality and Support Day

10. Following the findings from the NHS Wales Staff Survey 2024, the Operations Directorate agreed, through discussions in EMG (EMS Management Group) and SOT (Senior Operations Team) meetings, that a forthcoming Quality and Support Day will concentrate on the Staff Survey. All service areas agreed a collaborative approach to the Q&S Day with the following focus:
 - To comprehend the experiences of staff who took part in the survey and to pinpoint the obstacles encountered by those who did not complete it.
 - To collect feedback on the 2024 staff survey results and to ascertain what actions and next steps staff feel would be most beneficial.
11. Data is currently being collected and discussed within the service areas, with a view to develop action plans for improvements.

FINANCE AND CORPORATE RESOURCES

Finance

12. The finance team continue to support the delivery of the financial plan for the 2025/26 financial year as detailed in the submitted version of WASTs IMTP and MDS (Minimum Data Sets), following Trust Board approval in March 2025. Delegated budgets were set at the opening of the financial year in core finance systems and formal budget delegation meetings between the Executive Director of Finance & Corporate Resources, Chief Executive and each Executive Director continue and will be finalised by end of July 2025.
13. Despite the slight worsening of the in year financial position reported elsewhere this month, the finance team continues to play a key part in the delivery of the 2025/26 financial plan by supporting those developments identified in the IMTP. The team continues to support the savings

programmes identified and the re-purposing of the Financial Sustainability Programme (FSP) with the ongoing identification of schemes / themes for this and future financial years.

14. Two of the agreed objectives for the finance team for the 2025/26 financial year continues to be rolled out and include
 - developing our digitalisation of WAST financial performance and monitoring for budget holders using dashboards and QlikSense tools;
 - developing a programme of enhanced finance training for budget holders and non-finance managers, with this also running in parallel to the above where documentation has been shared to all budget holders.
15. The Finance Team continues to participate in the NHS Wales Finance Academy programme (Finance Operating Model) to review all job families to ensure future proofing of services and delivery. Programme for the job families of Finance Business Partnering and Management Accounts, Financial Accounting and Director and Deputy of Finance have concluded to date.
16. As Trust Board members will be aware, the audited accounts for 2024/25 were presented to ARAC on 24th June, and subsequently approved by Trust Board on 26th June and signed by the Audit General for Wales on 27th June prior to their then final submission to WG on 30th June 2025.
17. Work is progressing at pace around the forecasting and planning associated with the 2025-26 capital programme the vast majority of the budget is allocated to individual schemes and monitoring continues to ensure expenditure aligns to plan
18. Work continues to progress well with the development of the PLIC system, and local modelling being undertaken with comparison to the NHS England model, work will continue around the development of costing other elements outside the NHS England model including 111 and Ambulance Care.

Capital Development

19. A brief update on a number of the new and ongoing capital schemes this financial year is provided below:
20. **Dolgellau Ambulance Station** – the Trust Board approved the award of contract and approval of the lease in late June. Some landlord work has commenced, and the nominated contractor is confirming the programme of

works and start date for the work. It is anticipated that this work will be complete by the end of the financial year.

21. **Monmouth Ambulance Station** – Pre-planning application advice has now been received, and the Project Board has confirmed a renovation as the preferred option. Final specifications are being prepared for tender.
22. **Bangor Fleet Workshop** – significant further work has been done to identify achievability of this scheme within the cost envelope. Trust Board will be asked to approve a business case to confirm the preferred option at the July meeting.
23. **Thanet House, Swansea** – the project has now been confirmed from discretionary capital. The scheme looks to relocate staff from Matrix One ground floor to Matrix House third floor (taking on space from NWSSP who own the building), to free up Matrix One ground floor space for the relocation of Thanet House staff. This will allow for the consolidation of the WAST presence on the Matrix site.
24. **Abergavenny (Targeted Estates Funding - TEF)** – this scheme includes renewable energy aspects and improvements to welfare facilities for staff. The specification is currently being finalised with a view to going to full tender over the summer.
25. **HART Heating System (TEF funding)** – this scheme will go out to full tender by the end of July
26. **Infrastructure for placement of hybrid and full electric vehicles** – work continues on a programme of works for further EV infrastructure across the Trust estate, focused on both slower and rapid charging capacity.

Estates, Environmental and Facilities

EFPMS

27. Estates and Facilities Performance Management System (EFPMS) data is due for submission to Welsh Government by the end of July 2025. This data is used to facilitate and monitor building improvements within WAST.

Fire Safety Audit

28. NWSSP Audit team are currently auditing the trusts' Fire Safety compliance. The following sites will be audited in the month of July - Vantage Point

House, HART, Beacon House, Matrix One, Merthyr Fleet Workshops and Ammanford Ambulance Station.

ISO14001

29. ISO 14001 is an internationally agreed environmental standard that sets out the requirements for an environmental management system. It helps organisations improve their environmental performance through more efficient use of resources and reduction of waste. WAST is the only ambulance service in the UK to have achieved ISO14001 accreditation for all of its activities and has held it for 9 years. The 2025 audit is due in July and the following sites will be audited: - HART, Bryncethin, Neath, Carmarthen, Tenby, Pembroke Dock, Aberystwyth & Newtown Ambulance Stations.

Fleet

31. Following Trust Board approval at its last meeting in January 2025, a revised Fleet Procurement Strategy for 2025-30 was formally submitted to Welsh Government on 31st January. The strategy included a BJC for the vehicle replacement programme for 2025/26.
32. Confirmation has since been received from WG that the WAST vehicle replacement programme BJC for 2025/26 was fully funded and we are to receive the requested £22.452m to replace 142 vehicles, as follows:
 - 44 Emergency Ambulances
These are Mercedes Box body Emergency Ambulances. The chassis are ordered, and the conversion work begins in October, through to January 2026.
 - 12 Single Response Vehicles
These are plug in petrol hybrid vehicles based on the Ford Transit Custom as per that procured in 2024/25. The vans are now with the nominated contractor ready to be converted into an SRV.
 - 65 Large Ambulance Care vehicles. (30 wheel-chair accessible and 35 Stretcher bearing)
Following a successful tender process the contract for the conversion of these vehicles has been awarded. The vans are in production and will be with the contractor during August.
 - 13 small Ambulance Care vehicles, a combination of cars and minibus type vehicles.

The vehicles have all been ordered using a Crown Commercial Services purchasing framework, facilitating a “one stop shop” with Ford and their Special Vehicles Operations division. All 13 vehicles are Battery Electric Vehicles (BEVs) with zero tail pipe emissions.

- 2 Occupational Health vehicles
These vehicles are also BEVs with zero tail pipe emissions.
- 3 Fleet support vehicles
These vehicles are also BEVs
- 1 Hazardous Area Response Team (HART)
Work is ongoing to the replacement of this vehicle.
- 2 large Driver Training Vehicles.
The chassis were purchased during 20224/25 and are about to be converted to the proven and coveted driver training assets that we have come accustomed to.

CORPORATE GOVERNANCE

33. Effectiveness reviews of committees for 2025/26 have begun in response to ARAC’s challenge to further streamline the structures, ensuring a broader spread of Non-Executive Director attendance and potentially reducing frequency. There is a sub-set of ARAC supporting this work and an update will be provided to their September meeting.
34. ARAC received the 2024/25 Annual Report & Accounts on 24 June 2025 after which it was approved by the Trust Board at an extraordinary meeting on the 26 June 2025.
35. Consultation on the new front covers and SBAR combination report, as well as writing and presentation guidance has been positive and well received. Any improvements and adjustments will be made over the coming weeks with a launch of the new templates in August.

Welsh Language

36. In May 2025, a self-assessment exercise was undertaken to review compliance against the Welsh Language Standards, receiving 33 responses from managers across the Trust. The findings have prompted further engagement with the Emergency Medical Service (EMS) to raise awareness and encourage use of the Welsh Language across all localities. The

assessment also highlighted strong interest among staff in developing Welsh Language skills and identified examples of good practice that could be shared more widely.

37. In collaboration with the Training and Development Team, a bespoke online Welsh Language course has been developed via LMS365. This 10-week course (1 hour per week) is aimed at Emergency Medical Service (EMS) staff with either little or no previous Welsh language experience. The course has already gone live, with the first cohort of staff currently being identified.
38. On 8 July 2025, representatives from the Trust's Welsh Language Service attended a one-day conference on 'Developing The Use Of Welsh in the Workplace', organised by the Welsh Language Commissioner and the National Centre for Learning Welsh. The conference focused on sharing experiences and approaches to increasing the use of the Welsh language in the workplace. Insights and ideas from the event are now being used to strengthen the Trust's Welsh language education offer to staff, ultimately enhancing the Welsh language service available to users and improving their overall experience.

Audit

39. We continue to make strong progress in addressing Internal Audit recommendations. Of the 83 recommendations due for completion during Quarter 4 of 2024/25, 58 (70%) were confirmed as closed within the quarter. The Internal Audit Plan for 2025/26 has now been finalised and includes 20 audits across all directorates, ensuring continued focus on priority areas and system-wide improvement.
40. The 2024/25 Internal Audit Plan has been delivered in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, with one final report due to come to the September ARAC meeting. Of the 20 internal audits reported during the year, 2 received substantial assurance, 13 reasonable assurance, 4 limited assurance, and 1 (Contract Management – an NHS Wales wide audit) was advisory. The Head of Internal Audit Opinion for 2024/25 stated that "The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively." Some matters regarding control design or compliance, require management attention, and appropriate actions have been agreed to address these recommendations. There is a Low to Moderate impact on residual risk exposure until these matters are resolved.

Policy

41. The 2025/26 Policy Work Programme sets a compliance target of 90% of Trust-owned policies being within review date by 31 March 2026. The Corporate Governance Team continues to deliver the programme, with progress reported to the Policy Group and reflected in AAA reports. Looking ahead, the expected reduction in policy reviews during 2026/27 offers an opportunity for the Policy Group to begin reviewing the development and management of Standard Operating Procedures (SOPs), supported by a new register and a task and finish group to establish interim guiding principles. Additionally, planning is underway for scoping the Policy Transformation Programme, due in Q1 2026/27, which will include a full review of the Trust's policy template, approval process, stakeholder engagement, and an update to the Policy on Policies.

STRATEGY, PLANNING AND TRANSFORMATION

Planning

Integrated Strategic Planning & Transformation

42. The WAST IMTP received approval from the Welsh Government on 30 June 2025, subject to the standard accountability conditions previously agreed upon.
43. Both the Welsh translation and summary versions of the IMTP for public and staff engagement have been completed, with the main document being available on our website.
44. Directorate-level planning has been rapidly finalised to align with IMTP delivery objectives, with progress against Q1 deliverables reported at the Strategic Transformation Board meeting held on Monday, 30 June 2025. The planning team have developed digitised systems to support directorate level planning as part of the overarching planning process for the organisation going forward. The system provides a live dynamic source of information to support planning and provide assurance, aligned to the Quality and Performance Management Framework.
45. Senior leaders attended the Southwest Wales, regional, joint Hywel Dda, SBUHB and WAST all day workshop setting out our approaches to Remote access clinical care and single points of access, exploring with CGI Generative A.I (British Columbia examples) approaches to compliment these and collaborative working in this partnership/s.

Health Board Strategic Service Planning

46. The planning team continue to engage with our system partners across Wales, at national, regional and local level to collaboratively assess any implications for the Trust and support any strategic service changes.
47. National; continued engagement on optimisation of stroke services across Wales, supporting the modelling of any potential reconfiguration.
48. Mid & West Wales; developments continuing for Ophthalmology and Stroke pathways regionally for Powys, Hywel Dda and BCUHB. NHS Performance & Improvement working closely to align to a national model. WAST attendance at the Hywel Dda Clinical Services Plan (CSP) public consultation continues to run to end of August ahead of H Dda September Board presentations of recommendations and feedback for 9 x service reconfiguration options to be confirmed.
49. All changes including Pentre Awel premises and Carmarthen HWB development (H Dda) will have implications for emergency response and ambulance care, requiring adjustments financially and in workforce planning and coordination with health boards to ensure appropriate non-emergency transport provision.
50. South East; the team continue to engage with regional stroke and ophthalmology discussions, the opening of the new Radiotherapy Satellite Centre at Nevill Hall Hospital working collaboratively with the service to determine the impact on our non-emergency transport service and the how best to support and the planning for the Llantrisant Health Park. The team also continues to work with the region to understand the change in patient flows following the unplanned stroke service change at Prince Charles Hospital.

Strategy

51. Following a period of recruitment, the strategy team is back to full complement following the permanent appointment of the Strategy & Transformation Engagement Manager and a new Strategy Development Manager due to start in mid-July.
52. Work has continued in the strategic space to prepare for the October Board Development session, with discussions taking place with external organisations to explore opportunities to co-facilitate the workshop. The

team have supported a number of external workshops with key partners and Health Boards & Welsh Government to support the continued development of a joined-up system approach for Remote Clinical Assessment and the development of the 'Clinical Conversation Before Conveyance' concept in collaboration with the Six Goals Programme.

53. During this period the team have been heavily involved in supporting the planning and preparation for the internal and external communications in readiness for the introduction of the first phase of Welsh Governments new Ambulance Performance Framework on the 1st July. Further details are provided in the Partnership & Engagement section.

Clinical Model Transformation

54. The Clinical Model Transformation (CMT) Programme continues to progress at pace, supporting the transition to a clinically-led, digitally-enabled Clinical Services Model across the Trust. Significant progress has been achieved in strengthening programme management infrastructure. Key programme controls—including risks, issues, and decisions—have now been fully digitised through a centralised MS365 Programme Portal. This has improved visibility, enabled dynamic tracking, and supported interdependency mapping across workstreams. Delivery plans are being transitioned into MS Project to allow for enhanced resource planning and alignment with IMTP milestones. In parallel, work has commenced to develop automated Power BI reporting, initially focusing on risk and issue management. A proposal to enhance project management capacity within the Transformation Support Office is being considered to support the scale and complexity of the programme.
55. Progress on Quality Impact Assessments (QIAs) remains a priority. To date, QIAs have been approved for three of the five core workstreams, with the remaining two scheduled for Clinical Quality Governance Group (CQGG) review in July. The programme-level Equality Impact Assessment (EQIA) has received approval from both the CMT Board and the Strategic Transformation Board (STB), reflecting our commitment to equitable and inclusive transformation. Benefits mapping has been completed across all workstreams, establishing a consistent methodology for identifying measurable outcomes. Draft scorecards have been developed and will undergo consultation with workstream SROs and Executive Sponsors, underpinning the benefits realisation approach and informing the development of workstream-level dashboards by the IDS team, enabling routine monitoring of benefit delivery across the programme.

Significant progress has been made across the CMT workstreams:

56. Digital Front-End: Despite exceptional efforts, progress within the Digital Front-End workstream has been impacted by delays to key deliverables. The implementation of the Virtual Assistant for the NHS111.Wales website was deferred to early July due to the time required to address Information Governance requirements, despite earlier completion of both the security assessment and DPIA. The Virtual Assistant is now go-live ready, with launch confirmed 9th July.
57. In parallel, delivery of the Online Symptom Checker and the web-based Call Prioritisation Streaming Service (CPSS) has been slightly delayed, due to some procurement processes that needed to be finalised but this is now ready to progress further.
58. Development of the longer-term business case continues, with engagement underway with Welsh Government colleagues. A high-level summary has been submitted and an initial meeting took place in April to explore strategic alignment. However, the current absence of a clear steer from Welsh Government on digital investment priorities may limit the pace of progress and scope of deliverables within this financial year.
59. Remote Integrated Care: The Remote Integrated Care workstream continues to develop in line with programme ambitions. The formal establishment of the Care Planning function is progressing, with early implementation underway. However, further operational development is required before a full evaluation can take place. A longer-term strategic planning process is being scoped to support its evolution into a sustainable service offer. In parallel, proposals have been submitted to secure the resourcing needed to continue and enhance the Winter Desk function and strengthen the application of the Call Prioritisation Streaming System (CPSS). The feasibility of these proposals remains contingent on the availability of capital and the capacity of supporting systems.
60. Efforts to improve digital infrastructure within Integrated Care are ongoing. A key development is the planned introduction of video consultation functionality, which will enable integrated care clinicians to conduct visual assessments remotely. While this capability is not intended to replace in-person care, it offers an additional channel to support clinical decision-making and improve access, particularly for patients in remote or mobility-limited settings.

61. Progress also continues on the alignment of Clinical Support Desk (CSD) and NHS 111 clinicians under a single integrated model. Strong engagement has been reported across operational clinical professionals (OCPs), and no barriers have been identified regarding terms and conditions. This alignment is helping to foster greater collaboration and shared ownership of patient pathways across teams.
62. Urgent Community Response: The Urgent Community Response workstream continues to move forward, with key components of the model in development. A draft proposal outlining implementation options for the UCR Scheduling project is due to be presented to the Workstream Board in July, with the aim of supporting operational readiness ahead of Winter. The national UCR Service Specification has now been formally approved, marking a critical milestone in defining the service offer, and a closure report is being prepared for the original Task & Finish Group.
63. Within the Falls and Frailty Response Model, ongoing data analysis has identified inefficiencies in how these cases are managed and responded to. Further data requests have been submitted to the Insights & Data Services (IDS) team to inform the next phase of model refinement. However, delivery timescales are currently unconfirmed due to wider demands on IDS capacity.
64. The Tasking Optimisation project is also making headway. The first draft of the evaluation report for the Mental Health Response Vehicle (MHRV) is nearing completion, and recruitment is underway for an additional Mental Health Practitioner. In parallel, the Advanced Practice Delivery Group is working to expand the advanced paramedic workforce to a target establishment of 130.7 FTE. While progress is being made, there are challenges in aligning recruitment timelines with clinical placement availability and university scheduling. The group is therefore considering a phased approach, based on a minimum viable staffing level, to enable forward planning and mitigate risk to delivery.
65. Emergency Response: The Emergency Response workstream continues to progress to plan, with the successful introduction of revised emergency call categories on the 1st July 2025. These changes are designed to streamline clinical triage for the most urgent cases, enabling faster escalation and improving patient outcomes through a more responsive and clinically targeted model. The revised model includes the introduction of three new categories: 'Purple' for patients in cardiac or respiratory arrest, 'Red' for those at imminent risk of arrest, and 'RCS0' for all remaining conditions previously captured within the Red category. These changes reflect a shift from time-based response targets to a model focused on clinical

outcomes—such as Return of Spontaneous Circulation (ROSC)—and the quality of care provided during critical incidents.

66. To support implementation, the Trust has issued a comprehensive package of support materials. This includes updated policies, refreshed training modules, and a dedicated interactive SWAY resource to guide operational teams. In addition, both staff and public-facing communications have been developed to explain the rationale behind the changes and how they align with the Trust's ambition to deliver more personalised and effective emergency care.
67. Health Transport: The Health Transport workstream is progressing in line with expectations, with two priority initiatives now underway as part of the newly established Access to Transport for Planned Care (ATPC) project. These developments follow the April workshop and are focused on improving patient access to appropriate transport for planned care, while alleviating unnecessary pressure on emergency services.
68. The first initiative is centred on the development of a dedicated referral pathway from Remote Integrated Care (RICS) to planned transport services. This pathway will ensure that patients assessed as requiring planned care are transferred efficiently and without unnecessary delay. The objective is to enhance coordination across services, support more effective use of available resources, and improve the overall patient experience.
69. The second initiative seeks to address current barriers to accessing planned taxi transport for patients who meet the relevant Standard Operating Procedure (SOP) criteria but are currently unable to utilise this pathway due to mobility concerns. In the absence of appropriate alternatives, these patients are often allocated an Emergency Ambulance, adding to the operational burden on the 999 service. To address this, a proof of concept will be launched in Q2 to review existing SOPs and referral mechanisms, with the aim of enabling eligible cases to be appropriately routed to planned care transport solutions. This approach is expected to reduce unnecessary conveyance by emergency services and support more responsive, needs-based care.
70. The Commissioning & Performance Team has had a busy quarter 1 supporting the Trust on a number of key pieces of work. The Team's primary focus in Q1 was the CMT Metrics development of the definitions for the new Arrest, Emerg and RCS0 categories, with a high degree of collaboration at pace between colleagues across the Trust and with the Director of

Commissioning for Ambulance Services & 111. There has also been associated work on the monitoring & assurance plan required for this to go live. The CMT Metrics Workstream, which led on the definitions, will now go on to focus on phase 2 of the Ambulance Performance Framework in the second-half of the year. Another key piece of work has been the review of 111 rostering practice. This is an area of interest to Welsh Government and the JCC and also for our people who want more workable rosters. An initial report has been produced and shared with the Director of Commissioning for Ambulance Services & 111 and the Trust is now undertaking detailed staff engagement on roster preferences. Similarly, the team has been supporting the Trust with the NEPTS re-roster project. The initial keys produced were considered unworkable from our people's perspective, so a further modelling run has been undertaken which indicates that we can increase the number of patient journeys and provide our people with workable roster patterns.

71. The team continues to produce its usual run of accountability reports, with quarter 1 involving the year end Annual Performance Report, which will go forward to the Trust's AGM. This is a substantial body of work alongside the usual run of reports into ELT, committees, the JCC and Welsh Government. Quarter 1 saw the year end Joint Executive Team (JET) meeting with WG, which was positive. It remains important that quality and performance information going into these settings is to a high standard and gives internal and external stakeholders confidence in the Trust.
72. The new JCC structures and appointments into them are still emerging but beginning to become clearer. July's Finance & Performance Committee received a report updating the committee on developments in the JCC.
73. Finally, the team continues to develop the Trust's Quality & Performance Management Framework, with a particular focus being directorate/service level self-assessments, and July's Finance & Performance Committee receiving a benefits map for the Framework, to answer the "so what?" question of what benefits successful implementation will give the Trust and ultimately our patients and our people.

CLINICAL DIRECTORATE

WAST Recruitment Day

74. The Clinical Directorate Senior Management and Business Team were delighted to support the WAST Recruitment Day on 20 June in Swansea with

our Executive Director of Paramedicine - Andy Swinburn, Consultant Paramedic Urgent Care – Advanced Practice - Kerry Robertshaw, Professional Development Lead End of Life Care - Ed O’Brian, Health Board Clinical Lead – Dai Thomas, and Senior Advanced Paramedic Practitioner – Emma Nurse, all giving talks to the newly qualified paramedics (NQPs). The team also hosted several stands promoting CHARU and Research & Innovation amongst others and supported the People & Culture Recruitment Team with interviewing NQPs on the day in the panels. Congratulations to all of the NQPs who were offered a place within WAST!

W45 Taskforce, Save a Life Cymru & Welsh Government Training

75. Executive Director of Paramedicine – Andy Swinburn, and Executive Director of Quality and Nursing – Liam Williams, have been invited by Welsh Government to join the W45 Taskforce, a group with the mandate of collaborating on improving ambulance handover times. This comes at a time when WAST will be leading in the Ambulance Service sector by being the first ambulance service to adopt the Chain of Survival as a cardiac arrest measure, as opposed to a time-based measure for responding to the most severely ill patients for emergency services.
76. In a well-timed transition with this initiative, Save a Life Cymru (SaLC), the Welsh Government-developed group to promote the Chain of Survival Recognition of cardiac arrest, Early CPR and Early Defibrillation elements of the Chain of Survival have become part of the Clinical Directorate in WAST following a TUPE process. The team of 8 including a Programme Manager, Communications Manager and Public Access Defibrillator Coordinators will be instrumental to the delivery of the out of hospital cardiac arrest programme actions being implemented by the Trust in the coming years and we welcome them into the Directorate during this exciting period of change.
77. SaLC have already supported members of the Senior Clinical Team from the Directorate in delivering defibrillator and CPR training to members of Welsh Government and the Senedd this year, following the announcements around the cardiac arrest metrics. Thank you to all of the team who supported these training sessions to mark the implementation of this important clinical change.

Performance Framework

78. As part of the new ambulance performance framework, the Clinical Intelligence and Assurance Team (CIAT) is actively developing a

comprehensive suite of clinically driven indicators. These indicators are designed to offer enhanced assurance and insight into the quality of care delivered to patients whose call is prioritised within the EMERG category. These indicators will look at a small suite of generic measures but also see to develop condition (or complaint) specific gauges.

Proposed Interim Performance Measures for Development

Generic Clinical Metrics:

- Pain Management
- Physiological Scoring
- Condition Coding

Condition-Specific Metrics to include:

- Respiratory problems
- Maternity
- Anaphylaxis
- Convulsions
- Major Trauma

79. These indicators will be informed by data recorded by WAST clinicians via the electronic Patient Clinical Record (ePCR) system. The technical specifications for these metrics are currently under development by CIAT and will form the basis for robust, clinically meaningful performance monitoring aligned with patient outcomes.

Medicine Management

80. From a medicines management perspective, we had the successful introduction of Magnesium Sulfate across Wales with each health board live within 10 days of the roll out on the 11th March 2025. PGD compliance for Magnesium Sulfate was registered on ESR - a first for monitoring PGD compliance. There have been no reported adverse incidents since its introduction.

DIGITAL SERVICES

Emergency Services Network (ESN) Phase 2 Outline Business Case

81. The ESN Phase 2 Outline Business Case completed its journey through the Trust Governance when present to the Board in May 2025. Endorsement was given at each of the stages and therefore, the OBC has been formally submitted to Welsh Government for their endorsement. The next phase of developing to Full Business Case has started in anticipation of formal submission to Welsh Government for approval by the end of the current financial year.

EPCR

82. Significant steps have been made with the TerraPACE 2025 App Refresh by WAST and ePCR suppliers. A comprehensive wireframe has been sent to the developers; cross Directorate engagement is ongoing to fully maximise this opportunity capture meaningful data that improves our service delivery and enhances the care we provide to our service users.
83. April's application update has brought increased functionality for our front-line colleagues and has allowed us to tighten overall application patient safety issues. Specifically, these include:
 - Improved Welsh General Patient Record integration: This interface allows clinicians at the side of the patient to access their General Practitioner held record and review the information within it to gain a comprehensive understanding of the patients medical history. The current design limits access to Advanced Paramedic Practitioners and Senior Paramedics, the added improvement will allow for clinician grade access tailoring the presented information to ensure patient safety is supported whilst providing the users with information relevant to their scope of practice. Further development work is underway to lift and embed the information into the ePCR application reducing transcription errors and streamlining record completion.
 - Mobile Data Vehicle Solution (MDVS) terminal QR Code Sign-On: Clinician held tablets will be utilise this feature to electronically tie them to the resource. This functionality will reduce the risks of colleagues selecting an incorrect vehicle or moving between vehicles during the shift. Senior users and remote clinicians will still keep original functionality allowing vehicle choice from within the eCPR application.
84. Since the last update, the longstanding Corpuls monitor, connectivity issue has significantly improved. Further software will be introduced onto the patient monitor that provides a deeper analysis of the 12 Lead ECG. This technology will improve the clinician experience and increase confidence in interpretation of the captured ECG.

ICT

85. Following the successful and seamless transition of the Llanfairfechan-based departments to Ty Elwy, the ICT team are continuing to work on moving Trust ICT infrastructure from the Llanfairfechan site. This work is planned over the next 12 weeks with several system moves planned in overnight to minimise operational impact as services are moved.
86. Work is ongoing to replace the 999 MIS C3 CAD servers, and in April work commenced to update the 999 Paramount and AQUA environments across both data centres. These systems provide the clinical decision and prioritisation for 999 calls processed by the CAD. This is a significant piece of work which involves a completely new system architecture, which will not only enhance resilience and disaster recovery (DR) capabilities but will also improve data access for enhanced reporting.
87. Improvement work continues across the wider ICT infrastructure with a number of systems being upgraded. Good progress is also being made on Windows 11 adoption, which follows a comprehensive period of testing by teams to ensure there are no issue with systems in use across the Trust.

Insight & Data Services

88. The Trust has surpassed the 85% minimum threshold for Information Governance training compliance, with staff across the organisation up to date with either the ESR or LMS 365 modules. This was the only category where WAST did not meet minimum expectations for the 2024/25 IG Toolkit submitted in March 2025. With this criteria now met (and as long as it can be maintained), puts us in a strong position for this year's submission. In addition, this reduces risk of rejection by the Health Research Authority's (HRA) independent Confidentiality Advisory Group (CAG) where WAST require use of personal-data for research, and with more staff awareness and confidence regarding data protection topics, helps mitigate some elements of the corporate risk.
89. The Insight & Data Services (IDS) function received additional investment for 2025/26, and currently has 4 roles at advert, 2 new job descriptions to be developed to support the expansion of the team, and has brought in 2 short-term posts to support with the high-priority deliverables (such as the new Performance Model Framework data and reporting).

90. On 1st July 2025, the new Call Flow and categorisation model was implemented, with experts from across IDS supporting in this delivery – from Information Governance and Data Quality, to Data Engineering, Analytics and Reporting. The team ensured new key metrics were available from go-live in 6 agreed priority reports, supporting Operations, Clinical and leadership in decision-making on the day and with assurance. The implemented reports are based on logic that has been defined and developed collaboratively between the IDS team and the supplier's developer, and will continue to be refined over coming weeks. In parallel, the external reporting for Commissioners and Welsh Government, namely the Ambulance Service Indicators (ASIs) and Official Statistics, are also in development, with a wholesale change to the metrics that will be published required by the August submission.

Digital Transformation and Innovation

91. Strong foundations continue to be laid in developing our digital transformation and innovation offer. The team structure has been developed and is currently going through job evaluation with an aim to recruit and have the substantive team in post by Autumn 2025. This team has been carefully crafted through working with colleagues both within the directorate but also the wider organisation to ensure value add and avoid duplication. This is an exciting time for the directorate, increasing the visibility of what the digital directorate can bring.
92. Alongside establishment of the team, a series of sprint meetings to design the Digital Transformation Innovation Programme (DTIP) is well underway. The purpose and strategic value of DTIP will be to:
- Ensure digital efforts are prioritised, visible and aligned to the Trust's broader objectives.
 - Position Digital as a driver of transformation, not just a support service.
 - Enable the Trust to say "no" or "not yet" to non-priority work, with transparency and justification.
93. Work is also ongoing to align the above to the Clinical Model Transformation (CMT) Programme allowing us to better prioritise and be involved in projects at the right time.

94. Aligned to our directorate plan, an outline has been developed in several areas including our innovation labs, automation and digital engagement. We have also concluded phase one of our copilot pilot and we are moving to phase 2 where we will build a bespoke education offer for WAST and continue to understand how to implement value-add use cases across the organisation in a safe, compliant and ethical way.

HSJ Awards

95. On Thursday 26th July, colleagues from both people and culture alongside digital joined forces to celebrate being shortlisted for a prestigious HSJ Digital Award in the category *Digital Equality, Diversity and Inclusion Award*. While we did not win, being shortlisted was a testament to WAST's unwavering commitment to innovation and excellence in digital healthcare. The evening also spurred many ideas of future projects in partnership between the directorates to continue this important work, ensuring we continue to do good with digital while closing the gap on inequalities. Jonny Sammut, Leanne Smith and Aasha Cowey were also recognised in their roles as judges for other categories, which provided excellent opportunities to learn from peers and celebrate success in others.

PARTNERSHIPS AND ENGAGEMENT

96. Much of the activity in recent weeks has focused on the pilot changes to Welsh Government's Ambulance Performance Framework from 1 July 2025. More than 300 stakeholders received briefing materials including stakeholder letters, an FAQ document, detailed stakeholder briefing pack and a dedicated internet page outlining the changes in detail, in line with the external communications strategy. A visit by the Cabinet Secretary for Health and Social Care to the Trust's fleet workshop in Merthyr Tydfil also presented an opportunity to record media interviews on the changes. Media coverage more broadly was amplified by a BBC Wales feature across platforms (TV, radio and online) featuring interviews and access which had been facilitated over a number of months. Among the other materials to support communication with the wider public were new website content, an animation, social media content, and poster. A range of tailored materials was also developed to support different internal staff groups in understanding the changes to the performance framework, including a series of informative videos, targeted FAQ documents and comprehensive content hosted on a dedicated Siren page.

97. Further communications activity, including media and internal communications, has been undertaken in relation to the recent announcement of further changes to the performance management framework to improve care for patients with strokes and other serious conditions such as heart attacks. A new "orange: time sensitive" category will prioritise fast assessment, response, clinical care and transport, ensuring patients quickly reach specialist care.
98. The changes replace the current categories with:
- 'Orange: time sensitive' - for conditions needing a fast response and care from ambulance clinicians before transport to hospital for specialist care, such as a stroke.
 - 'Yellow: assess and respond' - for conditions which require further clinical assessment to determine the best pathway of care, such as a person suffering from abdominal pain who may be suitable to stay at home or may need further investigations.
 - 'Green: planned response' - for conditions such as a blocked catheter which may require community care or planned transport to urgent care services.
99. The new categories, which replace the current amber category, are scheduled to be implemented before winter this year as part of a new emergency ambulance performance framework.
100. Long Service Award season is underway. Two of three events took place in July, and the final event is planned for October. In parallel, work continues to refresh all content across the WAST website to ensure alignment with the latest developments within the Trust since the site's initial launch. Additionally, the team is collaborating with colleagues in Digital Health and Care Wales (DHCW) to develop standardised templates aimed at enhancing the accessibility of our content and formal papers.
101. The Director of Partnerships and Engagement chaired the recent North Wales Regional Partnership Board (nominated vice chair) in a positive planning session with Betsi Cadwaladr University Health Board, as well as attending a development session with Prof Michael West as a member of Cardiff and Vale Regional Partnership Board. The Director also led the media exercise element of the recent Chief Executive recruitment process.
102. The Directorate has recently welcomed the Communications Manager from Save a Life Cymru (SALC) to the team, as part of the wider integration of

SALC into the Trust following the Cabinet Secretary's renewed focus on the importance of bystander CPR as part of the new performance management framework. The team is working through a refreshed communications plan with a focus on creating a "nation of lifesavers".

QUALITY SAFETY AND PATIENT EXPERIENCE DIRECTORATE

Dementia Action Week

103. From Monday, 19th May to Friday, 23rd May, the dementia team undertook a series of visits to various stations and contact centres across Wales as part of Dementia Action Week. One notable visit was to Wrexham station, where they were joined by Ronnie, an individual living with dementia, along with staff members and the Dementia Lead for North Wales Police. The discussions included potential dementia-friendly modifications to a vehicle in Wrexham and the necessary engagement from the team.
104. Key actions and outcomes from the week comprised requests for Continuing Professional Development (CPD) training sessions during the summer, providing personal advice to staff regarding family members with dementia, and a request for a reference sheet on grounding techniques during crises and managing carer communication barriers. Ideas also emerged for increased collaboration with the new Care Planning team, follow-up CPD sessions, engagement with Practice Educator Lead Ruth Lander for 111/CSD, directories of services, and auditing calls on CAD, e-CNS, and CPSS platforms, particularly concerning frequent calls from care homes.
105. Additionally, we co-delivered a webinar for dementia carers to 12 staff members, featuring Ronnie, who lives with dementia. Collaboration with the Communications team led to the promotion of the Dementia Concern Referral and associated learning resources, including top tips on [effective communication](#) and developing [meaningful connections](#) with individuals living with dementia.
106. In addition to the adjustments we have previously reported for our NEPTS vehicles, we have modified five emergency ambulances to be dementia-friendly across Cardiff & Vale (as part of a Bevan Exemplar project) and over the summer we will work on 1 vehicle in the North Wales area.

EDUCATION PROFESSIONAL AND CLINICAL PRACTICE TEAM

Wellbeing initiative

107. [New hiking group aimed at supporting men's mental health and wellbeing:](#) Keiran Reynolds is a Training Assistant based at Ty Elwy. He has created a men's walking group, entirely of his own initiative, and it's already having a real impact encouraging colleagues to come together, support each other, and focus on their well-being. Kieran has previously secured funding for additional equipment for the gym at Ty Elwy, as well as arranging gym induction to all staff.

WASTQ QUALITY EVENT

108. The second annual WASTQ Quality Event, held in Cardiff on 10 July 2025, marked a significant milestone in our continuous improvement journey. Opened by Bethan Evans, Non-Executive Director and Chair of QuESt, the event revolved around the inspiring theme of "Lasting Impact and the Domino Effect on Excellence". Attendees were enriched by a diverse array of speakers from across the organisation, who shared invaluable insights and experiences. A highlight of the event was the Guest Speaker, Dr Adrian Neal, whose session on compassionate communication resonated deeply with all present. Additionally, the emotive and information-rich Patient Panel, featuring our lived experience advisors, fostered meaningful engagement and underscored the importance of patient-centred care. The success of this event highlights our commitment to fostering a culture of quality across Team WAST.

QUALITY IMPROVEMENT - SIMPLY DO!

109. The quality improvement team are launching the new Simply Do platform as a replacement for our WiN network. The new software takes a collaborative approach to improvement initiatives allowing our teams to not only provide solutions to the challenges we set but to also engage and interact with each other's ideas to find a collaborative and innovative solution. The platform is being piloted in our integrated care environment and is already proving insightful and engaging. The work so far was showcased at our WASTQ event and all attendees were keen to get involved. Once the pilot programme has been completed, and lessons learned from our first endeavours the QI team will be officially launching the QI hub across the organisation.

REMOTE CLINICAL CARE LEADERSHIP TEAM

110. Further to the ongoing evaluation of the NHS 111 Wales digital tool, Call Prioritisation Streaming System (CPSS), to help call handlers assess patients and direct them to the right care, a further paper has now been published in the BMJ Open.

PEOPLE AND CULTURE DIRECTORATE

Culture

Promoting Sexual Safety across the Organisation

111. Our rollout of the multi-level training programme continues to gain momentum, with over 40 staff having completed the general awareness training to date. This initiative is a key component of our commitment to fostering a safe, respectful, and inclusive workplace culture. By creating a workplace where all staff feel safe and respected is fundamental to our values. This training directly supports our strategic goals around inclusion, wellbeing, and organisational integrity, while also aligning with national priorities on tackling sexual harassment and gender-based violence. Key Insights from Participant Feedback includes:

- **Practical Impact:** Majority of participants reported they would apply the knowledge gained "often" in their roles, indicating strong relevance to day-to-day work.
- **High Satisfaction:** The training received an average rating of 4.57 out of 5, with participants stating they learned "a lot" from the session.
- **Strong Advocacy:** 92.9% of attendees said they would recommend the session to others.

112. Furthermore, emerging themes from Qualitative Feedback include:

- The effectiveness of delivery was frequently praised.
- Participants highlighted the importance of addressing verbal sexual harassment specifically.
- There were suggestions for face-to-face sessions and follow-up resources to deepen learning.

113. In response to growing interest, the EDI team has seen an increase in requests from specific teams for tailored sexual safety training. Over the past month, they have collaborated with the Resourcing Team and APPs to enhance our approach to sexual safety across the organisation.

114. Our Assistant Director for Inclusion, Culture and Wellbeing, Dr Catherine Goodwin, continues to share our learning and best practices with partner organisations. Notably, Dr Goodwin led a workshop at the Public Sector Leaders Conference on tackling workplace sexual harassment. During the event, Johanna Robinson, Welsh Government's National Advisor for Violence Against Women, Gender-Based Violence, Domestic Abuse and Sexual Violence, once again recognised WAST as a leader in this space.

Celebrating Eid: Promoting Inclusion Through Cultural Awareness

115. As part of our ongoing commitment to fostering an inclusive and culturally aware workplace, the BEAM Network continues to actively engage with staff by celebrating key cultural events. Most recently, the Network hosted an Eid celebration at VPH, where colleagues were invited to share traditional foods and connect with network members in an informal and welcoming setting. The celebration was well attended, reflecting an interest in cultural learning. A new member of staff, attending on only their second day at the Trust, expressed how meaningful it was to see their religion celebrated so openly. Resulting in them joining the BEAM Network, underscoring the positive impact of inclusive practices on staff experience and retention.
116. By recognising and celebrating cultural and religious events, we build a sense of belonging and respect across our workforce. These moments of connection contribute to a more inclusive organisational culture, where diversity is valued and individuals feel seen and supported. These events not only strengthen internal community bonds but also reinforce our values of equity, diversity, and inclusion in everyday practice.

Pride Cymru 2025: Celebrating Visibility and Solidarity

117. Our LGBTQ+ Network invited colleagues to join them in representing the Trust at this year's Pride Cymru event in Cardiff. Participation in Pride Cymru is a visible demonstration of our support for LGBTQ+ staff, patients, and communities. It reinforces our values of respect, dignity, and equality, and helps foster a workplace culture where everyone feels safe to be themselves. Events like this, alongside other NHS organisations, strengthen our commitment to inclusive healthcare. Staff from across the organisation took part, proudly marching under the NHS banner. The event provided a valuable opportunity to celebrate diversity, raise awareness, and build community connections. This kind of engagement is a powerful reminder that inclusion is not just a policy, it's something we live and demonstrate through action.

Mastering Change: National Recognition for EDI Leadership

118. We are proud to share that two of our colleagues from the EDI team were recently recognised at a prestigious national event celebrating women in leadership and change-making. Kat Cobley, Head of Inclusion and Engagement, and Hayley Jones Dunne, Organisation Development Manager for EDI, were invited to attend the third annual Women Mastering Change event at the House of Lords in London. The event was hosted by Baroness Tanni Grey-Thompson and organised by Bernie Davies, founder of Mastering Diversity. The event brought together women leaders from across sectors to share personal stories and practical strategies for navigating change, with focussed discussions on embedding diversity, leading with authenticity, and building inclusive cultures.
119. This was the first time WAST has been represented at the event, marking a significant milestone in our national engagement on inclusion. Kat and Hayley's participation not only amplifies our voice in the national conversation on diversity but also strengthens our internal momentum for change. Their insights will help inform our ongoing work to create a more inclusive and equitable organisation.

Capacity

Improving Access to Occupational Immunisations

120. Our Occupational Health team have launched a new immunisation drop-in service across the Trust's three main sites: Ty Elwy, Matrix One, and VPH. This initiative is designed to improve service efficiency by reducing the number of missed appointments and DNAs, which have previously impacted capacity and delayed staff onboarding. This is important as timely immunisation is a critical part of our occupational health provision, ensuring our people are protected and fit for duty from the outset. By minimising missed appointments, we can free up clinical capacity for pre-placement medicals and ongoing health surveillance, enabling new starters to begin their roles more promptly and ensuring all staff receive the support they need throughout their careers. This flexible, accessible model supports our wider goals of improving workforce health, streamlining onboarding processes, and enhancing the overall employee experience.

Inclusive Recruitment Initiative

121. We are proud to share that our inclusive recruitment initiative within the Digital Team was shortlisted for an HSJ Award, recognising our proactive

efforts to increase workforce diversity and remove barriers to employment. Key features of this initiative included:

- Targeted outreach to ethnically diverse communities to raise awareness of roles within the Digital Team
- Pre-application support provided to help potential candidates understand the team's work, digital strategy, recruitment process, and employee benefits
- Unconscious bias training delivered to recruiting managers to promote fairer decision-making and raise awareness of the systemic barriers faced by ethnic minority applicants

122. As a result of this, we seen a notable increase in applications and appointments from ethnic minority candidates. In addition to receiving positive feedback from both applicants and recruiting managers on the accessibility and fairness of the process. We have continued to use elements of this approach which were also applied to the NQP recruitment event, and plans are underway to replicate the model for ACA recruitment next year. Building a diverse and inclusive workforce is essential to delivering equitable, innovative, and person-centred services. This initiative demonstrates our commitment to addressing underrepresentation and ensuring fair access to opportunities across the Trust.

Skills Mix Task & Finish Group

123. The Skills Mix Task and Finish Group has now completed its round of meetings, and a report outlining key outcomes and recommendations has been submitted to the ELT. A follow-up report, including additional data and planning insights, will be presented to ELT in mid-August. This work is a critical component of our People and Culture Plan, as it directly supports the delivery of the Strategic Workforce Plan by helping us better understand and optimise the mix of skills across the organisation, ensuring we can meet service demands effectively while remaining within our financial envelope. The insights from this group will inform future workforce modelling and help ensure we have the right people, in the right roles, with the right skills to deliver high-quality care and support across the Trust.

Improving Workforce Processes

124. The People Services Team has been leading a significant programme of work to enhance key workforce processes, with the aim of improving

organisational culture, safeguarding staff wellbeing, and reducing operational risk. Robust and transparent people processes are essential to maintaining a safe, fair, and supportive working environment. This work directly contributes to our goals of improving workforce safety, reducing avoidable harm, and fostering a culture of trust and accountability.

125. Key Developments include the establishment of a Task and Finish Group, bringing together colleagues from People Services, Clinical, and Safeguarding teams to review and strengthen critical workforce procedures. The Groups areas of focus included: managing referrals to professional bodies, processes for withdrawing employment offers, strengthening the decision-making framework for suspensions and reviewing the handling of safeguarding allegations.
126. Furthermore, a consultation with the Operations Leadership Team was conducted to ensure alignment and operational insight. This resulting in a report outlining the findings and recommendations was presented to ELT, where the proposals received full support. We are now developing a detailed project plan to guide the implementation of these improvements. This will ensure consistent, fair, and timely processes that protect both staff and the organisation, as well as reducing risks and avoidable harm to colleagues.

Progress on the People Development Plan

127. We are making progress in developing our WAST People Development Plan, which is firmly grounded in the principles of the Wellbeing of Future Generations (Wales) Act. By embedding these principles, we are not only addressing current organisational needs but also proactively preparing for future challenges. This forward-looking approach supports the creation of a more inclusive, skilled, and adaptable workforce that aligns with our long-term strategic goals and values.
128. To date, we have undertaken stakeholder engagement made up of representatives from each directorate. Their contributions have been instrumental in shaping the structure of the plan, defining career pathways, and conducting a horizon scan to identify potential future workforce gaps. In parallel, we have extended the opportunity for wider staff participation, ensuring that the policy and implementation plan reflect a broad range of perspectives from across the organisation.
129. We have also made significant progress in delivering targeted learning and development opportunities. The Level 3 Safeguarding course is now available, marking a key milestone in our training offer. In support of our

commitment to bilingual service delivery, we have launched a new Welsh Language in an Emergency course, which is currently open for expressions of interest. Additionally, the first 100 participants have successfully completed the Level 3 Certificate in Effective Mentoring for EAPs, further strengthening our internal mentoring capacity.

130. These developments represent important steps toward building a workforce that is not only capable and confident but also aligned with the values of wellbeing, sustainability, and continuous development.

Capability

Embedding Our WAST Way

131. On 28th May, we officially launched Our WAST Way, our new leadership and management framework built on the principles of Care, Connect, and Value Everyone. It reflects both national leadership expectations and what our people have told us matters most. Since launch, we've been running Our WAST Way: Applied sessions each week, introducing the framework and providing practical tools and development to support day-to-day leadership.
132. We now move into the next phase, with Essential Conversations workshops starting mid-July. These in-person sessions are for all colleagues with people management responsibilities and focus on building the skills and confidence to have meaningful conversations, including:
 - Regular check-ins and informal 121s
 - Discussions that support wellbeing, growth, and performance
 - Sensitive or complex conversations that are often avoided
133. At our recent Leadership Symposium, senior leaders piloted the workshops — contributing valuable feedback and helping shape the final design. Their input has ensured the content is practical, relevant, and grounded in the real challenges of leading in WAST. By having these conversations earlier and more consistently, we can resolve issues before they escalate, support positive relationships, and reduce reliance on formal processes.
134. Our WAST Way is not a one-off training offer, but a commitment to sustained culture change through consistent behaviours, better conversations, and more human leadership - every day, at every level.

Strategic Equality Plan Annual Report

135. The draft Strategic Equality Plan (SEP) Annual Report for 2024/25 is currently under consultation across the Trust. This year's report outlines the progress made against our four SEP objectives and highlights the tangible impact of our equality, diversity, and inclusion efforts. This demonstrates our commitment to advancing equality and reducing disparities across the organisation. It provides transparency on our progress, informs future priorities, and ensures we remain aligned with our legal and moral obligations under the Equality Act 2010 and the Public Sector Equality Duty. Key highlights demonstrate a reduction in the Gender Pay Gap, reflecting our efforts to promote pay equity and inclusive career progression. As well as an increase in workforce diversity, indicating improved outreach, inclusive recruitment practices, and a more welcoming organisational culture. The final report, along with supporting data, will be published on the Trust's website in the Autumn, providing stakeholders with a clear view of our achievements and areas for continued focus.

Future Workforce Solution Programme: Preparing for ESR Replacement

136. The Trust continues to monitor developments in the Future Workforce Solution Programme, which will replace the current ESR system across NHS England and NHS Wales. The announcement of the new provider is expected in Autumn 2025. This programme represents a major transformation in how workforce data is managed across the NHS. It will impact the organisation, requiring significant planning and change management. A modern, integrated workforce system will support more efficient processes, better data insights, and improved staff experience.

137. To date, the People Services and Digital teams have registered interest in participating in the Design and Build phase workshops. We are currently awaiting confirmation of role allocations, other directorates across the Trust will be required in the implementation of this programme. In addition, internal programme planning has commenced within WAST to prepare for the implementation phase, which is expected to run from 2026 to 2028. We will continue to collaborate and plan to ensure a smooth transition and maximise the benefits of the new solution.

RECOMMENDATION: The Trust Board are invited to discuss and note the contents of this report.



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

ACTIONS TO MITIGATE AVOIDABLE PATIENT HARM IN THE CONTEXT OF EXTREME AND SUSTAINED PRESSURE ACROSS URGENT AND EMERGENCY CARE

MEETING	Trust Board
DATE	31 st July 2025
EXECUTIVE	Rachel Marsh, Interim Chief Executive
AUTHOR	Hugh Bennett, Assistant Director Commissioning & Performance
CONTACT	Rachel.Marsh3@wales.nhs.uk

EXECUTIVE SUMMARY

1. At its July 2022 meeting, Trust Board received and discussed a report relating to avoidable patient harm. The original report was accompanied by a supporting action plan designed to mitigate patient harm. Updates have been provided at every subsequent Board meeting.
2. At its September 2024 meeting Trust Board received a closure report for the patient mitigations action plan and agreed to receive just the patient harm scorecard going forward.
3. The Trust continues to take many actions to mitigate patient harm, at a strategic, tactical and operational level, which are reported through to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report, Monthly Integrated Quality & Performance Report, QuEST committee agendas etc.
4. The Trust went live, as planned, on phase one the new 999 emergency pathway clinical categories (Arrest, Emergency and Rapid Clinical Screening (RCS) 0) of the new Ambulance Performance Framework on 01 July 2025. On 17 July 2025, the Cabinet Secretary announced phase two (Time Sensitive, Assess & Response and Planned Response) with a back stop delivery date of 01 December 2025.
5. *Appendix 1* contains the patient harm mitigations one-page scorecard. This is the third scorecard that contains the impact of clinical model transformation changes switched on through winter 2024/25.
6. Key headline patient harm mitigation metrics for Q1 2025/26 include:
 - The Trust is responding to more Red 8-minute incidents (reporting on Red 8 minute performance ended on 30 June and was replaced with the new

categories of Arrest, Emergency & RCS0);

- Patient cancellations are reducing and automatic Clinical Safety Plan “can’t sends” have been switched off;
- The Trust achieved a 20% consult & close rate in June 2025. This is a material increase on the previous pre-rapid clinical screening change of 15%;
- There was a material reduction in hospital handover lost hours in June 2025 to 15,278 compared to 22,229 in the same month last year;
- Whilst this reduction is very welcome, the Trust has previously estimated that no hospital waits over an hour would equate to 7,000 lost hours (the Trust’s EMS roster keys are predicated on 6,000 hours of hospital lost hours); and
- As a result, the levels of avoidable patient harm in the 999-emergency ambulance care pathway remains unacceptably high, making further clinical model transformation by the Trust and further handover lost hour reduction by health boards strategic imperatives.

RECOMMENDATIONS

Trust Board is asked to:

- **NOTE** that the Trust’s clinical model transformation is beginning to take effect.
- **NOTE** that has been a material reduction in hospital handover lost hours.
- **NOTE** that whilst these are positives, the continued level of avoidable patient harm in the 999-emergency care pathway remain too high.
- **NOTE** the continued need for health boards to further reduce hospital handover lost hours, including reaching the 45-minute target expected by the Cabinet Secretary by October 2025, and for the Trust to support health boards in achieving this by continuing to evolve its clinical model.

KEY ISSUES/IMPLICATIONS

As outlined in the Executive Summary above.

REPORT APPROVAL ROUTE

Date	Meeting
21 July-25	Director of Partnerships & Engagement/Interim Executive Director of Strategy, Planning and Performance
31 July-25	Trust Board

REPORT APPENDICES

Appendix 1 – Patient Harm Mitigations Dashboard

REPORT CHECKLIST

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

SITUATION

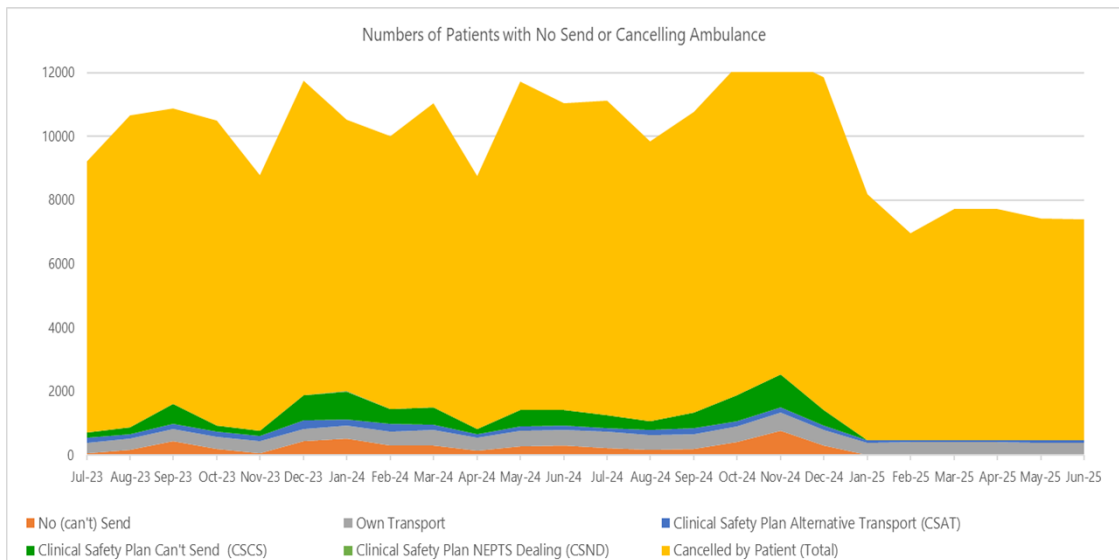
1. Sustained and extreme pressure across the Welsh NHS urgent and emergency care system is negatively impacting on patient flow leading to avoidable patient harm and death.
2. This report provides Trust Board with a patient harm mitigations dashboard.

BACKGROUND

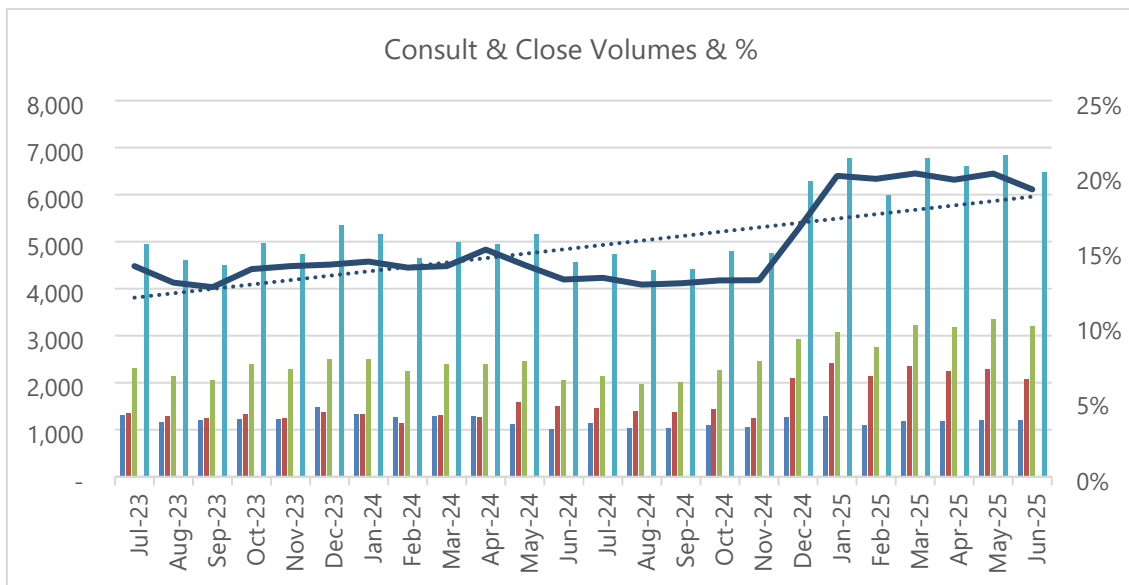
3. The 28 July 2022 Trust Board received the first iteration of a report and actions to mitigate real time avoidable patient harm which has then been updated for every Board meeting.
4. At its September 2024 meeting Trust Board received a closure report for the patient mitigations action plan and agreed to receive just the patient harm scorecard going forward.
5. The Trust continues to take many actions to mitigate patient harm, at a strategic, tactical and operational level, which are reported through to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report, Monthly Integrated Quality & Performance Report, QuEST committee agendas etc.
6. The Trust went live, as planned, on phase one of the new Ambulance Performance Framework on the 01 July 2025. On the 17 July 2025 the Cabinet Secretary announced phase two with a back stop delivery date of 01 December 2025.

ASSESSMENT

7. *Appendix 1* contains a simplified patient harm mitigations dashboard. These metrics indicate continuing levels of unacceptable patient harm, for example:
 - 542, 513 and 416 patients were estimated to have come to severe harm outside EDs in April, May and June 2025 respectively because of extended handover times;
8. There are a number of positives connected to the Clinical Model Transformation Programme-
 - There were zero Clinical Safety Plan “can’t sends” in the last three months, as a result of the introduction of RCS and a change in the plan from the automatic deployment of “can’t sends” at higher levels of the plan to a last resort at the discretion of the strategic commander.
 - Similarly, there was a 28% reduction in patient cancellations (pre-arrival) (see graph overleaf), which the Trust believes is attributable to the implementation of RCS; and
 - A 3.4% lower conveyance to EDs in Q1 25/26, compared to Q1 24/25.



9. As previously reported, the switching on of RCS has driven more patient flow into Integrated Care i.e. remote telephony triage, which in turn is leading to a higher consult & close rate, as illustrated the following graph:



10. The Trust achieved a 19%-20% consult & close range in Q1, five percentage points higher than the highest rate the Trust has previously achieved, and consistent with the 2023 EMS Demand & Capacity Review modelling. The switching on of RCS and the increased patient flow into Integrated Care marks a “cultural shift” for the Trust away from traditional dispatch to remote care and community care.
11. The final stage of rapid clinical screening, RCS0, was switched on as part of the Arrest and Emergency categories go-live on the 01 July 2025. This final stage focused on screening part of the old red category calls, in particular, breathing difficulties. At this stage, it is too early to report publicly on Arrest, Emergency and RCS0 performance with the first public release of data due on 21 August 2025. The Trust put in place a suite of internal quality, safety and performance reporting for the go-live and submitted a week one assurance report to the

Director of Commissioning for 111 & Ambulance Services and to Welsh Government.

12. On 17 July 2025 the Cabinet Secretary announced phase two of the Ambulance Performance Framework with a back stop date of delivery by 01 December 2025. Phase two will involve the introduction of three new categories:
 - **'Orange: time sensitive'**– for conditions needing a fast response and care from ambulance clinicians before transport to hospital for specialist care, such as a stroke;
 - **'Yellow: assess and respond'**– for conditions which require further clinical assessment to determine the best pathway of care, such as a person suffering from abdominal pain who may be suitable to stay at home or may need further investigations; and
 - **'Green: planned response'**– for conditions such as a blocked catheter which may require community care or planned transport to urgent care services.
13. Phase two will be more complex/transformational than phase one, moving away from the final disposition/outcome being an MPDS code to one determined through the remote clinical assessment process e.g. ideal response.
14. There was a material reduction in hospital handover lost hours in June 2025 to 15,278 compared to 22,229 in the same month last year. Whilst too early to officially report, July appears to have sustained a trend of comparative improvement. The Trust is aware of targeted actions at some sites in Wales which may be positively impacting patient flow, and therefore patient handover at the emergency department. However, a seasonal impact may also be contributing to improvement. Only time will now tell if the reduction is sustained as activity will inevitably pick up as we emerge from summer into autumn and winter. It is important to stress, that while improvement is showing, the quantum of lost capacity to handover is still high and warrants further reductions. The taskforce established in response to the Ministerial Advisory Group (MAG) on NHS Wales Performance & Productivity which include a recommendation to reduce handover waits to 45 minutes, has started to meet with the Trust represented.
15. The Trust has already received winter planning guidance from Welsh Government. There is no specific requirement for the Trust to produce its own plan, but it will need to feed into the regional self-assessments that are required ensuring a system-wide approach to winter planning in which the needs and actions of the Trust are reflected. The primary focus for the Trust this winter will be implementing phase two of the Ambulance Performance Framework as detailed above, along with established practices e.g. festive season planning, forecasting & modelling, capacity management etc.
16. In conclusion, there are some positive indicators in the Q1 Patient Harm Mitigations Dashboard, in particular, reduced patient cancellations, an increased consult & close rate and hospital handover reduction. On 01 July 2025 the Trust

went live as planned with the new Arrest and Emergency categories and has switched on the final part of rapid clinical screening, RCS0. The Trust has a clear strategic plan for winter i.e. phase two of the Ambulance Performance Framework and there is a much stronger focus by health boards on hospital handover reduction. The Trust will need to continue to monitor the effect of these changes through the scorecard into the rest of the year and whether there is a meaningful reduction in patient harm.

RECOMMENDATIONS

Trust Board is asked to: -

- **NOTE** that the Trust's clinical model transformation is beginning to take effect.
- **NOTE** that has been a material reduction in hospital handover lost hours.
- **NOTE** that whilst these are positives, the continued level of avoidable patient harm in the 999-emergency care pathway remain too high.
- **NOTE** the continued need for health boards to further reduce hospital handover lost hours, including reaching the 45-minute target expected by the Cabinet Secretary by October 2025, and for the Trust to support health boards in achieving this by continuing to evolve its clinical model.

Patient Harm Mitigation Indicators Dashboard



Top Monthly Indicators	Target 2026/26	Apr-25	May-25	Jun-25	2 Year Average	RAG	Top Monthly Indicators	Target 2025/26	Apr-25	May-25	Jun-25	2 Year Average	RAG
Our Patients							Partnerships / System Contribution						
Volume of Red Responded Incidents in 8 Minutes	↑	2,600	2,575	2,547	2,467	G	Successful Consult & Close Outcome	17.0%	20.16%	19.74%	20.15%	15.09%	G
Volume of Amber 1 Responded Incidents	↑	9,988	10,601	10,794	10,941	R	% of EMS Verified Demand Accessing SDECs	↑	0.6%	0.7%	0.7%	0.52%	G
Can't Send & Cancelled by Patient Volumes	↓	7,712	7,430	7,397	9,938	G	Number of Handover Lost Hours	7,500	21,193	19,670	15,278	21,620	R
Our People							Number of Patient Handovers > 45 mins						
Sickness Absence (<i>all staff</i>)	6.0%	7.13%	6.81%	N/A	8.10%	R	Number of Patient Handovers > 1 hour						
Number of Shift Overruns	↓	3,773	3,745	3,441	3,912	G	Number of Patient Handovers > 4 hour						
Total EMS Resource (all types) UHP	95%	97%	95%	94%	96.27%	A	Immediate Released (Red) Declined						
Value							Immediate Released (Amber 1) Declined						
% of Conveying Production Lost Due to Handover Lost Hours	7.81%	22.2%	20.0%	16.0%	22.4%	R	Patients Estimated to be coming to Severe Harm (from long ED wait)						
% of 111 Demand Referred to ED	↓	15.18%	15.71%	15.99%	14.50%	R	Joint Investigation Framework Incidents Referred to Health Boards						
% of EMS Demand Conveyed to ED	↓	34.81%	36.20%	36.81%	35.86%	G							
Average Jobs per Shift (All Vehicles)	·	2.64	2.64	2.33	2.36	A							

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)



GIG
CYMRU
NHS
WALES

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

AGENDA ITEM No	9
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	3

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Trust Board
DATE	31 July 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks.
2. A summary table of these risks is set out in Annex 1 with a detailed description of each contained within the Board Assurance Framework (BAF). All updates are highlighted in blue on the BAF.
3. The BAF has been included in the reading room facility in Ibabs, which is a digital space that hosts documents. Access to the reading room is through the documents/shared folder in Ibabs' main menu. For those without access to Ibabs, the BAF is available on the Trust's website alongside this meeting's papers.
4. The document has been included in the reading room given its significant size and the fact that it has been reviewed by each of the committees during this quarter. Any changes to it have been drawn out within this report.
5. The more detailed description contained within the BAF provides the Board 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 in Annex 2.
6. The Board can take assurance that each of the principal risks have been reviewed in line with the agreed schedule detailed at Annex 3 and that the Executive Leadership Team (ELT) approved the principal risk activity on 09 July 2025 having considered the review of each risk undertaken throughout June 2025 by Risk Owners and the Assistant Director Leadership Team (ADLT).
7. This executive summary continues to outline the broader discussions across the senior leadership teams and the Committees on the higher rated risks and signposts the Board accordingly. The Risk Owners have an opportunity to further add to this narrative and

detail of any assurances or escalations during the meeting and Committee Chairs will also contribute to this as appropriate, drawing from the Alert, Advise, Assure reports (AAA).

8. This report and the risk management work programme outline the significant work undertaken, to keep under review, the Trust's principal risks, and the Audit, Risk and Assurance Committee (ARAC) scrutinised each of these at its meeting on 24 June 2025 as well as the progress made against the work programme. Each of the Committee AAAs before the Board describe the discussions against risks within their remit.
9. Whilst there have been no material changes to the principal risks during this period the report foreshadows changes in scores for Risks 139 and 160 in the next round.
10. **Risks 223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 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*) remain at the highest score of 25.
11. The score is not based on the volume of cases of catastrophic harm; it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.
10. These two risks continue to be dynamically reviewed with the following updates:
 - 10.1. Whilst reducing, handover delays continue to present patient safety risks and extended waits in the community with a deteriorating performance being outside of what is acceptable to deliver a safe emergency service.
 - 10.2. The number of lost hours due to handover delays remained significant, reported at 19,673 in May and 15,276 in June.
 - 10.3. That said, the significant drop in handover lost hours in June and onwards into July, demonstrates some improvement across key hospital sites in reducing handover delays. Whilst this marks positive and welcome progress towards the 45-minute handover ambition, this downwards trajectory must continue to be sustained over a longer period of time prior to any consideration of a reduction in risk score.
 - 10.4. Phase one of the Trust's Clinical Transformation Model - specifically the introduction of Code Changes for response - has now gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the Wait 45 handover standard by some Health Boards represents a positive step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment.
 - 10.5. The Trust Board continues to focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm paper

which is presented at each Board meeting. Additionally, scrutiny is undertaken through the papers presented to the Quality, Patient Experience and Safety Committee (QUEST).

- 10.6. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) and committees and Trust Board in a variety of reports e.g. IMTP Assurance Report and described in the Monthly Integrated Quality & Performance Report to address these risks.
 - 10.7. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. A key one being that a Handover Improvement Group has been established by the NHS Executive.
 - 10.8. Most of the Trust's actions in the dashboard have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to mitigate the scale of handover lost hours due to the environment which it is operating in or make improvements in performance because of the continued challenges in the urgent and emergency care system.
 - 10.9. It's important to note that while some of the target dates of the mitigating actions are showing in the past, there has been close scrutiny of these two risks in dedicated workshops; the outcome of which was presented to the June ARAC meeting for discussion.
11. **Risk 160** (*high absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service*) is rated 20.
- 11.1. This risk has had an in depth review at several forums and it is likely that the score will decrease in the next round.
12. **Risk 201** (*A loss of stakeholder confidence that damages the Trust's reputation*) remains static at 20.
- 12.1. The risk was discussed at the last People & Culture Committee on 15 May 2025 and the tension in the reputational risk was noted that while the Trust has positive relationships with stakeholders, the patient experience remains poor due to harm in the community.
 - 12.2. A deep dive will be conducted on the risk over the summer to consider splitting it into a stakeholder risk and a patient experience reputational risk.
 - 12.3. This approach aims to address the different aspects of reputation and ensure the risk is accurately profiled.
13. **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).
- 13.1. This is due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations.
 - 13.2. The risk is reviewed in closed sessions of committees and Trust Board given that the specific detail and planned mitigations of this risk are of a sensitive and security based nature.

- 13.3. The high level detail of the risk and its rating is included in the overall risk dashboard for open session; however, the full detail is not included in Annex 4.
- 13.4. The risk is included for discussion in closed session of Trust Board today and is scheduled for considered by the closed meeting of the Finance & Performance Committee (FPC) on 22 July 2025.
14. **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 of the Board 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.
15. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4).
- 15.1. This risk was discussed in detail at the FPC on 20 May 2025 and a meeting with FPC Non-Executive Directors and the risk owner and risk team has taken place to consider repositioning the risk and a new approach to the way this is presented.
- 15.2. 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.
16. **Risk 558** *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures*, **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* and **Risk 623** *Failure to comply with Data Protection Legislation* all remain unchanged this period and static at a score of 15 (3x5).
- 16.1. The Welsh Ambulance Services Partnership Forum (WASPT) will undertake a deep dive on Risk 558 at its July 2025 meeting.
17. **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 163** *Maintaining Effective & Strong Trade Union Partnerships* remain unchanged at a score of 12 (3x4). The WASPT reviewed this risk at its meeting on 30 May 2025.
18. **Risk 139** *Failure to Deliver our Statutory Financial Duties* remains unchanged at a score of 8 (2x4) 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.
19. 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:

20. Members are asked to consider and discuss the contents of the report and:

- a) Receive assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees.
- b) Note the ratings and mitigating actions for each principal risk.

KEY ISSUES/IMPLICATIONS

The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE

Each of the Principal Risks have been or will be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period:

- Executive Leadership Team (09 July 2025)
- Assistant Directors Leadership Team (21 July 2025)
- Finance & Performance Committee (22 July 2025)
- Trust Board (31 July 2025)
- Quality, Safety & Patient Experience (05 August 2025)
- People & Culture Committee (12 August 2025)
- Audit, Risk and Assurance Committee (02 September 2025)

REPORT ANNEXES

- Annex 1 - Summary table describing the Trust’s Principal Risks.
- Annex 2 – Scoring Matrix
- Annex 3 – Frequency of Risk review




REPORT CHECKLIST

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death.	<p>IF significant internal and external system pressures continue</p> <p>THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community</p> <p>RESULTING IN patient harm and death</p>	Executive Director of Operations	25 (5x5) ➔
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service.	<p>IF patients are significantly delayed in ambulances outside A&E departments</p> <p>THEN there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised</p> <p>RESULTING IN patients potentially coming to harm and a poor patient experience</p>	Executive Director of Quality & Nursing	25 (5x5) ➔
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service.	<p>IF there are high levels of absence</p> <p>THEN there is a risk that there is a reduced resource capacity</p> <p>RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience</p>	Director of People & Culture	20 (5x4) ➔
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation.	<p>IF there is an inability of the Trust to deliver its core services because of system or organisational pressures</p> <p>THEN there will be a loss of stakeholder confidence in the Trust</p> <p>RESULTING IN a lack of stakeholder support for the Trust's long term</p>	Director of Partnerships & Engagement	20 (4x5) ➔

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny		
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	<p>IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place</p> <p>THEN there is a risk of a significant information security incident</p> <p>RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life</p>	Director of Digital Services	20 (4x5) 
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	<p>IF the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared</p> <p>THEN there is a RISK that the Trust's Incident Response will be suboptimal</p> <p>RESULTING IN avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability</p>	Executive Director of Operations	20 (4x4) 
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	<p>IF there is a lack of resources and available technology and infrastructure</p> <p>THEN there will be a failure to deliver the commitments outlined in</p>	Executive Director of Finance & Corporate Resources	16 (4x4) 

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		<p>the action plan and within the Welsh Government timelines</p> <p>RESULTING IN negative environmental and social impacts causing and reputational damage</p>		
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	<p>IF significant internal and external system pressures continue</p> <p>THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST</p> <p>RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm</p>	Director of People & Culture	15 (3x5)
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.	<p>IF a major incident or mass casualty incident is declared</p> <p>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</p> <p>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.</p>	Executive Director of Operations	15 (3x5)
623 FPC	Failure to comply with Data Protection Legislation	<p>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</p> <p>THEN the Trust will breach its legal obligations and potentially cause</p>	Director of Digital Services	15 (3x5)

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		<p>the personal or sensitive data to be compromised, lost, or inappropriately used</p> <p>RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.</p>		
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.	<p>IF WAST fails to persuade JCC/Health Boards about WAST ambitions</p> <p>THEN there is a risk of a delay or failure to receive funding and support</p> <p>RESULTING IN a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered</p>	Executive Director of Strategy Planning & Performance	<p>12 (3x4)</p> <p></p>
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	<p>IF the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained</p> <p>THEN there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised</p> <p>RESULTING IN a negative impact on colleague experience and/or services to patients.</p>	Director of People & Culture	<p>12 (3x4)</p> <p></p>
139 FPC	Failure to Deliver our Statutory Financial	<p>IF the Trust does:</p> <ul style="list-style-type: none"> • not achieve financial breakeven and/or 	Executive Director of Finance &	<p>8 (2x4)</p> <p></p>

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
	Duties in accordance with legislation.	<ul style="list-style-type: none"> • 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) <p>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)</p> <p>RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage</p>	Corporate Resources	

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.	Local 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

AGENDA ITEM No	10
OPEN	Open
No of ANNEXES ATTACHED	2

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – June 2025

MEETING	Trust Board (TB)
DATE	31 st July 2025
EXECUTIVE	Estelle Hitchon – Interim Director of Strategy, Planning & Performance
AUTHOR	Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Mark.Thomas12@wales.nhs.uk Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY
<ol style="list-style-type: none"> 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 June 2025. 2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators. 3. Data quality issues have been identified and are being addressed within 111 and APPs with the result that there are a number of Board approved metrics which are not available at this time. 4. The response times for red 8-minute performance was 50.7% in June 2025, with performance marginally decreasing compared to May 2025. The Amber 1 median was 1 hour 29 minutes, which was also a slight improvement on the 1 hour 51 minute 12-month average. The Trust knows these extended times (the ideal is 18 minutes) lead to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining levels of EA production (91% in June, slightly below the benchmark) and fully rolling out the CHARU service (85% in June); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.

5. The Trust lost 15,278 hours to handover in June 2025 (30-days), one of the lowest levels for four years. However, this level of lost capacity is still difficult to compensate for, despite all of the actions being taken by the Trust.
6. The 2024/25 budget included further investment in activities designed to shift demand left and mitigate the impact of handover lost hours investing in clinical screening and APPs (both delivered), which form part of the CMT Programme.
7. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in June 2025, with performance improving slightly to 10% from 10.5% in May 2025. There is currently a review of 111 rostering practice – initial report expected in late July.
8. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is stable, with both oncology and renal journeys remaining above target in June 2025. The NEPTS transport roster review has now started, which is a key efficiency.
9. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 7.50% in June 2025. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions remain above the 30% benchmark figure in June 2025 at 32.63%.
10. The Trust is continuing to deliver its Clinical Model transformation (CMT) programme at pace. Key parts went live in December, in particular, remote clinical screening (RCS), which was a cultural shift in how the Trust manages 999-demand. There are early indications in the data in this report that the clinical model transformation changes implemented over the winter are having an effect. The new Purple Arrest and Red Emergency categories were announced on 11 March 2025 and went live, as planned, on 01 July 2025.

RECOMMENDATION

Trust Board is asked to: -

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

REPORT APPROVAL ROUTE
23.07.2025 Assistant Director Commissioning & Performance 30.07.2025 Executive Leadership Team (ELT)

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

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

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **June 2025**.
2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators:-



BACKGROUND

3. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus: -
 - Our Patients (Quality, Safety and Patient Experience);
 - Our People;
 - Finance and Value; and
 - Partnerships and System Contribution
4. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust’s plans (IMTP) and strategies. A Board development session was held in April 2025 at which the annual review was undertaken. It was noted that there will be some changes to metrics in 2025/26, aligned to the new performance framework announced by the Cabinet Secretary. No 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. Appendix 2 to this report sets out the key areas of discussion.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

6. **999** call answering times worsened in June 2025 with the 95th percentile increasing to 26 seconds, compared to 22 seconds in May 2025. The 65th percentile and median performance remain consistently good; and data quality checks have been undertaken. Work is currently being undertaken on demand and capacity analysis of 999 call demand.
7. **111 call answering performance has minimally improved over recent weeks**, with the call abandonment performance for June 2025 being 10%, not achieving the 5% target. Recruitment has been undertaken to ensure that staff in post reflect the establishment position, and this has seen performance improve, but high abstraction levels are having an effect. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2025/65 compared to 2023/24 (-4%).
8. 111 demand in June 2025 was 9.39% lower than during June 2024. The Trust procured a third party in January 2025 to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.
9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 96.4%. Response times for lower priority calls declined, recording 87.5% and 52% for P2CT and P3CT respectively. This is consistent with previous years but needs to be monitored closely over the coming months.
10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for June 2025 was 50.74%, remaining below the 65% target, and increasing slightly compared to May 2025. The Trust is reaching more red patients in 8-minutes, but the denominator (demand) has also grown. The Amber 1 median in June was 1 hour and 29 minutes and the Amber 1 95th percentile was 5 hours 18 minutes. The Clinical Safety Plan and CHARUs will protect red demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on avoidable patient harm. The red and amber categories are currently undergoing a major transformation as announced by the Cabinet Secretary. Red was replaced by Arrest and Emergency on the 01 July 2025 and Amber will be replaced by Orange and Yellow in quarter 3 this year. The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand.
11. Traditionally the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. The Trust's main focus is to

implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme, elements of which have been implemented. Areas of focus for 2025/26 include: -

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

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

13. Ambulance Care (Patient Experience): Oncology performance in June 2025 was 76.3%, achieving the 70% target. Renal performance remained above target, achieving 72.57%; however, advanced discharge & transfer journey performance increased marginally to 80% (95% target). Same day discharge & transfer journey performance was just below the 95% target at 94%. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive Health Transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is currently re-rostering NEPTS transport (now started) which will better align available capacity with changing demand patterns (on target). This is proving complex and difficult but will be delivered.

14. National Reportable Incidents (NRIs) / Concerns Response: the Trust reported eight NRI's to the NHS Executive in June 2025, more than May 2025 (3) and 18 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In June 2025 complaint response times improved to

88%, compared to the 72% recorded in May 2025, exceeding the 75% target for the first time over the past 12 months, however cases remaining complex.

- 15. Clinical outcomes:** The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 89.8% in June 2025, minimally decreasing and remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system, and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate also decreased to 19.3% in June 2025 compared to 22.6% in May 2025.
- 16.** The Trust can report on call to door times for Stroke and STEMI patients. For June 2025, these highlight call to hospital door times of two hours and 24 minutes for stroke patients and two hours and twenty-six minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, because of the pressures and issues outlined in this report.
- 17.** In June 2025, 5,953 patients **cancelled** their ambulance (this figure excludes patients who refused treatment). This is a significant reduction on previous levels. This reduction is likely to be the impact of switching on RCS through the winter. The Trust believes that 50% (of the pre-RCS switch on figure) of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Anecdotal evidence from health boards suggests that as the Trust has switched on RCS and as the level of patient cancellations has dropped, so has the demand presenting elsewhere in the system. Caution is required at this stage though as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its Clinical Safety Plan in December, removing the "can't send" application, with the option remaining at the strategic commander's discretion in the new plan.

Our People (workforce resourcing, experience, and safety)

- 18. Hours Produced:** The Trust produced 115,205 Ambulance Response unit hours during June 2025 and delivered an emergency ambulance unit hours production (UHP) of 91%, remaining below the 95% target.
- 19. Response Abstractions:** EMS abstraction levels increased minimally to 32.63% in June 2025, remaining minimally above the 30% benchmark figure. Response sickness abstractions stood at 6.48% (benchmark 5.99%).
- 20. Trust sickness absence:** the Trust's overall sickness percentage was 7.50% in June 2025, up on the 6.83% recorded in May 2025. Actions within the IMTP concentrate on staff well-being with an aim to reduce this level to the IMTP ambition of 6%.

- 21. Staff training and PADRs:** PADR rates did not achieve the 85% target in June 2025 but increased slightly to 81.81%. Compliance for Statutory and Mandatory training also increased slightly to 88.05% continuing to achieve the 85% target.
- 22. People & Culture Plan:** the Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working, and the introduction of a staff pulse survey tool. The Executive Leadership Team is likely to undertake a round of a pan-Wales of CEO Roadshows in mid-October 2025.

Finance & Value

- 23. Financial Balance:** the reported outturn performance at Month 3 is a deficit of £0.197m with a forecast to the year-end of breakeven. The Trust is forecasting achievement of both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

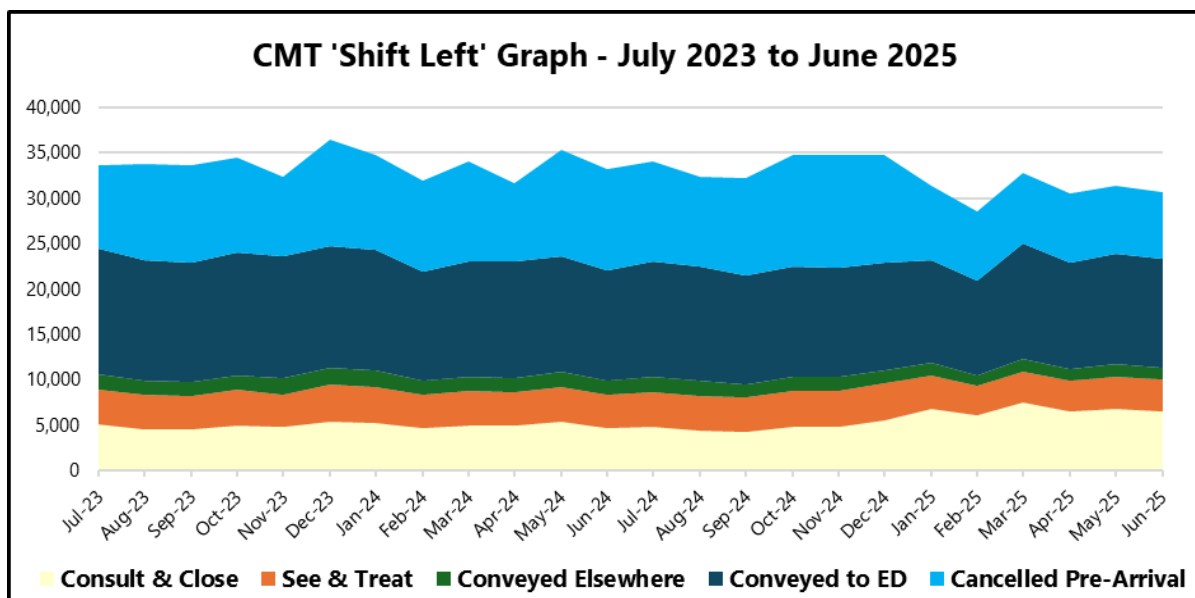
- 24.** The consult & close rate was 19.1% in June 2025, a slight decrease from the previous month continuing to achieve the IMTP ambition (and Welsh Government target) of 17%.
- 25.** Same Day Emergency Care (SDEC) centres continue only to see a low level of ambulance activity and handover levels remain extreme, which makes further work on the clinical model, before next winter, a tactical imperative.

Summary

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

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

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



RECOMMENDATIONS

Trust Board is asked to: -

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

Appendix 2

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

Board Development MIQPR Session

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

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

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

June 2025

Annex 1 – Top Indicator Dashboard



GIG
CYMRU
NHS
WALES

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

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard



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

Top Monthly Indicators	Target 2025/26	May-25	Jun-25	2 Year Average	RAG
Health & Well-being					
Sickness Absence (<i>all staff</i>)	6.0%	6.83%	7.50%	7.76%	R
Mental Health Absence Rates	Reduction Trend	2.34%	N/A	2.33%	R
Staff Turnover Rate	Reduction Trend	8.18%	8.44%	8.30%	G
Statutory & Mandatory Training	>85%	87.56%	88.05%	79.16%	G
PADR/Medical Appraisal	>85%	81.35%	81.81%	74.05%	A
Number of Shift Overruns	Reduction Trend	3,745	3,441	3,723	G
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	2.82%	2.53%	1.9%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	28.1%	26.6%	28%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.64	2.33	2.35	R
NEPTS on the Day Cancellations	Reduction Trend	13.4%	14.7%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	20.2%	19.1%	15.3%	G
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	10.10%	10.09%	11.2%	R
Number of Handover Lost Hours	7,500	19,670	15,278	21,619	R
NHS111					
NHS111 Dental Calls	Increasing Trend	8,827	8,749	7,894	G
Consult & Close Volumes by NHS111	Increasing Trend	2,372	2,238	1,310	G

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (*To Be Determined*)

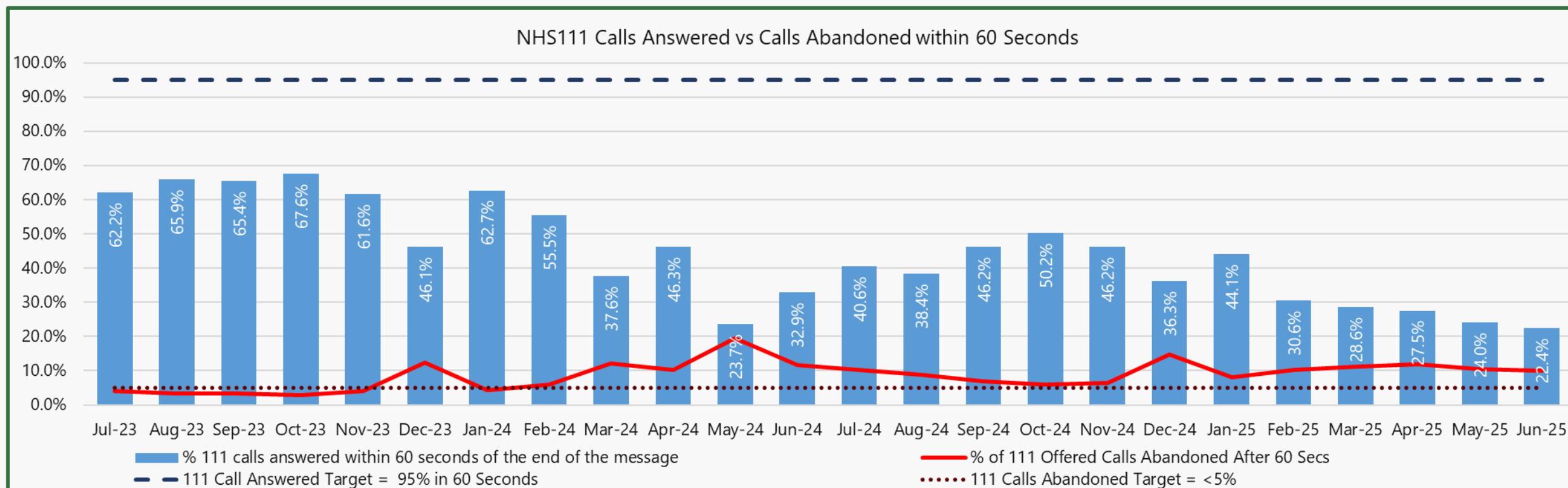
Our Patients: Quality, Patient Safety & Experience

111 Call Answering/Abandoned Performance Indicators

(Responsible Officer: Lee Brooks)



Influencing Factors – Demand and Call Handling Hours Produced



Analysis

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

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

Remedial Plans and Actions

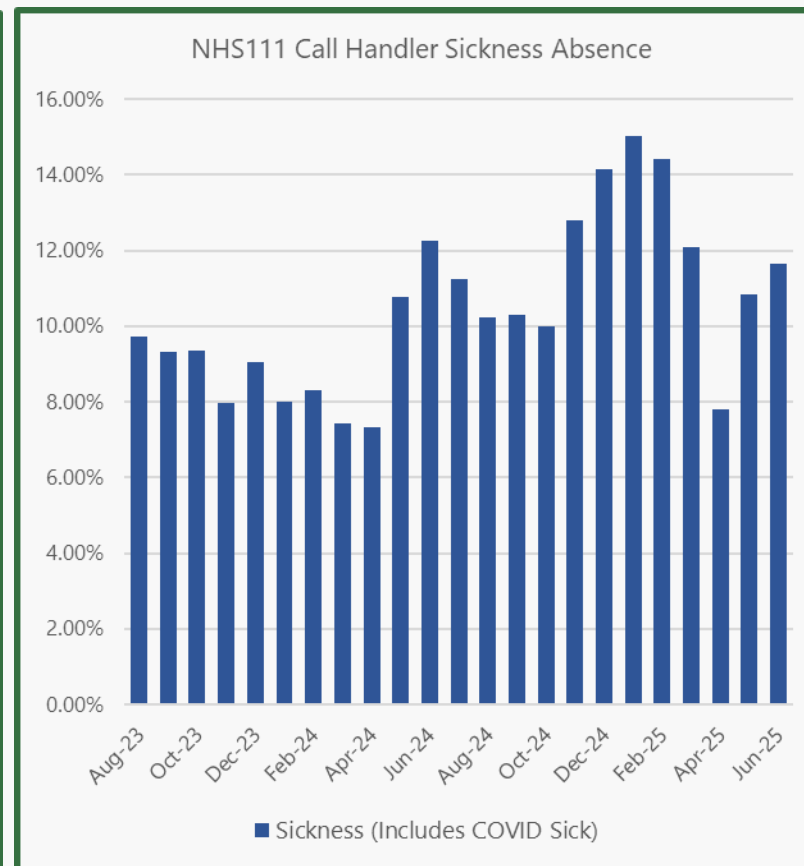
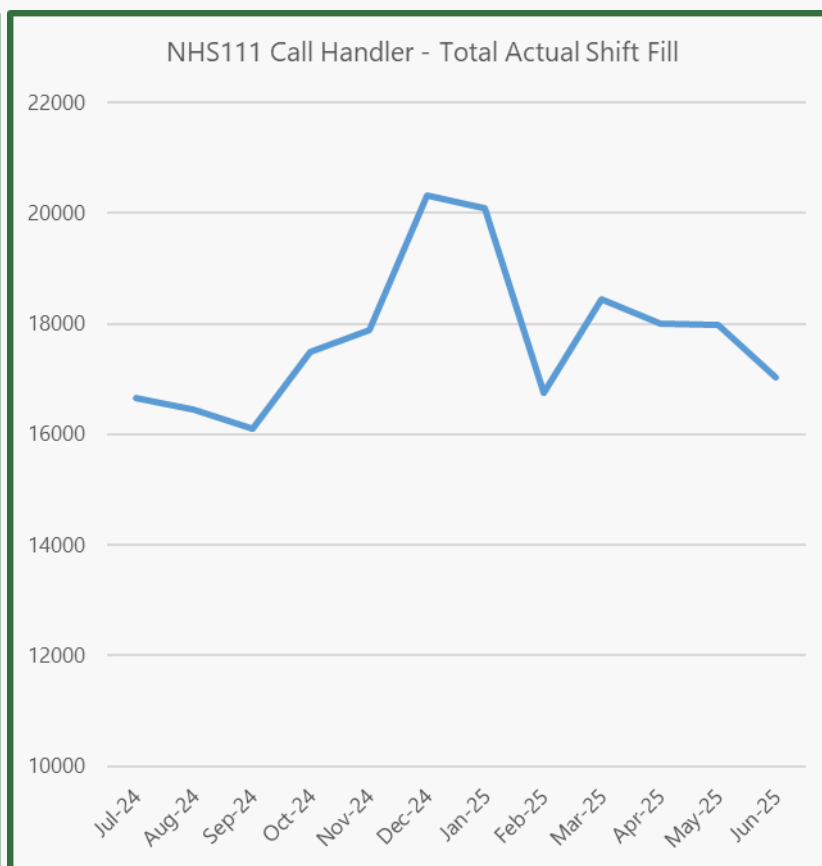
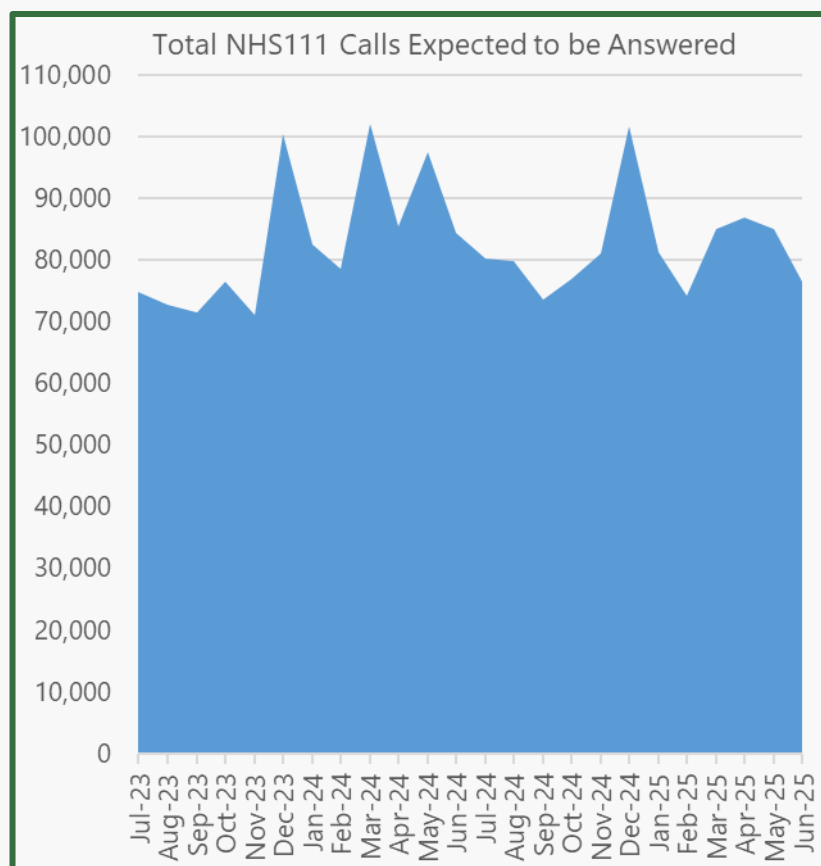
Key actions include:
 Actions have been undertaken to try and improve the call handling resourcing position through the summer; this includes an active recruitment plan.

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

The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.
 Actions are underway to increase the utilisation of virtual queuing and review the way patients who are re-accessing for the same care episode could be managed differently.

Expected Performance Trajectory

We might expect to see an improvement in performance in the summer, traditionally a period with lower demand and sickness. However, the external rostering review suggests there is a demand and capacity gap within the current funded establishment and the Trust is therefore unlikely to reach performance without an increased workforce.

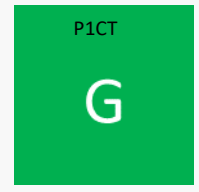


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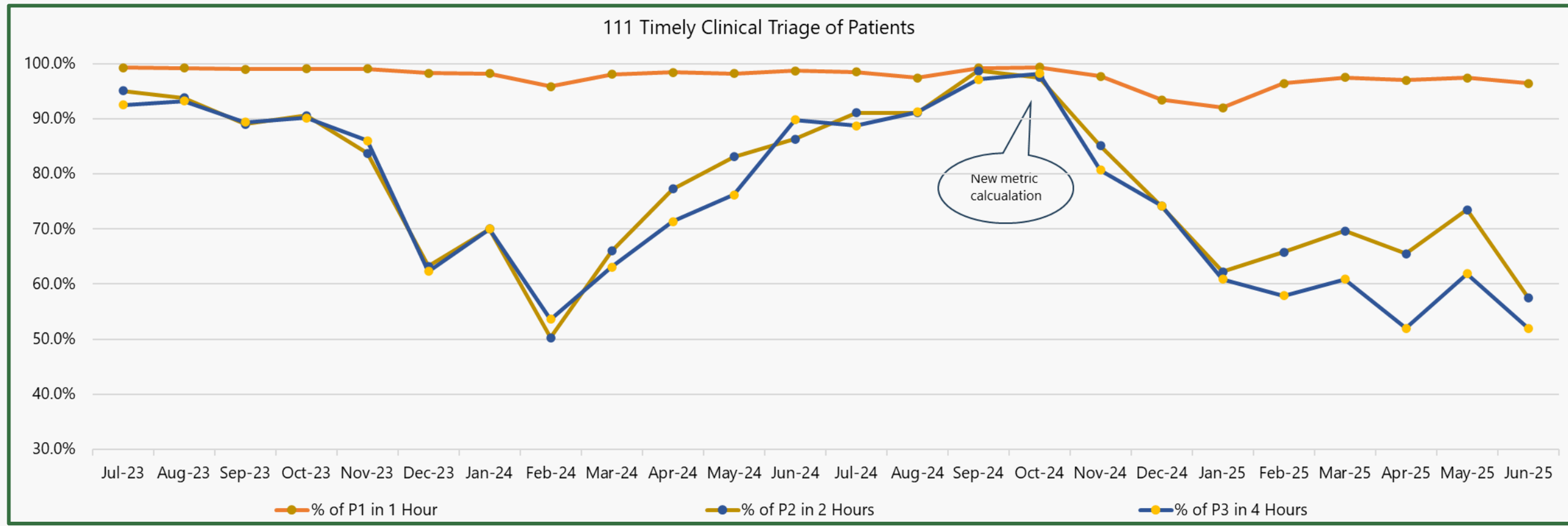
111 Clinical Assessment Start Time Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)



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



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

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

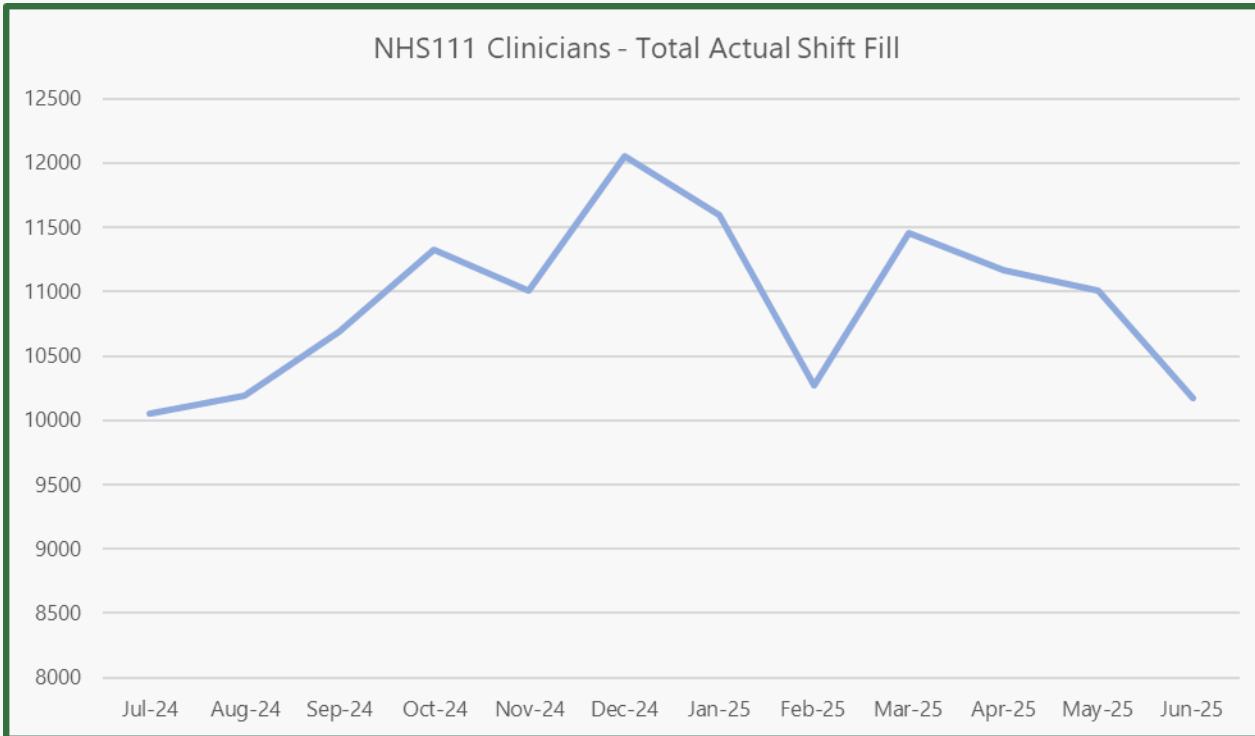
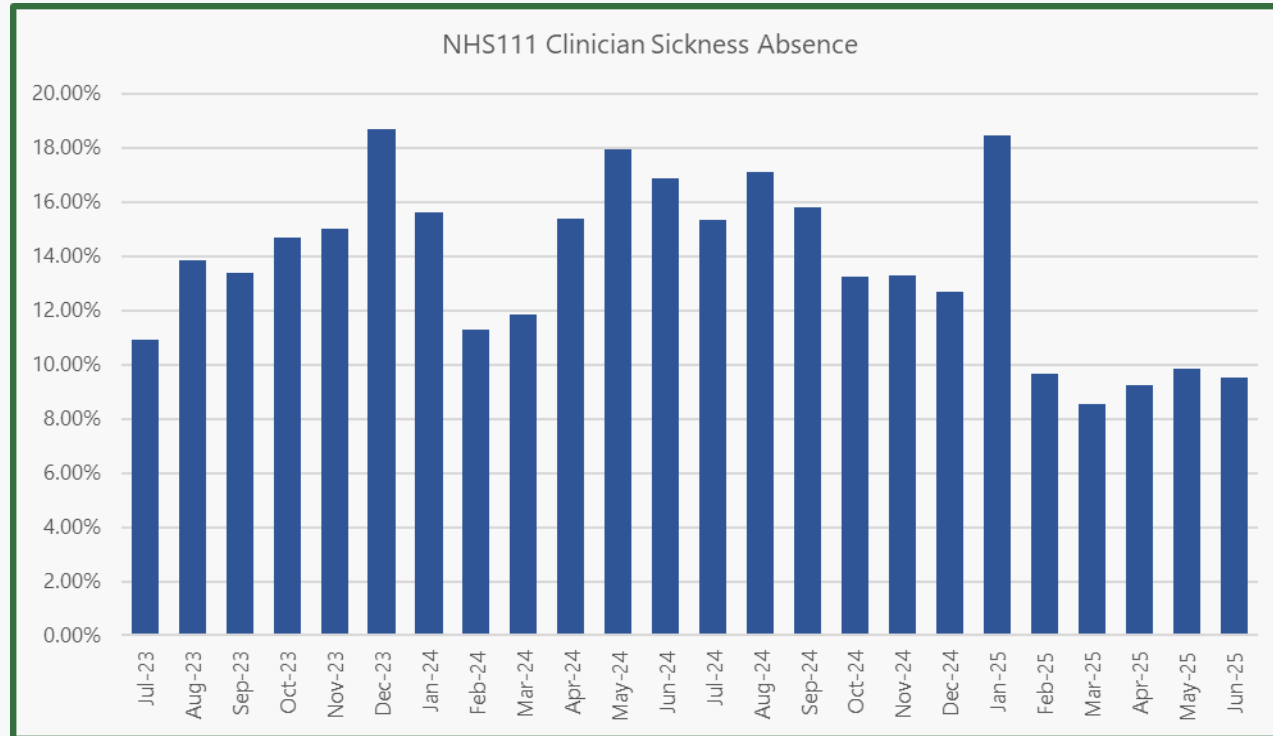
Numbers of clinician hours produced decreased again during June 2025, reducing from 11,004 hours in May 2025 to 10,173 hours in June 2025, albeit over one less day in the month. However, this was a 2.6% increase on the hours produced during June 2024. Clinician sickness absence decreased slightly during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

Remedial Plans and Actions
The key actions include:
A focus on delivering the benefits of the new 111CAS.
A review to determine appropriate levels of capacity to meet increasing demand, including rostering practice (review now live).

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

The P1-P3 metric calculation has changed. Previously it was when the Trust called back, now it is when the patient answers, this will be reversed in August,

Expected Performance Trajectory
It is likely that there will be a performance improvement through the summer however the external rostering review suggests there is a demand and capacity gap within the current funded establishment and the Trust is therefore unlikely to reach performance without an increased workforce.

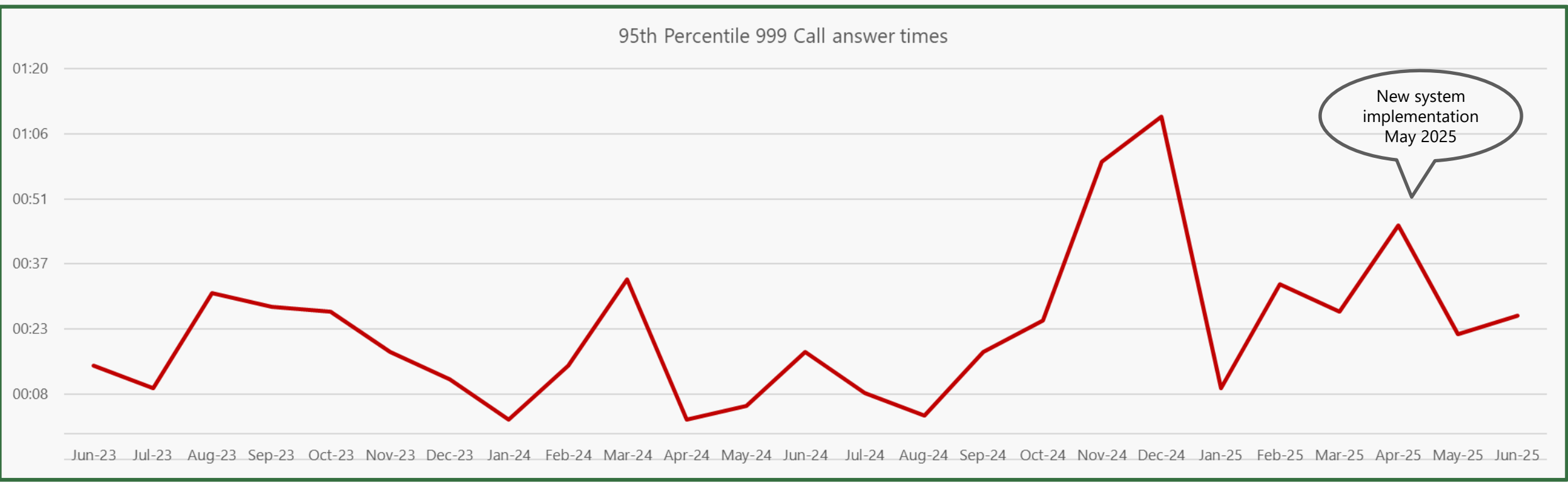
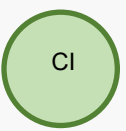


Our Patients: Quality, Safety & Patient Experience

999 Call Performance Indicators

Influencing Factors – Demand and Hours Produced

(Responsible Officer: Lee Brooks)



Analysis

The 95th percentile 999 call answering performance increased to 26 seconds in June 2025 and remaining above the 6 second target; however, the median call answer time for the 999-service has been consistently good at 1 second. The new system is now aligned with reporting and is signed off.

There was a slight decrease in demand during June 2025 to 45,286 calls from 45,814 in May 2025.

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

Remedial Plans and Actions

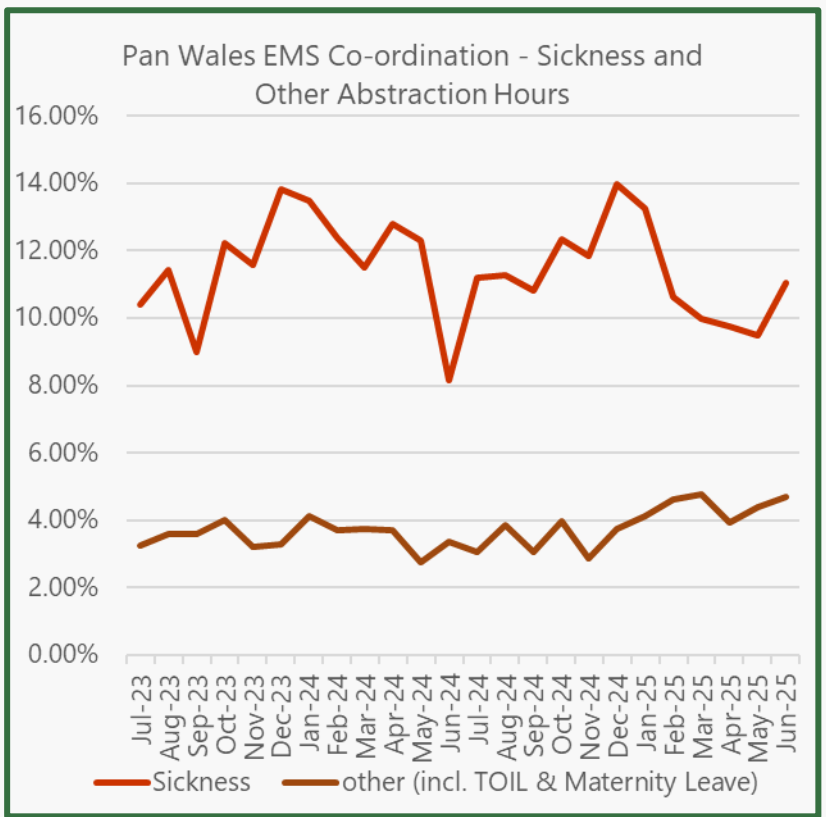
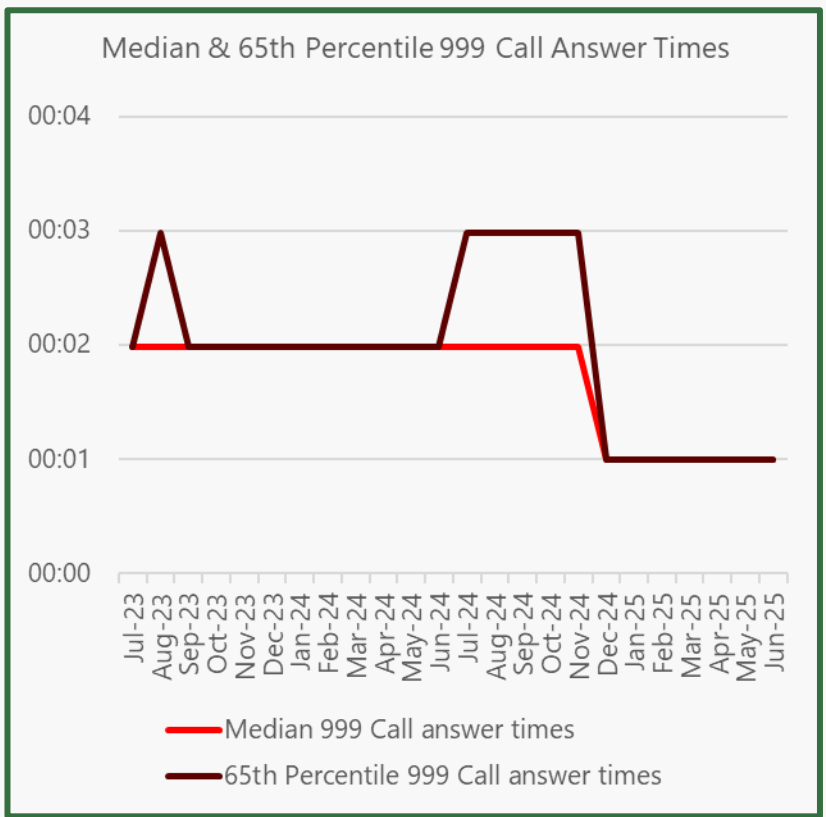
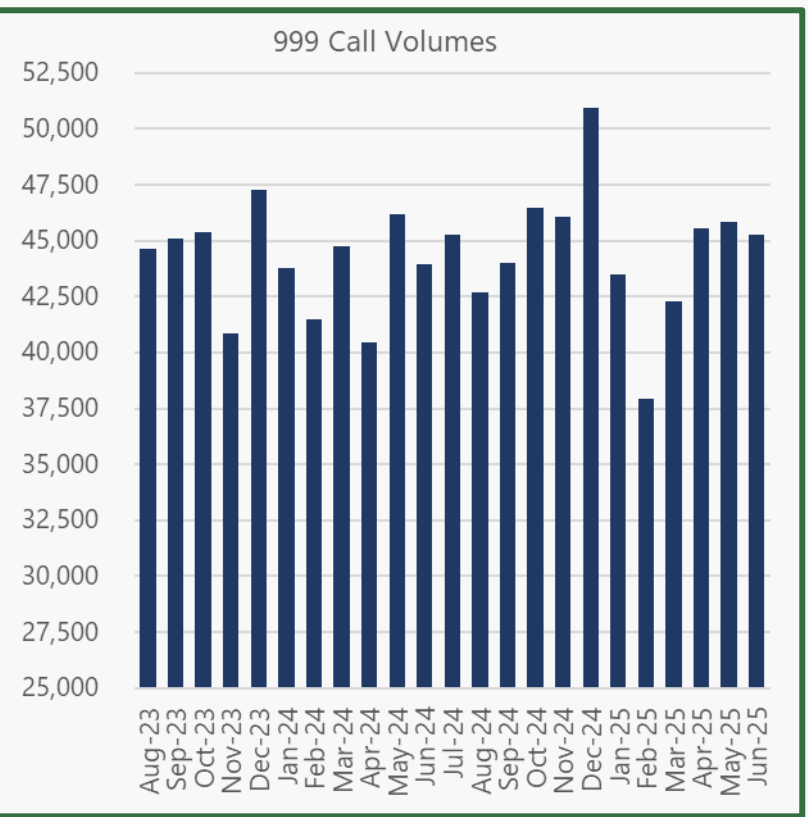
- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) which will also support potential losses from the Bryn Tirion move to Ty Elwy.
- Work is ongoing to identify what is contributing to high sickness via the Managing attendance at work and attrition via the recruitment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

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

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

Expected Performance Trajectory

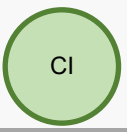
The median and 65th percentile are performing very well and are stable. Paper currently to be drafted on future resilience of EMSC i.e. winter demand v capacity (with efficiencies).



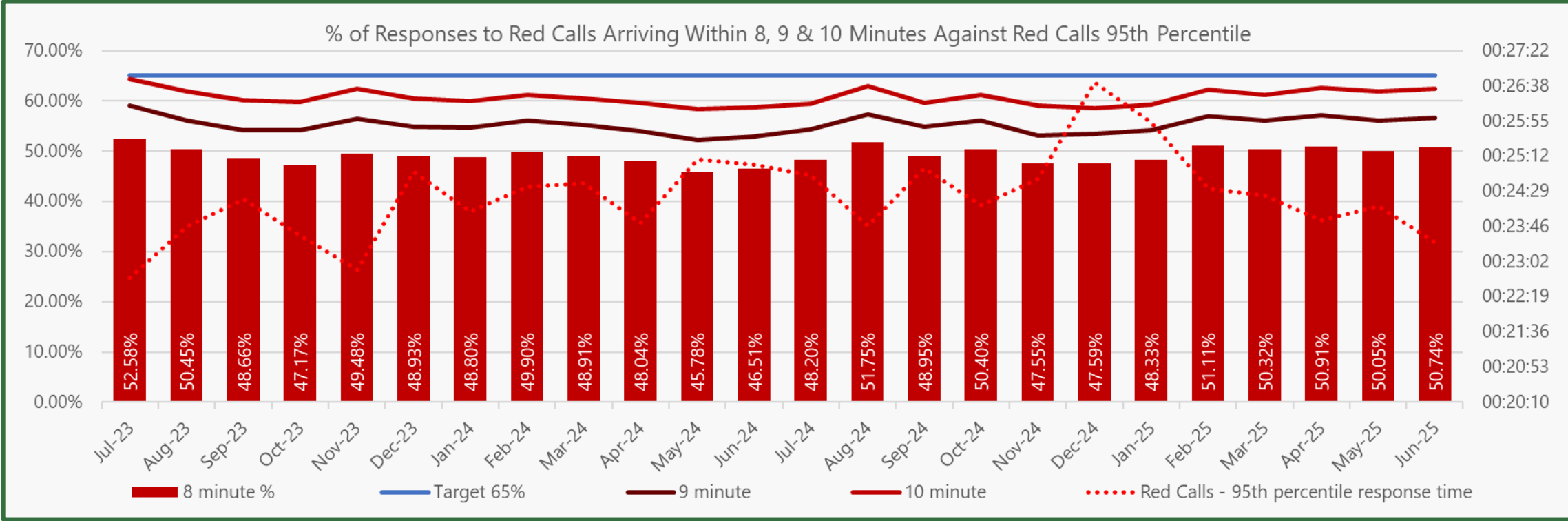
Our Patients: Quality, Safety & Patient Experience

Red Performance Indicators

(Responsible Officer: Lee Brooks)



Influencing Factors – Demand, Hours Produced and Hours Lost



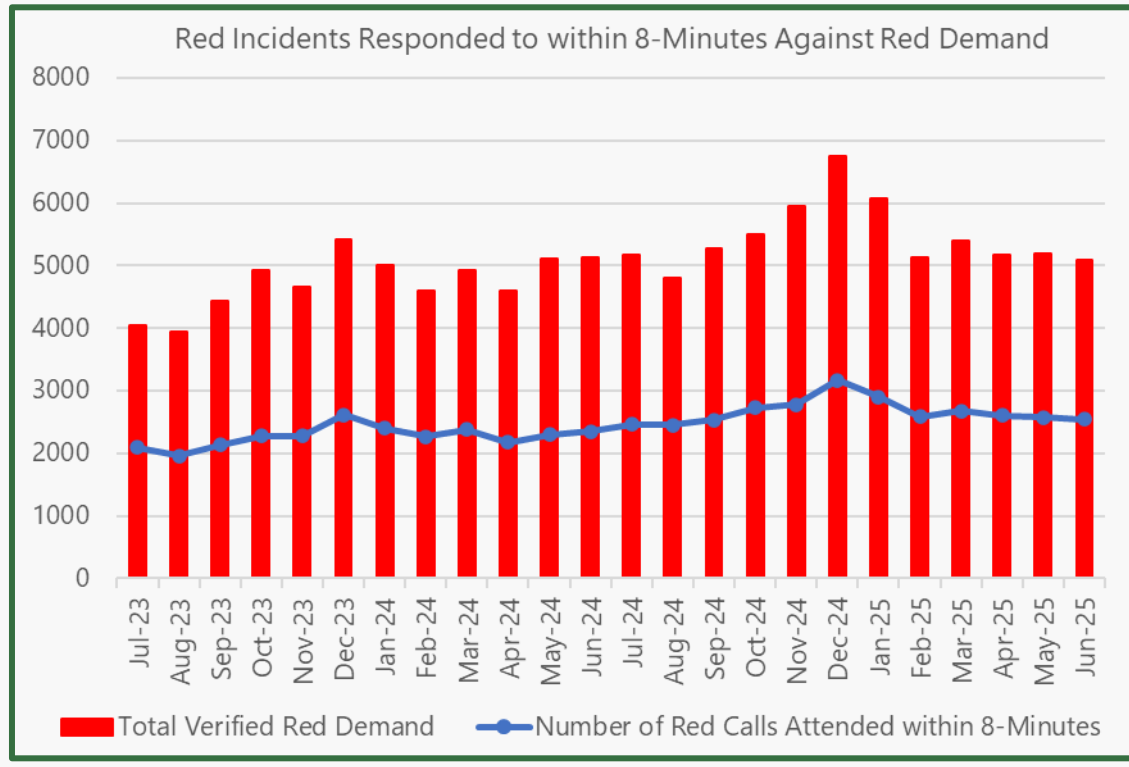
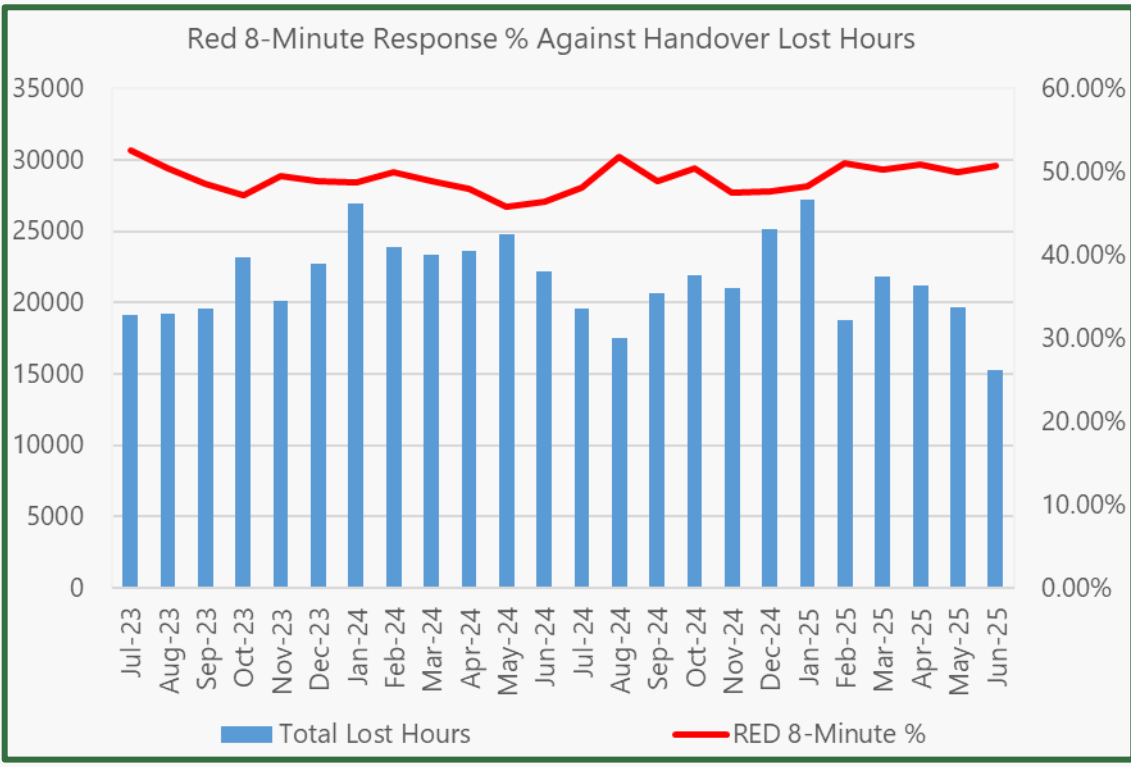
Analysis

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

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

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

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



Remedial Plans and Actions

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

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience

Amber Performance Indicators

(Responsible Officer: Lee Brooks)

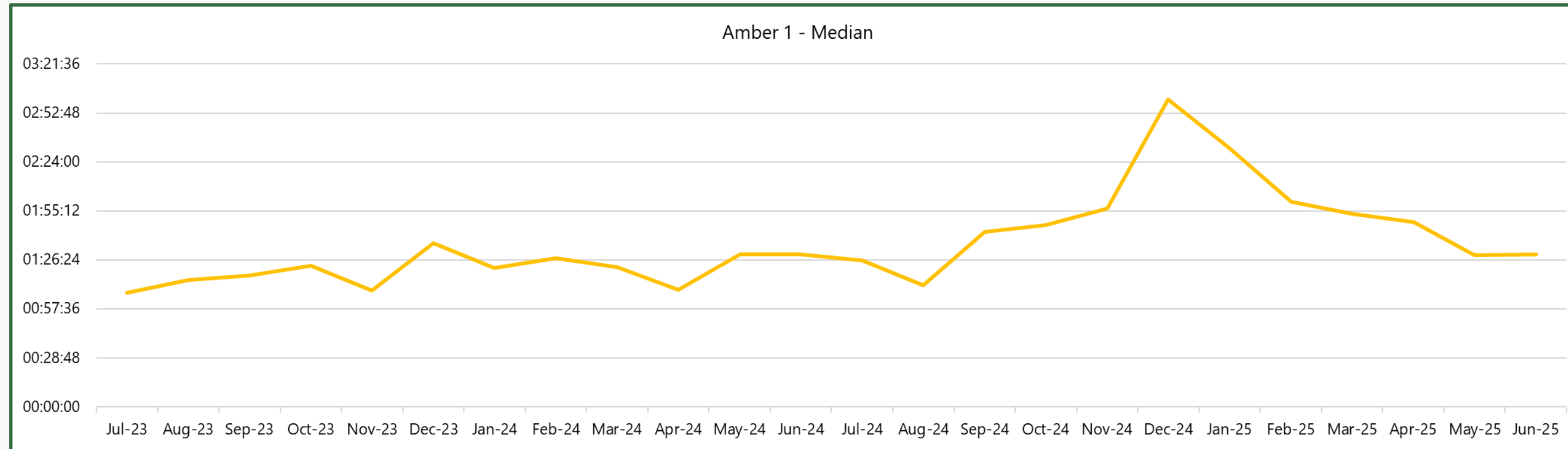
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Influencing Factors – Demand, Hours Produced and Hours Lost

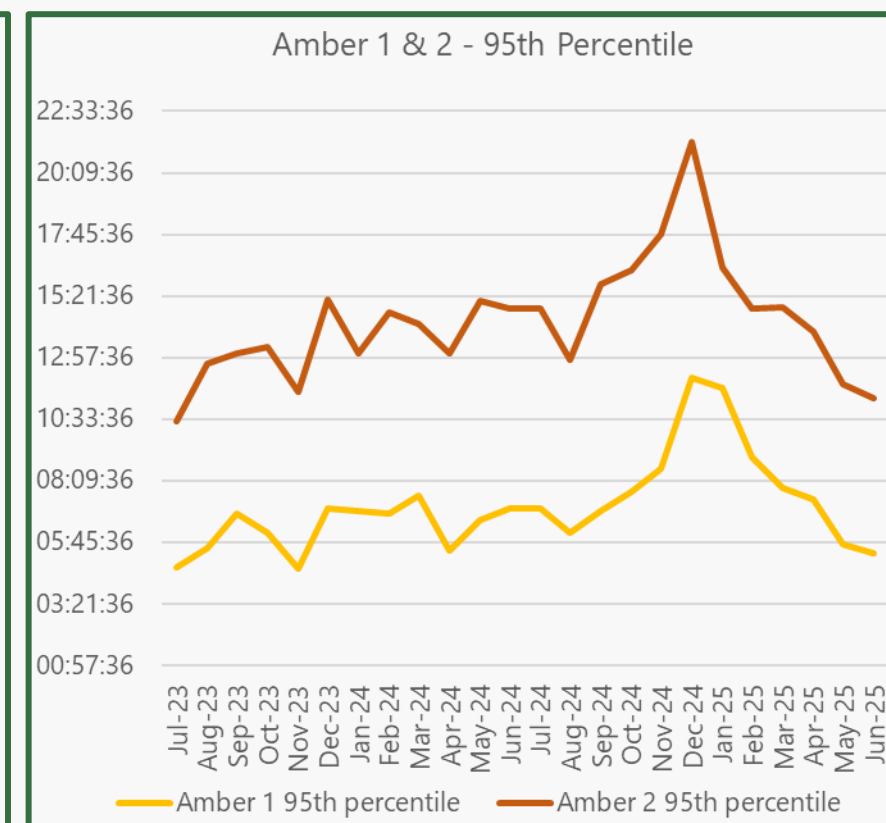
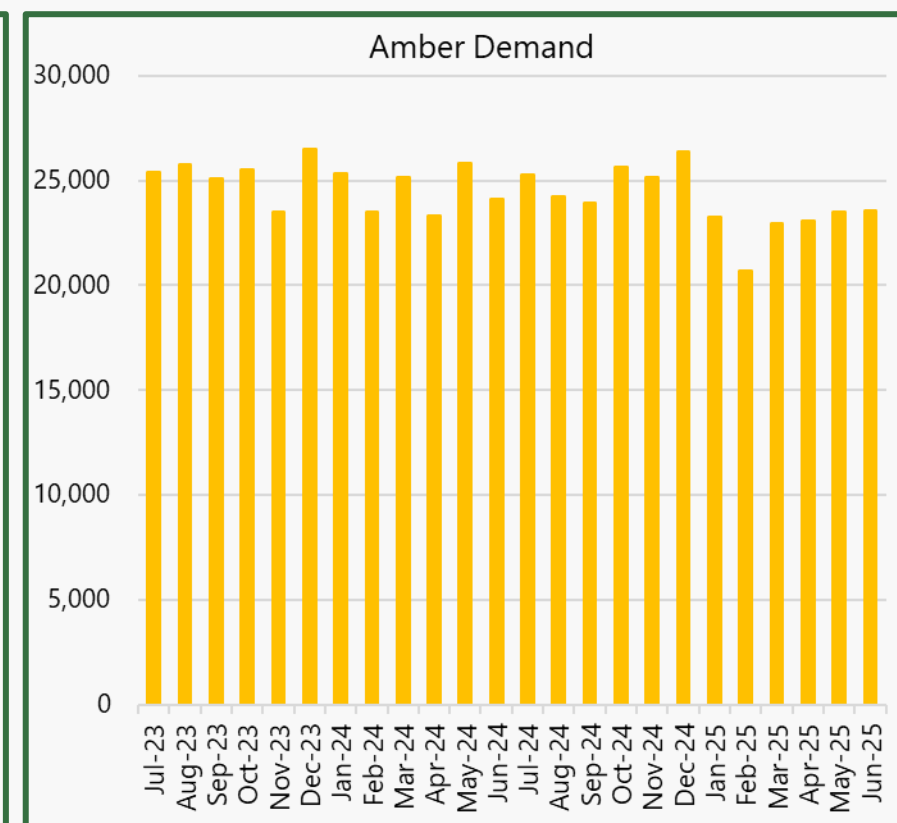
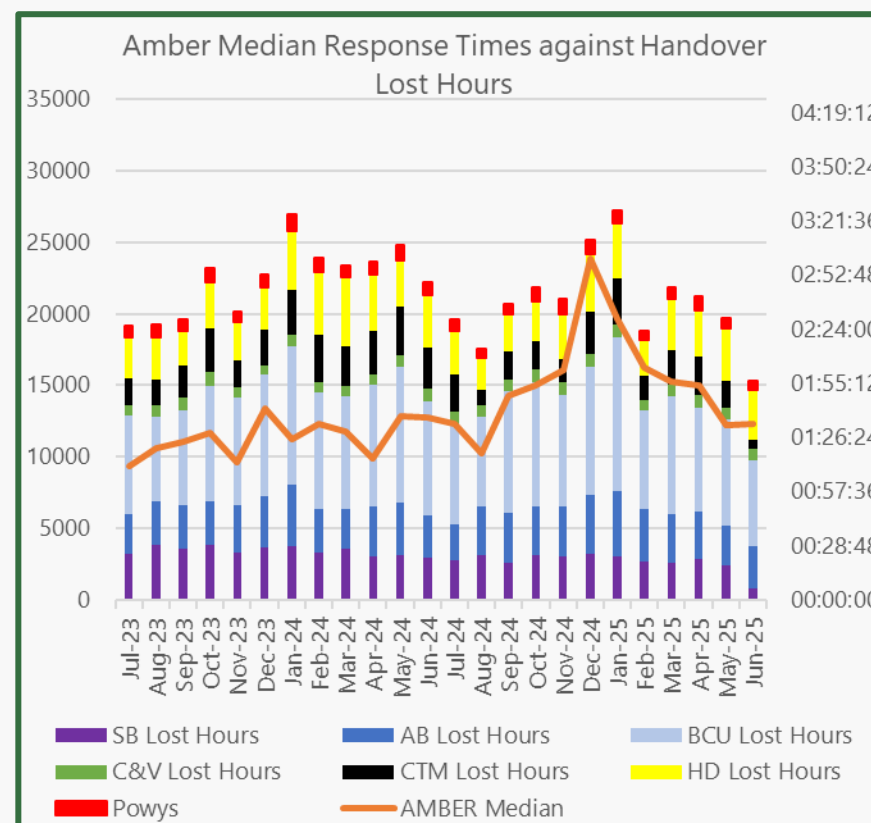


Analysis

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

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

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



Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide. Welsh Government has recently announced further changes to the Ambulance Performance Framework that will affect the existing Amber category.

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

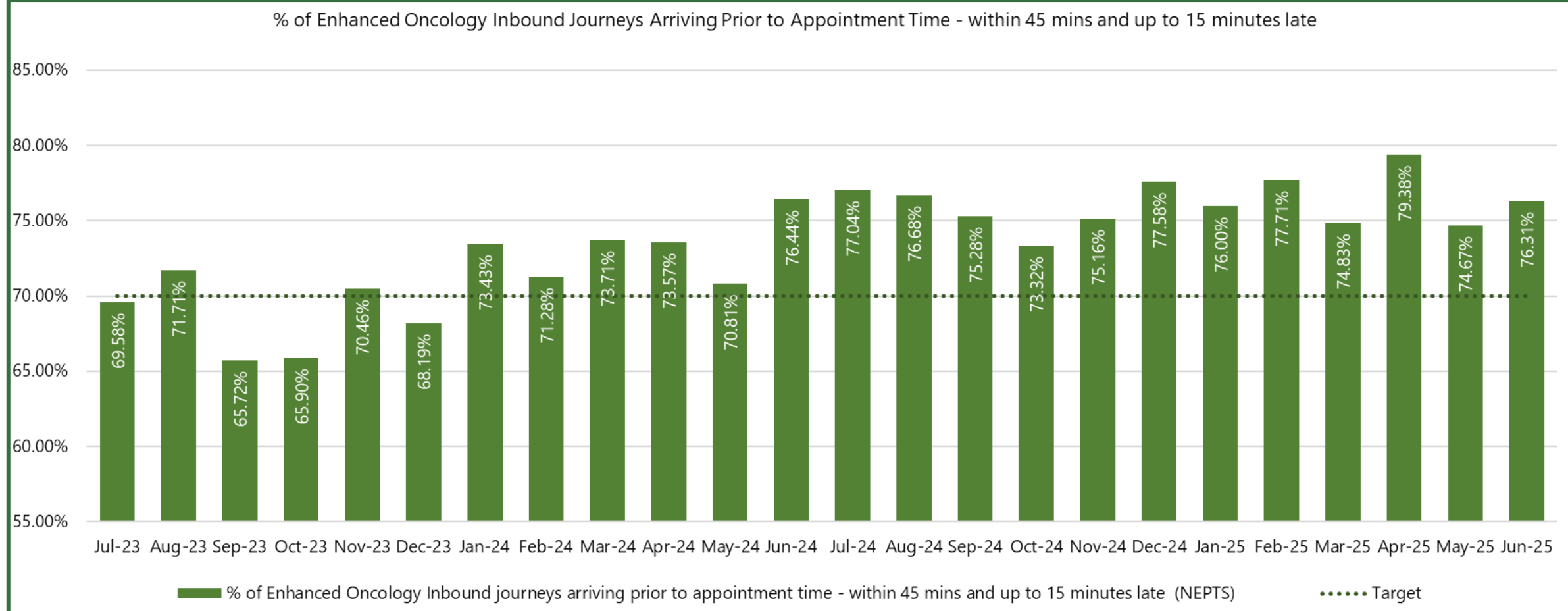
Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

D&T	Oncology	Welsh Calls
R	G	G

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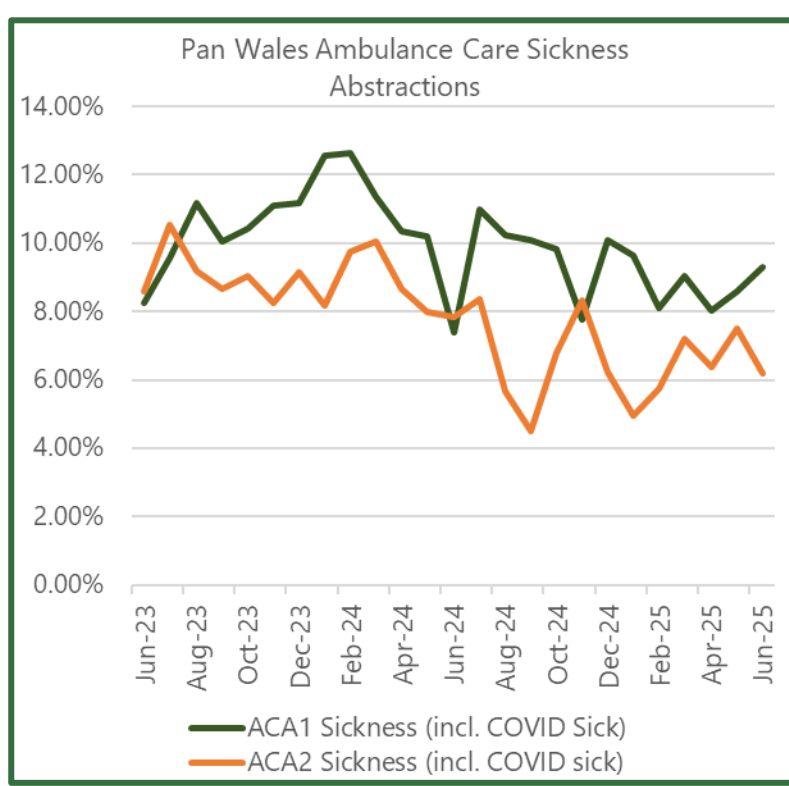
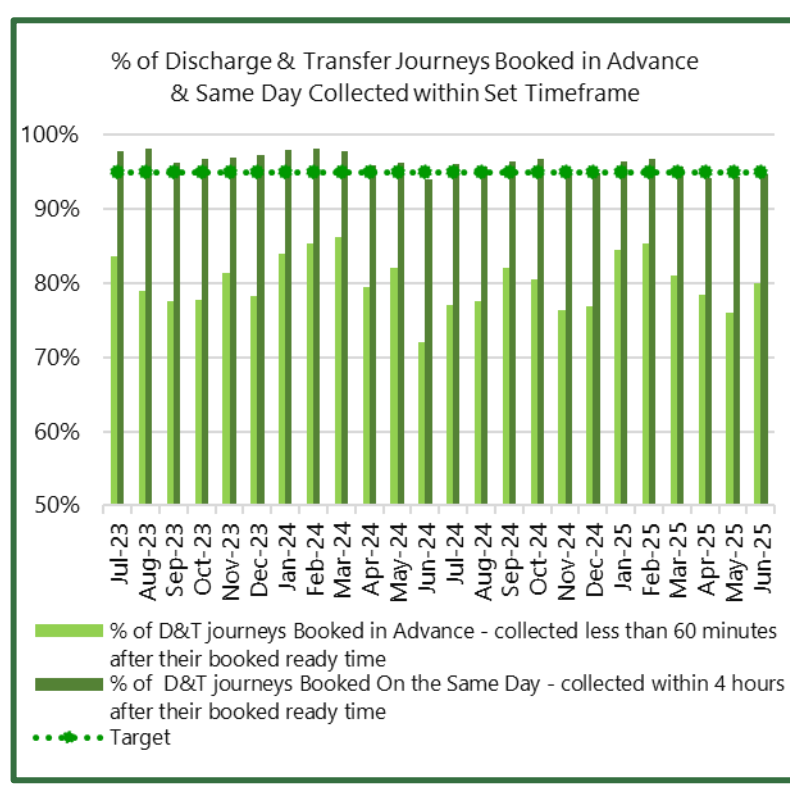
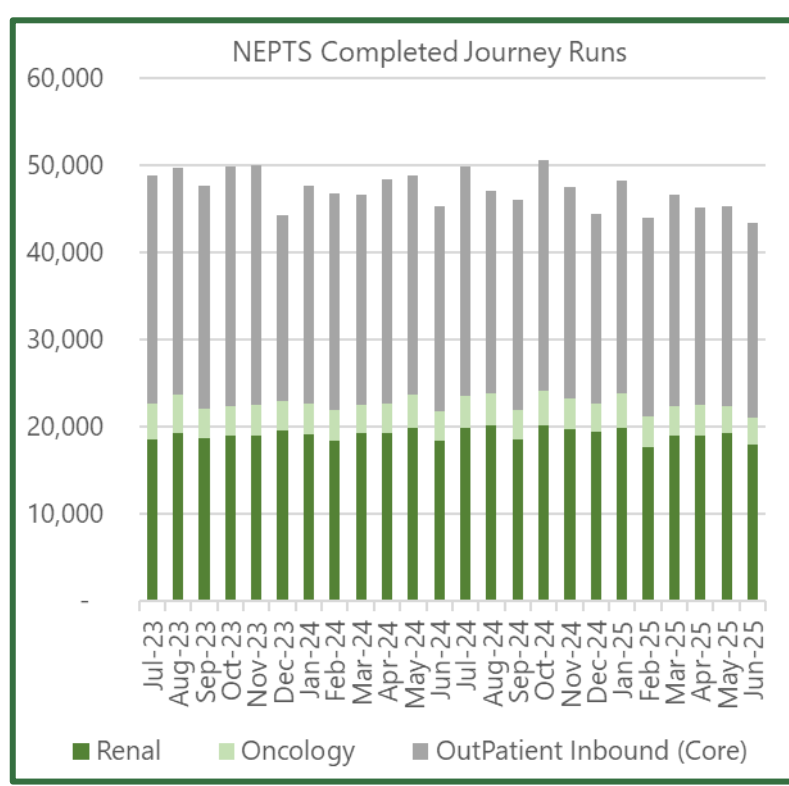
Analysis
 76.31% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in June 2025, once again achieving the 70% target.

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

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

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

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



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

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

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

Our Patients: Quality, Safety & Patient Experience

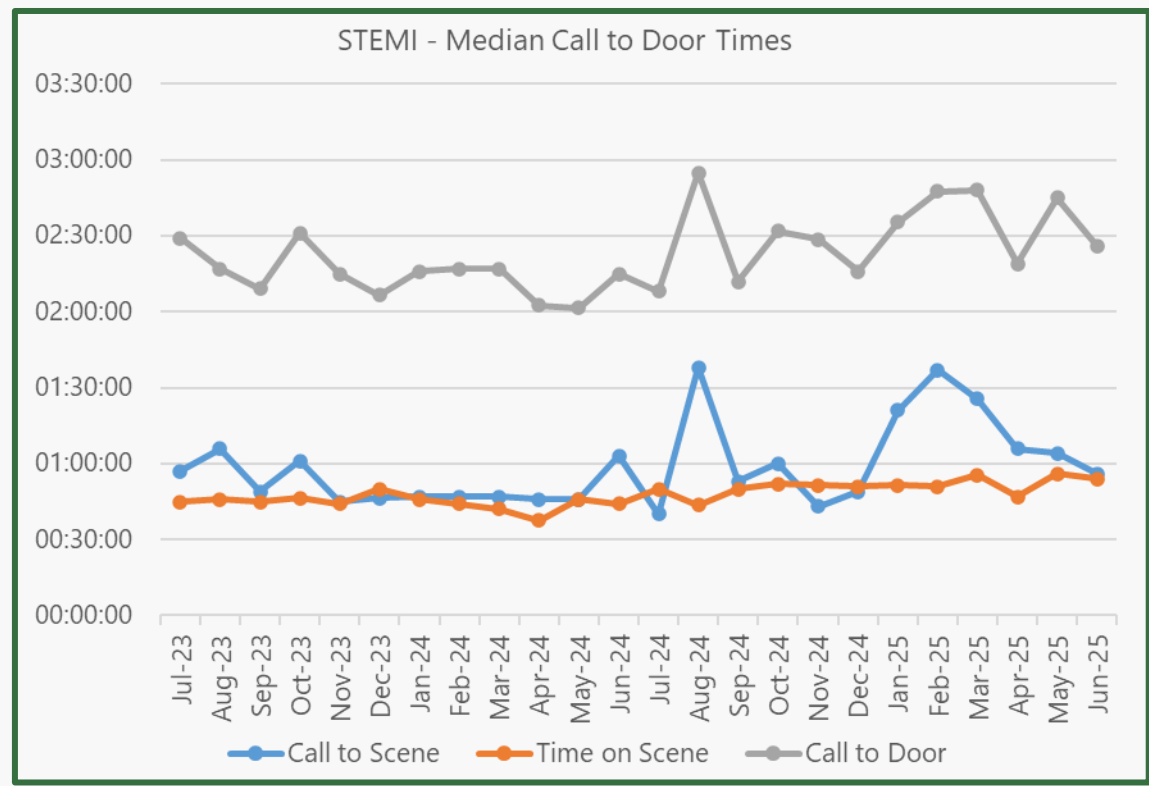
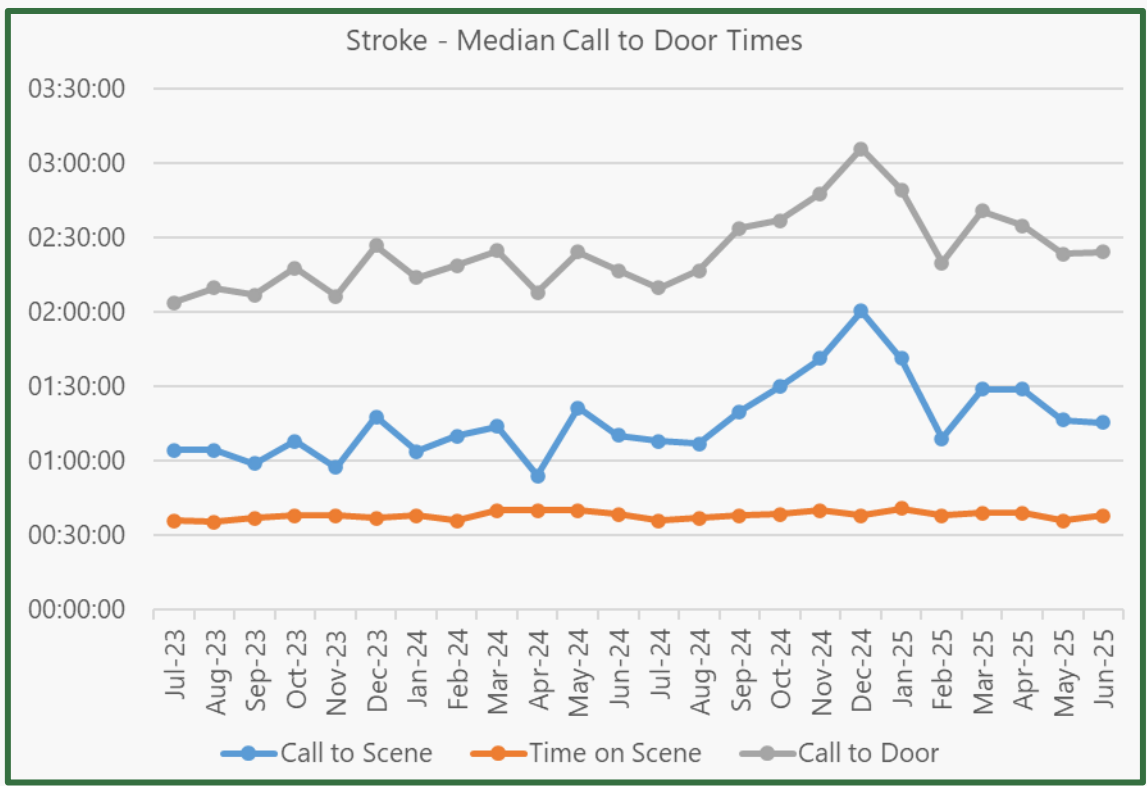
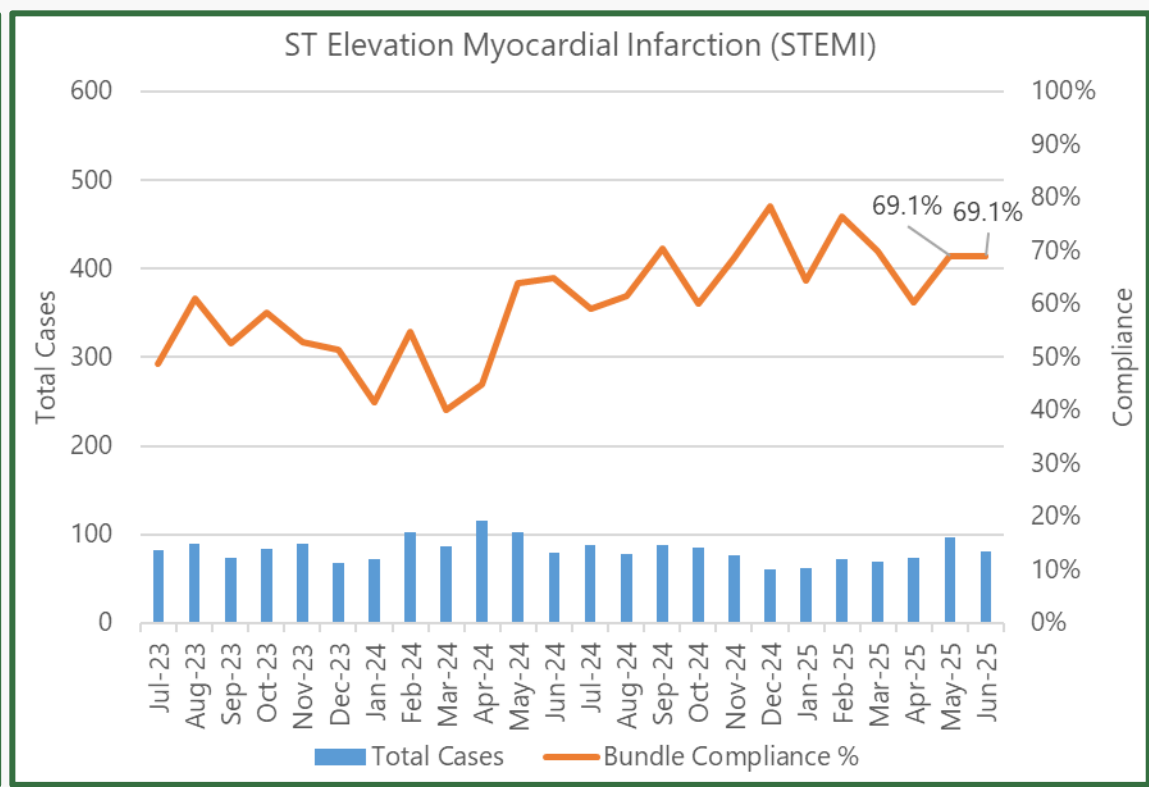
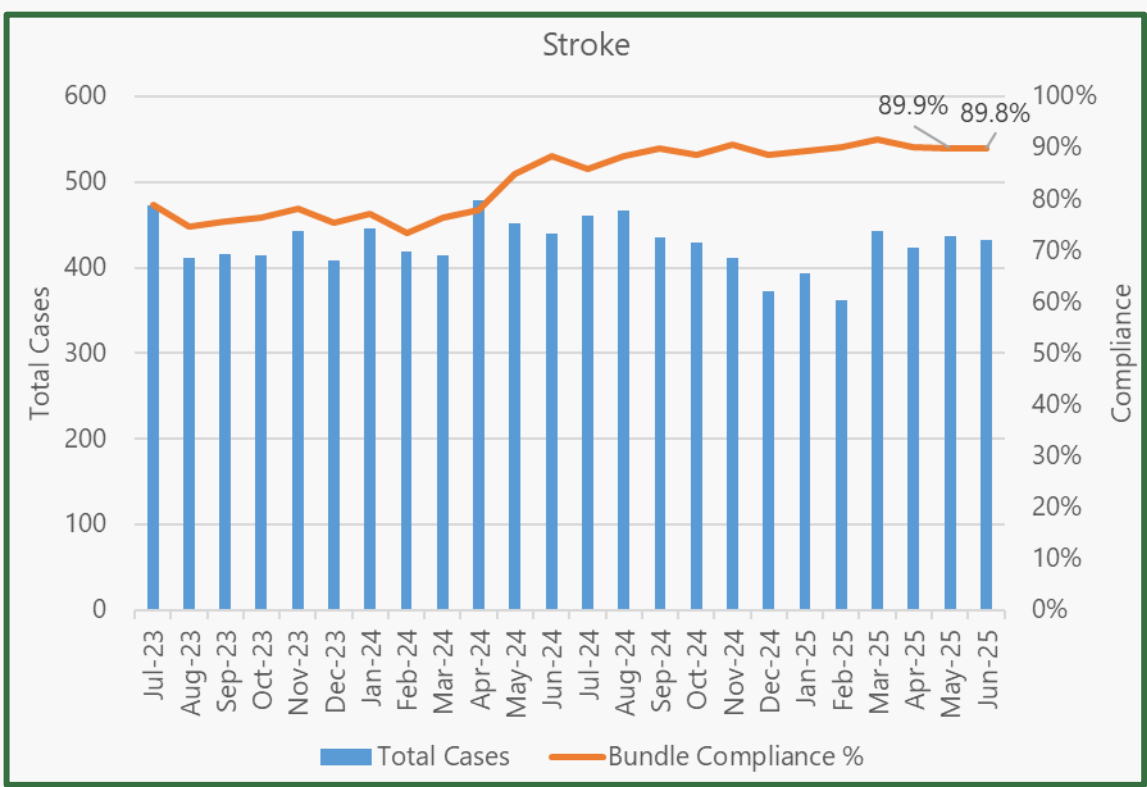
Clinical Indicators

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

Stroke	Stroke Call to Door	STEMI	Self-Assessment: Strength of Internal Control: Moderate
A	R	R	

(Responsible Officer: Andy Swinburn)

QUEST



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

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

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

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

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

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

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

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

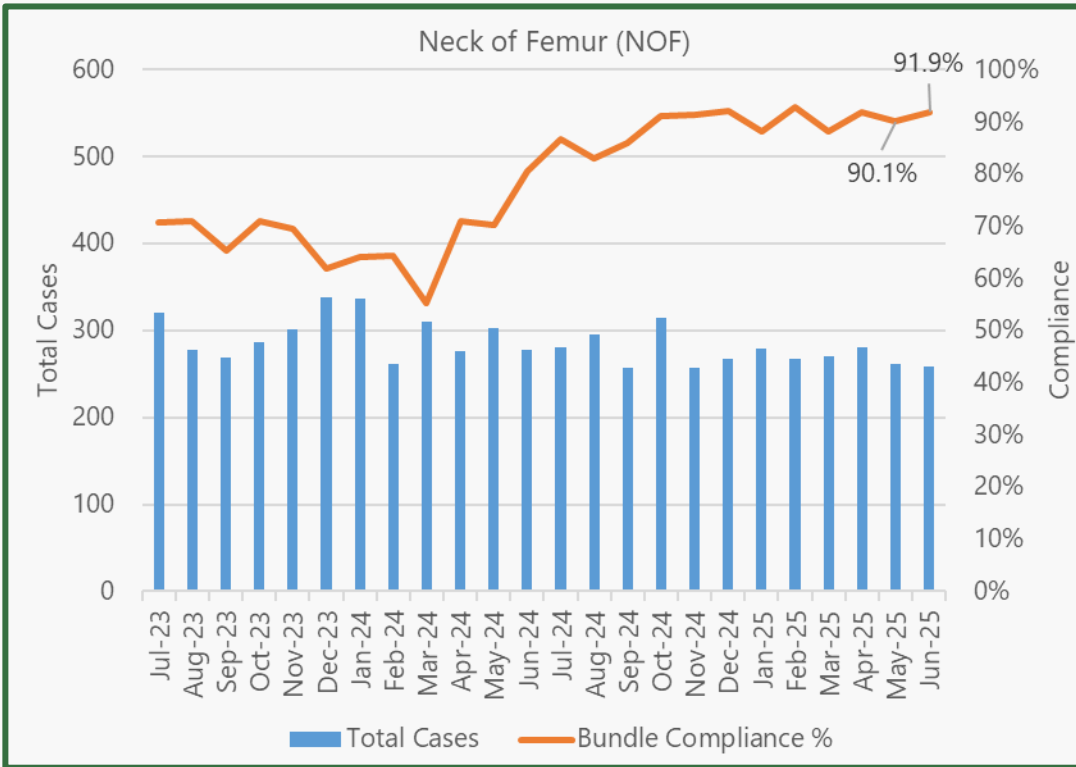
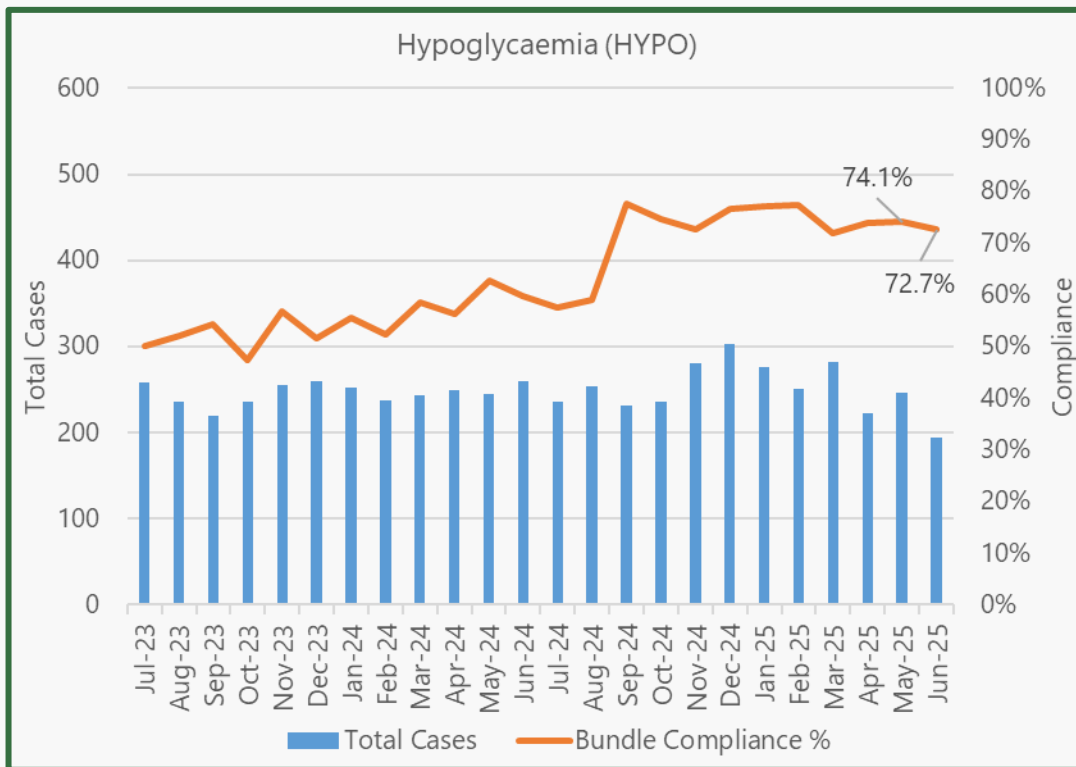
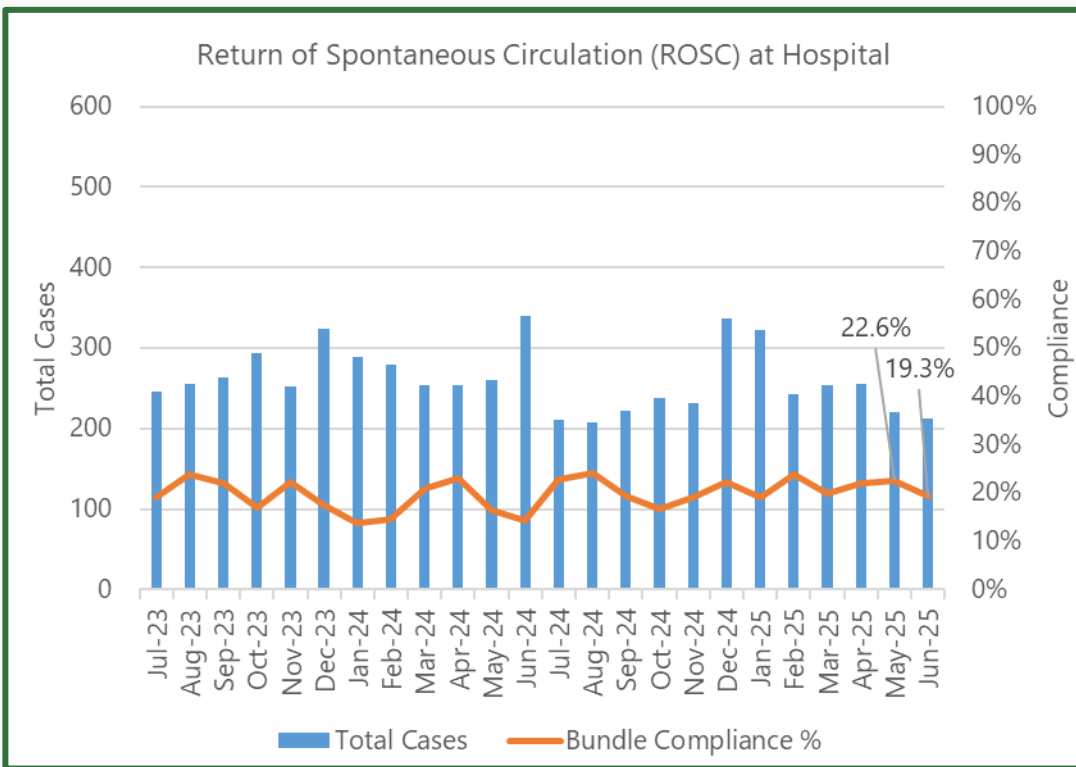
Further electronic Patient Clinical Record User Interface changes are planned for the next update, scheduled for Autumn 2025.

Our Patients: Quality, Safety & Patient Experience

Clinical Indicators

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

(Responsible Officer: Andy Swinburn)



#NOF Call 2 Door in development

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

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 19.33%, a decrease from 22.6% in May. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024. Both December and January continued to see higher numbers of cases in this indicator.

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

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

Remedial Plans and Actions

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

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

Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Duty of Candour Responses Indicators

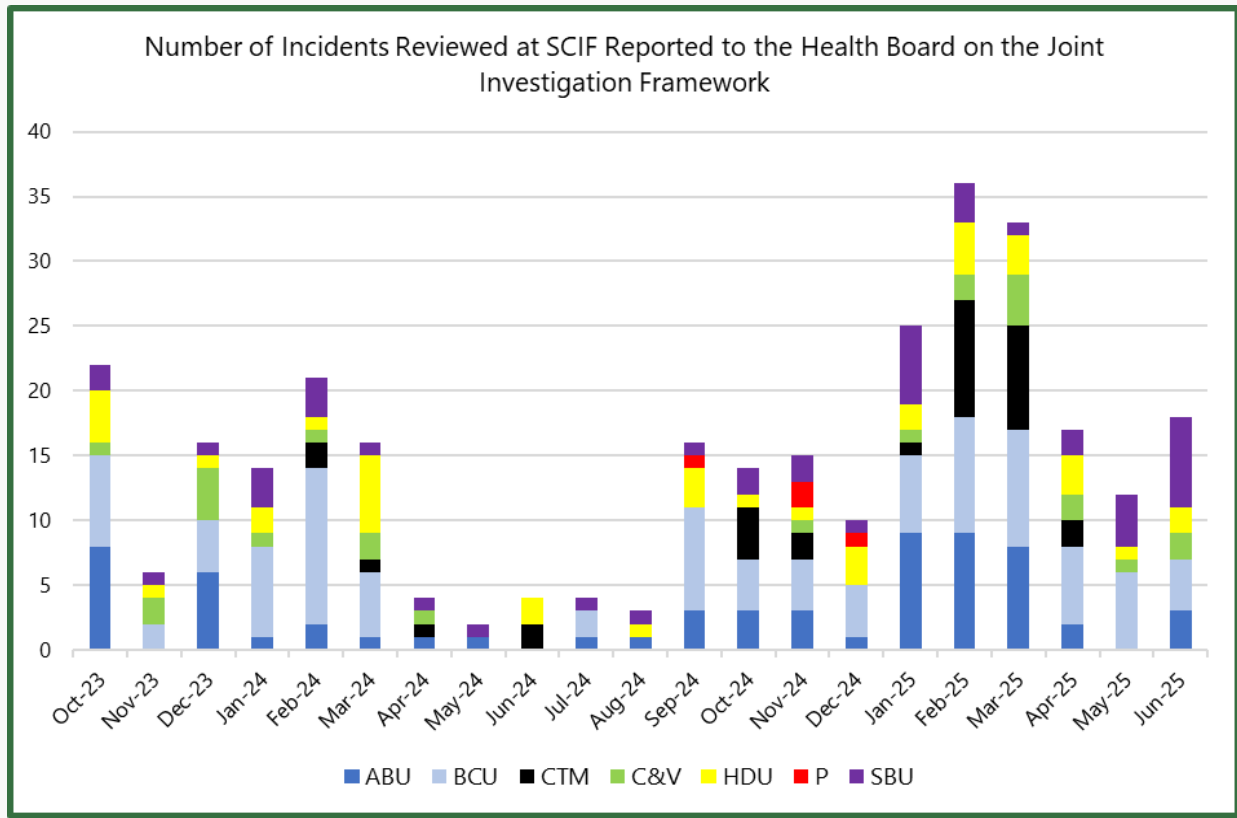
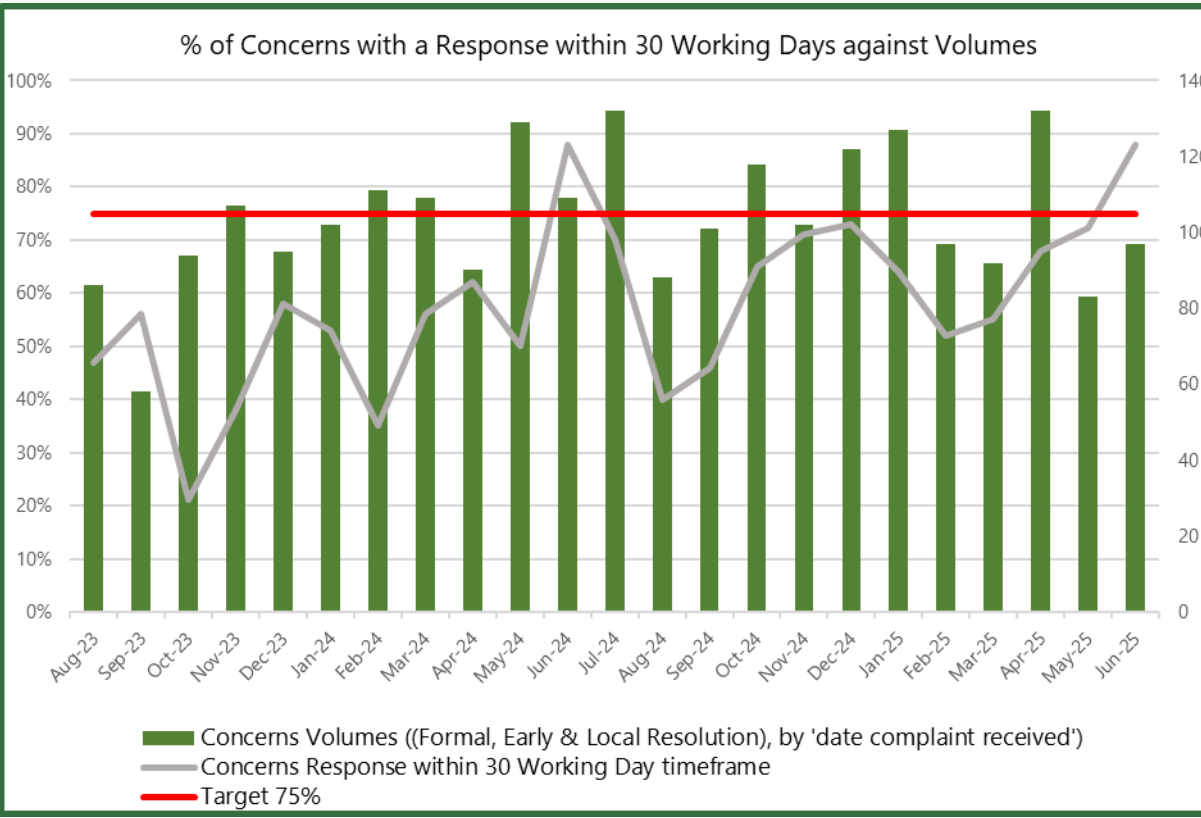
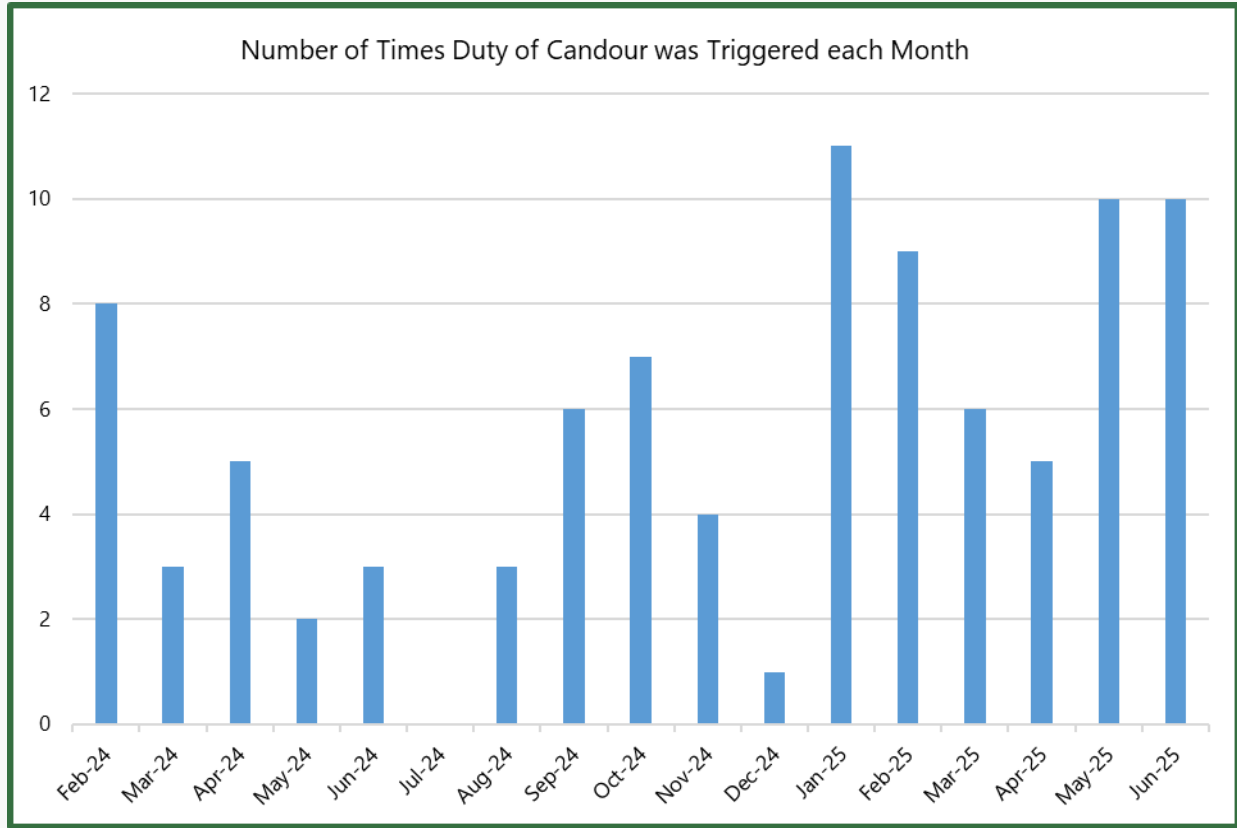
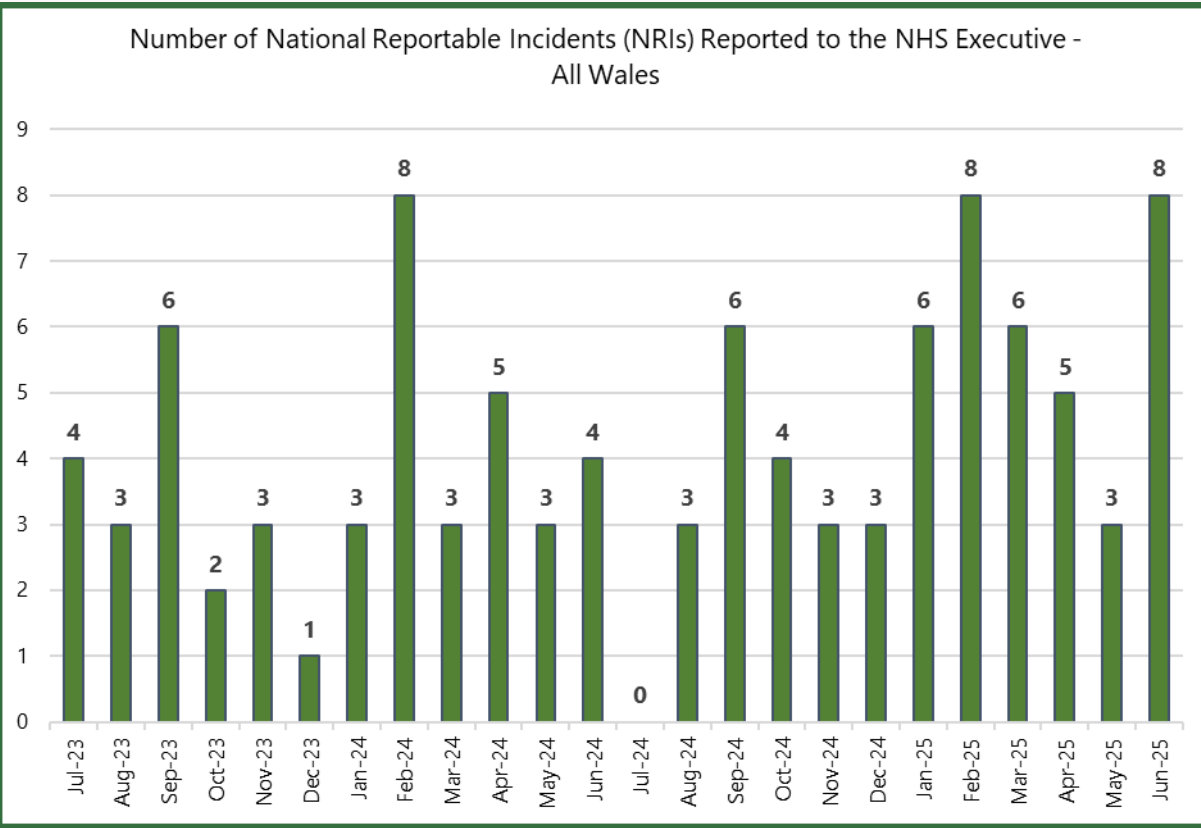
(Responsible Officer: Liam Williams)

Concerns.
G

Self-Assessment:
Strength of Internal Control:
Moderate

QUEST

Health & Care Standard
Health - Safe Care / Timely Care



Analysis
Compliance with the 30 working day complaints target was achieved for the first time since May 2024. Performance for closed complaints however masks a concerning picture of a growing number of open and overdue complaints. This is due to increased complexity of investigations within the Trust, an increased volume of incidents that may have arisen from planned changes in the Clinical Safety Plan and the need to recruit additional staff to support audit of the different interventions now in place across the Clinical Contact Centres; Clinical Navigators within Emergency Medical Service (EMS) and Emergency Communication Nurse System (ECNS) within 111Wales Integrated Care.

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

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

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

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

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

Our Patients: Quality, Safety & Patient Experience

Patient & People Safety Indicators

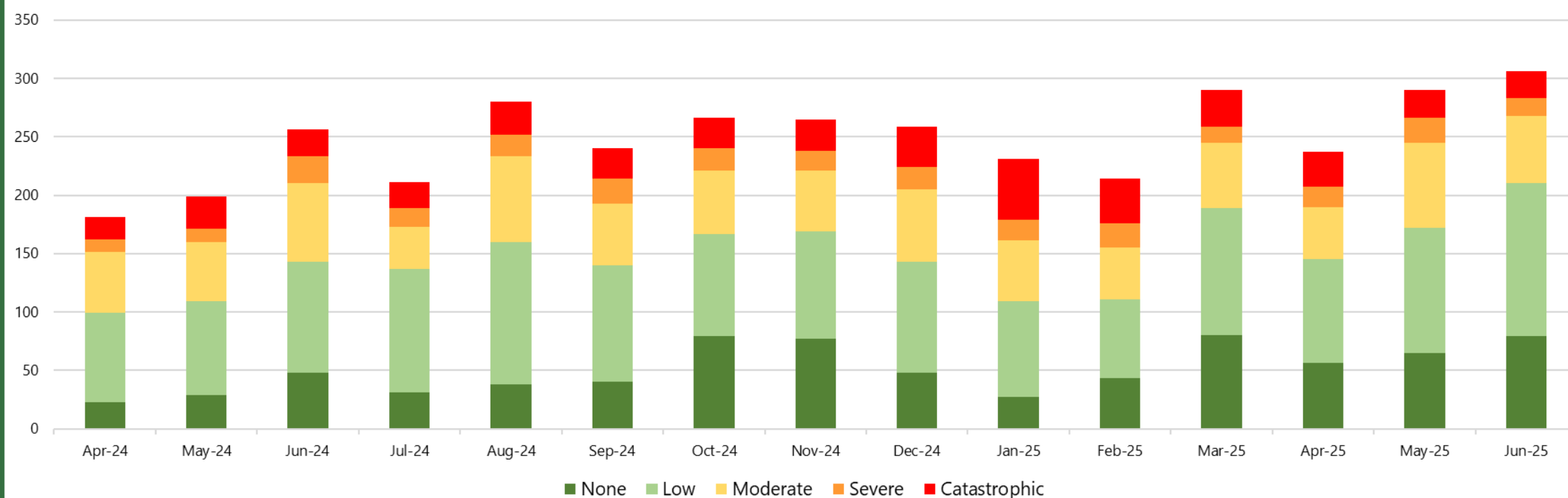
Self-Assessment:
Strength of
Internal Control:
Moderate

QUEST

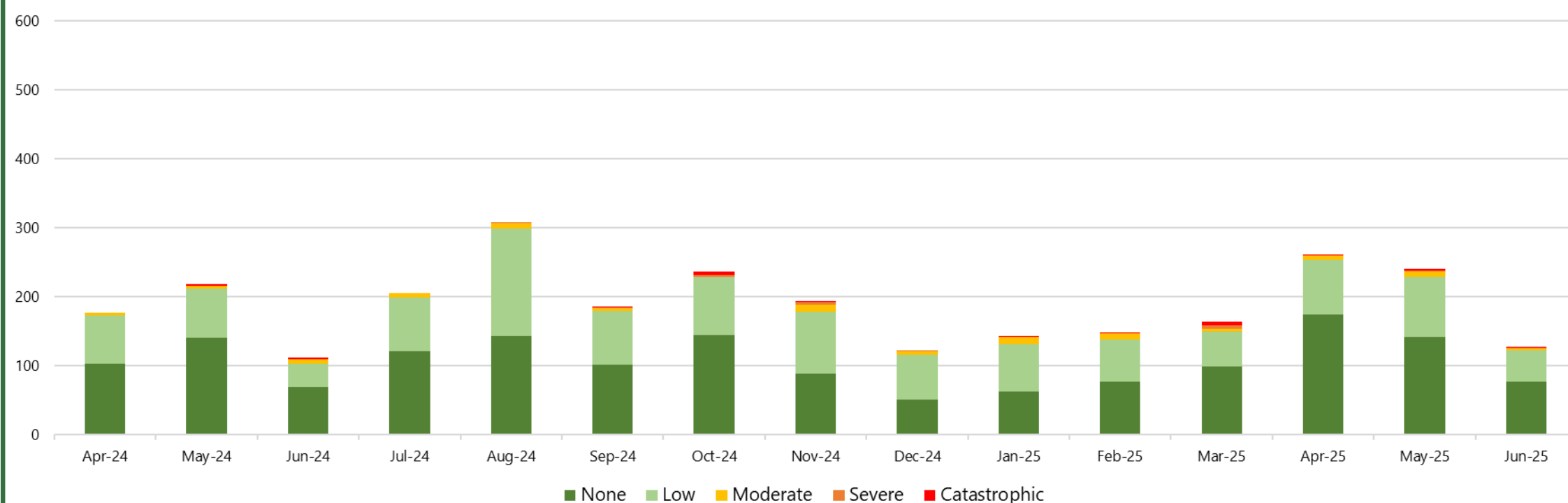
(Responsible Officer: Liam Williams)

Health & Care
Standard
Health – Safe Care

Number of Patient Safety Incidents Reported by Month by Initial Harm Assessment



Number of Patient Safety Incidents by Month Closed and by Post-investigation Harm Assessment



Analysis

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

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

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience

Coroners, Mortality and Ombudsmen Indicators

(Responsible Officer: Liam Williams)

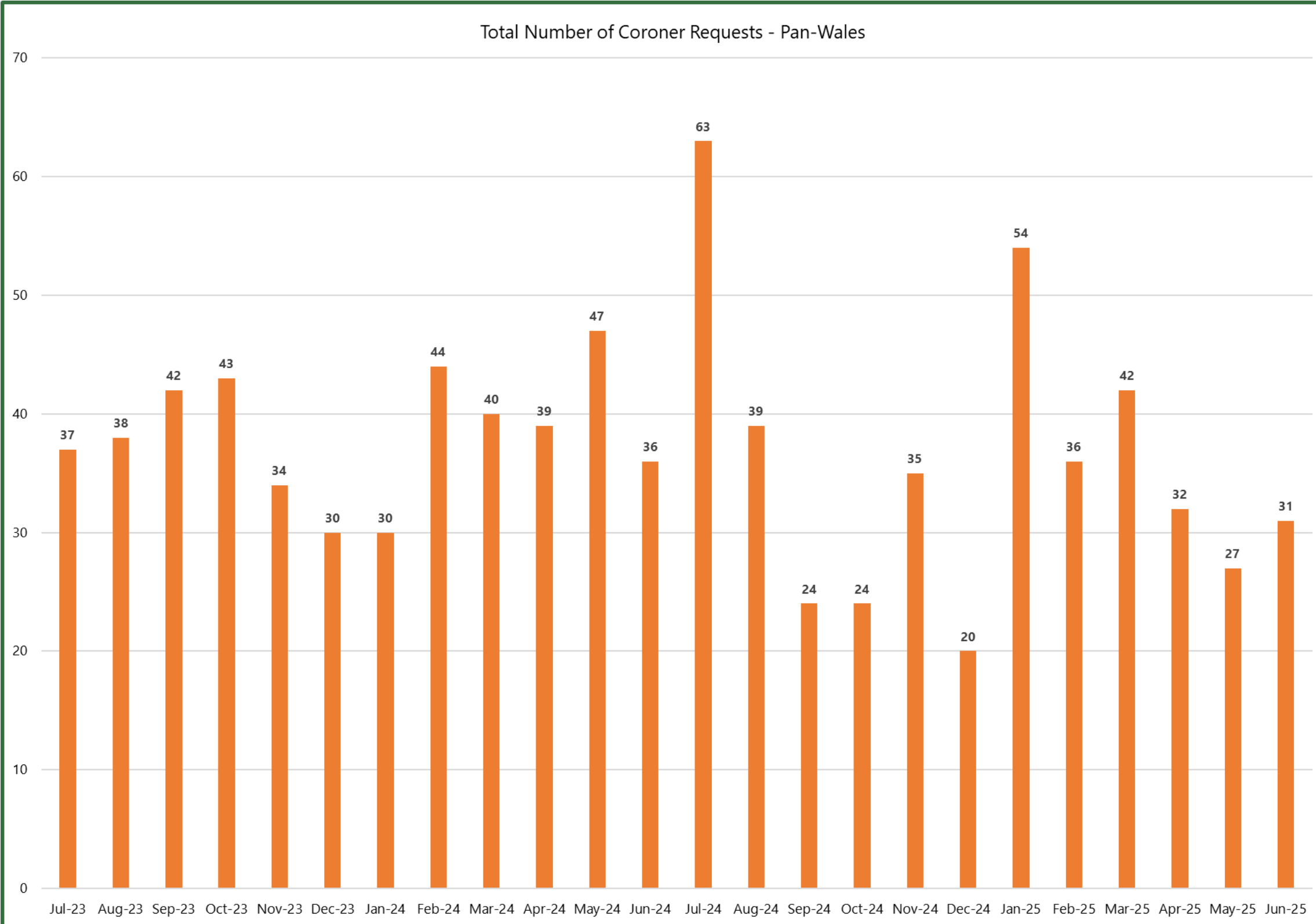
Coroners
Self-Assessment:
Strength of
Internal Control:
Moderate

Mortality
Self-Assessment:
Strength of
Internal Control:
Moderate

QUEST

Health & Care
Standard
Health – Safe Care

Total Number of Coroner Requests - Pan-Wales



Analysis

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

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

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

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

Remedial Plans and Actions

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

Coroner activity will continue to be monitored and delays in statement gathering escalated and prioritised internally as appropriate. Cross directorate teams continue to work together to ensure cases are prioritised.

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

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience

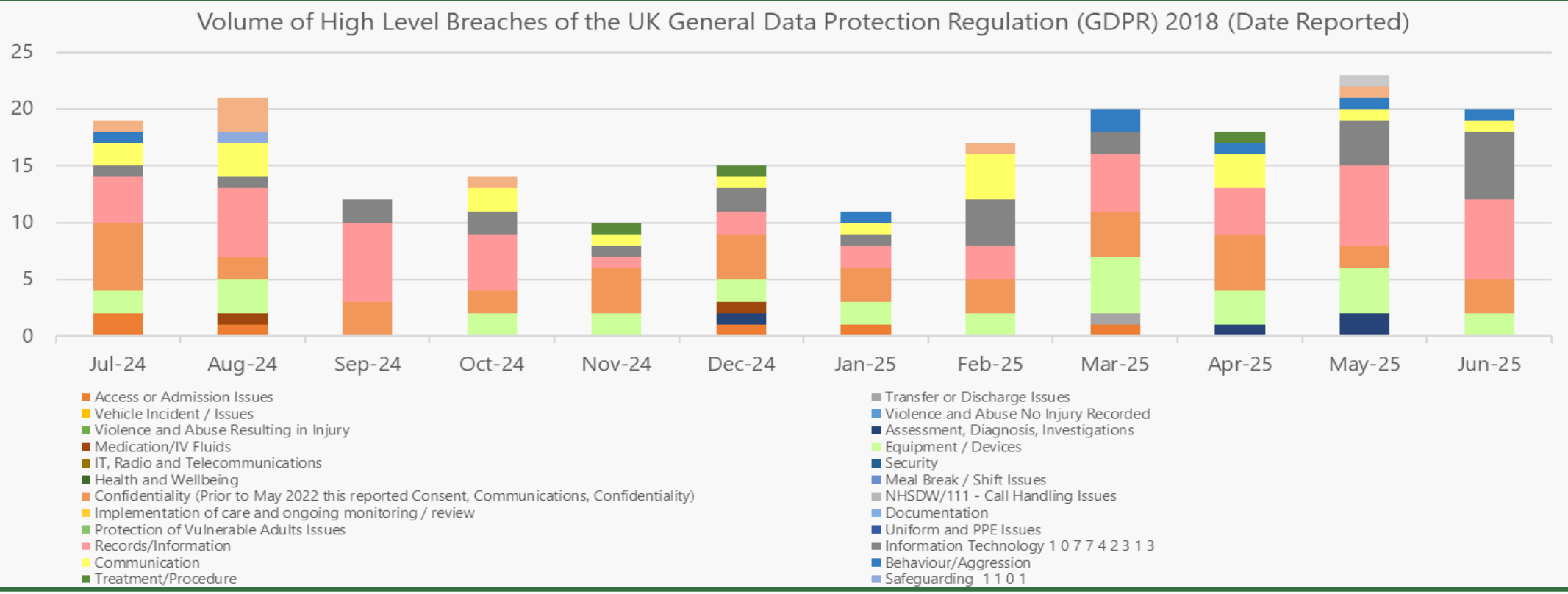
Safeguarding, Data Governance & Public Engagement Indicators

(Responsible Officers: Jonny Sammut & Liam Williams)

Health & Care Standard
Health – Safe Care

Self-Assessment:
Strength of Internal Control:
Strong

PCC



Analysis

Safeguarding: In June 2025 WAST colleagues submitted a total of 249 Adult at Risk Reports, 93% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 790 reports were shared with local authorities across Wales during this reporting period. There have been 263 Child Safeguarding Reports submitted in June 2025, 94% of these were processed within 24 hours.

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

Remedial Plans and Actions

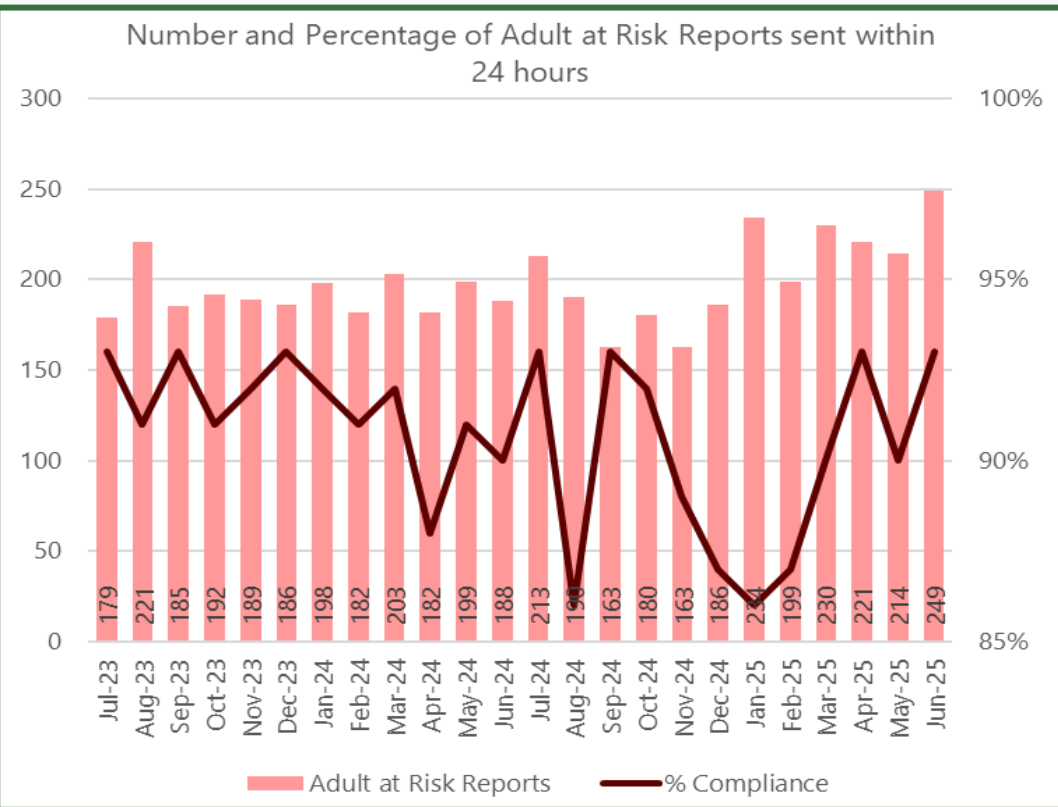
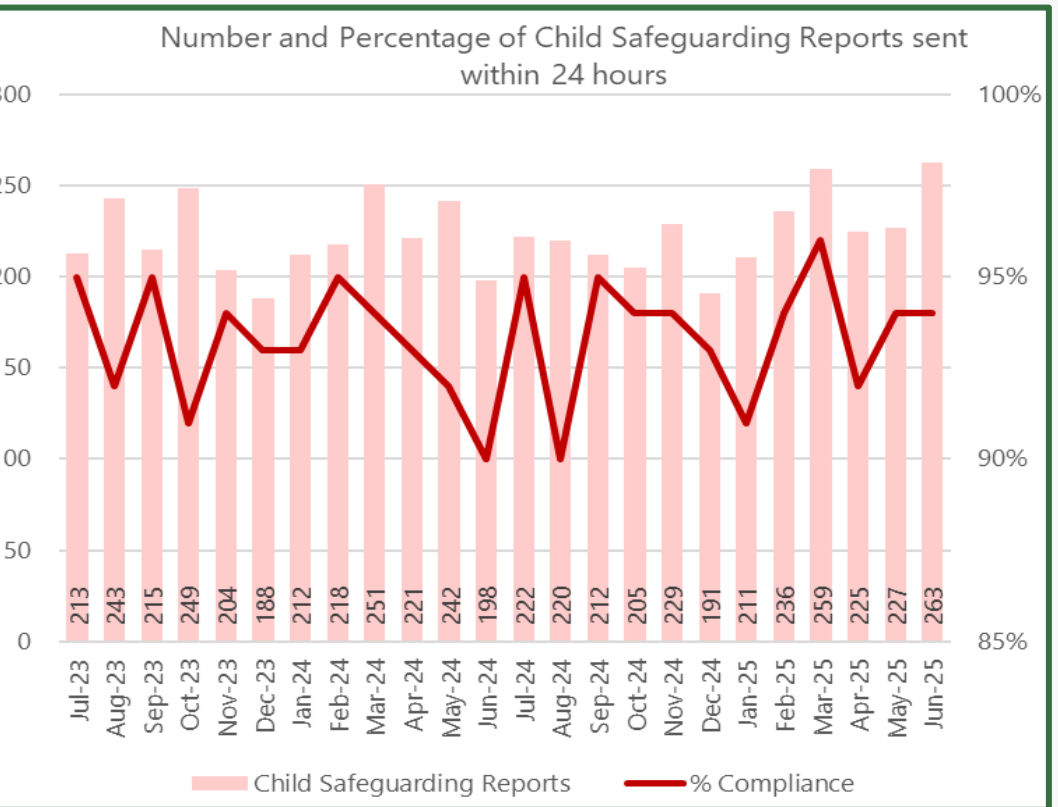
Safeguarding: The Trust manages all safeguarding reports digitally via Doc-works Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support WAST colleagues with using the Doc-works Scribe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

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

Expected Performance Trajectory

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

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



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

Safeguarding Data source: Doc Works

Our Patients: Quality, Safety & Patient Experience

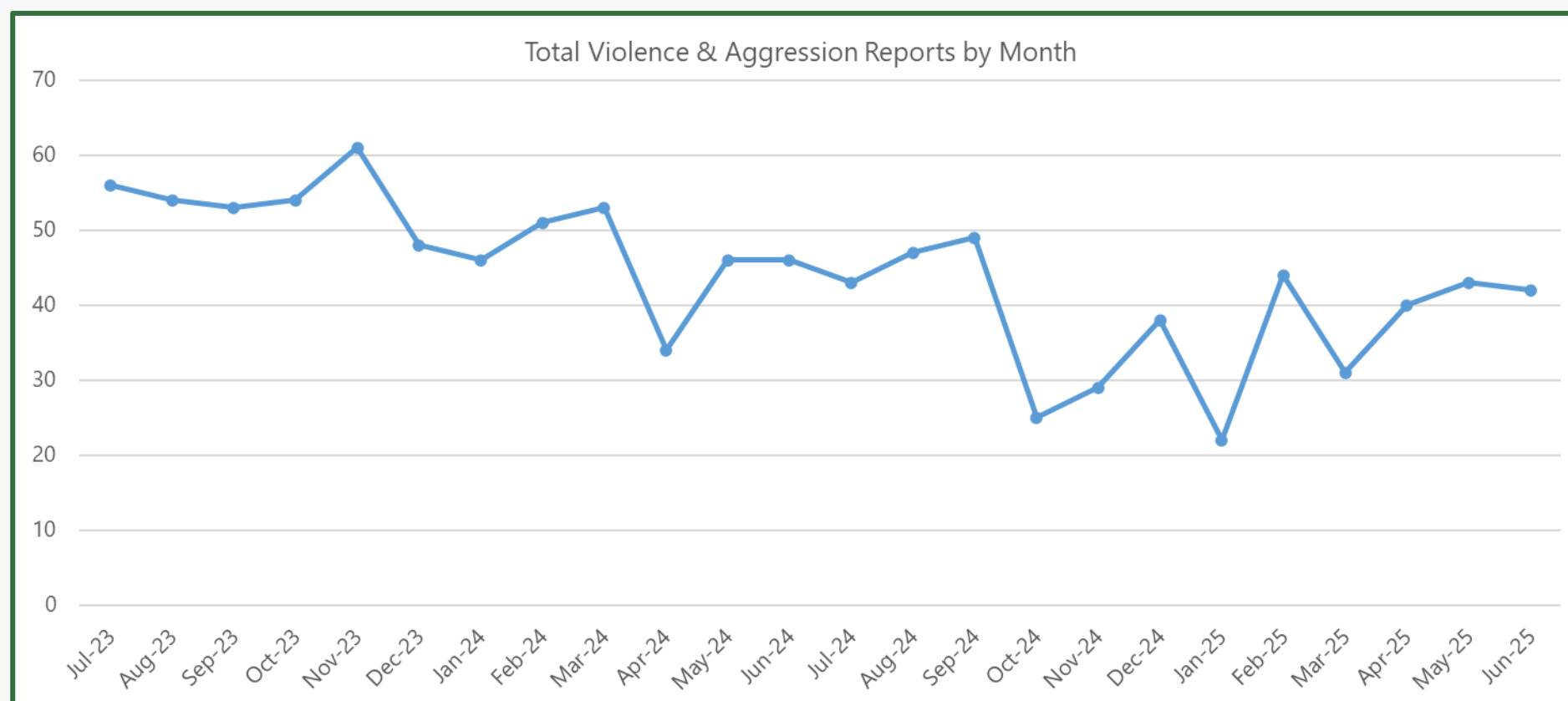
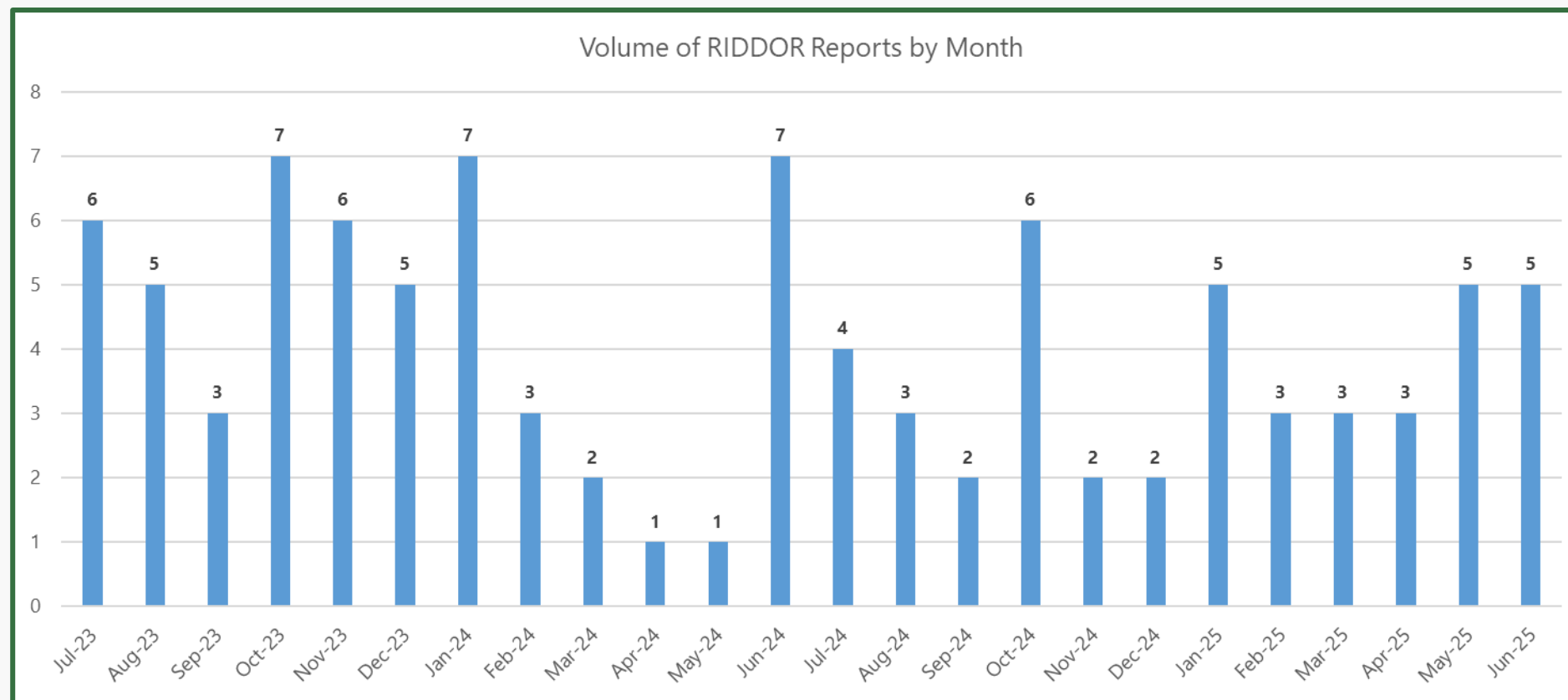
Health & Safety (RIDDORS) Indicators

(Responsible Officer: Liam Williams)

Self-Assessment:
Strength of
Internal Control:
Moderate

PCC

Health & Care
Standard
Health – Safe Care



Analysis

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

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

Violence and Aggression:

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

Remedial Plans and Actions

RIDDOR:

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

Violence and Aggression:

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

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

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

Expected Performance Trajectory

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

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

Data source: Datix

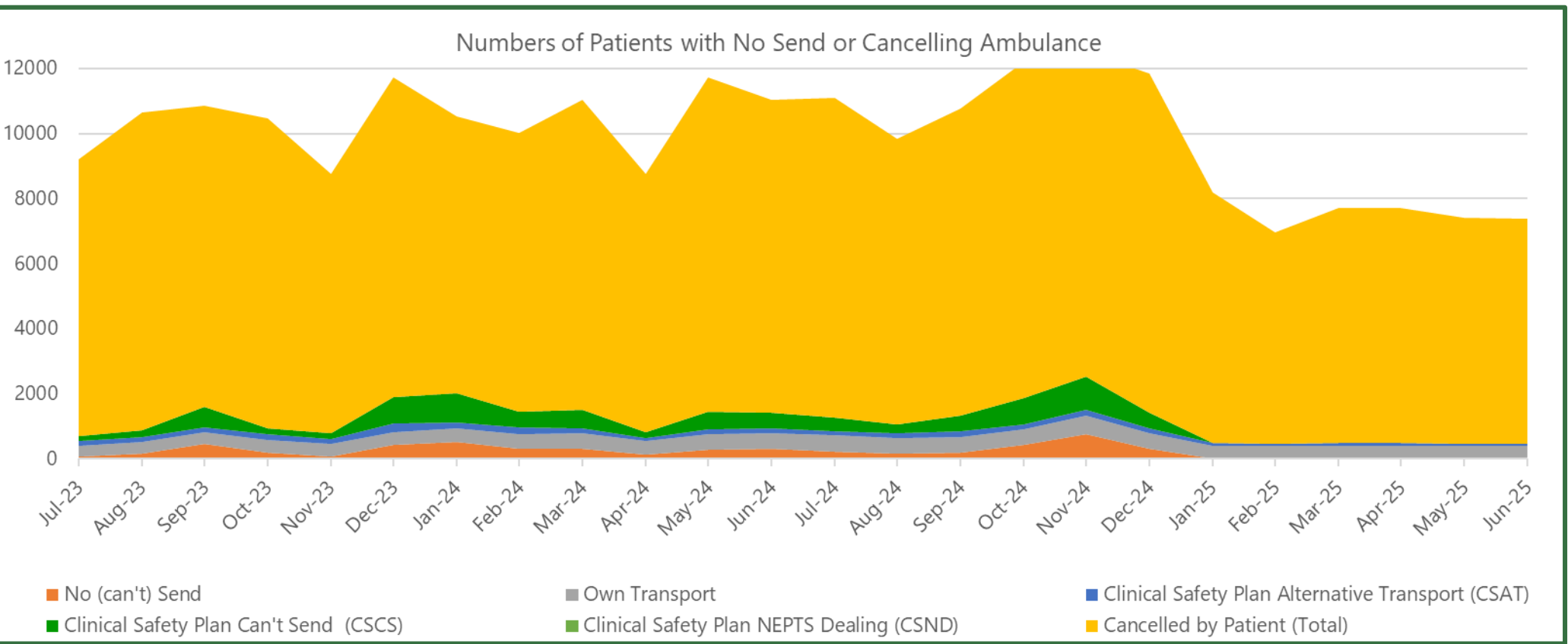
Our Patients: Quality, Safety & Patient Experience

Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn)

G

QUEST



Analysis

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

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

The graph in the bottom left shows the estimated level of patient harm during June 2025. Of the 4,625 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (694 patients) would experience no harm, 53% (2,451 patients) would experience low harm, 23% (1,064 patients) would experience moderate harm and 9% (416 patients) would experience severe harm.

In June 2025 CSP levels for the Trust were:

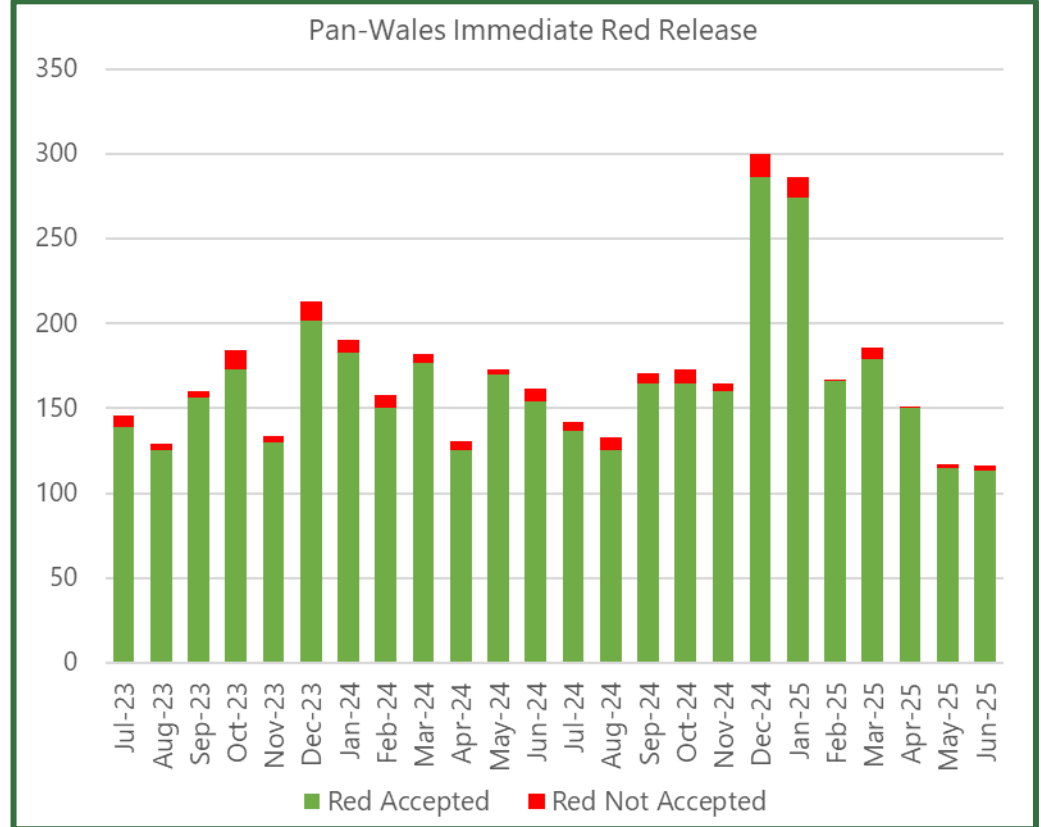
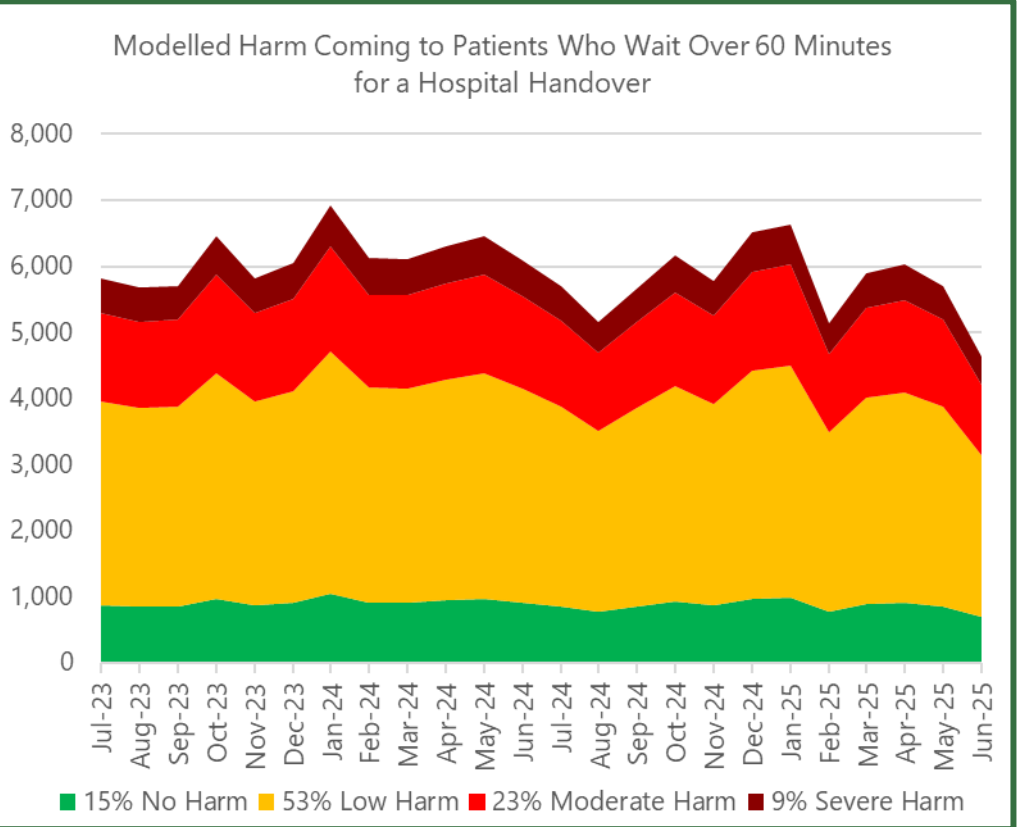


Remedial Plans and Actions

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

Expected Performance Trajectory

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



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

Our Patients: Quality, Safety & Patient Experience

Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment:
Strength of
Internal Control:
Moderate

PCC

Health & Care
Standard
Health – Safe Care

May & June 2025 Combined		
NEPTS (503 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	85
Were you happy with the transport you received?	85	95
999 (43 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	79
The 999-call taker who answered your call explained what was going to happen next.	85	80
The length of time I waited for an ambulance to arrive was acceptable.	85	56
111 (29 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	72
Did you follow the advice given to you by NHS 111 Wales?	85	87
Would you consider using NHS 111 Wales again?	85	91
WAST Overall - Friends & Family Test	Ranked from very poor to very good.	
How was your overall experience with the service today?		
o Ambulance care	92.22% Good	6.11% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	53.85% Good	23.08% Poor
o EMS (including CSD)	63.34% Good	18.18% Poor
o NHS 111 Wales Online	32.43% Good	51.35% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis

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

Throughout May and June, we continued to make available 4 patient experience surveys covering the Trust's main service delivery areas. Engagement and survey outcomes remain largely consistent and tell us that people continue to be very concerned about response times in the community and frustrated at hospital handover delays. 111 callers have told us that they experienced long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

The PECEI Team are still waiting the progression of an OCP which will see the Team restructured and re-aligned to meet the Trust's ongoing strategic objectives. For now, the PECEI Team continue to engage in an ongoing dialogue with the public about their experiences and expectations of using our services, though it is yet unclear how this will change and what Team will be responsible for public engagement in the future. As a result, the PECEI Team are not committing to a diary of future engagement events and are considering each community engagement request on a case-by-case basis.

Response rates to some of our PREM's surveys continues to be disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. A DPIA was submitted to the ICO for consideration, which would allow us to contact certain 999 callers by SMS Text to ask them to provide feedback. The ICO has responded with 7 recommendations which will be presented to IGSG and from there it will be reported to ELT as an AAA.

Expected Performance Trajectory

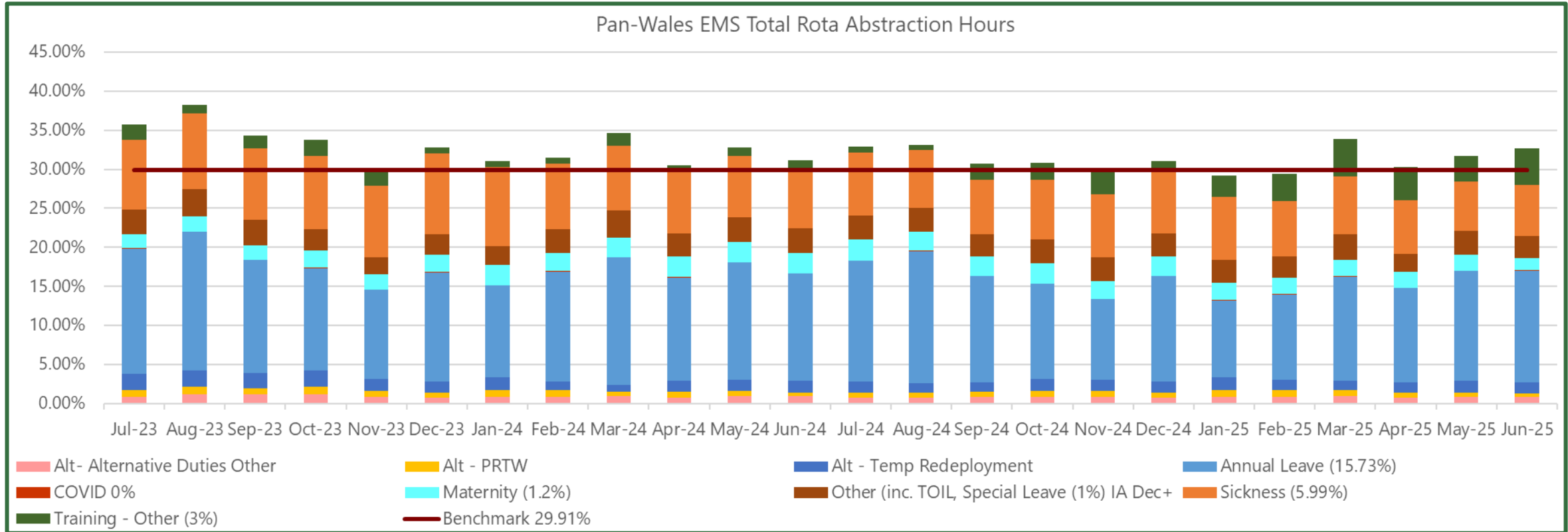
The Team has recently lost four members of staff to retirement or moving onto new positions elsewhere. The impending OCP means we are unable to back fill these posts. This will impact on our ability to support/attend community engagement opportunities.

Our People Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production
A

CI PCC FPC



Analysis

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

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

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

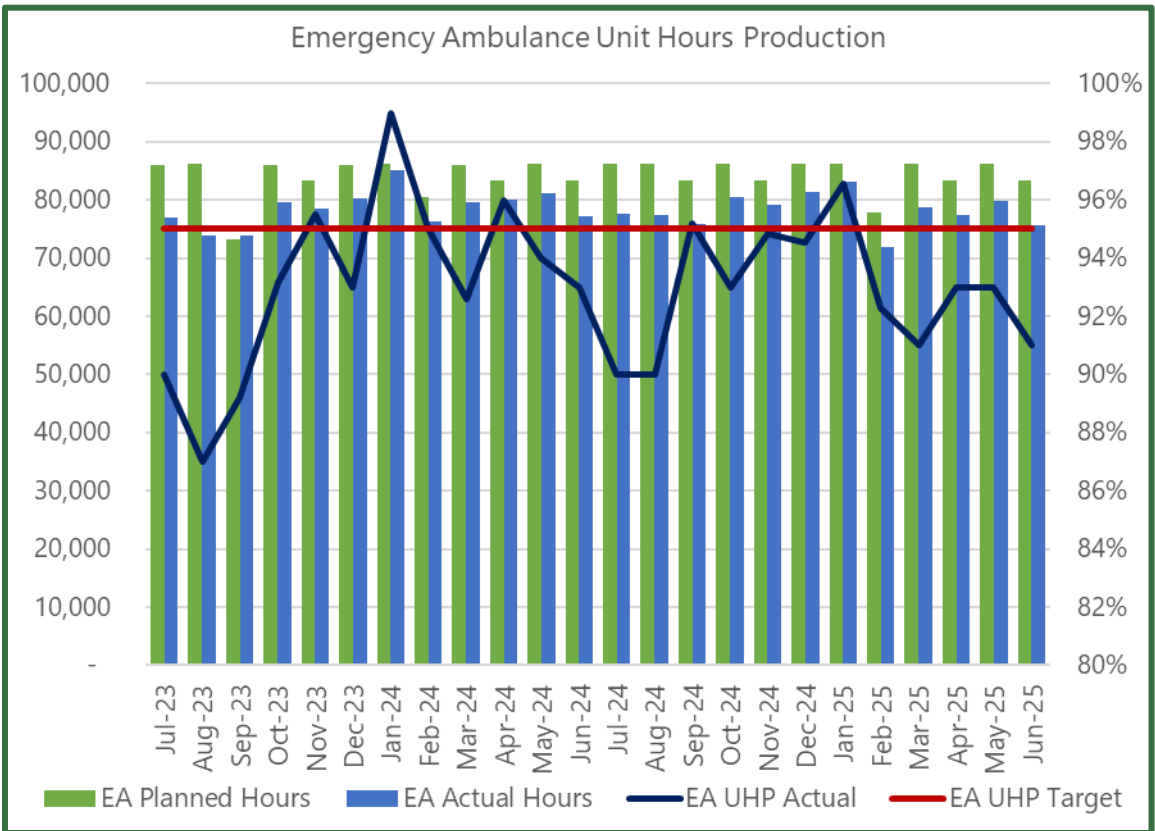
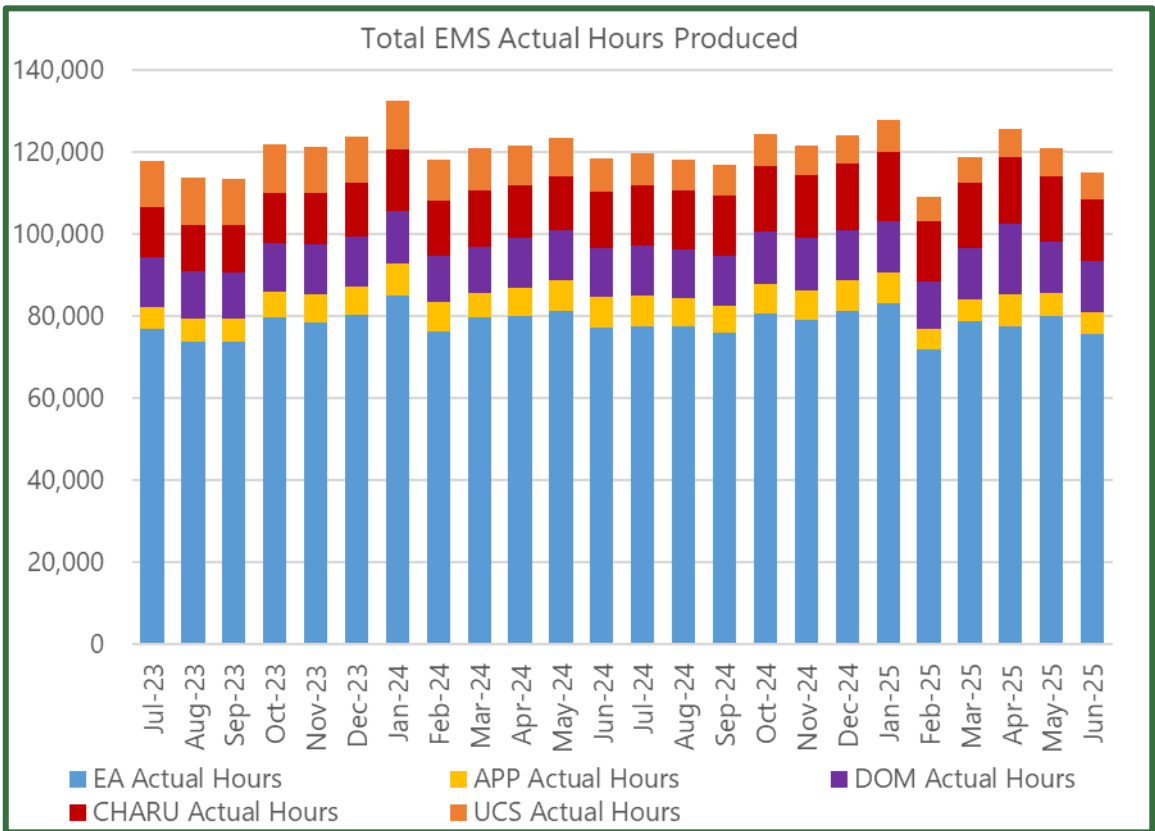
In June 2025 CHARU UHP was 85% against the full roll out requirement. A slight drop compared to the past seven months.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

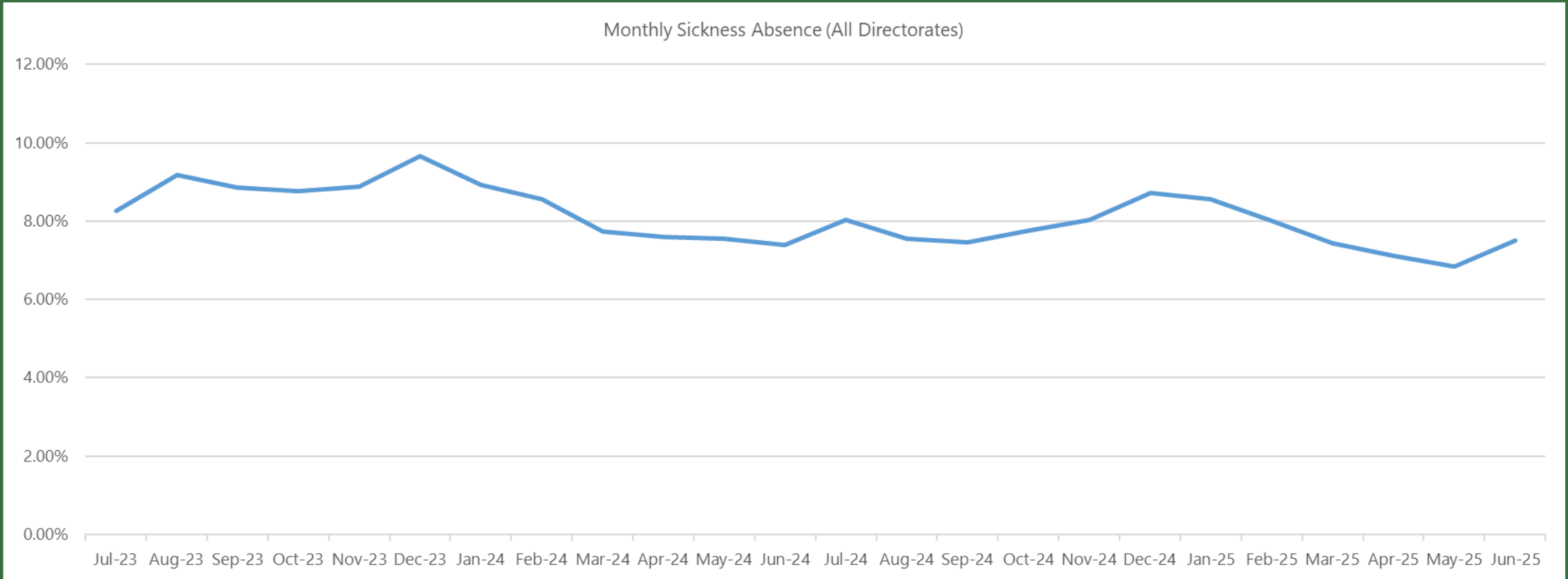


Our People Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Sickness **R** Mental Health **R**

PCC **CI**



Analysis

There was a slight increase in overall sickness absence rates between May 2025 and June 2025, rising from 6.83% to 7.50%. Long term absence decreased from 5.25% in May 2025 to 5.17% in June 2025, while short-term absence increased slightly to 2.33% (May 2025 - 1.38%).

The highest reasons for absence in June 2025 were Anxiety/ Stress/ Depression, other musculoskeletal problems, gastrointestinal problems, and injury fracture. Absence due to Mental Health increased slightly from 2.34% in May 2025 to 2.58% in June 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 June was 11.7 days.

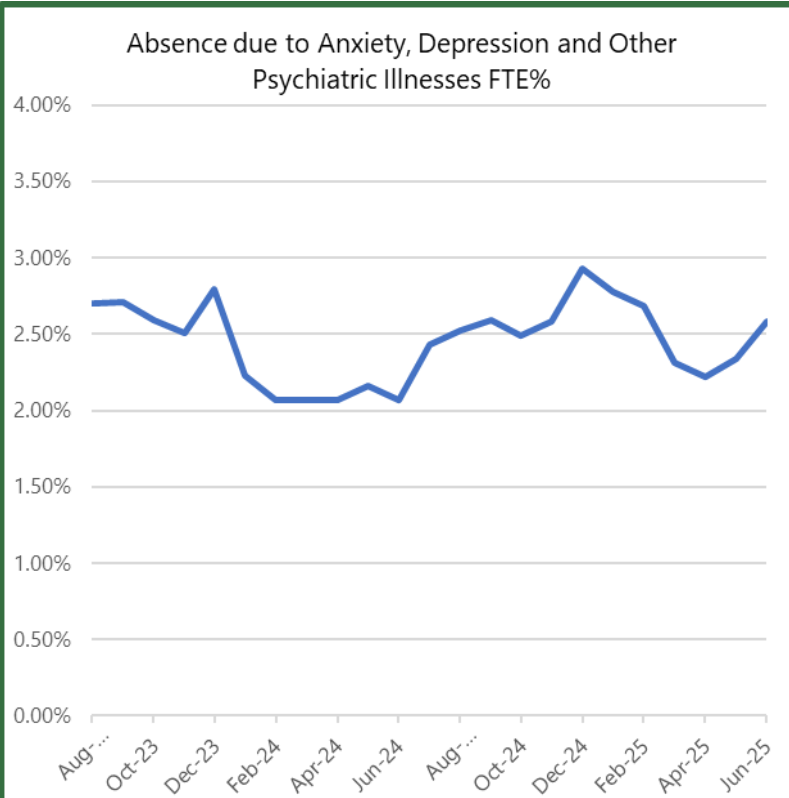
The team continue to triage all referrals and enquiries to ensure prioritisation of anything that requires urgent attention.

Remedial Plans and Actions

- The Health and Wellbeing Plan for 2025-29 has been approved by the WAST Board and a delivery plan has been developed and implemented. The focus of the plan is to improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges increasingly on a systemic level, in addition to providing support on an individual level.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits and drop-in clinics. We regularly give presentations to newly recruited staff to highlight and promote the Occupational Health & Wellbeing service.
- The programme plan for the pilot Health Check Programme, Health Diagnostics, (HD), has now started, and the team are scheduling clinics inviting staff to book screening appointments.

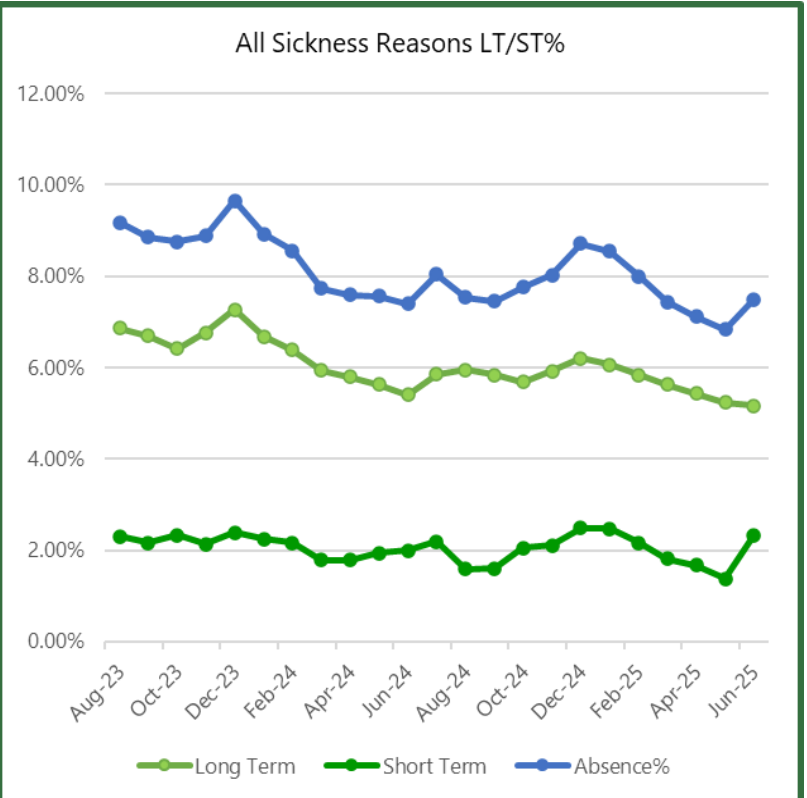
Expected Performance Trajectory

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



Average working days lost per FTE (Annual)	
17.66 days	
Single month Absence %	
7.50%	
Long Term	Short Term
5.17%	2.33%
Mental Health	Other MSK
(S10 Stress/Anxiety) 2.58%	(excluding Back) 0.77%

June 2025



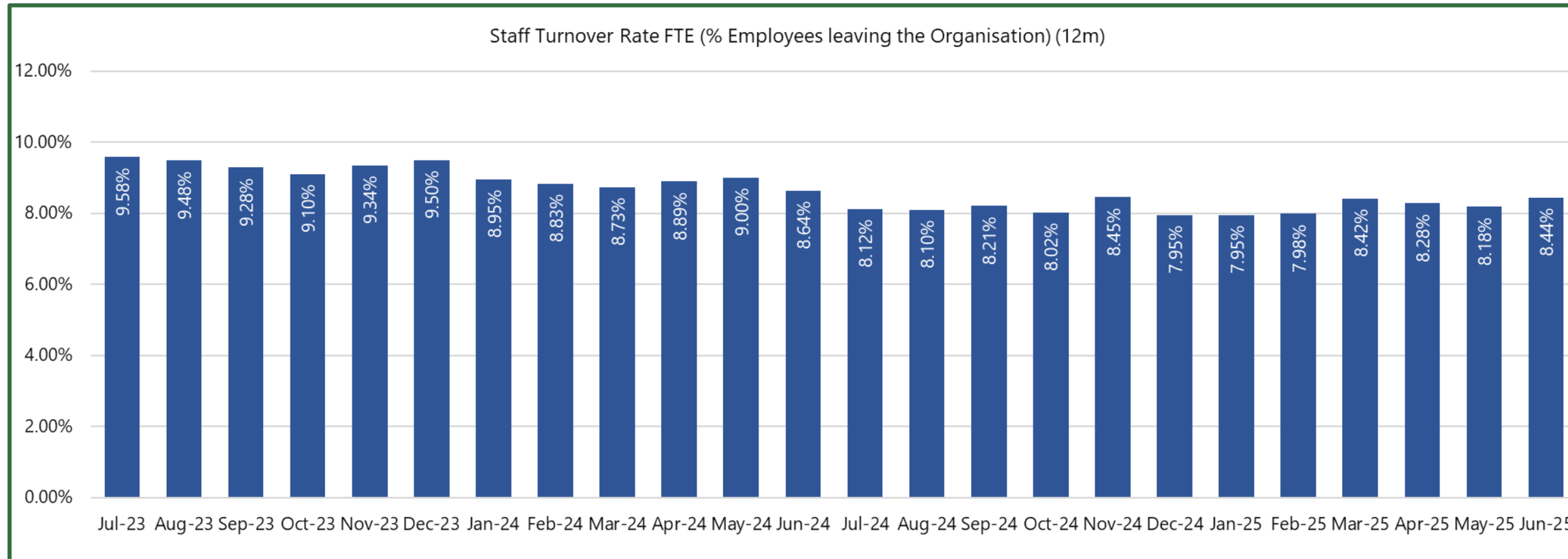
*NB: Sickness data will always be reported one month in arrears

Our People Capacity – Staff Turnover

(Responsible Officer: Angela Lewis)

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PCC



Analysis

The staff turnover rate in June 2025 was 8.44%, minimally increasing from 8.18% in May 2025. June saw 31 leavers (27.03 FTE). Of those leaving, the greatest number were Operational and included;

- Technicians (6 people)
- Staff Nurses (5 people)
- Ambulance Care Assistants/Patient Transport Drivers (4 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 June, most leavers mention changes in personal circumstances, better work location, retirement, better work life balance or better hours.

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

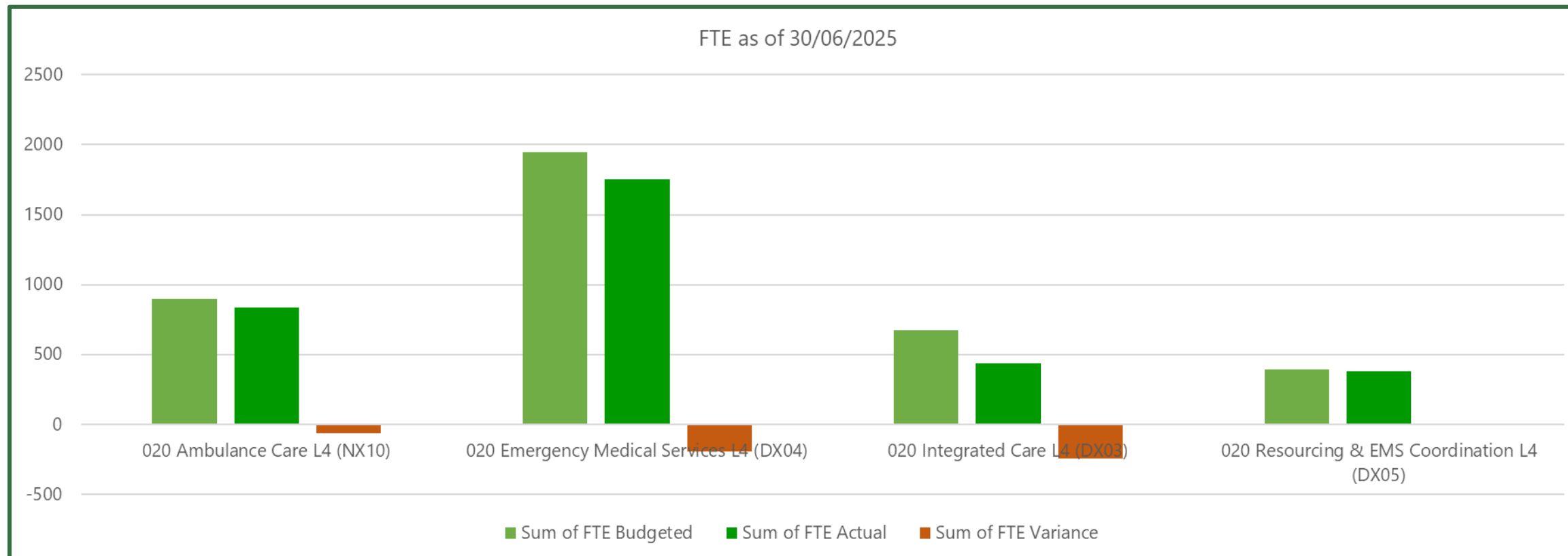
- Staff Nurses (8 people)
- Emergency Call Handlers (7 people)
- Urgent Care Assistants (6 people)
- Paramedics (5 people)
- Non-emergency medical Dispatchers (3 people)

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

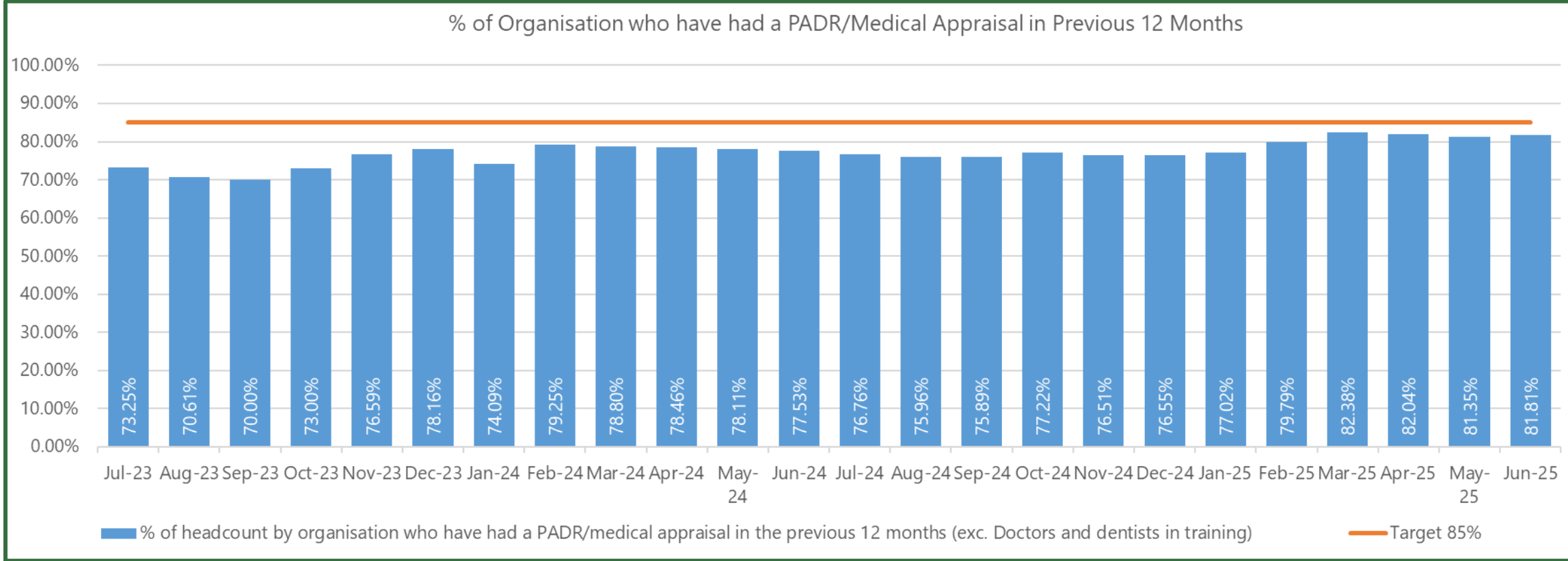
Stat & Mand
G

CI

PCC

Health & Care Standard
Health – Staff & Resources

Self-Assessment:
Strength of Internal Control: Strong



Analysis

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

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

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

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

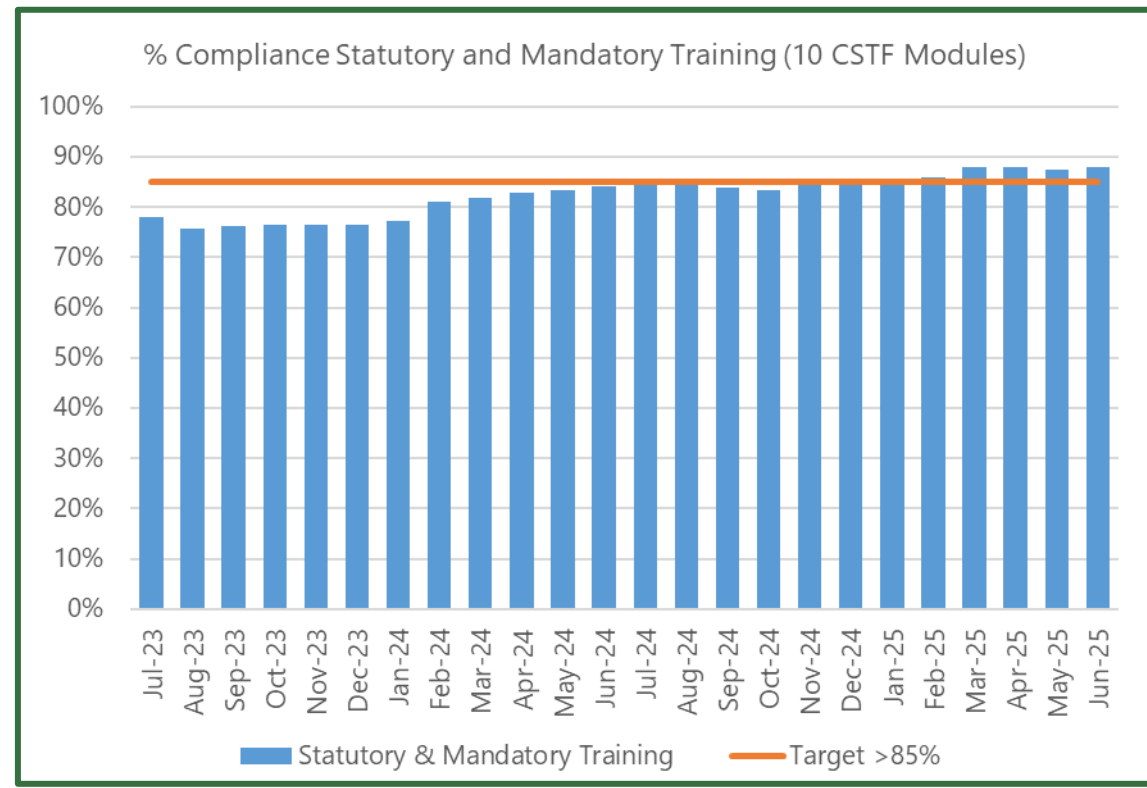
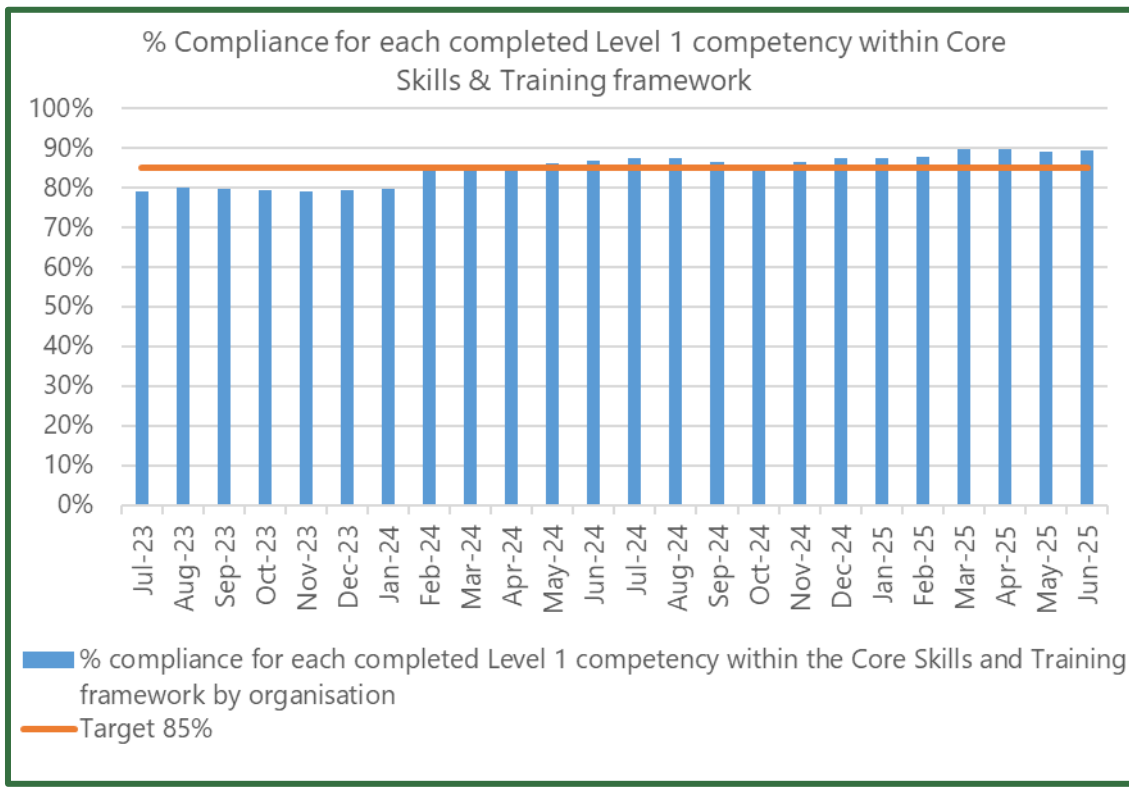
Remedial Plans and Actions

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.



Our People

Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

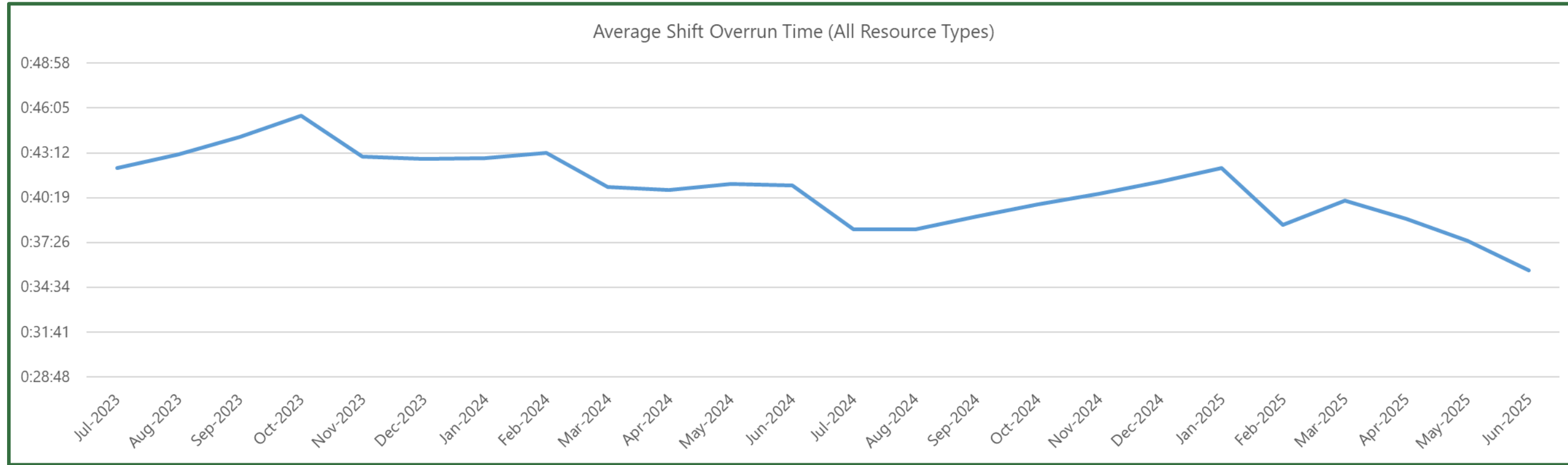
Overruns

G

CI

FPC

PCC



Analysis

There were 3,441 shift overruns during June 2025.

The average overrun figure for June 2025 was 35 minutes and 38 seconds, a minimal decrease from May 2025 (37 minutes 32 seconds). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 76.5% of the total. 18.7% fall within the 61 to 120-minute category, 4.2% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.2% in the 241 minutes and over category.

Remedial Plans and Actions

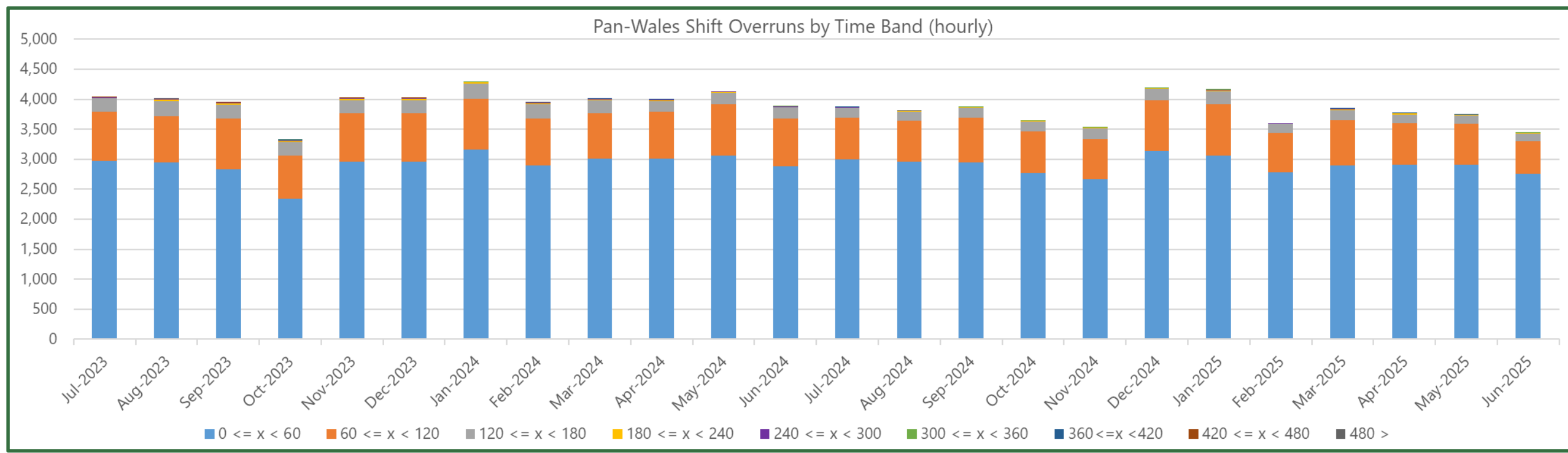
Shift overruns are a key element of staff wellbeing and work is ongoing to mitigate these in conjunction with handovers, as although not shown here there is a clear correlation.

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

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

Expected Performance Trajectory

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

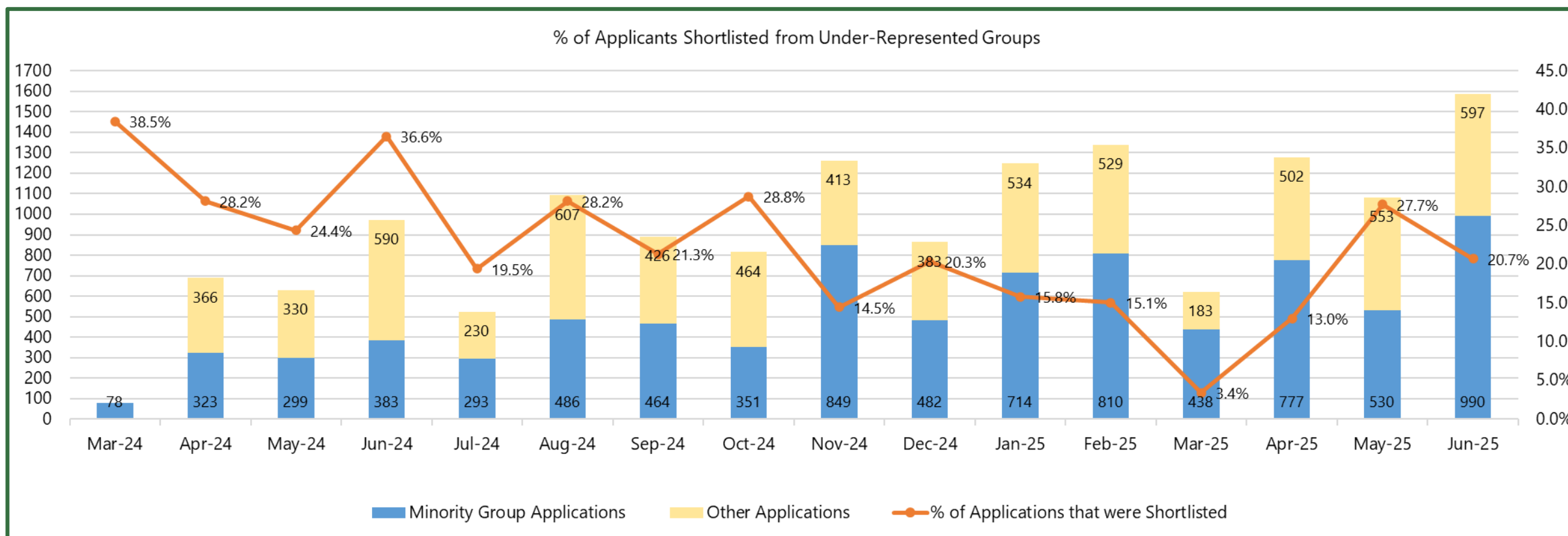
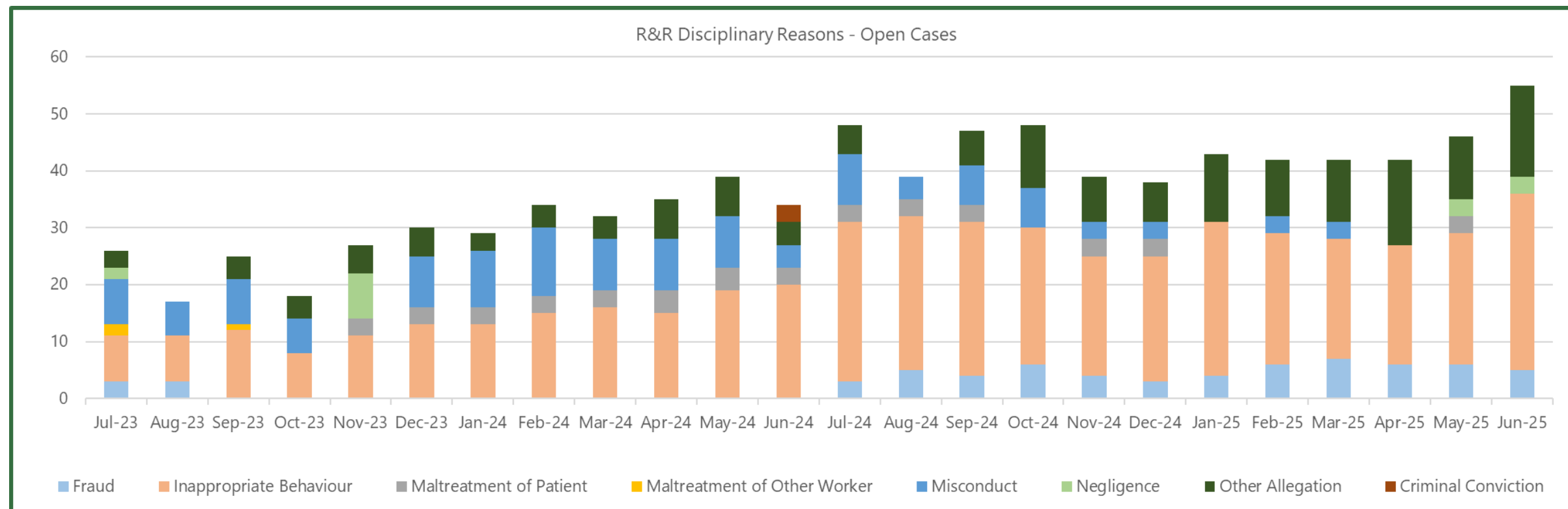


Our People

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

(Responsible Officer: Angela Lewis)

Self-Assessment:
Strength of Internal
Control: Moderate



Analysis

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

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

The bottom graph shows that in June 2025, 1,587 job applications were processed, and 490 interviews planned.

Of the 1,587 applications, a total of 990 were from under-represented groups with 607 in the category of Ethnicity, 203 within Disability and 180 identifying within Sexual Orientation.

In June 2025, 20.7% (n=205) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 27.7% in May 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.

The work continues with the digital directorate and the ED&I team to host recruitment workshops for Black, Asian and Ethnically diverse applicants. The ED&I team are also hosting unconscious bias training for the managers within the digital directorate this is also being undertaken with the interviewers for our annual Graduate Paramedic recruitment. We have also set up support workshops for applicants that have a protected characteristic that have been invited to interview for the Graduate Paramedic position.

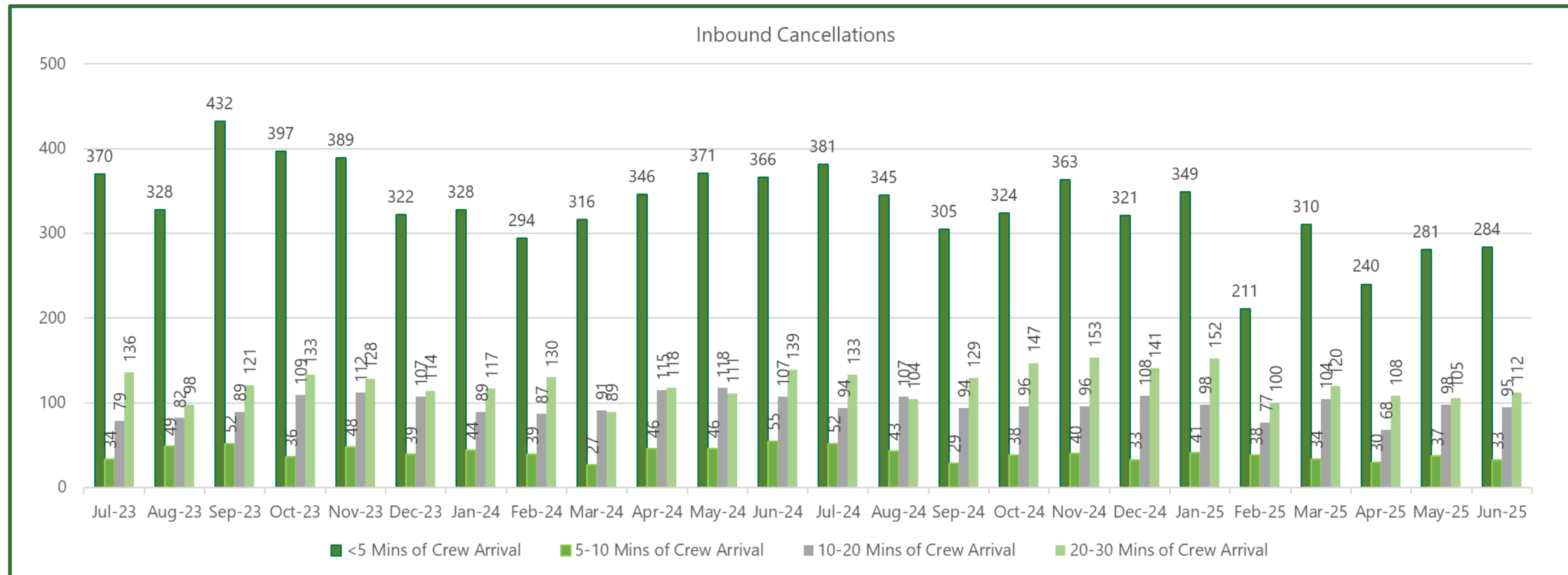
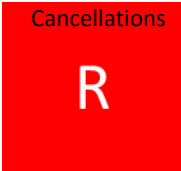
Expected Performance Trajectory

Continue to monitor levels, no trajectory for this measure.

Finance, Resources and Value

Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)



Analysis

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

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

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

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

Remedial Plans and Actions

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

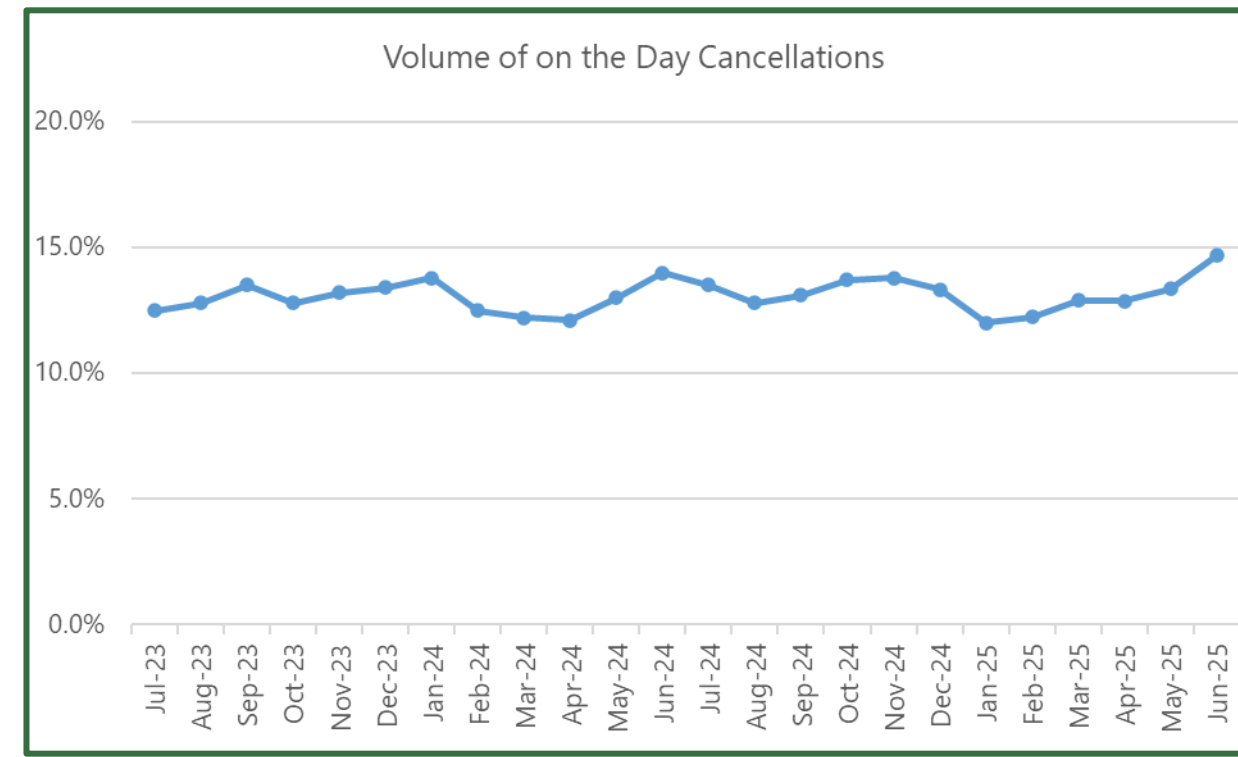
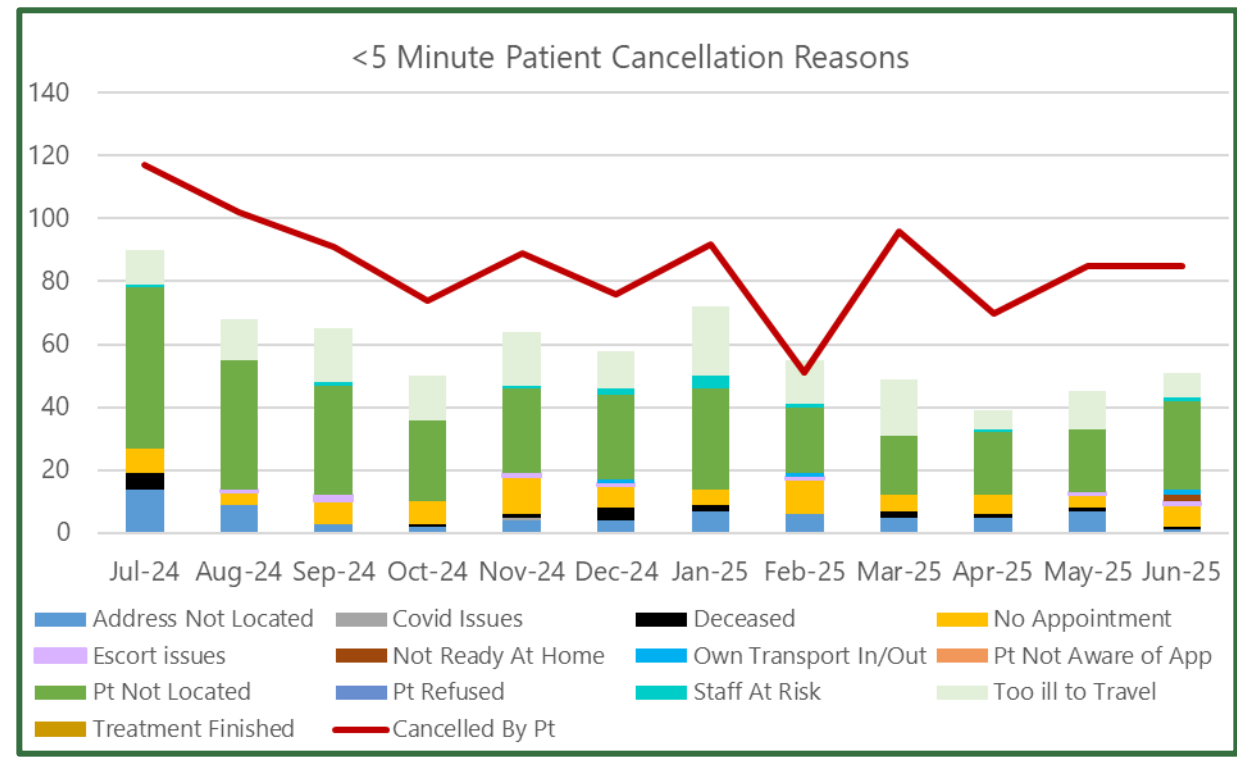
Work is also underway to enhance the service's text messaging options to improve notification to patients.

Expected Performance Trajectory

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

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

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



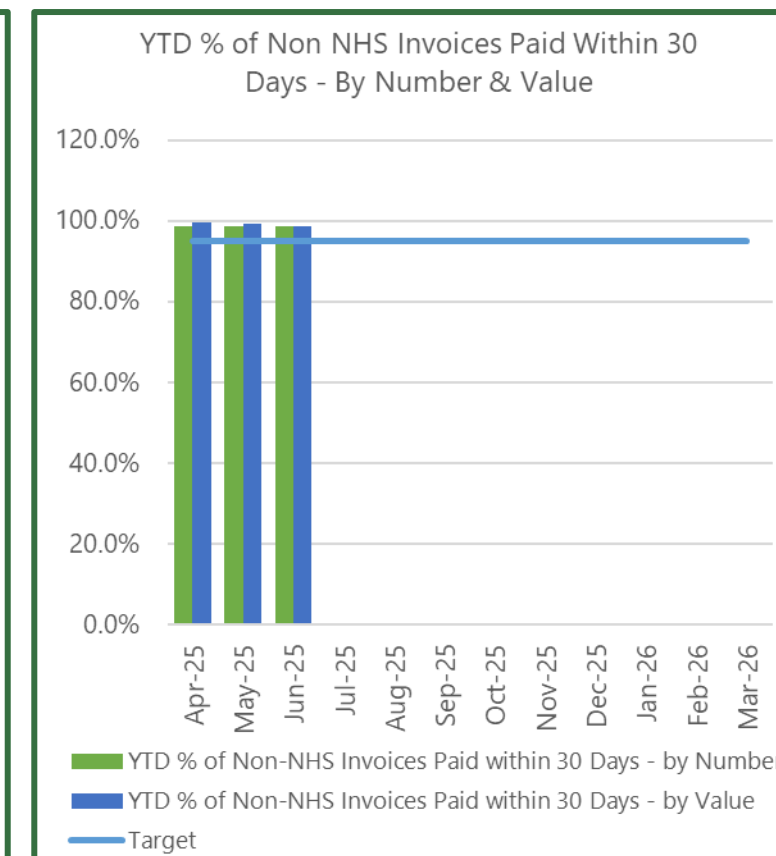
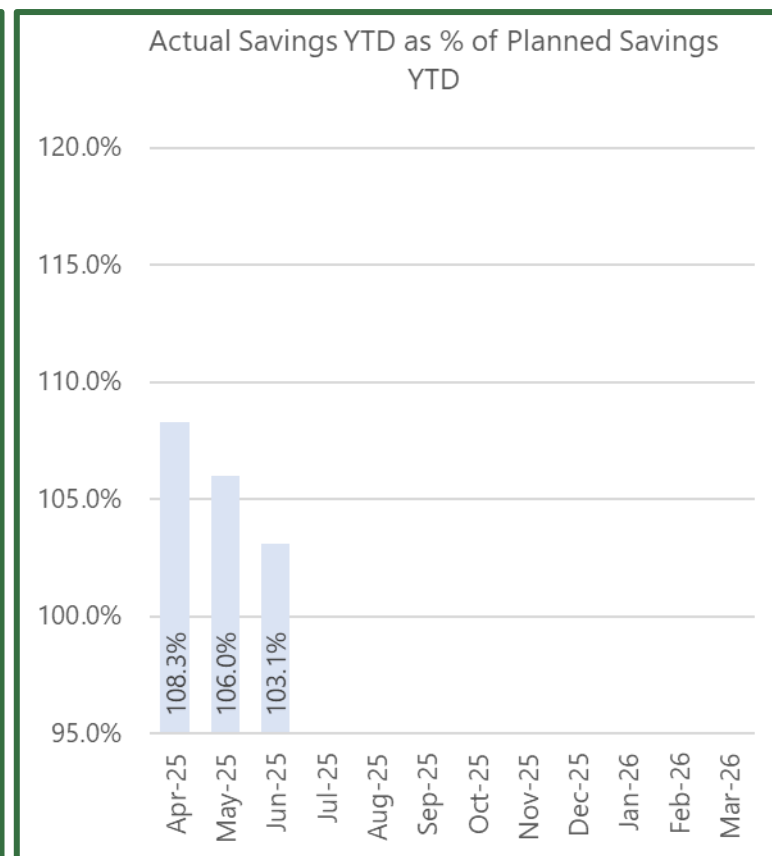
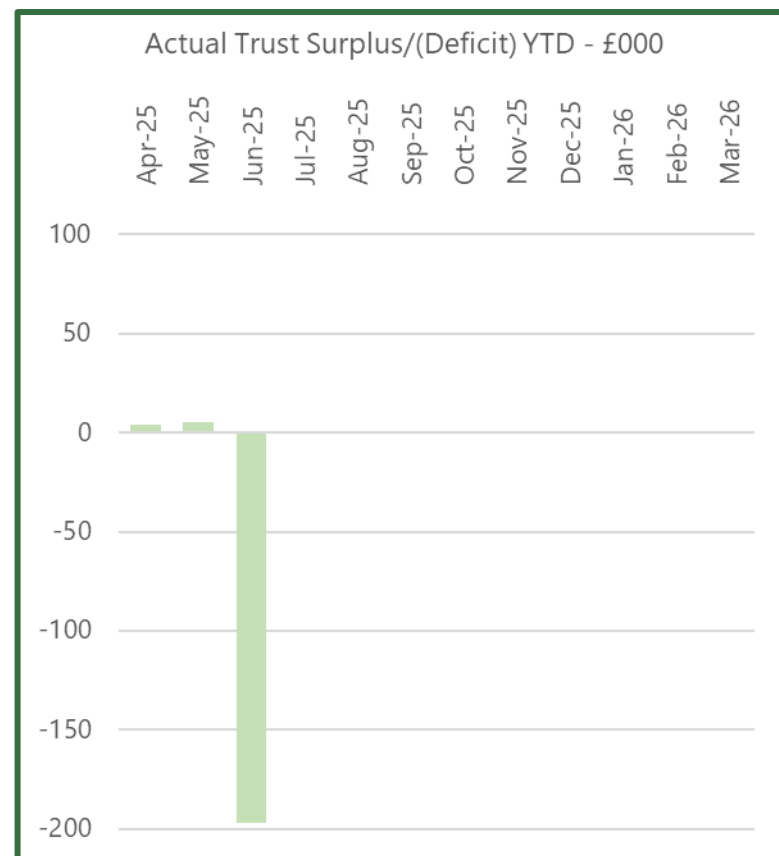
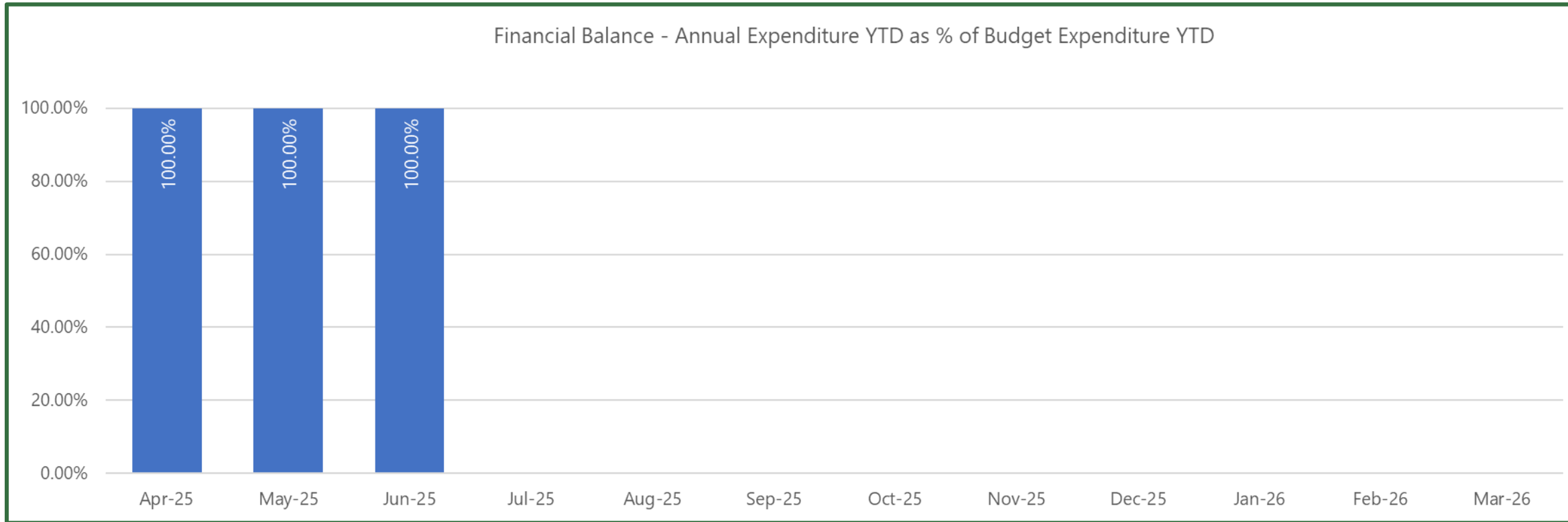
Finance, Resources and Value

Value - Finance Indicators

(Responsible Officer: Chris Turley)

G

FPC



Analysis

The reported outturn performance at Month 3 is a deficit of £0.197m, with a forecast to the yearend of breakeven.

For Month 3 the Trust is reporting planned savings of £2.073m and actual savings of £2.137m (an achievement rate of 103.1%).

The Trust's cumulative performance against PSPP as at Month 3 is 98.7% against a target of 95%.

At Month 3 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.

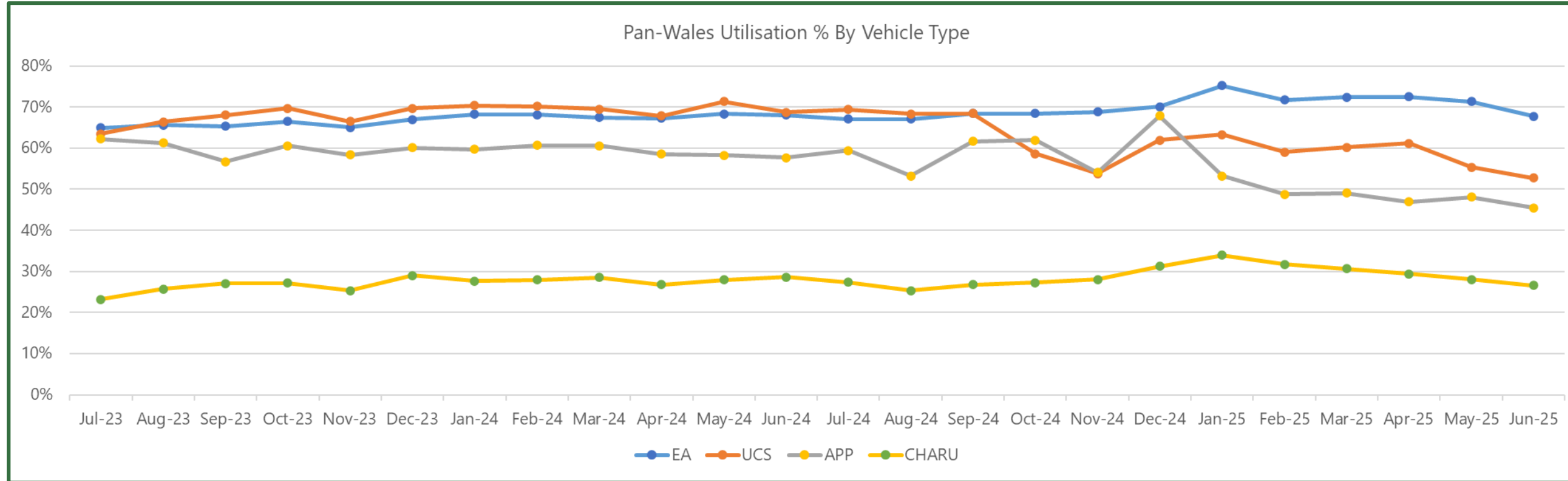
Finance, Resources and Value

EMS Utilisation

(Responsible Officer: Lee Brooks)

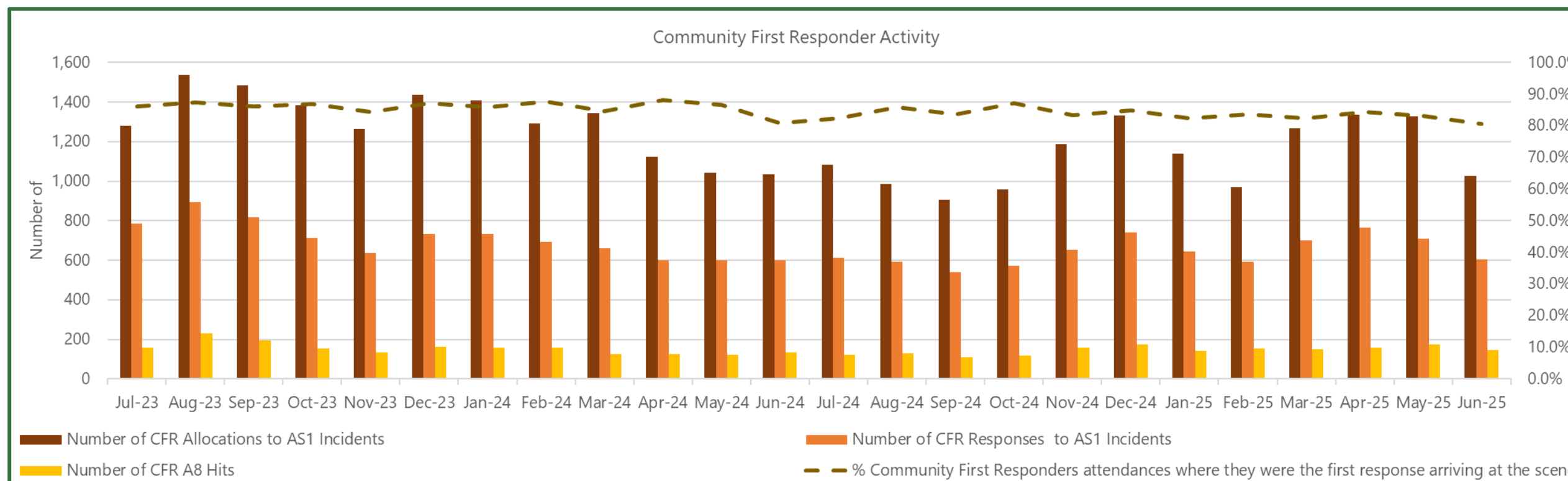


NB: Data quality issues have been identified within APP & CFR data. These are currently being addressed.



Analysis
Pan Wales Utilisation metrics in June 2025 were 53.6% for all vehicles types, a decrease from 56.5% in May 2025. EA saw the highest rate during the month at 67.8%, a decrease compared to the upward trend over the previous months. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

CFR data collation is under review due to the new Assemble system going live in June 2025. At present hours for which a CFR volunteers are entered manually by the individual, however there is work ongoing to connect this to the current CAD system from which they are dispatched to appropriate call codes. From the data available, in June we can see that CFRs were allocated to 1,025 EMS incidents and responded to 606. In June 2025 80.7% Community First Responders attendances where they were the first response arriving at the scene.



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

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

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

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

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

Finance, Resources and Value

Average Job/Shift Times

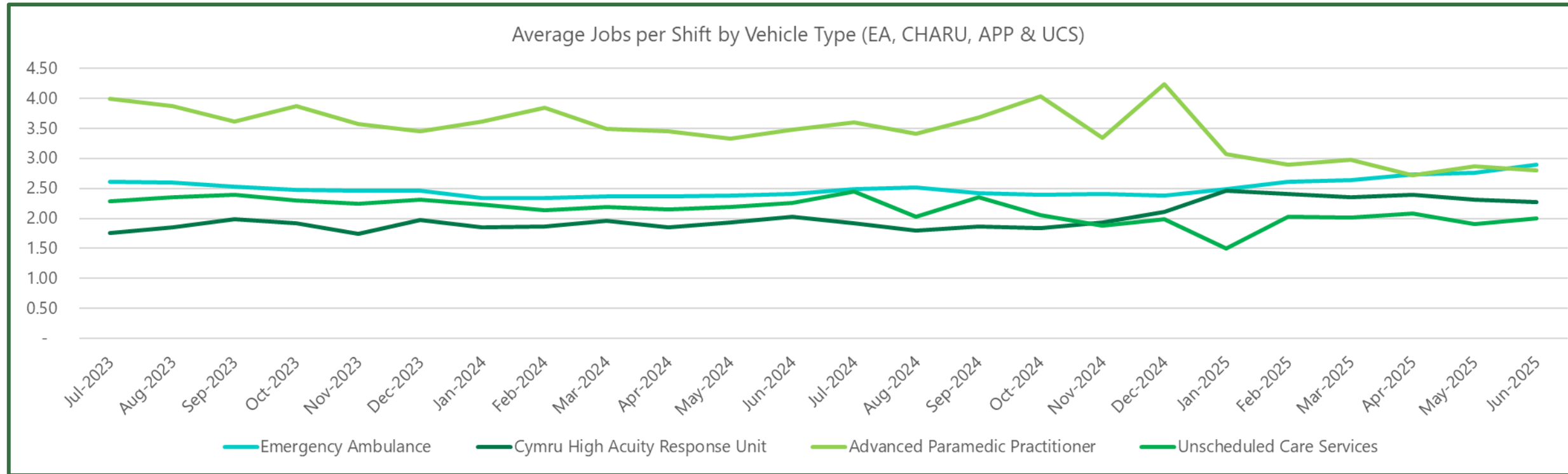
(Responsible Officer: Lee Brooks)

Jobs Per Shift

A

FPC

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

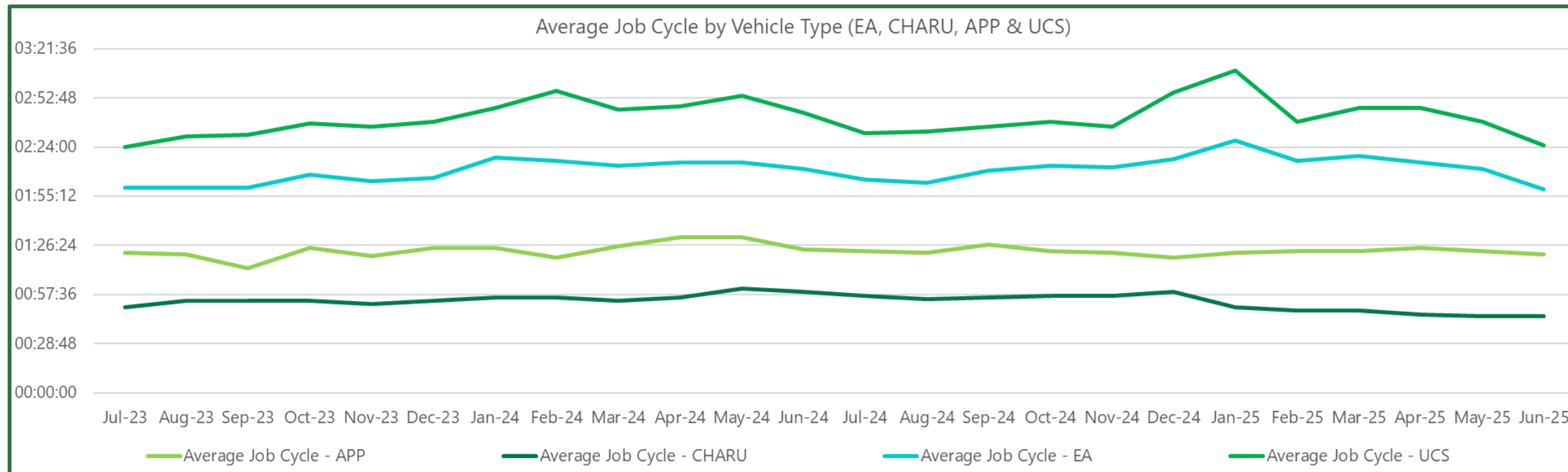


Analysis

Overall average jobs per shift was 2.33 in June 2025, a decrease from May 2025 (2.64). EAs averaged 2.89 jobs per shift and UCS crews 2.0. This is lower than what would be ideal and a product of handover delays.

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

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



Partnerships / System Contribution

NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

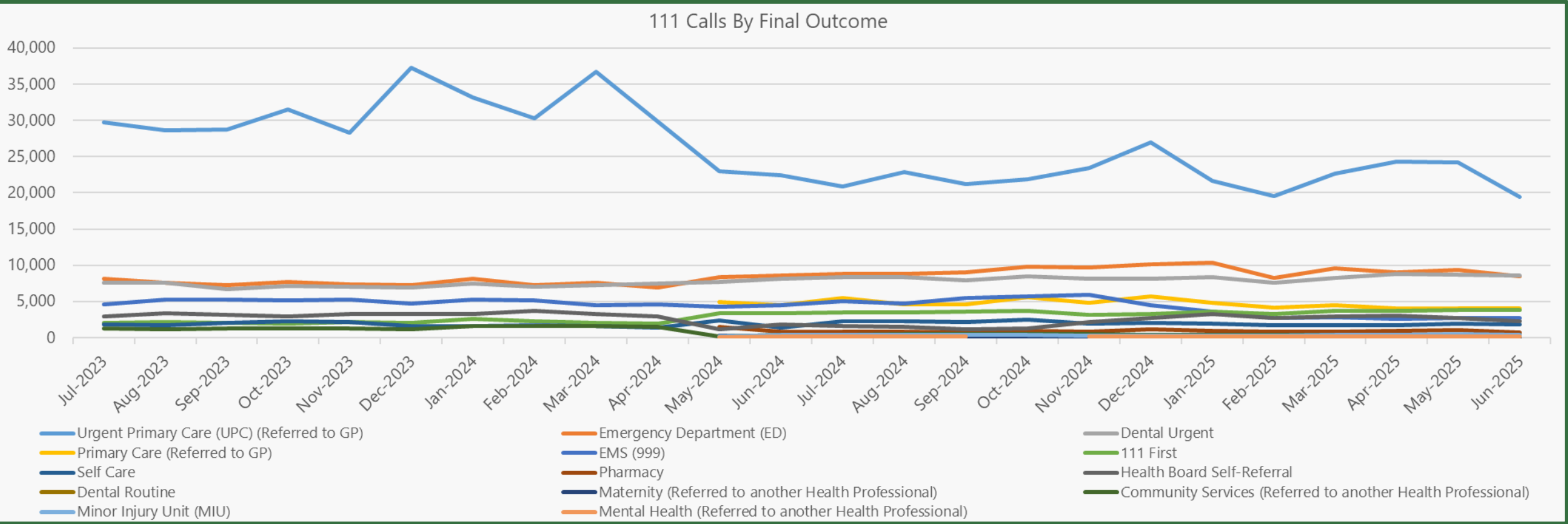
Influencing Factors – Demand and Clinical Hours Produced

Dental
G

C&C Volumes
G

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(Responsible Officer: Lee Brooks)



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

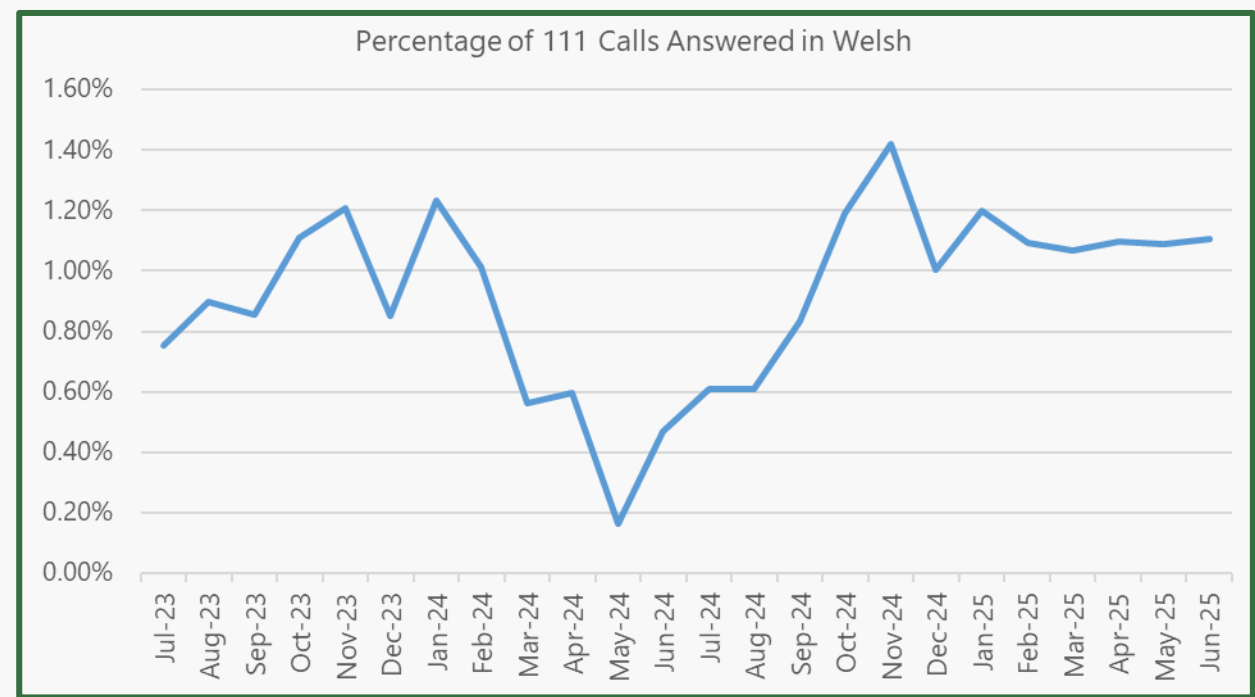
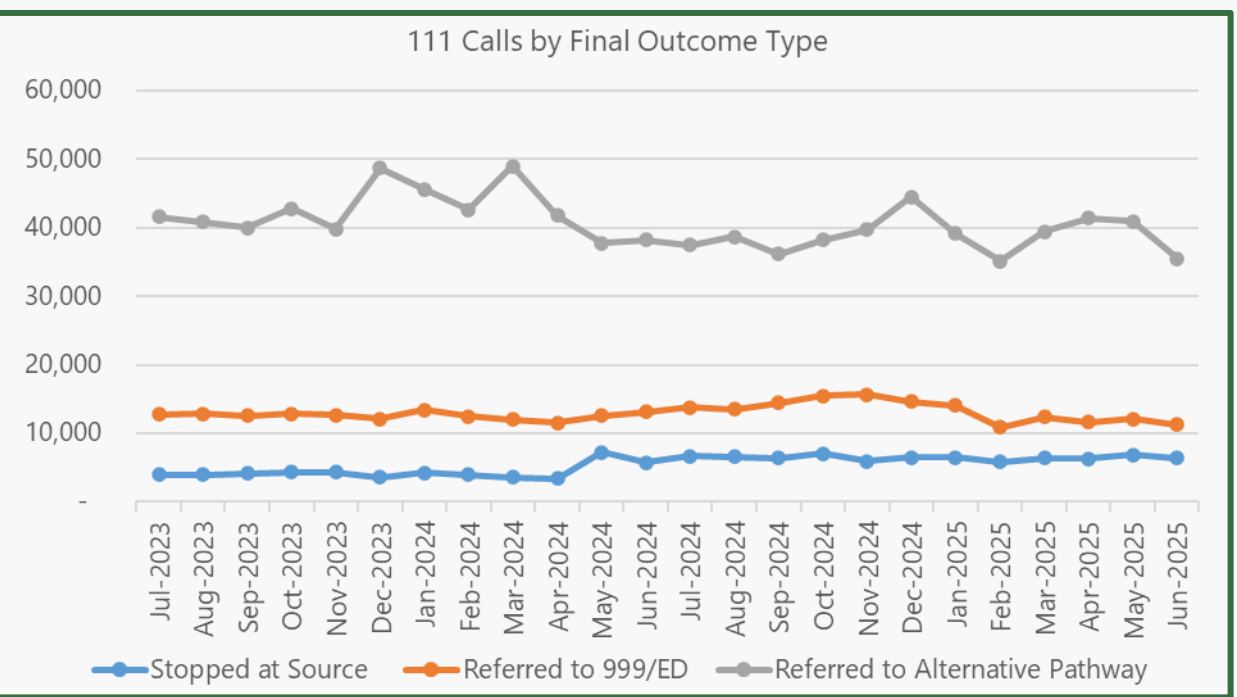
Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 31.81% of all calls during June 2025, but there has been a material drop since the implementation of the new 111CAS system.

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

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

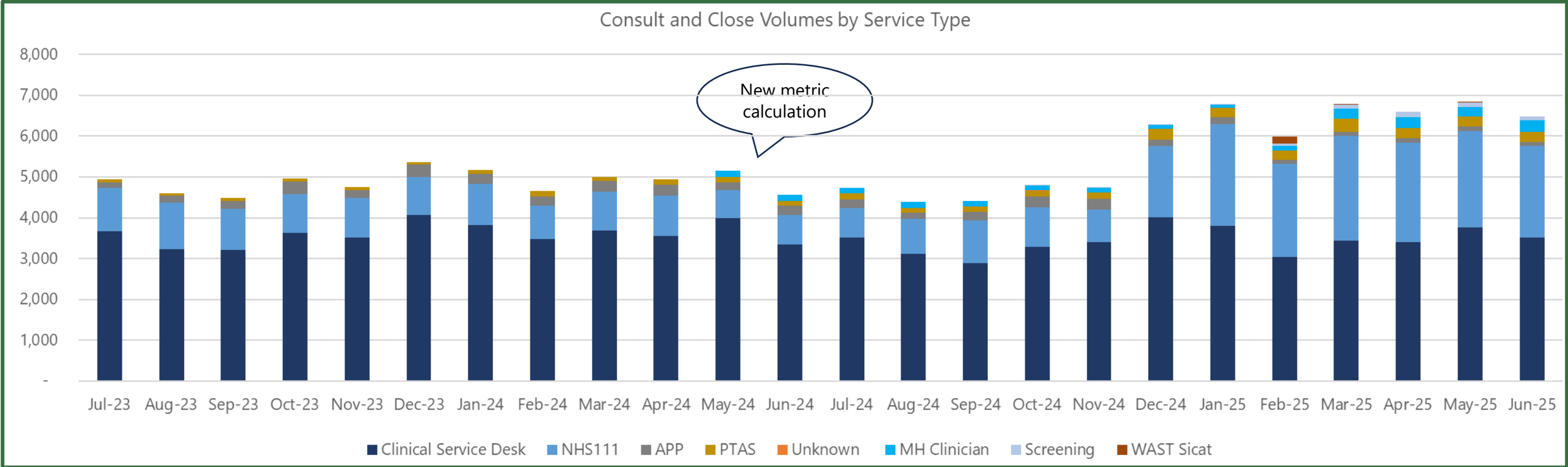
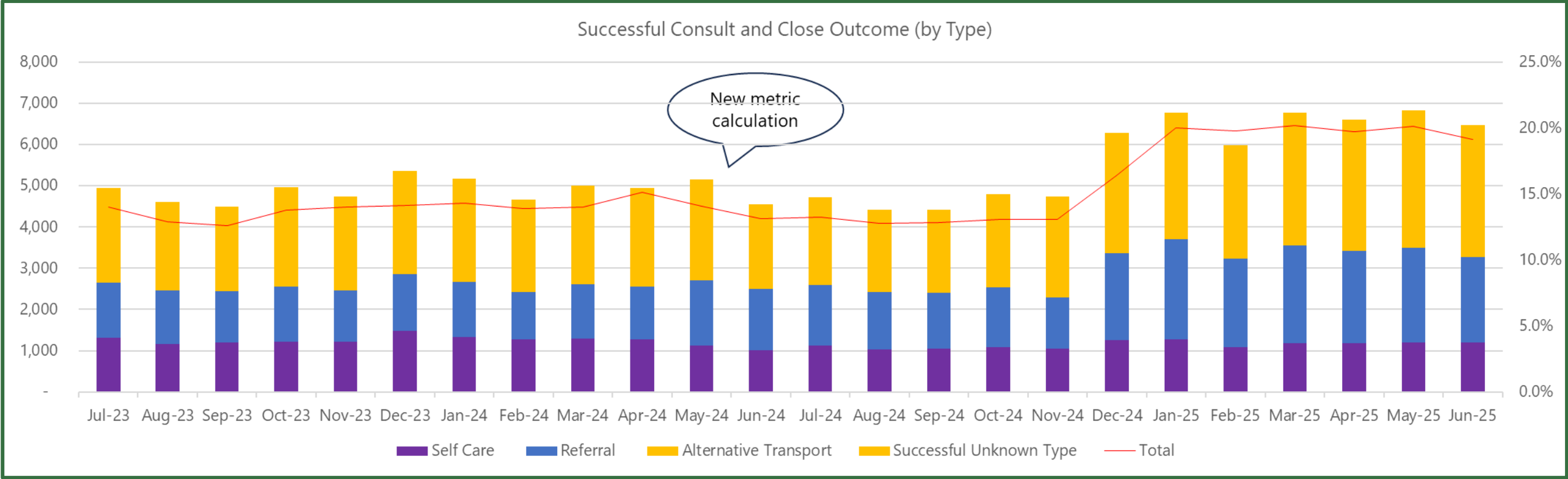
Remedial Plans and Actions
There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST, Six Goals, commissioners and DHCW. The focus is the development of a nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators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

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



Partnerships / System Contribution Consult & Close Indicators

(Responsible Officer: Lee Brooks)



Analysis

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

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

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

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Partnerships / System Contribution Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

Conveyances

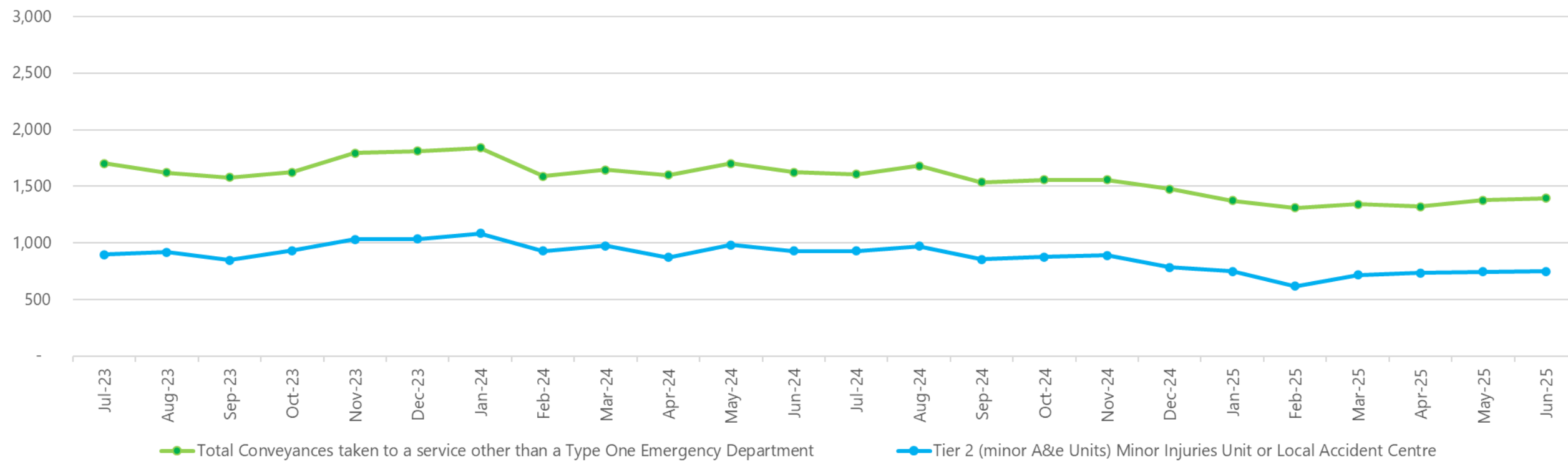
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Ministerial Measure

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

Total Conveyances taken to a Service other than a Type One Emergency Department vs Total Conveyances to a Minor Injury Unit



Analysis

In June 2025 10.09% of patients (1,397) were conveyed to a service other than a Type One ED. 5.4% (749) were conveyed to a Tier two Minor Injuries Unit or Local Accident Centre while 36.81% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers decreased, from 3,487 in May 2025 to 3,426 in June 2025.

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

Taxi conveyance has remained consistent for the past 12 months, averaging 832 per month to hospitals.

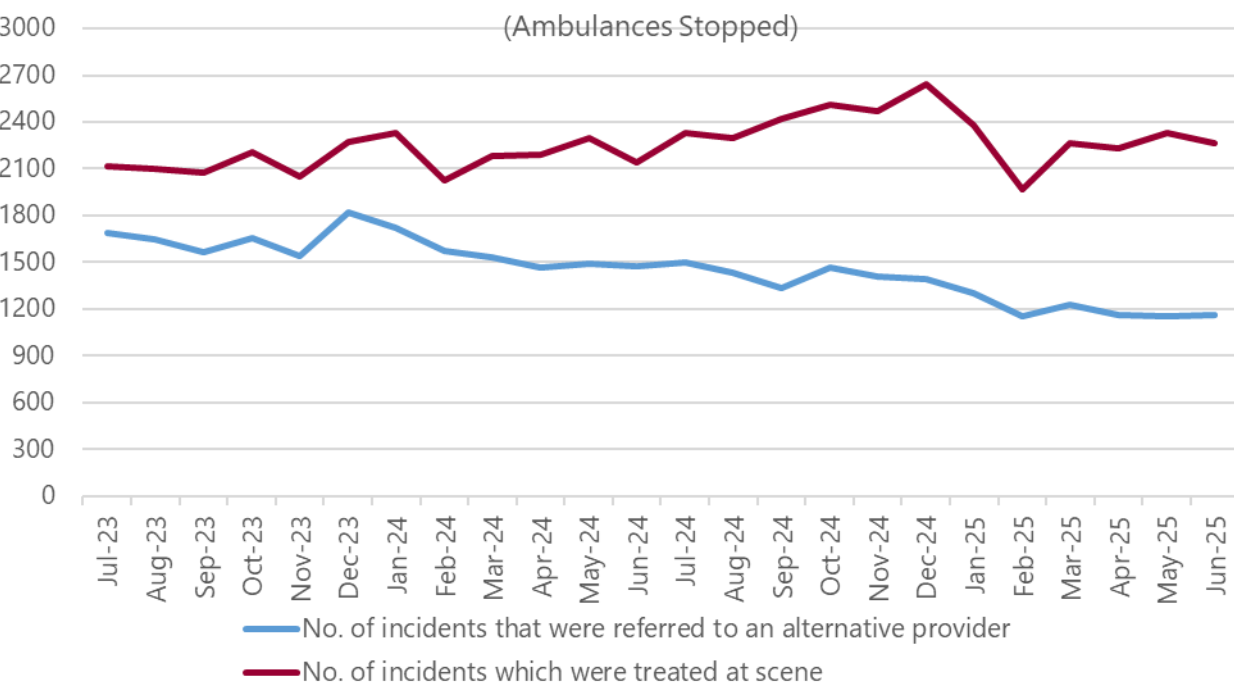
Remedial Plans and Actions

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

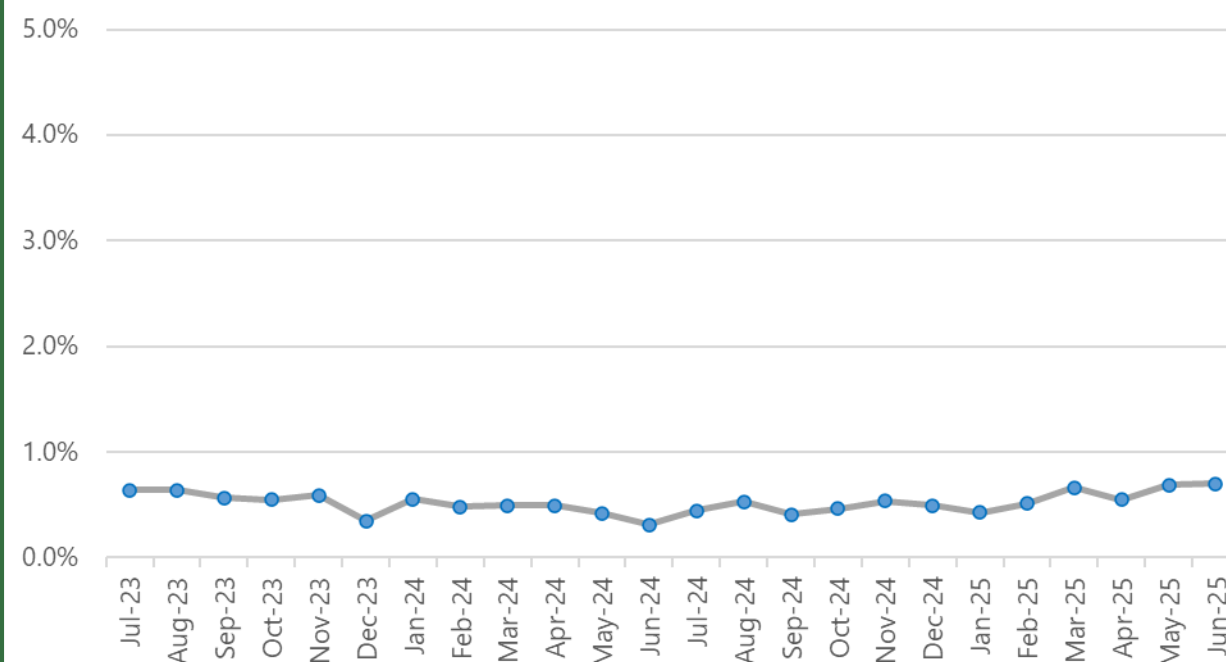
Expected Performance Trajectory

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

Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



% Patients Conveyed to SDEC Units Pan-Wales



Partnerships / System Contribution

Handover Indicators

(Responsible Officer: Health Boards)

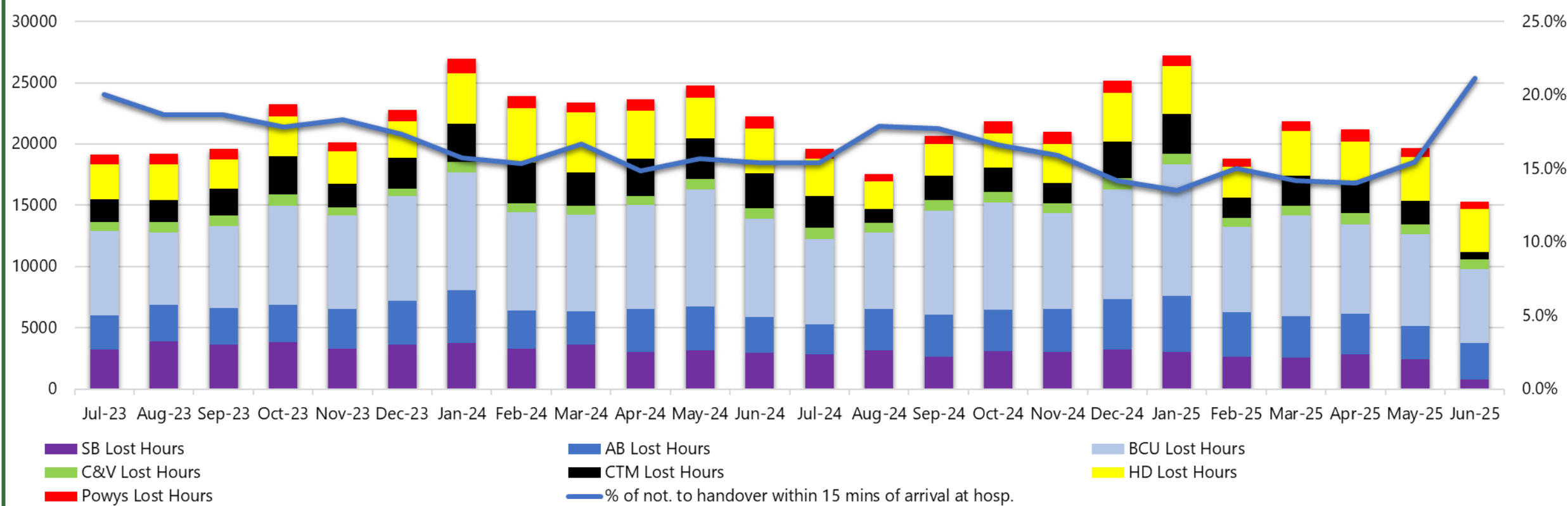
Lost Hours

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CI

QUEST

Notification to Handover Lost Hours by Health Board



Analysis

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

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

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

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

In June 2025, the Trust could have responded to approximately 4,819 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

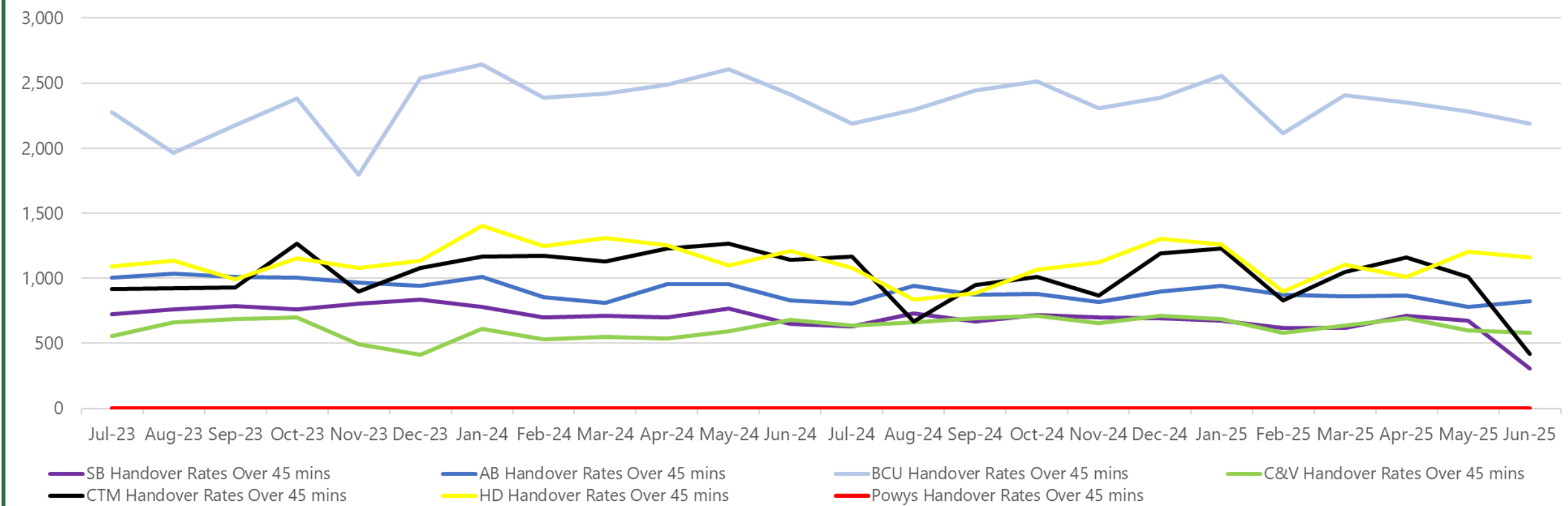
Remedial Plans and Actions

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

Expected Performance Trajectory

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

Handover Rates Over 45 Minutes (including first 15 minutes) by Health Board



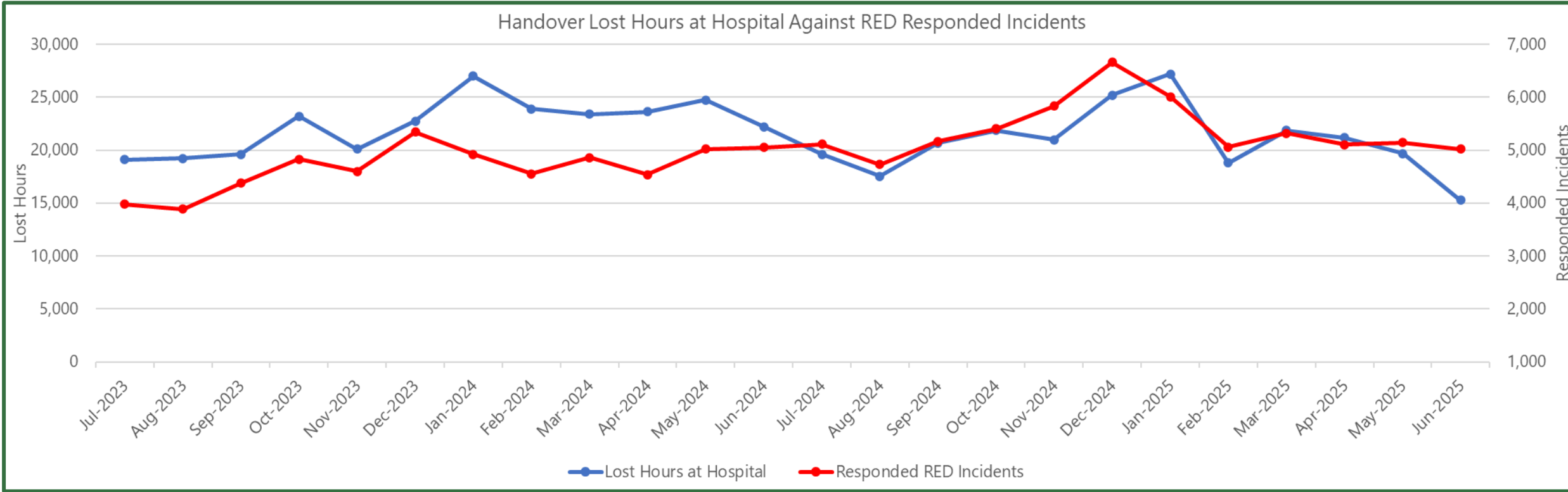
Partnerships / System Contribution

Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI

QUEST



Analysis

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

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

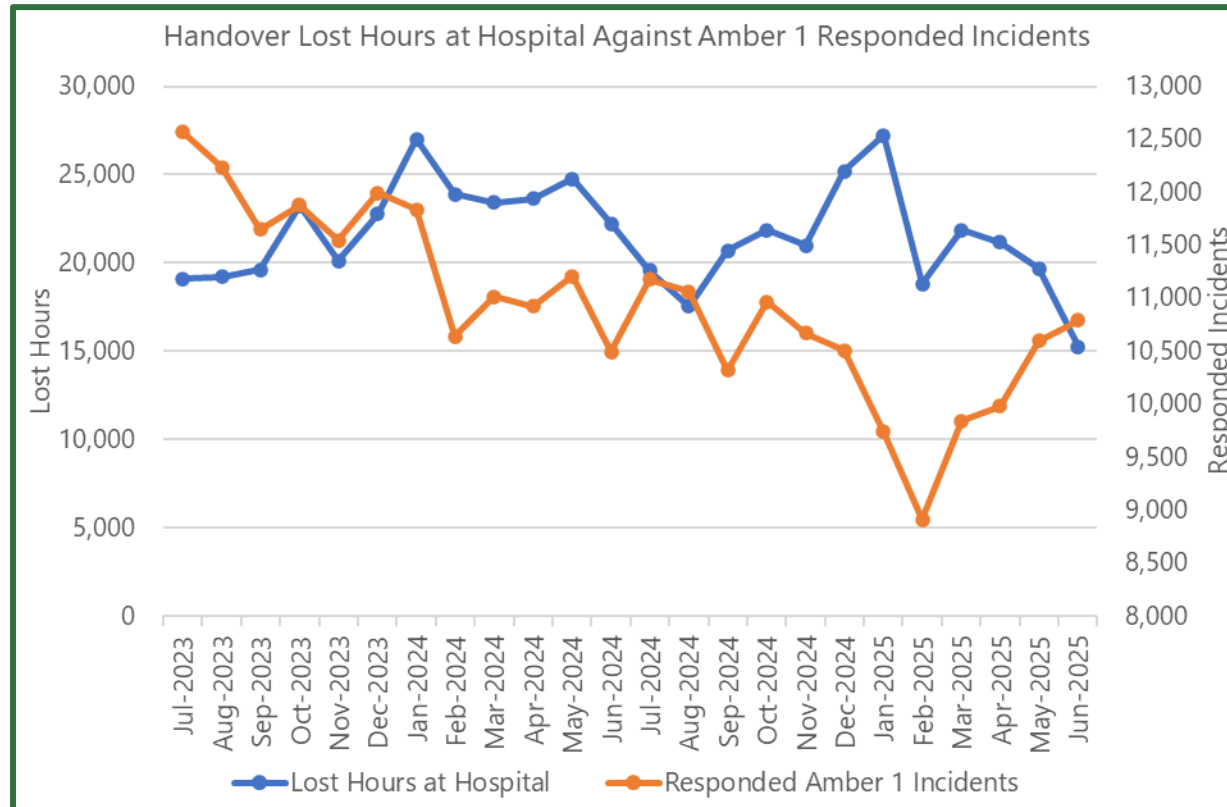
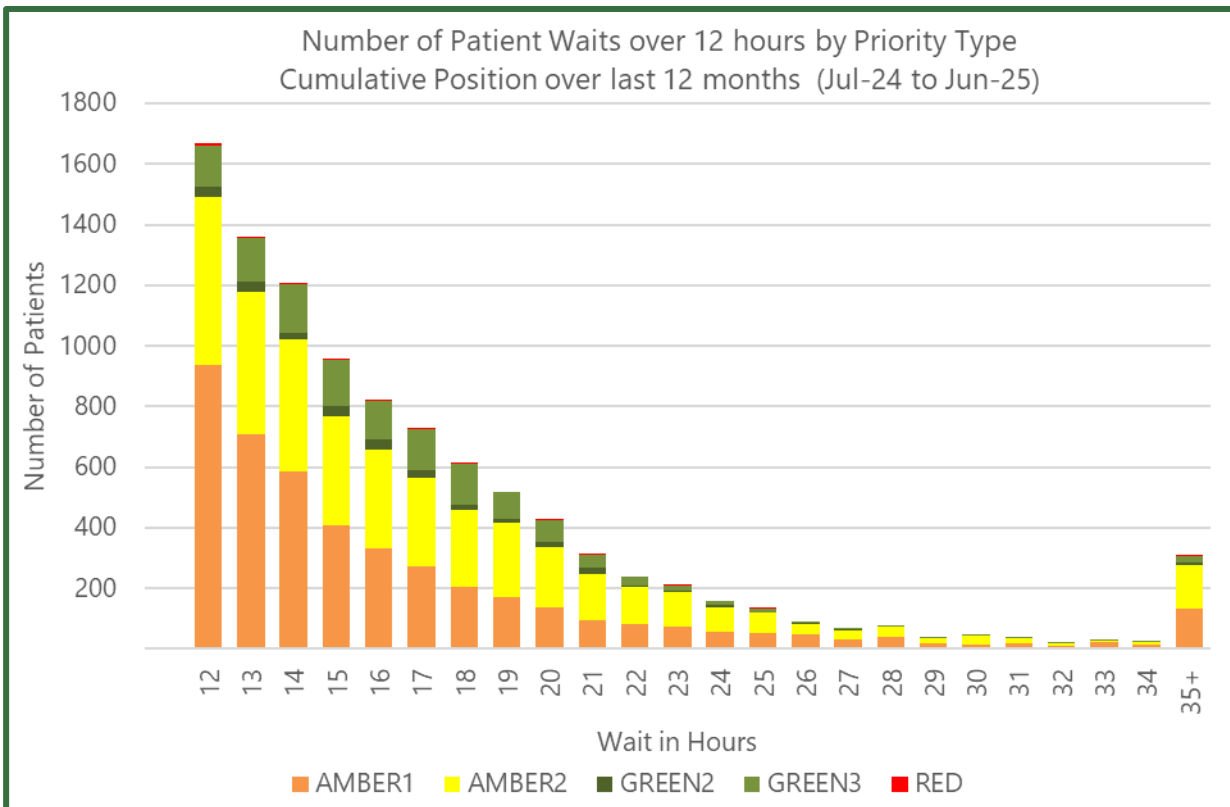
In June 2025, 402 patients waited over 12 hours for an ambulance response.

Remedial Plans and Actions

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

Expected Performance Trajectory

The 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 care that 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



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AGENDA ITEM No	11
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	2

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

MEETING	Trust Board
DATE	31 July 2025
EXECUTIVE	Estelle Hitchon – Director of Partnerships & Engagement
AUTHOR	Alexander Crawford - Assistant Director of Planning & Transformation Heather Holden, Head of Transformation Deborah Kingsbury, Senior Planning & Performance Business Partner
CONTACT	alexander.crawford2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide the Board with an end of Q1 position for IMTP delivery and assurance for the 2025/26 year of the 2025-28 IMTP. This report has already been scrutinised by Finance and Performance Committee (FPC).

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

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

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

RECOMMENDED:

That the Board:

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

3. **Notes** the Directorate-led IMTP end of Q1 position; and
4. **Notes** the Q1 position for the Cabinet Secretary's priorities set out in the 2025-26 planning framework.

KEY ISSUES/IMPLICATIONS

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

Clinical Model Transformation (CMT) Programme Key Issues/Implications:

The end of Q1 position has been summarised within the main SBAR and the complete assurance report included as Appendix A.

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

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

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

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

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

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

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

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

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

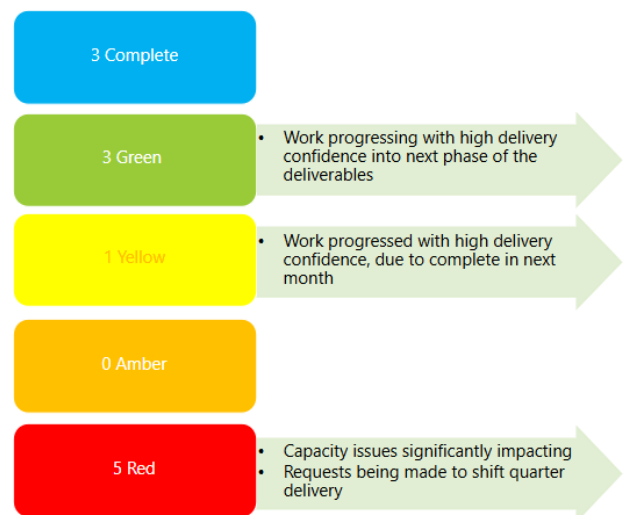
Directorate-led IMTP Portfolio Key Issues/Implications:

The assurance report in Appendix B sets out the end of Q1 position for the directorate led portfolio of IMTP deliverables.

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

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

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



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

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



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

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

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

Objective	IMTP Deliverable	Q1 RAG Status	Delivery Confidence	Progress Summary
SO2: Enabling our people to be the best they can be.				
Ensuring the right capacity needed to achieve our purpose	Outputs of the work of the Shift Overrun task and finish group delivered by Q2	Green		An SBAR has been submitted to Formal SOT To highlight the work in partnership that has been completed and recommendations made (2) for Formal SOT membership to review and discuss and approve if appropriate.
Ensuring the skills and capability needed to achieve our purpose	Our WAST Way leadership behaviours framework and an aligned development framework, developed and launched in 2025/26 (this incorporates 1:1 conversations)	Green		• As per earlier slide on our WAST Way
SO3: Being at the forefront of innovation & technology				
Pillar 1 Everyday Essentials	Simplified sign on will be developed and implemented by the end of Q4 giving users a better digital experience	Green	Moderate	The discovery piece is near conclusion and a "show and tell" of the work undertaken to date took place on 5th June 2025 with digital, estates and workforce all in attendance. Indicative costings are to follow to enable a decision to be made on next steps and plan delivery of any smart station initiatives.
Pillar 4 Security, Safety & Cyber	Smart station initiative will be rolled out by Q4	Green	Moderate	Current initial delays to development due to dependency on work by DHCW

Forward assurance plan in 2025/26

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

Ministerial priorities

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

Outcomes measures

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

REPORT APPROVAL ROUTE

Strategic Transformation Board (STB) 30 June 2025

REPORT APPENDICES

Appendix A – 2506 - CMT Programme Highlight Report [Appendix A](#) (separate attachment)

Appendix B – IMTP Delivery Assurance Report [Appendix B](#) (separate attachment)

Appendix C- Assurance against the Cabinet Secretary's priorities 2024/25

REPORT CHECKLIST

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

Appendix C

Assurance against the Cabinet Secretary's priorities 2024/25

BACKGROUND

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

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

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

ASSESSMENT

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

Cabinet Secretary Priority	Area for WAST	Milestones Q1	RAG (Delivery)	Progress
Timely Access to Care	Ambulance Target Review & Call Categorisation Respond to the outcome of the Welsh Government-led Task & Finish group to determine the appropriateness of the current Red 8-minute target.	<ul style="list-style-type: none"> 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) 		<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Implement RCS0 call category 		<ul style="list-style-type: none"> Completed
	RICS Strengthen and expand the use of the Call Prioritisation Streaming System (CPSS) enabling call handlers to provide safe, effective advice and referrals to a broader range of calls Design and implement processes and policies to deliver an effective integrated care clinical team including revisions to SOPs, alignment of terms and conditions, strengthened quality and safety governance arrangements, and implementation of a Home and Remote Working Model to enhance service delivery and support seamless collaboration	<ul style="list-style-type: none"> 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 		<ul style="list-style-type: none"> Review of winter desk completed with proposals for establishment of a permanent desk presented. A quality and safety dashboard has been developed SOPs in development – in year sign off via SOT – staggered due to volume Consultation on the 20th May - verbal feedback on progress to be provided
	Transfer & Discharge Service Model Engage with commissioners to develop a Transfer & Discharge service model appropriate to Health Board & strategic service development needs - including opportunities to implement a Transfer Clinical Hub (subject to external funding)	<ul style="list-style-type: none"> 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 		<ul style="list-style-type: none"> Internal vision being progressed, further discussions with Commissioners to ensure alignment with national direction of travel
	Non-Emergency Patient Transport Service (NEPTS) Continued development of the service to ensure the right capacity is in place to meet demand to support planned care and cancer services.	<ul style="list-style-type: none"> Data and insights to improve co-ordination and decision making with health boards throughout 25/26. 		<ul style="list-style-type: none"> Ongoing collaborative work with Health Boards

Cabinet Secretary Priority	Area for WAST	Milestones Q1	RAG (Delivery)	Progress
	<p>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.</p> <p>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.</p> <p>Online Symptom Checker (OSC) Identify and implement an effective Online Symptom Checker tool to enhance patient access to timely, accurate advice</p>	<ul style="list-style-type: none"> • Deliver and evaluate the initial proof of concept for the Virtual Assistant (navigation of the A-Z Directory (funded)). 		<ul style="list-style-type: none"> • <i>Green</i> Outline Business Case submission provided to Welsh Government. • <i>Green</i> Soft Launch go live of the Virtual Assistant achieved early July 2025. • Online symptom checker -Trust Board approved direct award, enabling us to move forward on the single tender action process. Funding dependency.
<p>Population Health and Prevention</p>	<p>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.</p> <p>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.</p> <p>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</p>	<ul style="list-style-type: none"> • 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 		<ul style="list-style-type: none"> • Data analysis undertaken, additional work ongoing to develop data further once capacity available within in digital. • Ongoing work collaboratively on falls model

Cabinet Secretary Priority	Area for WAST	Milestones Q1	RAG (Delivery)	Progress
	Specification including subsequent transformational amendments to Falls incident management and deployment (including RICS, RCS, Care Planning, and UCR Hubs) to ensure patient safety.			
Building Community Capacity	<p>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.</p>	<ul style="list-style-type: none"> Engagement with HBs to identify opportunities to co-locate APP Navigators in MDT hubs 		<ul style="list-style-type: none"> APP Navigators embedded in all health boards, ongoing collaborative work.
	<p>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.</p>	<ul style="list-style-type: none"> Implement Care Planning capability Expand volunteer and community resource numbers including CWRs 		<ul style="list-style-type: none"> Workshop undertaken, evaluation & long-term planning process scheduled to commence. Further exploration into sustainable remote monitoring solutions will be undertaken to support future service delivery models
	<p>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</p>	<ul style="list-style-type: none"> 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) 		<ul style="list-style-type: none"> Phase 1 and 2 of Marie Curie funding bid complete. Ongoing work with Swansea University regards palliative care training and APP recruitment
	<p>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.</p>	<ul style="list-style-type: none"> Development of MoUs with Health Boards System integration / interoperability to enable the dynamic transfer of patients Development of inclusion/exclusion criteria and ability to identify suitable patients 		<ul style="list-style-type: none"> Ongoing collaboration with Health Boards seeking sign off for governance documentation to enable CTAS further.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	RAG (Delivery)	Progress
<p>Mental Health Access</p>	<p>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</p> <p>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.</p>	<ul style="list-style-type: none"> • Implement care planning capability • Quality measures confirmed • Performance metrics, and service offer defined - MHRV Logic Model approved 		<ul style="list-style-type: none"> • Care planning as noted above under care planning section • Logic model and draft evaluation near completion to inform further development of the service model.

It is **recommended** that the Board:

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

Welsh Ambulance Services University NHS Trust

Clinical Model Transformation (CMT) Programme Highlight Report



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Welsh Ambulance Services
University NHS Trust

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

Transformation Support Office





Content

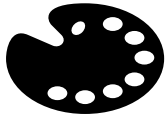
- **Programme Management Update**
 - Quality Impact Assessment Update
 - Programme Improvement Plan
- **Workstream & Enabling Group Updates**
 - Enabling Groups
 - Digital Front-End
 - Remote Integrated Care
 - Urgent Community Response
 - Emergency Response
 - Health Transport



Use hyperlinked headers to navigate to each section

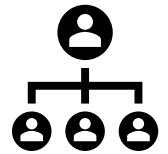


Programme Management Highlights



Developing our programme vision:

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



Establishing the CMT Programme Delivery & Assurance Arrangements:

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



Developing formal programme documentation and audit readiness:

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



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

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

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



QIA Update

April **May** **June** **July**

Clinical Quality Governance Group
Approval Group

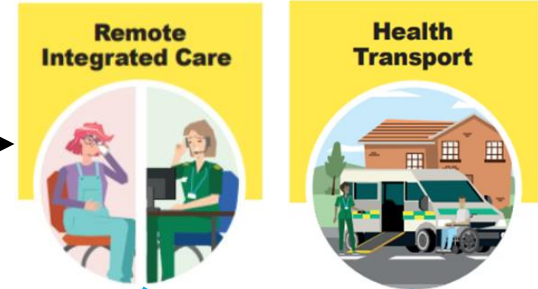
APPROVED
(14/04)



APPROVED
(12/05)



SCHEDULED
(15/07)



REVIEWED
(23/05)



REVIEW SCHEDULED
(27/06)

Minor revisions required prior to CQGG submission



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

CMT Programme Update – Enabling Groups



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

ENABLING GROUP UPDATES

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

Welsh Ambulance Services University NHS Trust

Clinical Model Transformation (CMT) Programme Workstream Updates

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



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Gwasanaethau Ambiwllans Cymru
Welsh Ambulance Services
University NHS Trust

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

Heather Holden, Programme Manager

Navigation



Status	Description	Characteristics
Green	<p>Project is on track and progressing well, meeting or exceeding expectations in terms of schedule, budget, quality, and objectives.</p> <p>Action Required: No immediate action is necessary, but ongoing monitoring and regular reporting are still required to ensure the project maintains its positive trajectory.</p>	<ul style="list-style-type: none"> • 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	<p>Provides an early warning that challenges or barriers are anticipated, but are not yet impacting on progress.</p> <p>Action Required: Close monitoring of factors anticipated to impact on progress, contingency planning, and reprioritisation if appropriate.</p>	<ul style="list-style-type: none"> • 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	<p>An amber status signifies a cautionary state, indicating that the project is encountering challenges or potential risks that need attention to prevent further escalation.</p> <p>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.</p>	<ul style="list-style-type: none"> • 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	<p>A red status indicates a critical situation where the activity is significantly behind schedule, over budget, or facing major issues that jeopardize its success.</p> <p>Action Required: Immediate attention and intervention are necessary to address the issues and bring the project back on track.</p>	<ul style="list-style-type: none"> • 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

A man in a white shirt and yellow tie is sitting on a sofa, looking confused. He is holding a green apple in his hand. The background shows a living room with a bookshelf and a lamp.

Not sure
what to do?

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

Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View
Virtual Assistant Implementation	Red	↓	<ul style="list-style-type: none"> Security Assessment and DPIA approved by the Project Group. Preparations for deployment of Virtual Assistant on NHS 111 Wales website being made by WAST and Supplier. Expected go-live postponed to mid-Jun due to delay meeting Information Governance requirements. 	<ul style="list-style-type: none"> Virtual Assistant to be deployed on live NHS 111 Wales website (mid-Jun, postponed from Apr-end). Over 60 suggestions received from CEO Roadshow to name the Virtual Assistant. Survey for 'Bot' name to be shared via Siren during soft launch.
Symptom Checker Funding Decision	Red	↓	<ul style="list-style-type: none"> Delayed approval of the use of the discretionary funding and the route to market by Trust Board means that it is unlikely we will be able to deliver the web-based version of Call Prioritisation Streaming Service (CPSS) and deliver revised symptom checkers before the end of the financial year as per our IMTP commitment for 2025/2026. Quotes requested for external independent commercial advice on CPSS Intellectual Property; expectation that this will cost up to £15,000. 	<ul style="list-style-type: none"> Unable to progress without Trust Board direction; legal advice being sought on Intellectual Property concerns.
Business Case Development	Yellow	↓	<ul style="list-style-type: none"> Awaiting Welsh Government feedback – Meeting took place between WAST and WG in early April on how we progress the Digital Front End opportunities. High-level summary of Business Case shared with WG for initial feedback and to propose a way forwards (including potential investment). 	<ul style="list-style-type: none"> Feedback outstanding from WG to fully develop the Business Case (currently in draft). The governance route for approval has been mapped, and timelines will be finalised following receipt of the proposed way forward from WG. Yellow (cautionary status) as continued lack of direction from WG could present a barrier to our ability to deliver meaningful change within the financial year.
Project Management	Green	↔	<ul style="list-style-type: none"> Project plan has been digitised and shared with Project Group members to ensure alignment and visibility. 	



Remote Integrated Care Service Workstream

Executive Sponsor: Liam Williams

Senior Responsible Owner: Pete Brown

Remote Integrated Care Workstream Update



Report Date:	Current RAG	Previous RAG	For Noting:	SRO:	Pete Brown
Jun-25	Yellow	Green	The overall RAG status is trending downward towards Yellow (cautionary status), driven by interdependencies with concurrent projects and reliance on external providers such as MIS. Additionally, there is a strategic need to assess and evaluate key functional areas, including Care Planning, to mitigate emerging risks and maintain project alignment.	Project Manager:	Rebecca Whitmore
Scope:	Phase 2 of Remote Integrated Care Service developments which fall under the Clinical Model Transformation (CMT) Programme Board.				
Task / Milestone	Status	RAG Trend	Current Position	Forward View	
Project Management	Green	↔	<ul style="list-style-type: none"> Project documentation produced in draft. QIA endorsed at CAG with minor amendments (30/05). 	<ul style="list-style-type: none"> Approvals of associated documentation. 	
Care Planning Function	Amber	↓	<ul style="list-style-type: none"> Following the recent Care Planning workshop, it was determined that further operational development is necessary to refine and shape the function prior to undertaking a formal evaluation. A verbal update following the workshop was given to the Board outlining the need for a strategic paper outlining roles, functionality, and how we establish success. 	<ul style="list-style-type: none"> A comprehensive evaluation and long-term strategic planning process for the Care Planning function is scheduled to commence. Further exploration into sustainable remote monitoring solutions will be undertaken to support future service delivery models. 	
New Call Flows & Categories	Green	↔	<ul style="list-style-type: none"> Planning activities and development of supporting documentation for the introduction of RCSO—aligned with ARREST and EMERG—are actively underway. Notable progress is being achieved across technical implementation, standard operating procedures (SOPs), and communications. 	<ul style="list-style-type: none"> Testing and exploration are underway to assess communication and training requirements, including an evaluation of potential resourcing needs for the Rapid Assessment Queue to ensure operational readiness and effectiveness. 	
Strengthening, Application, and Evaluation of CPSS	Yellow	↓	<ul style="list-style-type: none"> Proposals regarding the funding and resourcing model have been submitted for consideration to sustain and enhance the current Winter Desk function. Further exploration into potential expansion is ongoing; however, the feasibility and timelines will be influenced by available funding and MIS system capabilities. 	<ul style="list-style-type: none"> Ongoing expansion of the current Winter Desk function is in progress. Concurrently, exploration into additional expansion opportunities is underway to assess broader applicability and impact. Further planning into the resourcing and improvement of the Winter Desk. 	
Alignment of CSD and 111	Green	↔	<ul style="list-style-type: none"> Significant progress continues in establishing the necessary structures for RICs, with strong engagement from OCPs and overall progress remaining on track. No issues have been identified regarding the alignment of Terms & Conditions, which is supporting effective collaboration across teams. 	<ul style="list-style-type: none"> Detailed plan and process to be shared outlining the development and reviewing of existing SOPs 	

RICS Enabling Deliverables



Report Date:	Remote Integrated Care Enabling Deliverables	For Noting:
Jun-25		The following key milestones and deliverables, while not directly reporting into the CMT governance structure, are critical enablers for broader transformational outcomes and are therefore important to highlight
Scope:	Phase 2 of Remote Integrated Care Service developments which do not fall under the Clinical Model Transformation (CMT) Programme Board however are key enablers for delivering objectives relating to Remote Integrated Care.	
Task / Milestone	Update	
Integrated Care Structures	<ul style="list-style-type: none"> • Consultation with the Senior Management Team has concluded, with job descriptions developed, evaluated, and shared with affected staff. • Co-design sessions are currently underway with the SCA/DOM First Line Management teams to shape roles for Remote Integrated Care. • Job descriptions for the Audit & Education Team will shortly be shared to commence the OCP. • Rostering Review • IC Terms and Conditions alignment. 	
Evaluations of Tests of Change	<ul style="list-style-type: none"> • In-depth evaluations have been presented at the RICS Board, with recommendations for continuation and improvement for the following initiatives: <ul style="list-style-type: none"> • 111 Call Handlers Managing Green 3 Calls • 111 Clinician-Led Ambulance Response • Luscii Remote Monitoring Tool • The evaluations received agreement to continue these initiatives with enhancements, along with a commitment to ongoing review and continuous improvement. 	
Integrated Care Support Desk	<ul style="list-style-type: none"> • Building on recommendations from the Winter Desk Evaluation, a proposal to establish a permanent Integrated Care Support Desk—expanding on the original remit—was presented. This will optimise resources and capacity within Integrated Care. • The SBAR outlining this new function was approved by SLT (27/05) and the RICS Board (28/05), with support from TU colleagues. • A Quality Impact Assessment (QIA) is scheduled for endorsement at the next CAG meeting. 	
Digital Capabilities	<ul style="list-style-type: none"> • An SBAR recommending the adoption of a single, consolidated LowCode list for Integrated Care Clinicians has been approved. • A CAD options appraisal is in development and will be presented at the RICS Board on 25/06. • Implementation of video functionality across Integrated Care is scheduled in the coming weeks. • Work is progressing toward all Integrated Care teams operating on a unified telephony system. 	
SCW Outputs	<ul style="list-style-type: none"> • Following the evaluation of the Remote Integrated Care project, SCW has delivered several key outputs, including: <ul style="list-style-type: none"> • A RICS Review with proposed recommendations • A Quality and Safety Dashboard • A Case Study Evaluation of key tests of change • A review of these recommendations, along with a formal response, is currently being drafted. 	



Urgent Community Response Service Workstream

Executive Sponsor: Andy Swinburn

Senior Responsible Owner: Sonia Thompson

Urgent Community Response Workstream Update



Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:
Jun-25	Yellow	Yellow	<ul style="list-style-type: none"> Data limitations are affecting the ability to gather comprehensive baseline data for Falls & Frailty PDSAs. 3rd MHP recruitment approved and started, RISK regrading Dashboard development delays. Phase 1 and 2 of Marie Curie funding bid complete. Further APP recruitment planned with the aim to increase the establishment to 130.7 FTE. APP AQM testing completed in preparation for go live. 	Andy Swinburn SRO: Sonia Thompson
Project/Working Group	RAG Status	RAG Trend	Summary Position	
<u>UCR Scheduling</u>	Green	↔	<ul style="list-style-type: none"> Paper in draft to be brought to Workstream Board in July (ahead of next CMT Board), detailing options to implement scheduling before Winter. 	
<u>UCR Model</u>	Complete	↔	<ul style="list-style-type: none"> UCR Service Specification approved, CMT feedback incorporated re-circulated. Closure Report being drafted for UCR Workstream approval and feedback. 	
<u>Falls & Frailty Response Model</u>	Yellow	↓	<ul style="list-style-type: none"> Unable to submit request to add Falls Referral Field Guide ePCR until it is determined whether Emergence Ambulance Practitioner are permitted/not permitted to make referrals as non-registrants. Data analysis undertaken to assess the efficiency of Level 1 Falls Responders, focusing on response times, triage, and centralised management. Since Clinical Navigation removed predefined L1 responses, only 25% of calls are routed to RICs, with the rest returning for response. It remains unclear who manages RICs calls (CSD, Care Planning, or both), how long they stay in RICs, and when they are returned (unable to get this data). Agreed Falls Responders will adopt the existing CFR ePCR format, supported by a SOP for guidance on completing clinical documentation. Falls Responders will transition from Entonox to Pentrox (already covered in St John's in-house training) as Entonox not included as a medication in CFR ePCR. This change will also enable the capture of pain scores within the clinical indicator bundle. Request submitted for additional data to be included on the Falls Dashboard. IDS has agreed in principle but unable to confirm a start date, which is currently limiting our ability to meet Health Board data requests. 	
<u>Tasking Optimisation</u>	Green	↔	<ul style="list-style-type: none"> First draft of MHRV Evaluation nearing completion and due for review in late June/early July. Data limitations being worked through with IDS team. Request for third MHP now approved, recruitment process has begun. APP AQM and RCDM documents going through approval routes (CPAS 11/06, Workstream Board 04/06). Attached for noting under 'Information Items'. Ongoing discussions regarding APPNAV Power BI report; APP reporting requirements to be included in the overall CMT reporting request. 	
<u>Advanced Practice Delivery Group</u>	Yellow	↓	<ul style="list-style-type: none"> Recruitment adverts published for both Trainee and qualified APPs across Betsi Cadwaladr, Powys, and Hywel Dda Health Boards. Successful appointments will increase the overall workforce establishment to 130.7 FTE. Misalignment between recruitment processes and workforce planning may impact upcoming recruitment activity (e.g. stakeholder engagement/securing university place and clinical placements) and presents a strategic and reputational risk. To be considered whether this risk needs to be raised at a corporate level. Propose that a minimum staffing figure is agreed to allow planning to proceed with recruitment activities while awaiting final recruitment numbers. Approval will also be sought to transition from APP AQM to UCR AQM. A phased, health board-by-health board transition plan for completion by the end of Oct. Interest has been received to progress palliative care offering in Hywel Dda and Aneurin Bevan; however, timelines may be impacted by Swansea University not offering courses in March and is subject to uplift in APP establishment. Ongoing challenge in securing timely internal and Health Board sign-off for governance documentation is delaying the introduction of key services such as APPNav and CTAS. Delays pose a significant risk to progressing UCR Workstream. Recommend escalation to the UCR Workstream Board and Trish Mills (Director of Corporate Governance/Board Secretary) for strategic resolution. Luke Watkins (Clinical Development Lead) has offered support with requesting additional reporting requirements for APP transformation workstream. Longer-term planned work with regards to reporting APP activity while working on EAs has been deferred to Q3. 	



Emergency Response Service Workstream

Executive Sponsor: Lee Brooks

Senior Responsible Owner: Greg Lloyd

Emergency Response Workstream Update



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

Task / Milestone	RAG Status	RAG Trend	Current Position	Next Steps
Rapid Clinical Screening: Metrics and Reporting	Amber	↓	<ul style="list-style-type: none"> AQM reporting remains outstanding (currently an IDS team priority) presenting a barrier to effective evaluation of Rapid Clinical Screening (RCS). 	<ul style="list-style-type: none"> Implement AQM reporting once work completed by IDS
Call Flow Prioritisation: CAD Developments	Green	↔	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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	↔	<ul style="list-style-type: none"> 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). 	<ul style="list-style-type: none"> Expected approval to proceed with Call Flow Prioritisation Project from Welsh Government
Call Flow Prioritisation: Operational and Training Arrangements	Green	↔	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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	↔	<ul style="list-style-type: none"> 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:
Jun-25	Green	Green	Not Applicable.	Lee Brooks
				SRO: Mark Harris

Project/Working Group	In Scope	RAG Status	RAG Trend	Summary Position
<u>Access to Planned Transport</u>	Develop a pathway process from RICs	Green	N/A	<ul style="list-style-type: none"> Process mapping and systems flow to be completed Data analysis for taxi suitable patients to be completed Products required to implement identified and resource secured to focus on development Dates and Timelines will be agreed in collaboration with RICS Workstream
	Identify additional routes of call origin	Green	N/A	<ul style="list-style-type: none"> Opportunities for inclusion within Health Transport to be identified.
<u>Transfer & Discharge</u>	Continued engagement on options with health boards (commissioning response/ strategic service dev)	Yellow	↓	<ul style="list-style-type: none"> Engagement continues with Health Boards. Contact made with JCC to arrange meeting to discuss.
	Agree outline service model for further engagement with HB (commissioning response/ strategic service dev)	Yellow	↓	<ul style="list-style-type: none"> Session to be planned to agree the internal vision for T&D and a subsequent service definition. Date to be confirmed (diary hold sent for 24/06).
	Develop Transfer & Discharge service model	Not Started	N/A	<ul style="list-style-type: none"> Will follow on from actions above.
	Develop case for 24/7 Major Trauma Desk	Not Started	N/A	<ul style="list-style-type: none"> Data to support both options to be acquired and reviewed. Network keen to resubmit business case collaboratively when resource allows.

Welsh Ambulance Services University NHS Trust

IMTP Delivery Highlight Report Q1 (Outside Scope of CMT)



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IMTP Delivery Highlight Report
Released: June 2025

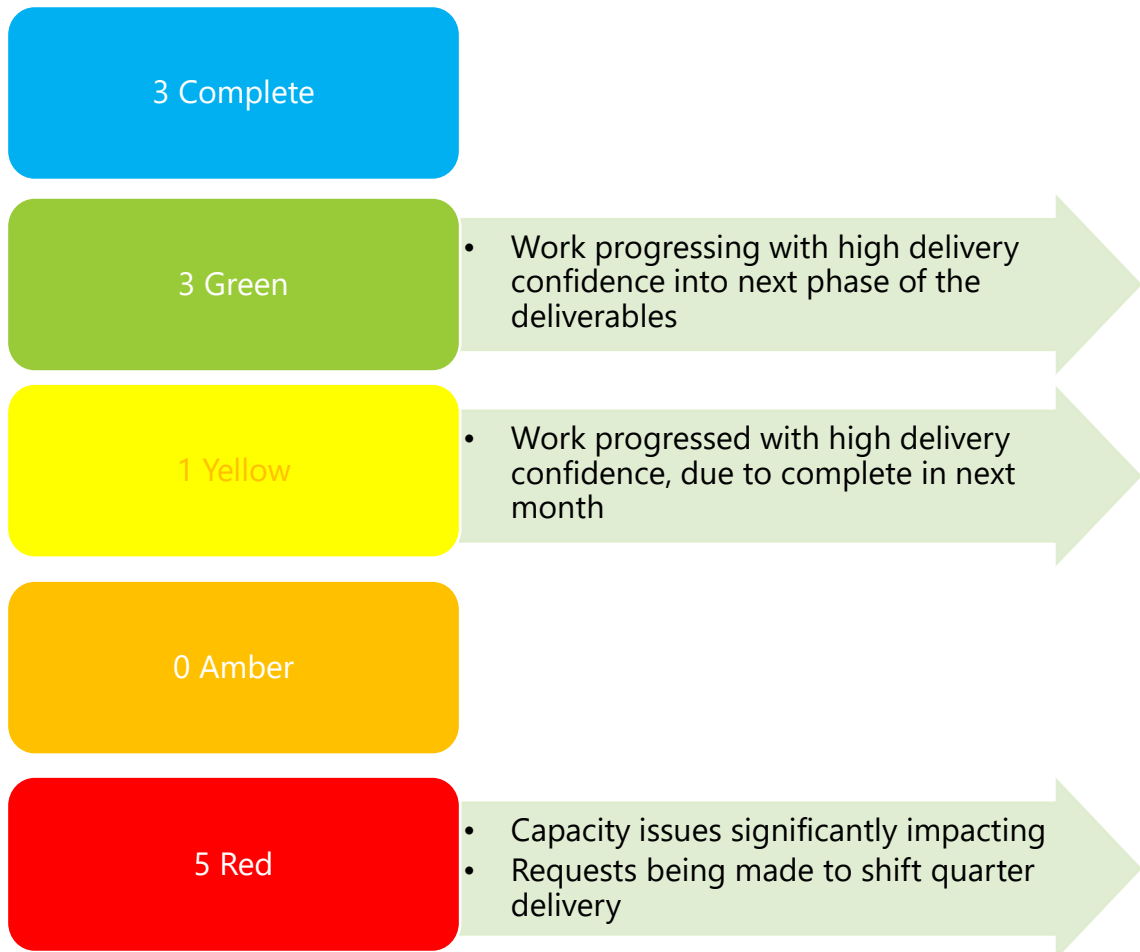
Planning & Performance Business Partners



Summary Position

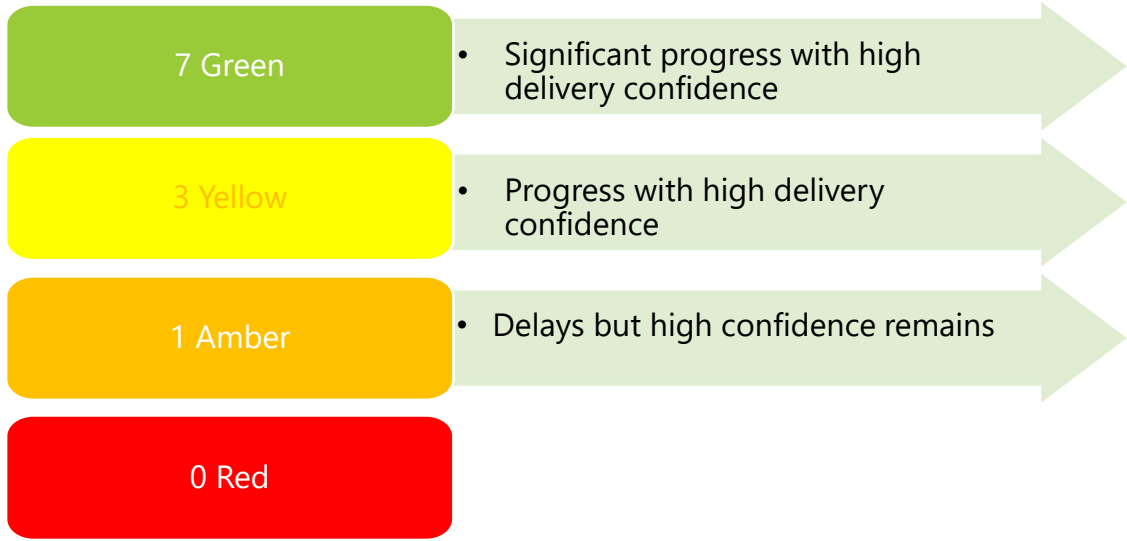
Q1 Deliverables:

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



Focus on SO2: Enabling our people to be the best

Updates provided for; updates provided against 10 key plans as full year deliverables plus specific update on commitments to our people by request.



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

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

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

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

Strengthen Welsh language compliance through strong leadership, enabling Welsh language to flourish	Engage with staff to ensure that their ESR Welsh language competencies are up to date.	Yellow	High	<ul style="list-style-type: none"> Working with Workforce Systems Team to finalise guidance for staff to complete and update their Welsh language skills on ESR. Completion expected by end of July.
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SO4: Developing our services in collaboration

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

SO5: Being Quality driven & clinically led

Defining our focus and delivering on population health and health inequalities	Draft Population Health Plan, approved.	Red	Low	<ul style="list-style-type: none"> 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. To secure support from within the directorate to start moving the Population Health Plan forward. Request for change in Quarter from Q1 to Q3 due to lack of capacity.
	Updated health inequalities maturity matrix for reducing impact	Red	Low	
A culture of quality improvement with robust quality management systems	WAST Quality Plan	Complete	N/A	<ul style="list-style-type: none"> Plan endorsed by QuEst on 09 May with a request for the associated draft implementation plan to be enhanced to ensure achievable timescales for delivery and appropriate prioritisation to support the delivery of the plan. The plan was subsequently approved by Trust Board on 29 May 25
High Quality Health and Safety systems	Develop WAST Health and Safety Strategic Plan to ensure compliance with existing and emerging legislation	Red	Low	<ul style="list-style-type: none"> Change in Quarter from Q1 to Q3 due to lack of capacity. Actions carried out to date; Manual handling improvements & list of recommendations. Q3 delivery as driving it via NARSF and taking it there in September 2025.
Excellent Clinical Leadership	Secure the Lead Midwife post by end of Q1	Complete	N/A	<ul style="list-style-type: none"> Post secured July 1st 2025 and in place to take forward the work.
Systems that meet the requirements of the Duty of Quality and Duty of Candour Align with Digital Pillar	Develop Data Engineering and modelling around HARM Developed in Q1	RED	Low	<ul style="list-style-type: none"> RED for Q1 delivery due to requirements unknown (by both Digital and PTR). Flagged by H.O. PTR as unknown also with Digital Director – scope and requirements unknown. Change in Quarter from Q1 to Q4 to allow for this to be understood.

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

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
Ensuring the right Capacity needed to achieve our purpose	Embedding Health & Wellbeing Plan	Yellow	High	<ul style="list-style-type: none"> Delivery of the objectives outlined within the Health & Wellbeing programme remains on track. Notable progress has been made in both promotion and prevention initiatives. Highlights include strong attendance at our REACT sessions and the successful launch of Health Diagnostic Testing. Development of SOPs is progressing, to help achieve SEQOHS accreditation, albeit at a slower pace than anticipated due to reduced team capacity. However, recruitment efforts are underway to address this and support timely delivery moving forward.
	Enhancing Organisational Retention	Green	High	<ul style="list-style-type: none"> Continued development of the digital corporate onboarding and induction programme remains on track for completion in Q2. Planning is in place for pilot implementation and testing in Q3 to ensure a smooth and effective rollout. Coaching and Mentoring Guides have been completed and are now being embedded as core resource and linked to Our WAST Way. Next phase will focus on promoting uptake and embedding the guides across the organisation, with ongoing evaluation to ensure continued relevance and impact.
	Delivery of Strategic Workforce Plan	Amber	High	<ul style="list-style-type: none"> Data / Analytics: The Power BI Workforce Dashboard is currently in development. However, the Generic Workforce Monitoring Report is not yet automated due to data correlation issues between ESR and the Data Warehouse. As a result, dashboard production remains labour-intensive. Work is ongoing to resolve these integration challenges and streamline reporting processes. Workforce Plans: Ongoing efforts are underway to engage directorates in the development of directorate-level workforce plans.
	Delivery the outputs of the NHS Workforce Solutions Transformation Programme	Green	High	<ul style="list-style-type: none"> Work progressing to deliver key projects as part of ESR Optimisation in readiness to transfer data into a new products. Business case for additional resource in development. Anticipated risk if no funding available to recruit a dedicated Project Manager for the NHS Workforce Solutions Transformation Programme. This poses a significant risk to the programme's delivery, as the absence of a Project Manager will impact the team's capacity to effectively plan, coordinate, and execute key transformation activities.

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

IMTP Objective	IMTP Deliverable	Q1 RAG Status	Delivery Confidence	Progress Summary
Ensuring the skills and Capability needed to achieve our purpose	Embed Our WAST Way Leadership Framework	Green	High	<ul style="list-style-type: none"> Our WAST Way officially launched on 28 May 25. Series of introductory sessions scheduled from June through August, with strong early engagement, over 100 staff attended the first three sessions, reflecting positive momentum from early adopters. Essential Conversations sessions have been successfully incorporated into the recent Leadership Symposium. A broader rollout to all managers is planned for the next quarter to further embed these principles across leadership levels.
	Develop Managers Capabilities to lead and manage Change	Green	High	<ul style="list-style-type: none"> Change Management Toolkit launched for managers to access on the 15 May 25. Products being discussed at Change Management Community Forum to seek feedback and make improvements, ensuring skills associated with Change Management are threaded into our WAST Way.
	Development of WAST People Development Plan	Green	High	<ul style="list-style-type: none"> Progress continues the development of the PDP, with milestones achieved in the policy formulation and strategic document. Key stakeholders have been identified and engaged in the development of these documents.
Establishing our Culture as the way we achieve our purpose	Enhanced approach to amplifying voices	Green	High	<ul style="list-style-type: none"> Progress remains on track with the NHS Staff Survey results. Directorate leads identified and directorate level data released. Directorate leads to produce a set of agreed actions. HIVE Pulse Survey went live 02/06/25. Discussions underway to refresh the hierarchy structure for the 2025 Staff Survey and identify how we promote uptake.
	Oversee the implementation of the Strategic Equality Plan Objectives	Yellow	High	<ul style="list-style-type: none"> Good progress made against the legislative requirements and Statutory Action Plans. Continuing to roll out a range of development initiatives, including Our WAST Way: Essential Conversation, which places a strong emphasis on inclusion and equity. We recognise that staff are currently facing challenges in attending specific EDI training sessions. There is a range of training opportunities available and the ongoing need to maintain high-quality service delivery. To address this, we will be working closely with SOT to plan and schedule training in a way that supports both operational demands and staff development. We aim to maximise engagement and participation across all our learning and development programmes. Completed a Digital Team Inclusive Recruitment Initiative to fill 19 vacancies, following two targeted workshops held to support BAME applicants, 1270 applications were received with 1005 (79%) from BAME candidates. All 19 roles were filled, with 5 offers (26%) made to BAME applicants.
	Promote and enable Sexual Safety across the Trust	Green	High	<ul style="list-style-type: none"> Themed Sexual Safety workshops have been designed and delivered to the TUPs with feedback incorporated and these will be rolled out across the organisation during the next 2 quarters. Continuing to provide high level people & culture metrics in relation to speaking up and safety in the workplace

Update on Commitments to our people

Objective	IMTP Deliverable	Q1 RAG Status	Delivery Confidence	Progress Summary
SO2: Enabling our people to be the best they can be.				
Ensuring the right capacity needed to achieve our purpose	Outputs of the work of the Shift Overrun task and finish group delivered by Q2	Green		An SBAR has been submitted to Formal SOT To highlight the work in partnership that has been completed and recommendations made (2) for Formal SOT membership to review and discuss and approve if appropriate.
Ensuring the skills and capability needed to achieve our purpose	Our WAST Way leadership behaviours framework and an aligned development framework, developed and launched in 2025/26 (this incorporates 1:1 conversations)	Green		<ul style="list-style-type: none"> As per earlier slide on our WAST Way
SO3: Being at the forefront of innovation & technology				
Pillar 1 Everyday Essentials	Simplified sign on will be developed and implemented by the end of Q4 giving users a better digital experience	Green	Moderate	The discovery piece is near conclusion and a “show and tell” of the work undertaken to date took place on 5th June 2025 with digital, estates and workforce all in attendance. Indicative costings are to follow to enable a decision to be made on next steps and plan delivery of any smart station initiatives.
Pillar 4 Security, Safety & Cyber	Smart station initiative will be rolled out by Q4	Green	Moderate	Current initial delays to development due to dependency on work by DHCW

Status	Description	Characteristics
Green	<p>Project is on track and progressing well, meeting or exceeding expectations in terms of schedule, budget, quality, and objectives.</p> <p>Action Required: No immediate action is necessary, but ongoing monitoring and regular reporting are still required to ensure the project maintains its positive trajectory.</p>	<ul style="list-style-type: none"> • 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	<p>Provides an early warning that challenges or barriers are anticipated, but are not yet impacting on progress.</p> <p>Action Required: Close monitoring of factors anticipated to impact on progress, contingency planning, and reprioritisation if appropriate.</p>	<ul style="list-style-type: none"> • 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	<p>An amber status signifies a cautionary state, indicating that the project is encountering challenges or potential risks that need attention to prevent further escalation.</p> <p>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.</p>	<ul style="list-style-type: none"> • 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	<p>A red status indicates a critical situation where the activity is significantly behind schedule, over budget, or facing major issues that jeopardize its success.</p> <p>Action Required: Immediate attention and intervention are necessary to address the issues and bring the project back on track.</p>	<ul style="list-style-type: none"> • Major project objectives are not being met. • Critical milestones are consistently missed. • Key deliverables are incomplete or of poor quality. • Significant risks or issues are unresolved, and their impact on the project is severe.

RAG Status Definitions

AGENDA ITEM No	12
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	3

Financial Performance as at Month 3 – 2025/26
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MEETING	Trust Board
DATE	31 st July 2025
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Interim Assistant Director of Finance) Steph Taylor (Assistant Head of Capital Planning)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY
<p>This paper presents to the Board the latest Financial Performance Report of the 2025/26 financial year, the reported position as at Month 3 (June 2025).</p> <p>The Board 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.</p>

KEY ISSUES/IMPLICATIONS
<p>Key highlights from the report for the Board to note are:</p> <ul style="list-style-type: none"> ➤ The Trust is now reporting a year to date revenue deficit (£197k) for month 3 2025/26; ➤ In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust is currently continuing to forecast a breakeven position for the 2025/26 financial year end. However the risks of not achieving this have increased this month; ➤ Capital expenditure plans are being finalised with plans to fully achieve in year; ➤ In line with the financial plans that support the IMTP, gross savings of £2.137m have been achieved in month 3 against a target of £2.073m; ➤ Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.7% for the number, and 98.8% of the value of non NHS invoices paid within 30 days

REPORT APPROVAL ROUTE

- ELT – 16th July 2025 (Verbal update and presentation)
- FP&C – 21st July 2025 (Presentation)
- Trust Board – 31st July 2025

REPORT APPENDICES

Appendices 1 – 2 – *Monitoring return submitted to Welsh Government for month 3 – 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
TRUST BOARD
FINANCIAL PERFORMANCE AS AT MONTH 3 2025/26

INTRODUCTION

1. This report provides the Board with a summary of the revenue financial performance of the Trust as at 30th June 2025 (Month 3 2025/26), along with an update on the 2025/26 capital programme.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2025/26** (1st April 2025 – 30th June 2025) are that:
 - The cumulative revenue financial position reported year to date is an **overspend against budget of £0.197m**, based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2025/26, and some in year pressures that have emerged during month 3. The year-end forecast for 2025/26 currently remains as 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 **£2.137m** have been achieved against a target of **£2.073m**;
 - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 98.7% for the number, and 98.8% of the value** of non-NHS invoices paid within 30 days.
3. It is key to also note the following assumptions that have been made in reporting this current and forecast position, consistent with those included in the IMTP and opening financial plan:
 - The ability to deliver a minimum of c£8.500m in savings and efficiencies in year. This equates to c2.7% of the Trusts discretionary income;
 - No other developments, enhancements or cost increases not currently funded within budgets will be able to be progressed until a confirmed funding source for them is found, or an agreed equivalent value of cost is stopped or reduced elsewhere. These includes any costs, capital or revenue, emerging from the recommendations of the Manchester Arena Inquiry;

- Despite an element of additional funding provided, some cost elements are still hard to predict through the 2025/26 financial year (and beyond) and may remain volatile;
 - Where possible, the ability to manage in year cost pressures as they arrive, within the small contingency the Trust continues to hold.
4. Whilst any move into a deficit position is unwelcomed, this is fully explainable and, given some of the recent impact of some external challenges and changes to previous assumed funding coverage and cost base movement, is to be expected, at the very least in short term.
5. Specifically the following two external impacts emerged during June 2025, which has resulted in the current year to date deficit position:
- The confirmation that Welsh Government are not now in a position to be able to fully fund the costs of the increase in Employers NI in 2025/26 across the NHS, and indeed the wider public sector in Wales. Whilst the value of the funding shortfall for WAST is still being worked through with WG, as at the end of month 3 this was estimated to be at least a full year impact of c£0.330m. Further detail received in month 4 suggests this gap could be greater than this;
 - An update received via NWSSP on the forecast in year spend in relation to the Welsh Risk Pool across the NHS in Wales. This currently suggests a further significant shift (increase) from that provided through the planning period for 2025/26 (and included as a cost pressure in our opening financial plan), by up to c£42m across the NHS in Wales, of which WAST share via the current risk share agreement would be an additional in year cost of c£0.9m. Whilst the status, drivers and likelihood of this increased forecast and risk continues to be worked through across the NHS in Wales, and the resulting expected actual impact on our position, it has been prudent to reflect at least an element of this in the year to date position at this time.
6. Given the previous monthly positions year to date and the significant step up in savings requirements needed in 2025/26 to balance, it was never going to be possible for the Trust to absorb such impacts in the immediate term. However, the current reported YTD position at M03 does not assume all of these costs drop to the bottom line. We continue to do all that we can at this stage, with the time that we have had to respond to these in year changes, to look to mitigate what elements of these we are currently able to, including from the small contingency we hold for such events. However, should the resulting impact of these issues be even greater than this, these values could further increase from M04 reporting onwards.

7. At this stage, the Trust has not impacted any of this in our year end forecast, which remains a breakeven one and one we will continue to do all that we possibly can to achieve. However, this is in part due to the need to work through the likely full year impact, alongside a number of other in year risks, opportunities and variables that impact on a forecast position at any point in time. This will also include ensuring internal governance of any proposed changes.
8. Alongside this discussions have already been had, and will continue, with both the Commissioner and Welsh Government, investigating any additional saving options and options around disinvestment or reducing the scope of developments in year, should this be required and for the Trust to continue to seek to deliver year end balance. This is alongside balancing the risk of the inevitable resulting service, patient, quality and performance impacts. This will all be discussed at length at a planned Executive Finance Group meeting scheduled for 30th July, a further update following this will therefore be provided to the Trust Board on the day. However it must also be noted that any funding shortfall / cost increases are currently presented as likely to be recurring in nature, so any options considered will also need to be recurrent.
9. What is clear given the above is that the current risk of the Trust not achieving its breakeven target and forecast this financial year has significantly increased in month 3. The risks included in the Welsh Government Monitoring Return at Month 3 therefore reflect this alongside those in line with the submitted IMTP, and are summarised later in this report.

REVENUE FINANCIAL PERFORMANCE – MONTH 3 2025/26

10. The table and brief below presents an overview of the financial position for the period 1st April 2025 to 30th June 2025, which now includes the YTD impacts of that highlighted above.

Revenue Financial Position for the period 1st April - 30th June				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-312,669	-76,656	-76,816	-160
Expenditure				
Pay	234,649	58,261	57,952	-309
Non-pay	62,518	14,518	15,140	622
Total pay & non-pay expenditure	297,166	72,779	73,092	313
Depreciation & Impairments / interest payable & receivable	15,502	3,876	3,921	44
Total	0	0	197	197

Income

11. Reported Income against the initial budget set to Month 3 shows a net overachievement of **£0.160m**.

Pay Costs

12. Overall, the total pay variance at Month 3 is an underspend of **£0.309m**.

Non-pay Costs

13. The overall non-pay position at Month 3 is an overspend of **£0.622m**. In addition, for reporting purposes Depreciation, Impairment and interest is excluded from the above figure, a current overspend of **£0.044m**, hence the total overspend to budget YTD of **£0.197m**.

Savings

14. 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.

15. Month 3 in month performance was, plan of £0.746m and £0.731m achieved, therefore a small underachievement of £0.014m (recurrent underachievement of £0.072m and non recurrent overachievement of £0.057m), as per the below table.

	Annual Plan £000	In Month			Cumulative			Forecast		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Themes	6,225	556	484	-72	1,504	1,375	-129	6,225	6,037	-188
Non Recurrent Schemes / Themes	2,275	190	247	57	569	762	193	2,275	2,463	188
Overall Total	8,500	746	731	-14	2,073	2,137	64	8,500	8,500	0

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

16. Despite all of the above however, what does remain positive is the cumulative savings delivery as at the end of Q1, with gross savings of **£2.137m** having been achieved against a target of **£2.073m**

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

Financial Performance by Directorate

18. Whilst there is a deficit reported at Month 3, there are some small variances between Directorates, as shown in the table below, when compared to the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature, and given we remain fairly early in the financial year, but they will be continued to be closely monitored.

Financial position by Directorate @ 30th June	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	216,408	54,315	54,062	-253	-0.5%
Chief Executive Directorate	2,132	561	561	-0	0.0%
Board Secretary	671	159	159	-1	-0.3%
Partnerships & Engagement Directorate	563	130	129	-1	-0.4%
Finance and Corporate Resources Directorate	36,432	8,230	8,552	322	3.9%
Planning and Performance Directorate	3,005	687	670	-17	-2.5%
Quality, Safety and Patient Experience Directorate	7,070	1,730	1,702	-28	-1.6%
Digital Directorate	16,542	3,408	3,274	-135	-4.0%
People and Culture	6,286	1,550	1,542	-8	-0.5%
Medical & Clinical Services Directorate	5,853	1,395	1,398	3	0.2%
Trust Reserves	1,217	54	286	232	427.1%
Trust Income (mainly JCC)	-296,178	-72,220	-72,138	82	0.1%
Overall Trust Position	0	0	197	197	

19. Again the above table now also reflects that which we have had to recognise for the issues previously highlighted this month, and how and where these get reported through our delegated budgets. A brief commentary on significant key variances above is therefore as follows:-

➤ Most directorates broadly in line with budget plan for Month 3 with the exception of Trust reserves, Finance and Corporate resources and Trust income:

➤ Core budgets set for **Finance and Corporate resources** at the opening of the financial year are broadly balanced with the exception of the current cost pressure around Welsh Risk Pool (WRP), which is held and reported through this Directorate, on behalf of the Trust.

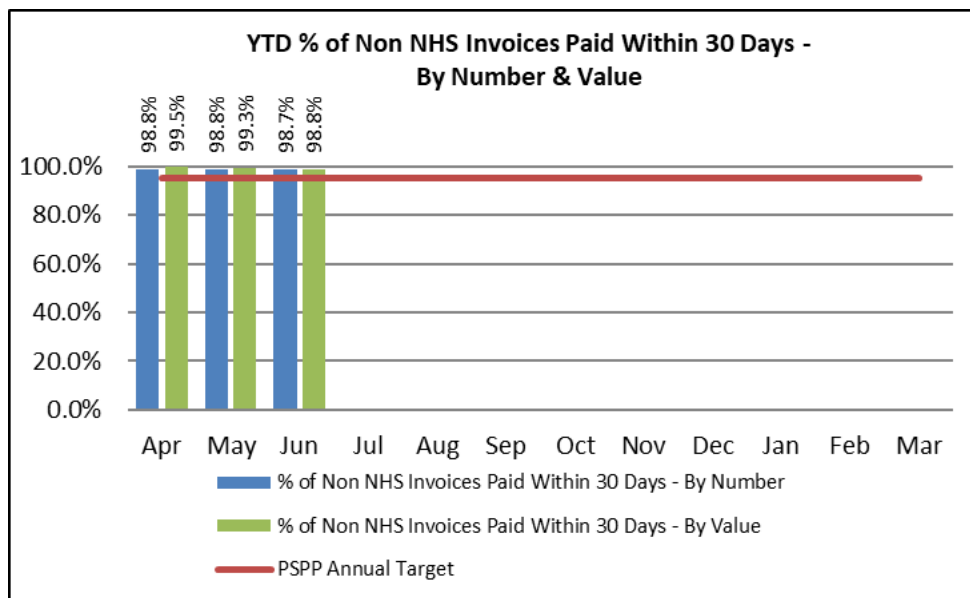
➤ Core budgets set for **Income** at the opening of the 2025/26 financial year included two main components:

- 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 in Month 3. The impact on WAST was a full year cost increase of c£4.69m and this was included in the opening financial plan with assumed full income coverage from WG. Initial discussions with WG colleagues in June suggested a potential funding shortfall of c7% (WAST impact of £0.330m) for NHS Wales organisations and hence based on this £0.082m is included in the M3 YTD financial reported position.

It must be noted that further correspondence has since been received in month 4 that suggests a larger funding shortfall figure in year, both across the NHS in Wales and specifically for WAST. Further clarification will therefore be required from WG over the next few weeks to work through this and the full implications on WAST's ability to continue to forecast and deliver a break even position this financial year.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

20. Public Sector Payment Policy (PSPP) compliance to Month 3 was **98.7%** against the **95%** WG target set for non-NHS invoices by number and **98.8%** by value.



2025-26 INITIAL CAPITAL PROGRAMME

21. As we are still in the relatively early stages of the financial year the discretionary capital programme and resulting cashflows are now being finalised.

22. At Month 3, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2025/26 is **£32.216m**. This includes **£26.268m** of All Wales Approved schemes and **£5.948m** for Discretionary schemes.

RISKS AND ASSUMPTIONS

23. Understandably this early in the financial year, the risks reported 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 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 apprised of such risks and any mitigating actions.

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

level of risk. Inevitably at the start of any financial year some of these values remain indicative.

25. The main and significant change in the risks reported this month though is as follows. Given the revised funding position along with the change in the Welsh Risk Pool (WRP) forecast, it is inevitable that the risk of not achieving financial balance this financial year has significantly increased in M03. Should both the previously indicated NI funding and latest WRP cost estimates be the final values in year, this would add a further c.£1.230m in year pressure to previous forecasts. Whilst there are probably some elements of mitigation that we can reasonably expect to be delivered between now and the end of the financial year, it would not be reasonable at this stage to expect all of this to be able to be absorbed, and certainly not without some significant service impacts. The only way to then further deliver in year balance would be by further stretching an already stretched savings target. Based on the assumptions within this report and that which has been assessed that could be reasonably offset against the above value, this has been estimated at this stage of being in the region of an additional £850k. Currently it would have to be stated that there is a high risk of this not being achievable, therefore the Trust has included a figure of **£0.850m** (high risk). Again, as also noted above, should any of the values used to assess any of this in m03 further increase, this risk and likely impact on the Trust's forecast year end position are also likely to further increase in future months.
26. 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, 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. The further external impacts on the Trust's current and forecast financial position and resulting updated risk profile also now needs to factor into any response to any such future request, should this be received.
27. Given the increased requirement again in our core savings target that has been required this financial year; to cover increasing cost pressures the Trust has included a risk around the identified savings, of **£1.000m** (low risk). Despite these schemes all being rated as "green" there is always a level of risk associated with the delivery of these schemes and given the weighting of some of these schemes into the latter part of the financial year.
28. 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.

29. The risk included for increase in handover delays (increase in overrun costs, due to HB reducing services) has been reassessed in month and reduced from £2.500m to **£1.500m** (low risk).
30. Also continued to be included is a financially unquantified risk associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if this recommendation is to be taken forward additional funding would be required in order to deliver. This is highlighted at this stage as being a low risk, and from a purely financial perspective it is, as costs have not been committed for this and are arguably not unavoidable – should these not be funded, costs for these cannot be incurred. However, the wider impact of such decisions may be argued as being of a higher than low risk, non-financially.
31. 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 Board:

- a) **Notes** and gains **assurance** in relation to the Month 3 revenue financial position and performance of the Trust as at 30th June 2025. Specifically **noting** the revised year to date revenue position and the impact on the Trust's forecast and in year financial risk of delivery;
- b) **Notes** the delivery of the 2025/26 core 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 3 Welsh Government monitoring returns submission included within **Appendices 1 – 2** (as required by WG).

Appendix 1

Monitoring return

Appendix 2

Worksheet – Available in the 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

3

	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	12	12	0	50	50	0
Balance Sheet Flexibility	200	50	50	0	50	50	0	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	0	-100
Disposals	250	0	0	0	0	0	0	250	250	0
End of Shift Overtime	100	9	9	0	27	25	-2	100	98	-2
Fuel	230	20	20	0	59	82	23	230	253	23
Interest Receivable	516	43	4	-39	129	82	-47	516	434	-82
Non Pay Local Schemes - Corporate	914	64	65	1	191	157	-34	914	913	-1
Non Pay Local Schemes - Operations	650	54	37	-18	156	130	-26	650	623	-26
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	312	296	-16	880	836	-44	3,140	3,140	0
Pay Vacancy Management - Corporate	2,275	190	247	57	569	762	193	2,275	2,463	188
Pay Vacancy Management - Corporate 25-26	75	0	0	0	0	0	0	75	75	0
Totals	8,500	746	731	-14	2,073	2,137	64	8,500	8,500	0

Savings Performance by Theme 25-26 - Recurrent

Reporting Month

3

	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	12	12	0	50	50	0
Balance Sheet Flexibility	200	50	50	0	50	50	0	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	0	-100
Disposals	250	0	0	0	0	0	0	250	250	0
End of Shift Overtime	100	9	9	0	27	25	-2	100	98	-2
Fuel	230	20	20	0	59	82	23	230	253	23
Interest Receivable	516	43	4	-39	129	82	-47	516	434	-82
Non Pay Local Schemes - Corporate	914	64	65	1	191	157	-34	914	913	-1
Non Pay Local Schemes - Operations	650	54	37	-18	156	130	-26	650	623	-26
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	312	296	-16	880	836	-44	3,140	3,140	0
Pay Vacancy Management - Corporate	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate 25-26	75	0	0	0	0	0	0	75	75	0
Totals	6,225	556	484	-72	1,504	1,375	-129	6,225	6,037	-188

Savings Performance by Theme 25-26 - Non Recurrent

Reporting Month

3

	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 Overtime	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	247	57	569	762	193	2,275	2,463	188
Pay Vacancy Management - Corporate 25-26	0	0	0	0	0	0	0	0	0	0
Totals	2,275	190	247	57	569	762	193	2,275	2,463	188

Please note figures are rounded to the nearest whole number



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans 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

11th July 2025

Your ref:

Dear Andrea,

Re: JUNE 2025 (MONTH 03 2025/26) MONITORING RETURN

Please find attached the Monitoring Returns for the Welsh Ambulance Services University NHS Trust for June 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 03 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 3 payment from JCC, however discussions are ongoing, and it is assumed this will pass through to the Trust.

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

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

www.ambulance.wales.nhs.uk

Pencadlys Rhanbarthol
Ambiwylans a Chanolfan
Cyfathrebu Clinigol

Regional Ambulance
Headquarters and
Clinical Contact Centre

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

The resulting reported performance at Month 3 as per Table B, is a overspend against budget / deficit of **£0.197m**

The reported total pay variance against plan as at Month 3 is an underspend of **£0.309m**, set against the budgets.

The non-pay position at Month 3 is a reported overspend of **£0.666m**.

Income at Month 3 shows an overachievement of **£0.160m**.

Whilst any move into a deficit position is unwelcomed, this is fully explainable and, given some of the recent impact of some external challenges and changes to previous assumed funding coverage and cost base movement, is to be expected, at the very least in short term.

Given the monthly positions year to date and the significant step up in savings requirements needed in 2025/26 to balance, as fully detailed within both our IMTP and previous months' reporting, it was never going to be possible for the Trust to absorb such impacts in the immediate term. And this is based on the assumption of the recent impacts being a c7% shortfall in funding in relation to increases in Employers NI (a full year impact of c£0.33m) and an in-year increase in our current cost forecast in relation to WRP being a FYE of c£0.9m. You will note that our current reported YTD position at M03 does not assume all of these costs drop to the bottom line, with all that we can do at this stage, with the time that we have had to respond to these in year changes, being done to look to mitigate what elements of these that we are currently able, including from any small contingency we hold for such events. However, should the resulting impact of these issues be even greater than this, including along the lines of that subsequently suggested on 4th July in relation to NI funding, these values will inevitably further increase from M04 reporting onwards.

We have at this stage not reflected any of this in our year end forecast, which remains a breakeven one and one we will continue to do all that we possibly can to achieve. However, this is in part due to the lack of time available to work through in any detail at this stage, including internal governance, the full potential impact of these most recent changes. This will be provided below in some detail now with further updates provided in M04 and beyond.

2. Movement (Table A)

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

It is noted that the underlying deficit did decline in month 2 following the deduction in a recurrent scheme however the Trust is always looking for opportunities to increase the number and value of recurrent schemes. **(Action Point 2.1)**

The minimal in year movements have been profile from month 3 onwards for the small movements the Trust see between periods, however this in effect is to manage the YTD impact of the previously discussed issues, which will require further work as we move through month 4 and beyond. **(Action Point 2.2)**

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 apprised 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.

Given the revised funding position along with the change in the WRP forecast, it is inevitable that the risk of not achieving financial balance this financial year has significantly increased in M03. Should both the previously indicated NI funding and latest WRP cost estimates be the final values in year, this would add a further c£1.23m in

year pressure to previous forecasts. As above, whilst there are probably some elements of mitigation that we can reasonably expect to be delivered between now and the end of the financial year, it would not be reasonable at this stage to expect all of this to be able to be absorbed, and certainly not without some significant service impacts. The only way to then further deliver in year balance would be by further stretching an already stretched savings target, based on the assumptions within this return of in the region of an additional £850k. Currently it would have to be stated that there is a high risk of this not being achievable. **(Action Point 1.6)**

Obviously if the values above further worsen through M04, including potentially based on that further received on 4th July re actual expected NI funding, which in itself could add in the region of c£0.9m to the above, these values, risks and indeed year end forecast position is likely to require further updating over the next few months.

A low risk has been included around any JCC additional, in year, saving request, this is currently low at present however this is on the basis that the Trust has had no direct contact from the JCC on any further ask. However in light of the comment contained in the m01 reply letter, the Trust acknowledges this could be an increased risk should such an in-year request be made. However, it remains that our current breakeven forecast assumes the current level of 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.

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

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

Included within the table is an unquantified risk, this is still being worked through internally, and relate to the costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if this recommendation is to be taken forward additional funding would be required in order to deliver. As noted within the returns, this is highlighted at this stage as being a low risk, and from a purely financial perspective it is, as costs have not been committed for this and are arguably not unavoidable – should these not be funded, costs for these cannot be incurred. However, the wider impact of such decisions may be argued as being of a higher than low risk, non-financially.

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

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

5. Monthly Profiles (Table B)

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

At month 3 the depreciation for IFRS 16 and corresponding income wasn't included in the ledger figures, this will however be progressed as we proceed through the coming months **(Action Point 2.3)**

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 3 totalled £0.073m. The current percentage of agency costs against the total pay figure remains very small, at 0.4%. This is to cover a small number of vacancies, in areas across the Trust which the Trust is having difficulties recruiting into, however it is hoped that some of these agency staff will be replaced by

permanent staff in the near future. Forecasts have been updated to show expenditure stopping after September. **(Action Point 2.4)**

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

For Month 3 the Trust is reporting planned savings (including Income generation) of £2.073m and actual savings of £2.137m.

As can be seen from Table C3, the Trust overachieved its savings target in month 3 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,

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 figure included in the month 2 response has been adjusted based on the interpretation of discussions at DDoF's and follow up emails between yourself and Edward Roberts, this resulted in the Trust excluding 7% of the income, this however was prior to the email received on the 4th July, as mentioned above in detail the share of the £97.5m being allocated in the way that it has. This will no doubt be further updated for M04.

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

At Month 3 there was 3 invoices over 11 weeks, there are no issues with these invoices and expect them all to be paid in month 4.

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	244	244	244	244	244	244	244	244	244	3,086
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	0	435	384	450	300	300	300	300	300	300	300	300	3,669
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	707	557	557	557	557	557	557	557	557	9,454

12. Public Sector Payment Compliance (Table H)

As per the guidance this has 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 3 Financial Monitoring Return will be presented to the Trust Board on 31 July 2025.

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

15. Other Issues

The Trust can confirm all LTA/SLA's have been signed (**Action Point 2.5**)


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

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

Yours sincerely



Chris Turley
Executive Director of Finance & Corporate Resources



Jason Killens
Chief Executive

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

Urgent and Emergency Care – Arrangements for Managing Demand Welsh Ambulance Services University NHS Trust

Date issued: April 2025

Document reference: 4820A2025

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We welcome correspondence and telephone calls in Welsh and English.
Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2024 review of the arrangements for managing demand for urgent and emergency care at the Welsh Ambulance Services University NHS Trust (the Trust). The work is the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase, which examined discharge planning and the impact of patient flow on urgent and emergency care, has been reported separately in regional reports covering the health board and local authorities for each of the seven health and social care regions¹.
- 2 Our approach recognises that the urgent and emergency care system is complex, with many different organisations needing to work together to provide urgent and emergency care and to ensure the wider system works effectively and efficiently. The Welsh Government's [Six Goals for Urgent and Emergency Care Programme](#) (Six Goals Programme) launched in 2021, provides the context for our work. At the time of our review, the urgent and emergency care system in Wales continues to be under significant pressure.
- 3 Our work has examined how the Trust is managing demand for urgent and emergency care services. Specifically, we looked at how it is working to reduce conveyance to Emergency Departments and how it supports the treatment of patients in the right place, first time for their needs, where better alternatives to attendance at Emergency Departments exist. The work has been undertaken to help discharge the Auditor General's statutory duties under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Trust has proper arrangements in place to ensure the efficient, effective, and economic use of its resources.
- 4 We undertook our work between May 2024 and January 2025. The audit methods and criteria we used to deliver our work are summarised in **Appendix 1 and 2**.

¹ The seven health and social care regions align with the seven regional partnership boards.

Key facts and figures

Calls to 111 and 999

2,427	Average number of calls to the 111 service every day in February 2024 ² (101 calls an hour).
14%	Calls to 999 that were ended following a WAST telephone assessment (providing advice or signposting to alternative services) in February 2024 ³ , compared to 8.2% in February 2019
178%	Increase in Category A (red) ambulance calls between February 2019 and February 2025.
15%	999 callers who cancelled their ambulance or were told that the Trust could not send an ambulance to them during February 2025, compared to 24% in November 2024.

Ambulance response

51%	Category A (red) ambulance calls responded to within eight minutes in February 2025, compared to 72% in February 2019. The national target is 65%. ⁴
02:03hrs	Average response time to amber calls in February 2025, an increase of 1 hour 37 minutes compared to the average in February 2019.
63%	Patients conveyed to hospital following a 999 call in February 2025, compared to 68% in February 2019.

² Due to the Trust implementing a new 111 system for call handling and clinical assessment there has been disruption to the reporting of this data since February 2024.

³ This verified data is currently only available up to April 2024, however February 2024 data used for comparative purposes.

⁴ As described in paragraph 55 the level of demand and the number of patients the Trust is reaching within eight minutes is growing.

Handover delays

16% Patients handed over from ambulance crews to an emergency department within 15 minutes of arrival in February 2025, compared to 53% in February 2019 and against a national target of 100%.

1,601 Number of patient handovers which took longer than 4 hours in February 2025.

18,812 Lost hours due to handover delays in February 2025, compared to 5,610 lost hours in February 2019. This is an increase of 235%.

463 Patients estimated to be coming to severe harm because of long handover delays in February 2025⁵. This equates to 3.5% of total handovers.

Funding

£0 Direct allocation of Six Goals Programme funding.

⁵ Based on [modelling developed by the Association of Ambulance Chief Executives, 2021](#)

Key messages

Overall conclusion

- 5 Overall, we found that **changes to service delivery are leading to improvements in managing urgent and emergency care demand, supported by clear and regularly monitored plans. However, their impact is hindered by limitations in joined up data and access to alternative pathways in health boards as well as by continually high levels of handover delays at Emergency Departments.**

Key findings

Planning arrangements

- 6 The Trust has robust and clear plans for managing urgent and emergency care demand, with changes aimed to better manage demand by treating patients in the community rather than taking them to hospital, where possible.
- 7 Plans are informed by data and seek to address the risks associated with urgent and emergency care with actions that are aligned to the Six Goals Programme. The Trust does not have direct access to national six goals funding in the same way as health boards. As a result, the Trust is largely reliant on identifying sources of, and bidding for, national allocations to enact service changes it believes could improve patient safety and experience, which has caused plans to be deferred or delayed in recent years. However, the Trust has prioritised the uplift in allocation to progress plans to transform its clinical model in an attempt to mitigate avoidable harm within its control.

Accessing services

- 8 The Trust employs a range of methods to provide members of the public with information on its urgent and emergency care services. Although there is no communication plan, the Trust has recently updated its engagement plan to support its Clinical Model Transformation Programme. The Trust uses methods including social media posts and public engagement events to engage with and inform the public about using urgent and emergency care services. However, there are no mechanisms in place to assess and monitor the public's understanding of its services and when these should be accessed.
- 9 The Trust is aware of ongoing issues with the 111 Wales website, including the symptom checker. While small improvements are being progressed to address immediate functionality concerns, a draft business case has been developed to support more substantial improvements. The symptom checker tool is currently signposting users to out-of-date information which the Trust recognises as a priority issue. The Trust has agreed to use discretionary capital funding to begin

work on updating the symptom checkers, with further funding to support comprehensive improvements included in the drafted business case currently under discussion with commissioners.

- 10 Over recent years, the Trust has expanded the range of services it offers, including expanding its clinical desk, developing additional specialist practitioners and increasing its use of advanced paramedic practitioners. These are having a positive impact on managing urgent and emergency care demand. Rates of providing remote advice to patients have risen since pre-pandemic levels, with early data indicating that there are further improvements since the Trust changed its clinical model in November 2024. As a result, more patients are being treated over the phone and less are being conveyed to hospital.
- 11 However, the Trust's ability to redirect patients is also reliant on the availability of alternative services in health boards. While referrals to the GP out of hours services are increasing, referrals to alternative services remain low. The Trust holds a directory of services for each health board area, but these are not always accurate and up to date. Issues accessing alternative pathways by Trust staff, including Urgent Primary Care Centres and Same Day Emergency Centres also means that conveyance to an Emergency Department often remains the default destination when remote or face-to-face clinical assessment have identified an ongoing healthcare need for the patient.
- 12 The benefits of the service changes made by the Trust also continue to be outweighed by the continuing problems with long handover delays across Wales. Only 16% of patients were handed over from ambulance crews to an Emergency Department within 15 minutes of arrival over the last twelve months, compared to a national target of 100%. Response times for both red and amber calls continue to be challenged, with risks that both delays in response times and handover delays are resulting in patients coming to harm. Lack of available ambulances is likely also leading to higher attendance rates at emergency departments across Wales, as patients make their own way to hospital. Some of these patients may not have needed to go to the emergency department, but opportunities for paramedics to treat patients remotely (See and Treat) earlier in their patient journey are being missed due to handover delays.

Scrutiny and monitoring arrangements

- 13 The Board and operational groups regularly monitor and scrutinise the progress of plans and their impact on mitigating avoidable patient harm and operational risks.
- 14 There is a range of data to monitor and scrutinise how the Trust's service changes are working. However, this data is not joined up with health board data, which limits the Trust's understanding of how its services impact on the entire patient journey, though the Trust is currently working to find solutions to this issue. The Trust is capturing staff and patient feedback, which it feeds into its future strategic plans, but response rates are low.

Recommendations

15 **Exhibit 1** details the recommendations arising from our work. The Trust's management response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations

Accuracy of 111 Wales website

R1 To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number (**Paragraph 27**).

Directories of Service

R2 To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories (**Paragraph 45**).

Detailed report

Planning arrangements

- 16 This section considers whether the Trust has robust plans in place to manage the demand on urgent and emergency care services. We were specifically looking for evidence of plans:
- being informed by relevant and up to date information;
 - identifying and seeking to address key risks associated with urgent and emergency care services;
 - aligning with requirements of the Six Goals Programme, and clearly setting out how alternative clinical pathways will work; and
 - identifying the current and required levels of resource and staffing to achieve the intended ambitions.
- 17 We reviewed the Trust's Integrated Medium-Term Plan (IMTP) along with its longer-term strategic framework, its plans relating to its Clinical Model Transformation Programme⁶ developed during 2024, and its winter plan for 2024-25.
- 18 We found that **plans for managing urgent and emergency demand are robust and clear and clearly align to the national Six Goals Programme.**
- 19 The findings from our review of the plans are summarised in **Exhibit 2.**

Exhibit 2: approach to planning urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Plans are informed by relevant and up to date information?	Yes	The Trust's plans contain relevant and up-to-date information, including operational performance, demographic predictions and demand and capacity data. They also include modelled scenarios for the Trust's performance, based on actual and potentially improved levels of handover

⁶ The Clinical Model Transformation Programme is a programme of work the Trust is leading, with the support of commissioners and partners. The programme seeks to increase clinical input within the patient call cycle and to provide a greater range of response options for patients who need a face-to-face assessment. These changes should enable more patients to access treatment appropriate to their needs without the need for a hospital conveyance.

Audit question	Yes/ No/ Partially	Findings
		delays experienced within the broader health system.
Plans identify and seek to address key risks associated with urgent and emergency care services?	Yes	<p>The Trust's plans clearly identify key risks and mitigating actions. Risks align with those identified through the Trust's corporate risk register. These risks focus on the impact of operational pressures on the Trust's ability to provide a safe service for patients. These risks have been at the highest score of 25 since December 2019 due to ongoing and increasing pressures.</p> <p>The Trust is currently engaged in a programme of work which includes a review of these risks to delineate between what can be managed and mitigated by the Trust and what external factors the Trust can monitor and seek to influence.</p> <p>Risks in relation to specific service changes and projects are also identified and regularly overseen by operational groups, with concerns escalated to the Trust's Strategic Transformation Board.</p>
Plans align with requirements of the Six Goals for Urgent and Emergency Care Programme , and clearly setting out how the alternative clinical pathways will work?	Yes	<p>The IMTP is explicit about its alignment to the Six Goals Programme and demonstrates how the Trust can make a meaningful contribution across each individual goal.</p> <p>Appendix 1 of the IMTP clearly articulates each goal, the relevant quality statement, the actions the Trust intends to take to achieve each goal and what it anticipates being the measurable benefits of its actions. Relevant sections throughout the body of the IMTP detail how alternative pathways or service improvements will work.</p> <p>The IMTP, along with the documents on the clinical model transformation programme outline changes aimed to better manage demand by treating patients in the community rather than taking them to hospital, where possible. These include introducing rapid</p>

Audit question	Yes/ No/ Partially	Findings
		<p>clinical screening for 999 calls to identify potential opportunities to signpost them to alternative services, expansion of Advanced Paramedic Practitioner roles and enhancing falls services.</p>
<p>Plans identify the current and required levels of staffing and resource to achieve the intended ambitions?</p>	<p>Partially</p>	<p>The IMTP has clear implications for increasing the workforce in specific service areas. Plans to support these implications are further detailed within the Trust's strategic workforce plan.</p> <p>The IMTP does not clearly identify the costs required to pursue additional schemes, and whether they require additional funding. However, this detailed information is available within the Trust's more detailed financial plans.</p> <p>The Trust does not receive a direct allocation of Six Goals funding in the same way as health boards, though it can access funding via the health boards to contribute to specific health-board schemes.</p> <p>The limited availability of additional funding has led to the Trust needing to slow the pace or defer planned changes to some of its services in recent years. However, in line with other NHS bodies, the Trust received an uplift in its core allocation during 2024-25, which enabled it to progress its clinical model transformation programme.</p>

Source: Audit Wales

Accessing services

- 20 This section considers whether the Trust has appropriate arrangements in place to encourage and enable people to access urgent and emergency care services that best meet their needs, and whether these arrangements are working. We were specifically looking for evidence of:
- effective signposting of patients to the most appropriate urgent and emergency care services;
 - staff having access to good information on the range of services available to patients, and the extent to which there is good engagement between Trust and health board staff involved in urgent and emergency care;
 - a range of services that help manage urgency and emergency demand; and
 - whether the above arrangements are helping to positively manage demand for urgent and emergency care services.
- 21 We found that **the Trust’s approach to managing demand is improving, but handover delays limit the operational efficiencies gained from improvements, and information on the entire patient journey is not joined up.**

Signposting of services to the public

- 22 We found that **activity to signpost information to the public is not evaluated to ensure it is effective, and there are ongoing issues with the 111 Wales website.**

Communication plans

- 23 The Trust does not have a communication plan which sets out how it engages with the public to improve and support their understanding of how to access urgent and emergency care services. However, the Trust has recently updated its Engagement Plan, originally developed in 2023, to support its Clinical Model Transformation Programme which includes information on public messaging. However, the engagement plan is very high-level and does not outline the details of its approach to public engagement.
- 24 The Trust employs a range of methods to provide members of the public with information on its urgent and emergency care services. These methods include social media posts, news coverage in times of significant pressure, and information contained on the Trust and 111 Wales websites. Through its Public Engagement and Community Involvement Team, the Trust also holds events to engage with the public. According to an internal audit report in February 2025, this team held 147 events between January 2023 and October 2024 where it met with a variety of community groups. As part of these events the Trust will inform patients which services they should access and when.

111 Wales website

- 25 The 111 Wales website describes itself as ‘the home of health advice and information for people living in Wales’ and is a key tool to signpost the public to healthcare options. It includes symptom checkers, information on what to do out of hours, a directory of nearby services and advice on planned care and living well. The number of website hits on the 111 Wales website increased significantly during 2023. Currently an average of 400,000 – 550,000 people access the 111 website each month across Wales.
- 26 Available data does not show the main reasons people visit the 111 Wales website, but there is data on the main reasons for people calling the 111 phoneline. The top five reasons for calls are set out in **Exhibit 3**.

Exhibit 3: top five reasons for calling 111 (February 2024)

All-Wales position	% of all calls
Dental problems	4.1
Abdominal pain	2.4
Chest pain	1.6
Cough	1.4
Rash	1.0

Source: Ambulance Services Indicators

- 27 We reviewed the 111 Wales website symptom checker to understand what advice is available to patients searching for help on the most common conditions. We found that the website can be unreliable, with the symptom checker sometimes failing and displaying an error message. Our tests of the symptom checker showed that it can also refer the user to out-of-date information, including the old NHS Direct Wales number (**Recommendation 1**). Furthermore, our review found that the skin rashes tool has limited functionality, consisting of a slideshow of images. The Trust routinely seeks feedback from the public via an online survey to understand their experiences of the 111 Wales website. Past feedback from the public has raised similar issues with the functionality of the symptom checker and the website more generally.
- 28 The Trust is aware of ongoing issues with the symptom checker and recognises the need for increased investment in the website. While small changes are being made to improve its functionality and user experience, the Trust has also invested in the development of virtual assistant technology during 2024-25, which was ongoing at the time of our fieldwork. To address wider challenges, the Trust has drafted a business case to support more substantial changes to the website,

including updated symptom checker functionality and enhanced governance of the digital front door. The business case will be submitted to commissioners and the national Six Goals Programme Board following discussions with Welsh Government regarding financial envelopes and commissioner expectations. The business case will also cover 111 communications activity, and as this work progresses, the Trust should ensure it includes mechanisms to evaluate the effectiveness of its public engagement and adapt its approach where needed.

Staff awareness and ability to refer



- 29 We found that **referral pathways and processes between the Trust and health boards do not work seamlessly which is impacting access to alternative services.**

Assessment and treatment

- 30 During the last ten years, the Trust has introduced many initiatives and service changes to enhance its clinical offering with the aim of increasing the treatment of patients within the community and reducing conveyances to hospital. This has included expanding its clinical desk to provide advice to patients over the phone to 999 callers as well as introducing a referral process for patients seeking mental health support to have fast and direct access to relevant health board services (referred to as '111 press 2'). The Trust has also invested in its ability to treat patients face-to-face within the community, enabling them to stay at home, including increased its advanced paramedic practitioner workforce.
- 31 The ability of the Trust to treat, provide advice or signpost information to patients to avoid conveyance to hospital is referred to as 'consult and close'⁷ and 'see and treat.' **Exhibit 4** sets out the extent to which the ambulance call centre can manage patients after assessment (consult and close), and ambulance crews can manage patients at the scene (see and treat).

⁷ Previously referred to as 'hear and treat'.

Exhibit 4: percentage of ambulance calls and responses ended after telephone assessment (May 2023 – April 2024) or at scene (May 2023– April 2024)⁸

Indicator	All-Wales position	Trend
% of ambulance 999 calls ended after telephone assessment (consult and close)	13.9	
% of ambulance responses treated at scene (see and treat)	12.1	

Source: Ambulance Service Indicators

- 32 The rate of consult and close has increased substantially in recent years, from 8.2% in February 2019 to 14% in February 2024. This increase is mainly due to an increasing investment in recruiting clinicians to operate its Clinical Support Desk, particularly as part of plans to mitigate annual winter pressures.
- 33 Recent unverified data shows that the number of patients treated or referred to alternative services over the phone is further increasing after the Trust introduced rapid clinical assessments. In 2023 WAST commissioned a clinical model design of the Trust’s EMS service by ORH.⁹ The work recommended that 999 calls should be reviewed and either referred for a fuller remote clinical assessment or returned to the queue to receive an ambulance dispatch. After receiving an increased core allocation to its base budget in 2024-25 due to inflation, the Trust decided to progress this recommendation and recruited 28 clinical navigators to launch the first phase of its Clinical Model Transformation Programme in November 2024. Unverified data for December 2024 showed the rate increasing from under 15% to over 20%.
- 34 When a call is ended through consult and close, a patient may have received a range of advice which can include self-care, contacting their GP within normal working hours, or signposting to other available services, (as set out in **Exhibit 5**). Within the Trust, there has been an increase in the range of available services to directly refer to. These include the mental health ‘111 press 2’ service which directs patients to mental health support, as well as the urgent dental service to book urgent appointments. The urgent dental service is available via 111 for five of the seven health boards (excluding Aneurin Bevan and Cardiff and Vale who have their own services).
- 35 In 2023, the Trust also developed its capability to remotely monitor and manage patients within the community through the Connected Support Cymru service. This

⁸ Data not available beyond April 2024.

⁹ ORH, also known as Operational Research in Health Ltd, is a company which conducts research and analysis of emergency services aimed at optimising resource use and response.

service uses the support of volunteer responders, clinical support desk clinicians and remote monitoring technology to manage patients remotely and keep them at home, where appropriate. This service is currently in its early stages, with plans for it to be scaled up over the next few years as outlined within the Trust's IMTP 2024-27. However, this service currently utilises short-term funding from NHS charities together which is due to conclude in March 2025. The future of this service depends on the level of additional investment available.







- 36 Whilst the rate of patients treated at scene increased during the 12 months between March 2024 and February 2025, the rate has decreased slightly over a longer period. Between March 2019 and February 2020, the rate stood at an average of 2,770 patients treated at scene per month, compared to an average of 2,321 between March 2024 and February 2025.
- 37 The Trust has been expanding its advanced paramedic practitioner service to avoid hospital conveyance and improve patient outcomes. Advanced paramedic practitioners provide enhanced treatments to patients within their homes or communities. Since the introduction of the advanced paramedic practitioner role in 2017, the number of these roles within the Trust has increased to 119 as of February 2025, with recruitment of a further 11 currently underway. The Trust's IMTP sets out plans to further increase this workforce by 40 per year up to 2027, dependent on availability of funding. Case studies, local evaluations and interviews show that the advanced paramedic practitioner role is making a significant impact in treating patients closer to home. However, this is not currently being demonstrated clearly within 'see and treat' data that is available. The Trust is undertaking work to understand the reasons for this.
- 38 In addition to advanced paramedic practitioners, the Trust has developed a Cymru High Acuity Response Unit (CHARU) which provides advanced care to the most critically ill patients, including those experiencing cardiac arrest or major trauma. Data presented to the Trust's Finance and Performance Committee in September 2024 shows the service supporting better outcomes for 'red' calls such as cardiac arrests.
- 39 For urgent needs that are not immediately life-threatening, the Trust is also seeking to develop its own services, including falls responders. The Trust provides two levels of falls response services, with level one focused on lifting patients from the floor. Level two works with health boards to provide greater support to patients following a fall that are experiencing worsening frailty, by undertaking a full medical and social assessment at the point of need.

Referral to other services

- 40 As well as the availability of its own alternative services, the Trust's ability to refer patients to alternative services depends on the availability of those services within the health board regions. We found each health board has a range of services in place to manage and treat urgent and emergency care needs.

- 41 **Exhibit 5** sets out the extent to which 111 has been able to refer patients to other urgent and emergency services.

Exhibit 5: referral to other services (March 2023 - February 2024)

Indicator	All-Wales position	Trend
% of 111 calls referred to GP out of hours	41.5	
% of 111 calls advised to attend Emergency Department / Minor Injuries Unit	10.6	
% of 111 calls referred to urgent dental service	9.7	
% of 111 calls referred to 999	6.7	
% of 111 calls advised to contact their GP (in-hours)	4.6	
% of 111 calls referred to another health professional	2.0	

Source: DHCW Urgent and Emergency Care Dashboard, GP Out of Hours Data, Ambulance Services Indicators

- 42 The data shows that the most common service 111 callers are referred to is the GP out of hours service, with this rate increasing between March 2023 and February 2024. This rate aligns to public messaging which signposts patients with urgent out of hours needs to contact 111 to access GP out of hours services and suggests that public messaging is generally working effectively in this regard. The rate with which 111 call handlers refer patients to contact their own GP in hours (4.6%), indicates that patients could be better informed about which service to access, however it is also likely to reflect how the public are increasingly struggling to gain appropriate access to in-hours GP appointments due to capacity issues within primary care. The low rate of referrals to other health professionals (2%) also suggests that there are limited alternative services in place for 111 call staff to refer patients with specific conditions to access.
- 43 Between February 2022 and February 2024, 5.2% of 999 calls were transferred to the 111 service, on the basis that the calls were deemed non-urgent and therefore could be dealt with through alternative services. However, 27.7% of these calls were transferred back to 999 with an outcome of ‘ambulance required’ This comparatively high rate suggests that while these cases are not sufficiently urgent to warrant a 999 response, options for alternative services were either not in place or not accessible.
- 44 To facilitate effective referral between the Trust and health boards, there needs to be a sufficient range of appropriate pathways that the Trust staff are aware of and can access. One of the key ambitions of the Clinical Model Transformation Programme is to increase collaboration between the Trust and health boards to

identify potential pathways for patients, and to ensure that Trust clinicians have appropriate access to those pathways, either by streaming patients to health board clinical hubs, or directly to a care pathway via the directory of service.

- 45 The Trust holds a directory of service for each health board area. Directories of service have been set up to hold accurate and up-to-date information on available alternative pathways that patients can be signposted to by remote clinicians and paramedics. However, our fieldwork found that arrangements for maintaining the directories of service need to be strengthened between the Trust and health boards to ensure they are accurate and up to date, including containing the right opening hours for services (**Recommendation 2**).
- 46 Where pathways are established, our fieldwork also found that there are issues with ensuring Trust staff can access them. This can be because:
- referral criteria is unclear or too limited;
 - pathways do not allow for referrals from Trust staff; or
 - the extent of variation in the way in which services operate make them more challenging for Trust staff to access consistently or efficiently.
- 47 Interviews with a range of staff groups suggested that the inconsistencies in the availability of, and access to, alternative services serve to reinforce Emergency Departments as the default destination for ambulance conveyances.
- 48 In line with the ambitions of the Six Goals Programme, some health boards have established Urgent Primary Care Centres (UPCCs). The principle of UPCCs is to provide diagnosis and treatment to patients with urgent but non-life-threatening injuries or illnesses. However, the UPCC models developed in response to the Six Goals Programme vary within and between health boards. The Trust has been piloting booking patients directly into UPCCs from the 111 service, but this is limited to a small number of appointments and for very specific conditions. This stops Trust staff from using UPCCs to their full potential to manage urgent demand in the way they are intended.
- 49 Another key ambition of the Six Goals Programme was for health boards to establish Same Day Emergency Centre(s) (SDECs) to provide same day assessments and treatment without the patient needing to be admitted into hospital overnight. We have found that the SDEC models developed in response to the Six Goals Programme also vary across health boards. This variation results in a lack of clarity for Trust staff as to the referral criteria in place and the pathways they should use to access SDECs.
- 50 In response to this issue, Welsh Government issued an all-Wales policy on direct paramedic referral to same day emergency care in April 2022. The policy clarifies the different expectations of Trust and health board staff to support effective referrals into SDECs. However, despite the policy stating that it is 'essential for the Welsh urgent and emergency care system that direct paramedic referral into SDEC/Ambulatory services is implemented', Trust data shows that, between May

2023 and February 2025, on average only 0.13% of patients conveyed were taken to a health board SDEC each month.

- 51 We heard varying reasons for this low rate of referral during our fieldwork. This included technical issues but more prominently because SDEC units tend to become full within minutes of opening due to broader pressures on Emergency Departments. They then remain full until it becomes too late to accept any new referrals before the units close.

Impact of services to help manage demand

- 52 We found that **recent work to reduce conveyance to Emergency Departments is outweighed by unacceptably long handover delays across Wales**

Ambulance response times

- 53 Data shows that demand on the Trust's services, particularly in relation to red calls, has increased, placing additional strain on its ability to provide a timely service. Red calls across Wales increased by 178% between February 2019 and February 2025, with an average of 5,367 red calls per month between March 2024 and February 2025 (an average of 179 calls per day). This is in part due to the need to increase the number of conditions within the red categorisation to ensure they receive a timelier response. Whilst the number of amber calls has declined slightly since the pandemic, they continue to account for most of the 999 calls, with an average of 24,412 calls per month between March 2024 and February 2025 (an average of 814 calls per day).
- 54 The average percentage of red calls responded to within eight minutes between March 2024 and February 2025 was 48.6% and significantly below the target of 65%. However, during those 12 months, performance has improved with the Trust reaching a greater number of patients within eight minutes. For example, in December 2024 and January 2025 the Trust reached 33% and 22% more patients than its average two-year rate. Following the recent announcement by the Cabinet Secretary for Health and Social Care there will be changes to monitoring performance, with the creation of two separate metrics: one for cardiac and respiratory arrest; and another for other red emergency calls. These changes will take effect from 1 July 2025¹⁰.
- 55 In contrast to red calls, responses to amber calls have become significantly poorer in recent years. On average, the response time to amber calls between March 2024 and February 2025 was 1 hour 50 minutes, rising to 9 hours 58 minutes for the patients who waited the longest (95th percentile). This performance fluctuated during those 12 months, with significant deterioration during December 2024 and

¹⁰ On 11 March 2025 the [Cabinet Secretary for Health and Social Care announced changes to the performance framework for ambulance services](#) effective from 1 July 2025.





January 2025 due to winter pressures. Average response times for those months were 3 hours, 1 minute and 2 hours, 29 minutes respectively.

- 56 Call handlers provide patients with their estimated response time during their call. As a result, since 2022 a significant proportion of 999 callers have called back to cancel their place in the queue for an ambulance response ('cancelled calls'). There have also been circumstances where call handlers have been required to inform patients that they were unable to dispatch an ambulance response to them due to operational pressures at that time ('no send/can't send'). Concerningly, there is no method to capture what happens to these patients to find out if they decided to make their own way to the Emergency Department, found alternative services for their needs or simply decided not to receive treatment.
- 57 The Trust routinely captures and reports data on the number of cancelled calls or calls that received a 'no send/can't send' response. In September 2024, this cohort accounted for 9,440 calls or 21% of patients who dialled 999 that month. Further work by the Trust has established that up to 20% of all cancellations come from patients presenting with chest pain or falls, conditions that can result in significant patient harm. The Trust Board has heard directly about the impact this can have on patients, including a patient story during 2023 where a patient suffered a cardiac arrest within the hospital car park after being driven to hospital by a family member due to lack of ambulance availability.
- 58 As part of the Clinical Model Transformation Programme, the Trust took the decision in November 2024 to stop providing a 'no send/can't send' response, relying on the impact of its new changes such as rapid clinical screening to better manage demand. This means that the Trust takes greater responsibility for the patient and patient risk. This appears to be starting to have a positive impact, as data from February 2025 shows that the numbers of cancelled ambulances had reduced to 5,815, accounting for 15% of the total calls for that month.

Conveyance to hospital

- 59 After the ambulance has been dispatched and it is decided that the patient needs hospital assessment and treatment, they will be conveyed. Whilst the conveyance rate to hospital by the ambulance service was substantially impacted during the pandemic, data since 2023 shows a steadily decreasing conveyance rate when compared with pre-pandemic levels, with rates dropping from 68% (19,022 patients) in February 2019 to 63% (11,705 patients) in February 2025.
- 60 Data that shows where patients are conveyed to indicates further opportunities to increase conveyance to destinations other than the Emergency Department. **Exhibit 6** sets out the destination for all conveyances.

Exhibit 6: conveyance destination as a proportion of total conveyance (March 2024 – February 2025)

Indicator	All-Wales position	Trend
% of patients conveyed to major emergency departments	88.7	
% of patients conveyed to minor injuries units	6.4	
% of patients conveyed to major acute medical admissions unit	3.1	
% of patients conveyed to other unit e.g. mental health or maternity unit	1.8	

Source: Ambulance Services Indicators

- 61 The overwhelming majority of conveyance continues to be to Emergency Departments. This is likely to be the most appropriate destination for many calls, which, are by their nature, urgent and/or life-threatening. However, our interviews with ambulance and health board staff suggest that barriers exist which inhibit ambulance crews from conveying patients to settings which may be more appropriate for their needs.
- 62 For example, conveyance rates to minor injuries units are consistently low. Part of the reason for this is that there is significant variation in opening hours and criteria for accepting referrals to the minor injuries units operating within and between health boards. As a result, those we interviewed stated that paramedics will tend to rely on Emergency Department conveyance. This reduces the risk that the patient will not be accepted by the minor injuries unit, which results in poor patient experience and inefficiencies in having to undertake additional transportation to the Emergency Department.
- 63 We also heard that some alternatives to the Emergency Department, such as direct referral to units within specialties can be reluctant to accept referrals from paramedics. This is due to the types of observations and tests paramedics can complete. These services would prefer for patients to be routed through the Emergency Department first.
- 64 However, data on conveyance to hospital following 999 calls from a care home is showing some signs of improvement. This rate decreased from a high of 64.8% in November 2023 to a low of 58.7% in September 2024. This suggests that some of the work the Trust is doing to support care homes, including by supplying lifting equipment or providing enhanced falls response services, is resulting in lower rates of conveyance to hospital.

Ambulance handovers

- 65 Data shows that ambulance handover delays continue to be at unacceptable levels. Only 16% of patients were handed over from ambulance crews to an Emergency Department within 15 minutes of arrival between March 2024 and February 2025, against a national target of 100%. This compares to 56% between March 2018 and February 2019. Under half (43.9%) of the patients conveyed to an Emergency Department were handed over within an hour during February 2025. The average time for patient handover in December 2024 was 2 hours, 12 minutes. In England, the average handover delay for December 2024 was 39 minutes.
- 66 These high levels of handover delay result in extremely high numbers of 'lost hours' where a paramedic crew is unable to respond to other calls within the community, with lost hours routinely over 20,000 a month during 2024. This roughly equates to between one quarter or one third of the available capacity of the ambulance service each month. Comparing lost hours for February 2025 with those in February 2019 shows a 235% increase. The lost hours in February 2025 equate to 1,597 12-hour paramedic shifts.
- 67 Research commissioned by the Association of Ambulance Chief Executives (AACE) states that patients experiencing delays of over one hour are much more likely to experience avoidable harm because of the delay they face. Using the modelling developed as part of that research, the Trust has estimated that 463 patients (3.5% of conveyed patients) came to severe harm because of long handover delays in February 2025.
- 68 Despite the Trust's increasing activity to avoid hospital conveyance by remote treatment, either over the phone or in person, data shows that there remains a significant amount of work to do to improve handover performance. Lack of available ambulances will also lead to higher attendance rates at emergency departments across Wales, as patients make their own way to hospital. Some of these patients may not have needed to go to the emergency department, but opportunities for paramedics to treat patients remotely (See and Treat) earlier in their patient journey are being missed due to handover delays.
- 69 Problems associated with handover delays are widely recognised. In March 2025, the Cabinet Secretary for Health and Social Services announced the establishment of a patient handover improvement delivery group. This group is intended to identify and oversee action aimed at improving ambulance patient handover performance, learning from UK-wide and international best practice. An update on the progress of this group's work is anticipated in July 2025.

Scrutiny and monitoring arrangements

- 70 This section considers whether the Trust is doing enough to monitor the performance of its urgent and emergency care services, and applying lessons learnt to improve services further. We were specifically looking for evidence of:
- arrangements for monitoring the impact of alternative clinical pathways; and
 - effective oversight and scrutiny of the delivery of plans for urgent and emergency care.

71 We found that **there is good oversight of performance and plan progress relating to urgent and emergency care demand which is informed by staff and patient feedback but is limited by lack of joined up data**

Monitoring impact

72 We found that **monitoring of plans is informed by regular staff and patient feedback, but without joined up data the Trust cannot monitor the effectiveness of referral pathways with certainty.**

73 The findings that have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: approach to monitoring the impact of alternative pathways on urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is the Trust tracking and reporting data to show whether patients are accessing urgent and emergency care services appropriately?	Partially	The Trust routinely tracks relevant data on demand, rates of signposting and referral to alternative services (consult and close) and rates of conveyance to hospital units, including Emergency Departments. However, Trust and health board information systems are not currently linked up to enable the tracking of an entire patient journey i.e. to confirm whether patients followed advice they have received.
Is regular patient feedback is being	Yes	The Trust captures patient feedback through regular CIVICA experience surveys ¹¹ . There are

¹¹ Civica Experience is a software which helps healthcare professionals collect and analyse data to turn patient feedback comments into insights.

Audit question	Yes/ No/ Partially	Findings
sought and used to inform and improve plans?		<p>surveys in place for 999, 111 and the Trust's falls service. These surveys capture patient responses to questions including their overall rating of the experience for the service they received, as well as more specific questions, such as whether patients intend to follow the advice they found on the 111 Wales website. The Trust recognises that response rates to these surveys are low, with 371 responses across each of those listed above between April and September 2024, and it continues to explore options to increase participation.</p> <p>Supporting appendices of the Trust's IMTP summarise patient feedback and concerns relating to services, including 111 and 999 services and links them to specific actions within the plan which aim to address those concerns and improve patient experience.</p>
Is there regular staff feedback on the impact of changes to services and pilots to identify and apply lessons?	Yes	<p>The Trust shows a commitment to hearing from staff, including via monthly WAST Live virtual staff meetings, surveys and bi-annual Chief Executive Officer roadshows held in ambulance stations and offices across Wales.</p> <p>Furthermore, the Trust involves trade union representatives in key working groups and each board committee, as well as through the Welsh Ambulance Service Partnership Team. These mechanisms provide a staff perspective during decision making.</p> <p>In January 2025, the Trust surveyed staff involved in delivering the Clinical Model Transformation Programme and the associated new initiatives. The survey asked staff for their views on the way in which changes have been implemented. The response rate was low at 17% (30 responses) and whilst overall scores were mostly positive, comments included concerns about the pressure caused by the pace and scale of the programme, as well as a need for more regular and meaningful staff engagement. The Trust is currently developing actions to respond to these concerns.</p>

Audit question	Yes/ No/ Partially	Findings
		Staff feedback and related actions to address areas of concern are also included within an appendix of the Trust's IMTP.

Source: Audit Wales

Oversight and scrutiny

74 We found that **there is regular operational and strategic oversight and scrutiny of the performance and the delivery of plans**

75 The findings that have led us to this conclusion are summarised in **Exhibit 8**.

Exhibit 8: approach to oversight and scrutiny of urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is there effective oversight of urgent and emergency care performance operationally, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	Yes	<p>The Trust provides operational oversight and scrutiny of its actions to improve demand management through its Clinical Transformation Board, and supporting workstreams, as well as its Integrated Strategic Planning and Development Group.</p> <p>These groups are supported by strong arrangements, including appropriate membership and regular frequency.</p> <p>The Trust continues to oversee and manage performance in line with its Quality and Performance Management Framework 2022-25. Operational performance is scrutinised at detailed levels by various operational, quality and planning subgroups before being collated and submitted for oversight and challenge by the Executive Leadership Team.</p>
Is there effective oversight of urgent	Yes	Performance information on the Trust's urgent and emergency care services is regularly

Audit question	Yes/ No/ Partially	Findings
<p>and emergency care performance at the committee and board level, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?</p>		<p>reported to the Performance and Finance Committee; the Quality, Experience and Patient Safety Committee; and the Board.</p> <p>In 2024, the Trust developed a patient harm mitigation scorecard. This provides a collective set of metrics to indicate the levels of harm that may be occurring as a result of system pressures. However, again this information is limited due to the absence of joined up information between the Trust and its commissioning health boards. As a result, the scorecard only indicates estimated levels of harm based on the AACE model.</p> <p>The Finance and Performance Committee and the Board are also responsible for overseeing the progress of the Trust's Integrated Medium-Term Plan.</p>

Source: Audit Wales

Appendix 1

Audit methods

Exhibit 9 sets out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 9: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: <ul style="list-style-type: none">• Integrated Medium Term Plan and appendices;• Corporate Risk Register and Board Assurance Framework;• Internal Audits;• Winter Plan; and• Clinical Model Transformation Stakeholder briefing document, September 2024.
Interviews	We interviewed the following: <ul style="list-style-type: none">• Executive Director of Operations;• Executive Director of Paramedicine;• Executive Director of Strategic Planning and Performance;• Director of Partnerships and Engagement; and• Assistant Director, Commissioning and Performance.
Group discussions	We held group discussions with the following: <ul style="list-style-type: none">• Advanced Paramedic Practitioners.
Observations	We observed the following meeting(s): <ul style="list-style-type: none">• Finance and Performance Committee; and• Board.
Data analysis	We analysed data relating to urgent and emergency care services, using the following sources: <ul style="list-style-type: none">• Ambulance Services Indicators;• Data provided from the Trust, including rates of consult and close and SDEC referrals;

Element of audit approach	Description
	<ul style="list-style-type: none"> • DHCW Urgent and Emergency Care Dashboard; • StatsWales; and • Data provided by Welsh Government in relation to GP out of hours services.
Website and practice reviews	We reviewed the Trust's website and social media accounts relating to the provision of information to the public on accessing urgent and emergency care services.

All audit work has been delivered in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) audit standards.

Appendix 2

Audit criteria

Exhibit 10 sets out the audit criteria that we used to deliver this work.

Exhibit 10: audit criteria

Audit questions	Audit criteria
Does the Trust have robust plans in place to manage the demand for urgent and emergency care services?	
Do plans seek to improve the management of demand through changes to service delivery in line with the six goals for Urgent and Emergency care?	<ul style="list-style-type: none">• Strategies and/or plans relating to urgent and emergency care:<ul style="list-style-type: none">– are based and grounded in rich and up-to-date information, informed by urgent and emergency care demand data (past and future), including peaks in activity at certain times/days and months, demographics, and conditions of patients.– identify and seek to address key risks associated with demand for urgent and emergency care services.– align with the plans of partner Health Boards.– align with the requirements of the Welsh Government Six goals for Urgent and Emergency Care for better managing demand.– include documented information on alternative clinical pathways, including how and when they should be accessed.
Do plans identify the current and required	<ul style="list-style-type: none">• Strategies and/or plans detail the:

Audit questions	Audit criteria
<p>levels of resource and staffing to achieve the ambitions?</p>	<ul style="list-style-type: none"> - resource requirements and identified funding to support any changes to service delivery included within the strategy/plan. - workforce and skills required to meet demand, including for changes in models of delivery such as winter peaks. The plan is clear about the required resources of clinical and non-clinical skills/staff.
<p>Are arrangements in place to encourage and enable people to access the right care, in the right place, at the first time, and are these working?</p>	
<p>Is the Trust effectively signposting urgent and emergency care services to the public, so they know how to access services appropriately?</p>	<ul style="list-style-type: none"> • The Trust provides clear information on available services and alternatives to emergency departments to the public through various avenues – websites, call handlers, posters/leaflets, advertisements, social media, videos etc. • Strategies and/or plans on public communication align to requirements of goals 2 and 3 of the WG Six goals for Urgent and Emergency Care (Right care, right place, first time) • There is evidence to suggest patients have a good understanding of how to access urgent and emergency care services that are appropriate to their needs
<p>Do staff have good knowledge of, and access to, information regarding the range of other services available to their patients and at what times they are available?</p>	<ul style="list-style-type: none"> • There is engagement between the Trust and health boards about alternative pathways in place and the future of urgent and emergency care services. Information on these pathways and services are accessible for staff. • Staff can refer directly / divert patients to more appropriate settings for their needs, including Minor Injury Departments, Urgent Primary Care Centres (UPCC) and Same Day Emergency Centres (SDEC).
<p>Is there evidence that changes to service delivery are resulting in</p>	<ul style="list-style-type: none"> • Referrals into new service models are in line with the ambitions of the six goals for urgent and emergency care policy handbook. • WAST can refer at least 4% of cases to SDEC.

Audit questions	Audit criteria
better demand management?	<ul style="list-style-type: none"> • Data indicates that there are increasing rates of See and Treat and Hear and Treat. • Calls to 111 are answered quickly and abandonment rates are low. • Emergency ambulance response times, ambulance handover delays and waits within Emergency Departments and Minor Injury Units are improving. • Data indicates that there are fewer amber calls requiring an upgrade to red due to lengthy response times. • Data shows decreasing volumes of patients with low acuity / minor complaints presenting at Emergency Departments. • Data indicates that calls diverted between 999 and 111/NHS Direct Wales are appropriate with low levels of calls diverted back and low numbers of re-contact rates.
<p>Is the Trust doing enough to monitor the performance of its urgent and emergency care services and apply lessons learnt to improve the services further?</p>	
Is the Trust monitoring the effectiveness of alternative clinical pathways, including by seeking feedback from staff and service users?	<ul style="list-style-type: none"> • The Trust tracks and reports data to show whether patients are accessing urgent and emergency care services appropriately. • The Trust can evidence that it seeks patient feedback regularly and uses it to inform and improve plans. • Regular feedback is sought from various staff on the impact of changes to services and pilots to identify and apply lessons
Is there effective scrutiny and assurance in relation to delivering plans for urgent and emergency care and alternative clinical pathways?	<ul style="list-style-type: none"> • There is effective oversight of urgent and emergency care performance operationally and at the committee and board level. This includes scrutiny and assurance on the effectiveness of the plans and actions being taken to better meet demand. Oversight and scrutiny are informed by comparative benchmarking and learning from other bodies where appropriate. • There are arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government. This includes establishing value for money and what difference the project has made.

Appendix 3

Management response to audit recommendations

Exhibit 11 sets out the Trust’s management response to the recommendations made because of this audit.

Exhibit 11: management response

Recommendation	Management response	Completion date	Responsible officer
<p>Accuracy of 111 Wales website</p> <p>R1 To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number (Paragraph 28).</p>	<p>The Trust accepts this recommendation. While WAST is not directly commissioned to manage the 111 Wales website, we fully support the need for accurate content to signpost patients safely. We routinely raise concerns, such as outdated references to NHS Direct Wales and will strengthen this by formally escalating issues through an agreed assurance route with Digital Health and Care Wales.</p> <p>A business case has been drafted to propose a new governance model with dedicated resources for oversight and content management to improve accuracy and ownership. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission.</p>	May 2026	Director of Digital Services

Recommendation	Management response	Completion date	Responsible officer
	<p>Website content accuracy will be a standing item at the monthly 111 Wales digital governance group. Over the next 12 months, issues will be actively monitored, and formal escalations logged to demonstrate progress and provide evidence of action taken.</p>		
<p>Directories of Service R2 To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories (Paragraph 46).</p>	<p>The Trust accepts this recommendation. We agree on the need for accurate and up-to-date service information. While WAST does not control the content provided by health boards, we maintain mechanisms to receive and manage this data. The recommendation is therefore best addressed through strengthened collaboration with health boards, who remain responsible for the accuracy of their service information.</p> <p>A business case has been drafted to improve Directory of Services (DoS) governance and support. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission.</p> <p>WAST will continue to update any content we own/publish into to the DOS and will escalate outdated information to relevant health boards. This will be monitored over 12 months, with escalations logged as evidence of action.</p>	<p>May 2026</p>	<p>Director of Digital Services</p>

Source: Audit Wales



Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.



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AGENDA ITEM No	14
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

GOVERNANCE REPORT

MEETING	Trust Board
DATE	31 July 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Alex Payne, Corporate Governance Manager Steve Owen, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report sets out where applicable the **Chair’s Action’s** taken since the last Board meeting and corresponding ratifications required, **use of the Trust Seal, decisions made in private session and any other governance matters.**

2. **Chair’s Action – Ratification**
The Board are asked to note the ratification made by Chair’s Action in the private session of the Board held on 29 May 2025 in respect of an approval of a contract award regarding Non-Emergency Patient Transport Services Vehicles. This is included here for transparency.

3. **Use of the Trust Seal**
The Trust Seal was applied on 26 June 2025 to the lease documentation for the new Dolgellau Ambulance Station building on Bala Road, Dolgellau. This relates to point 4.1 below.

4. **Decisions in Private Session**
The decisions made in private since the 29 May 2025 are as follows: -
 - 4.1 The approval of the affixing of the Trust seal to the lease to secure the Dolgellau Ambulance Station building, allowing for the commencement of works as soon as the Trust took possession of the building;
 - 4.2 The approval of the award of a contract in relation to work on the new Dolgellau Ambulance Station on 26 June 2025;
 - 4.3 The approval of the award of the conversion contract for Ambulance Care/ Non-Emergency Patient Transport Service Large Vehicles on 26 June 2025.



5. Other Governance Matters

Approval of the 2025/26 Annual Report and Accounts

5.1 The Board, on 26 June 2025, adopted and approved the Trust’s Annual Report and Annual Accounts for 2024/25 and approved the Trust’s Letter of Representation for 2024-25. Additionally, the Duty of Quality Annual Report 2024/25 was approved at this meeting of the board.

Welsh Ambulance Services Partnership Team Terms of Reference 2025/26

5.2 The Welsh Ambulance Services Partnership Team (WASPT) Terms of Reference (ToR) 2025/26 are included for Board approval. They were endorsed for Board approval at the WASPT meeting on 30 May 2025 and are being noted at the People and Culture Committee at its meeting in August.

6. RECOMMENDATIONS: The Board is asked to:

- 6.1 NOTE the ratification of the Chair’s Action in private session on 29 May 2025 and to NOTE the use of the Trust Seal which was applied on the 26 June 2025 to the lease documentation for the Dolgellau Ambulance Station;
- 6.2 NOTE the approval of the 2025/26 Annual Reports and Accounts for 2024/25 as detailed above and to NOTE the decisions made in private since the meeting held on the 29 May 2025;
- 6.3 APPROVE the Welsh Ambulance Services Partnership Team (WASPT) terms of reference for 2025/26, as endorsed at the WASPT meeting held on the 30 May 2025.

KEY ISSUES/IMPLICATIONS

Not applicable.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1: WASPT Terms of Reference 2025/26



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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	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA



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WELSH AMBULANCE SERVICES PARTNERSHIP TEAM (ADVISORY GROUP)

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2025-26

1. INTRODUCTION

- 1.1. The Trust's Standing Orders provide that *"The Trust may and where directed by the Welsh Ministers must, appoint Advisory Groups to the Trust to provide advice to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so"*.
- 1.2. In line with Standing Orders the Board shall nominate annually a committee to be known as the Local Partnership Forum, herein referred to as the **Welsh Ambulance Services Partnership Team (WASPT)**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

- 2.1. WASPT is the forum where the senior leaders, trade union partners and professional organisations work together to improve the Trust's services for the people of Wales. It is the principal partnership forum for the discussion of national priorities and strategies and where key stakeholders will engage with each other to inform, debate, and seek to agree priorities on workforce and health service issues.
- 2.2. WASPT will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply.



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- 2.3. Members will work in partnership, including:
- Showing joint commitment to the success of the organisation with a positive and constructive approach
 - Recognising the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
 - Demonstrating commitment to employment security for workers and flexible ways of working
 - Sharing success – rewards must be felt to be fair
 - Practising open and transparent communication – sharing information widely with openness, honesty, and transparency
 - Bringing effective representation of the views and interests of the workforce
 - Demonstrating a commitment to work with and learn from each other
 - Take account of social partnership duties in the Social Partnership and Procurement (Wales) Act 2023
- 2.4. The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.
- 2.5. The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.
- 2.6. In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this committee will adopt a long-term perspective in its deliberations and decisions. The committee will consider the broader implications of its actions,



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particularly in relation to the three wellbeing objectives established by the trust in order to contribute positively to the wellbeing of future generations. These objectives are: 1) being a socially responsible and inclusive employer, 2) fostering an innovative and sustainable organization, and 3) ensuring we are a proactive, accessible, and equitable care provider.

3. DELEGATED RESPONSIBILITY

WASPT will:

- 3.1 Establish a regular and formal dialogue between WAST management and trade union partners on strategic issues affecting the workforce and provide opportunities to input into organisational strategy and service development plans at an early stage.
- 3.2 Consider the implications on staff of service reviews and identify and agree new ways of working where required to deliver the service effectively.
- 3.3 Consider the implications for staff of NHS organisational change at a national level and to work in partnership to achieve mutually successful implementation.
- 3.4 Consider and discuss the Trust's services, activity and financial performance and the role of WASPT in improving performance and value for money.
- 3.5 Take account of, consider and communicate key decisions taken by the Board and senior management.
- 3.6 Develop and maintain in partnership appropriate facilities arrangements using Agenda for Change Facilities Agreement as a minimum standard.
- 3.7 Discuss and resolve escalations from sub-groups



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4. AUTHORITY

- 4.1. WASPT as an advisory group supports, advises and challenges on matters of partnership working at a strategic level. Whilst decisions on a range of issues will be made by WASPT relating to consultation, negotiation, next steps and communication, all decisions that have financial, performance, and workforce consequences must be made with reference to the authorities set out in the Standing Orders and its annexures, in particular the Scheme of Reservation and Delegation ('SoRD') which details where decisions are reserved to the Board and where they may be delegated to Executives. Table A of the SoRD details the non-financial delegations and Table B details the financial delegations to Directors and Officers. The SoRD can be found on the Trust [website](#).

Chair's Action

- 4.2. There may, occasionally, be circumstances where decisions which would normally be made by the group need to be taken between scheduled meetings, and it is not practicable to call a meeting of the group.
- 4.3. In these circumstances, the Co-Chairs may deal with the matter on behalf of the group after first providing, where possible, three clear days to for members to consider the decision by way of email circulation.
- 4.4. The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

- 4.5. WASPT may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of its business. Formal sub-committees may only be established with the agreement of the Board.



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- 4.6. Sub-committees shall report regularly to WASPT by way of a highlight report clearly indicating areas of escalation.

5. MEMBERSHIP AND QUORUM

Members

Membership of WASPT is proposed to be kept as small as possible to ensure its focus on strategic issues. A clear sub-structure for resolving issues at a local level and escalations will be put in place to support this. Membership is proposed as follows:

- 5.1. Management membership will be as follows:
- Chief Executive (management Chair)
 - Director of People
 - Executive Director of Operations
 - Executive Director of Strategy, Planning and Performance
 - Executive Director of Finance and Corporate Resources
 - Executive Director of Paramedicine
 - Director of Partnerships and Engagement
 - Director of Corporate Governance/Board Secretary
- 5.2. Trade Union Partner membership shall consist of 12 members, representing the four recognised Trade Unions (GMB, RCN, Unison and Unite). Trade Union Partner membership will collectively represent all major work groups and professional bodies at WAST.
- 5.3. WASPT shall have joint Chairs who will work in partnership and rotate the role each meeting. Joint Chairs shall ensure that key and appropriate issues are discussed by members in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.
- 5.4. The joint Chairs may extend invitations to other staff representatives, Directors and/or Senior Managers, and to officials (including full time officers) from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.



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- 5.5. All members must:
- Engage with and fully contribute to WASPT's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
 - Prepare fully for the meeting by reviewing any papers provided;
 - Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes;
 - Promote the work of WASPT within the directorate, Trade Union and/or professional discipline they represent.
- 5.6. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement members must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that they are unable to attend and the name of the member who will attend as the substitute.
- 5.7. The arrangements under which staff are allowed time off to attend meetings of the group and reimbursed expenses incurred in attending such meetings are set out in the agreed Policy on Recognition of and Facilities for Trade Unions.

Quorum

- 5.8. At least 50% of the management members and 50% of the Trade Union Partner members must be present to achieve a quorum.

Member Appointments

- 5.9. WASPT membership shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the group's remit, and, subject to any specific requirements or directions made by the Welsh Government. Membership will be reviewed by the Trust Chair annually.
- 5.10. Trade Union Partner membership (including the Chair) will be drawn from the elected staff side.



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- 5.11. It is intended that the majority of membership will be consistent to allow for continuity of discussions and ease of communication, other than when a deputy is required under the provisions in paragraph 5.6. Where a member does not attend for three consecutive meetings the joint Chairs may seek an explanation from the member and where necessary the replacement of the member.

6. COMMITTEE MEETINGS

Secretariat and Support to WASPT

- 6.1. The Director of Corporate Governance/Board Secretary, on behalf of the joint Chairs, shall:
- (a) Arrange the provision of advice and support to members on any aspect related to the conduct of their role;
 - (b) Facilitate the effective conduct of Trust business through meetings
 - (c) Provide the secretariat function to WASPT;
 - (d) Ensure members have the right information to enable them to make informed decisions and fulfil their responsibilities;
 - (e) Ensure that in all its dealings, WASPT acts fairly, with integrity, and without prejudice or discrimination;
 - (f) Monitor the group's compliance with its terms of reference
- 6.2. The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub-committees established.

Frequency of Meetings

- 6.3. Meetings shall be held no less than bi-monthly or as the joint Chairs deem necessary.
- 6.4. Due to the sensitivity of the issues being discussed, meetings shall be held in private session with the public and press excluded.



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Withdrawal of individuals in attendance

- 6.5. The Chair may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of particular matters.

Conflicts of Interest

- 6.6. Members must disclose all conflicts of interest in line with the Standing Orders and the Trust's standards of business conduct policy. Members may be asked to recuse themselves from all or part of discussions where a conflict is deemed to exist.

7. OPERATING ARRANGEMENTS

Agenda Setting

- 7.1. The joint Chairs shall meet with the Director of Corporate Governance/Board Secretary at least 5 weeks before a meeting to set the agenda which will be circulated to members within 5 working days of that meeting.
- 7.2. Changes to agenda shall only be made with the agreement of both joint Chairs.
- 7.3. Any items of 'other business' must be notified to the joint Chairs ahead of each meeting so that appropriate time can be provided for in the meeting for discussion.

Papers and timetables

- 7.4. The presentation of items on the agenda should be accompanied by sufficient information for WASPT to make a determination on that item. Where an SBAR is not possible due to operational pressures, a shortened template will be developed.



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- 7.5. Every effort will be made to share the agenda and key papers in time for Trade Union Partners to consider them ahead of any pre-meeting discussions. The final agenda and papers will be issued at least seven calendar days before the meeting, unless otherwise agreed by the joint Chairs. Trade Union Partners will also make best efforts to hold their pre-meeting within that seven-day period where possible.

8. REPORTING AND COMMUNICATION

Reporting

- 8.1. WASPT shall report into the People and Culture Committee of the Board as that Committee has the responsibility to provide advice and assurance to the Board on all matters relating to partnerships and engagement relevant to the remit of the Committee, including but not limited to trade unions, external organisations and staff communications.
- 8.2. Notwithstanding that the Standing Orders provide that WASPT's main link with the Board is through the executive members of the group, the joint Chairs shall prepare a AAA (alert, advise, assure) highlight report to the People and Culture Committee within 14 days of each WASPT meeting setting out any areas of escalation and key issues discussed. In turn, the People and Culture Committee will report such work in their highlight report to the Board. A copy of the AAA report will be distributed to the WASPT membership once approved by the Joint Chairs.

Minutes

- 8.3. Minutes will be prepared of each meeting in addition to the AAA report and presented to the Joint Chairs within 14 days of a meeting for review and approval.

Annual Report

- 8.4. WASPT shall submit an annual report to the Board through the Chair of the People and Culture Committee within three months of the end of the reporting year setting out its activities during the year and detailing the



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results of a review of its performance and that of any sub-Committee it has established.

Communication

8.5. The WASPT AAA highlight report will be used to communicate the work of the group to the organisation more widely. This is in keeping with the Standing Orders that requires advisory groups to report regularly on its activities to those whose interest they represent.

8.6. The Chair of the Trust Board shall meet with the Joint Chairs on a regular basis to discuss the WASPT activities and operation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Trust’s Standing Orders are equally applicable to the operation of WASPT, except in the following areas:

- Quorum
- Meeting in private session
- Reporting to the People and Culture Committee

10. REVIEW

These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

11. VERSION CONTROL TABLE

Version Number	Change	Author/ Reviewer/ Approver	Date
1.0	Terms of Reference and Operating Arrangements for Welsh Ambulance Partnership Forum (WASPF)	WASPF	TBD
1.1	Terms of Reference for	WASPT	15 November



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	reconstituted Welsh Ambulance Services Partnership Team (WASPT). Revised format and wording review approved		2022
2.0	Terms of Reference for reconstituted Welsh Ambulance Services Partnership Team (WASPT) – amendment sought to para 3.4	People and Culture Committee –	29 November 2022
2.1	Terms of Reference amendment to par 3.4 approved	WASPT	20 January 2023
2.1	Terms of Reference for reconstituted Welsh Ambulance Services Partnership Team (WASPT)	Trust Board – Approval	30 March 2023
3.0	<ul style="list-style-type: none"> 4.2 – removal of reference to review of trade union partner numbers in membership. However, trade union partner Chair will review membership to ensure that it is representative as far as possible of all major work groups and professional bodies at WAST as per the Terms of Reference. 5.2 – it had been anticipated that meetings might change to quarterly following the establishment of the local partnership forums, however following feedback from the survey it is agreed that meetings will be retained on a bi-monthly cycle. 	WASPT	19 February 2024



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	<ul style="list-style-type: none"> 7.3 – codifies the position with respect to minute taking and aligns to the timetable for Board and Committee drafts. 		
3.0	As above	Trust Board – Approval	30 May 2024
4.0	<p>TBC changes as agreed at WASPT on 28/3/25</p> <ul style="list-style-type: none"> Addition of duties related to the Wellbeing of Future Generations Act and the Social Partnership and Procurement Act. Amended wording on publication of papers Addition of the authority for Chair’s Actoin 	WASPT agreement	28 March 2025
4.0	Changes as above	Trust Board – Approval	31 July 2025

REMUNERATION COMMITTEE TO PUBLIC TRUST BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. Meetings of the Remuneration Committee are held in private session.

Trust Board Meeting Date	31 July 2025
Committee Meeting Date	3 June 2025
Chair	Colin Dennis

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Key issues/risk for the Board's attention)

1. No alerts from this meeting.

ADVISE

(Areas of on-going monitoring, approvals, decisions, or new developments to be communicated)

2. Following a formal job evaluation by Welsh Government (WG), **the roles of Executive Director of Paramedicine and Executive Director of Quality and Nursing have been re-banded** to ESP 14 and ESP 13 respectively, effective 01 June 2025. This reflects the expanded scope and responsibilities of both roles.

The Committee approved the new bandings and noted the associated cost pressures, as well as the potential implications for the wider Executive Leadership Team. Ongoing engagement with WG on senior post remuneration continues, with broader NHS Wales outcomes still pending. The Trust remains mindful of risks around fairness, retention, and market competitiveness during this period and it was agreed that the committee chair would escalate the issue further with WG.

At the 15 May 2025 extraordinary meeting a movement to the top of the banding (then Band 11) for the Executive Director of Paramedicine was approved, and a retention payment of £6,719 endorsed subject to WG approval. As a result of the current job evaluation however the previously endorsed retention payment for the Executive Director of Paramedicine role is no longer required.
3. The **recruitment process for the Chief Executive Officer (CEO)** post is now underway, with executive search agency GatenbySanderson appointed. The process has been designed to align with the current CEO's departure, ensuring a smooth transition. Key milestones include advert closure on 16 June, preliminary interviews on 18–19 June, shortlisting on 24 June, and final selection on 8–9 July 2025. The

selection process will include stakeholder engagement, a media exercise, and a formal panel interview chaired by the WAST Chair.

The CEO role remains evaluated at ESP Band 16. The Committee approved the remuneration and delegated authority to the selection panel to appoint within the pay scale. Any appointment outside this range would require further approval from the Remuneration Committee and WG. Weekly progress reviews are in place, and further updates will be provided as the process advances.

- The committee retrospectively endorsed two £20,000 **settlement agreements** with two former employees, following Employment Tribunal claims for unfair dismissal and disability discrimination. The settlements, negotiated without prior required approvals due to an internal oversight.

ASSURE

(Areas of assurance the Committee has received)

- The Committee reviewed the **CEO's outturn position for 2024/25**. The CEO's objectives for 2025/26 will be established once the new CEO has been appointed and has met with the Chair to discuss and set these objectives. These objectives will be drawn from those issued by CS-HSSG to the Chairman and following this meeting, the objectives will be shared and communicated to the relevant Executive Leadership Team as appropriate. The Committee noted the outturn position for 2024/25 was consistent with discussions held throughout the year. Jason was commended by members on his leadership, courage and commitment to transformational change against the backdrop of risk in the system.
- WG has accepted the **2025/26 NHS Pay** Review Body and Doctors' and Dentists' Review Body recommendations, confirming a 3.6% consolidated uplift for Agenda for Change staff and a 4% uplift plus £750 for Resident Doctors, effective from 1 April 2025. Reform proposals around job evaluation, locally employed doctors, and community dental services are expected in due course. No decision has yet been made on pay for Executive and Senior Posts (ESP), which will require future Remuneration Committee approval once communicated.
- The **board member annual eligibility checks** are set out in the Trust's Standards of Business Conduct Policy and require all Board Members (voting and non-voting) to declare their ongoing eligibility. Members were assured this is completed, with some elements of the annual reviews, particularly appraisals, being completed in June.
- The Committee's **cycle of business monitoring report** was received with no issues to escalate.

RISKS

Risks Discussed: N/A

AGENDA

JESP update for JDs for Executive Director of Paramedicine and Executive Director of Quality and Nursing

Process for appointment of CEO



CEO objectives outturn position 2024/25 and 2025/26 objectives	Update on 2025/26 pay award for NHS Staff
Retrospective settlement of employment tribunal claims	Annual board eligibility checks 2024/25
Committee cycle of business	AAA report from 15 May

COMMITTEE ATTENDANCE				
Name	15 May 2025 ¹	3 June 2025 ²		
Colin Dennis				
Rhiannon Beaumont Wood				
Peter Curran				
Bethan Evans				
Prof. Hayley Hutchings				
Ceri Jackson				
Hannah Rowan				
Jayne Beeslee				
Jason Killens				
Carl Kneeshaw				
Trish Mills				
Hugh Parry				
Damon Turner				

	Attended
	Sent Deputy
	Apologies
	No longer a member.

¹ Extraordinary meeting

² Jason Killens was recused for the discussion on the CEO's outturn position for 2024/25

REMUNERATION COMMITTEE TO PUBLIC TRUST BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. Meetings of the Remuneration Committee are held in private session.

Trust Board Meeting Date	31 July 2025
Committee Meeting Date	11 July 2025
Chair	Colin Dennis

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Key issues/risk for the Board's attention)

1. No alerts from this meeting.

ADVISE

(Areas of on-going monitoring, approvals, decisions, or new developments to be communicated)

2. The Committee reviewed and approved the recommendations for the **appointment of an external candidate to the role of Chief Executive Officer (CEO)** and the **appointment of Rachel Marsh as Interim CEO**, effective 19 July 2025. These recommendations were made by the recruitment panel.
3. The Committee noted that immediate communication would be issued to all Trust colleagues regarding the outcome. The name of the selected candidate will be disclosed upon the completion of due diligence checks.

ASSURE

(Areas of assurance the Committee has received)

4. There were no items from this meeting.

RISKS

Risks Discussed: N/A



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AGENDA

Chief Executive Officer Appointment

ESP Pay Review

COMMITTEE ATTENDANCE

Name	15 May 2025 ¹	3 June 2025 ²	11 July 2025 ³	
Colin Dennis				
Rhiannon Beaumont Wood				
Peter Curran				
Bethan Evans				
Prof. Hayley Hutchings				
Ceri Jackson				
Hannah Rowan				
Jayne Beeslee				
Jason Killens				
Carl Kneeshaw				
Trish Mills				
Hugh Parry				
Damon Turner				

	Attended
	Sent Deputy
	Apologies
	No longer a member.

¹ Extraordinary meeting

² Jason Killens was recused for the discussion on the CEO's outturn position for 2024/25

³ Extraordinary meeting



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QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

The papers for this meeting can be found by following this [link](#) to the Committee page on the Trust website.

Trust Board Meeting Date	26 June 2025
Committee Meeting Date	13 June 2025 – Extraordinary Meeting
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Nil

ADVISE

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

2. The committee held an extraordinary meeting to receive the **2024/25 Duty of Quality Annual Report** for endorsement ahead of approval at Trust Board on 26 June 2025.
3. The report ensures the requirements of the Duty of Quality statutory guidance 2023 are met and describes the Trust's compliance against the duty itself and its ambition for the years ahead. The annual report summarises the Trust's quality improvement progress across the 12 Health and Care Quality Domains during 2024/25; noting progress to improve the quality of our services and population outcomes and sets out the Trust's intentions for 2025/26.
4. The critical role of digital data was emphasised with the focus on building strong foundations for digital and data capabilities which are essential for supporting clinical practice and transformation. There is a plan to promote and make Equality, Diversity and Inclusion related intelligence more accessible through the duty of quality web page.
5. The launch of the Quality Hub and new tools like Simply Do and Life Qi will support improvement journeys, planning, and reporting and highlights that these initiatives are part of the effort to build QI capacity across the Trust. A key focus for the next year is on local and national partnership, collaboration and co-production.



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6. The Committee noted that whilst the Duty of Candour reporting will be incorporated into the Annual Putting Things Right Report for 2024/25, which will be published in October, the Duty of Quality report content is aligned with this activity as it helps the Trust hear the citizen's voice and produces opportunities to learn and drive improvement. The annual report has been produced using Sway to ensure the Trust meets its accessibility requirements when published on the website.
7. Four annexes to the report provide additional context and documentation related to the Duty of Quality Annual Report and statutory guidance.

ASSURE

(Detail here any areas of assurance the Committee has received)

8. Nil.

RISKS

9. Nil.

COMMITTEE AGENDA FOR MEETING

Duty of Quality Annual Report 2024/25		
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COMMITTEE ATTENDANCE

NAME	9 MAY 2025	13 JUN 2025	5 AUG 2025	4 NOV 2025	3 FEB 2026
Bethan Evans (Chair)					
Ceri Jackson					
Rhiannon Beaumont-Woods					
Liam Williams					
Andy Swinburn					
Lee Brooks	Peter Brown				
Rachel Marsh					
Jonny Sammut	Keith Williams				
Trish Mills		Juile Boalch			
Mark Marsden					
Hugh Parry					
Henry Garrard					

	Attended
	Deputy attended
	Apologies received
	No longer member



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AUDIT, RISK AND ASSURANCE COMMITTEE HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	31 July 2025
Committee Meeting Date	24 June 2025
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The **2024/25 Audited Financial Accounts** were presented and endorsed for approval by the board. Audit Wales were in attendance. The committee noted:
 - Total income was £325.2 million, with a corresponding expenditure, resulting in the break-even position. Key balance sheet items included a small reduction in debtors, a decrease in cash in bank, and a reduction in creditors. The capital expenditure limit was met with a spend of £20.5 million.
 - Audit Wales reviewed the accounts and provided their opinion. They noted the accounts were prepared in accordance with the required standards and provided a true and fair view of the Trust's financial position. A minor adjustment was noted regarding the treatment of benefits in kind for non-executive directors, which would be included in the final version of the accounts. The accounts were found to be robust and compliant with the relevant standards. The detailed work by the finance team was acknowledged and appreciated.

2. The **ISA 260** was presented by Audit Wales and the committee noted:
 - Audit Wales intends to issue an unqualified (clean) audit opinion on the accounts, subject to receiving the signed letter of representation.
 - The materiality for the audit was updated to just over £3.2 million, with a clearly trivial threshold of £163,000. Certain areas, such as the remuneration report and related party disclosures, had lower materiality levels due to their sensitivity.
 - No significant issues were identified during the audit. Some misstatements were corrected by management, but none impacted the final figures in the accounts. The corrected misstatements included adjustments to expenditure and income, reclassification within trade and other payables,



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updates to the contingent liabilities note, and inclusion of omitted related party transactions.

- The standard letter of representation was requested to be signed by the Trust Board, with no additional wording required.
 - Audit Wales emphasised the compliance with ethical standards during the audit and thanked the finance team for their cooperation and improvements from the previous year.
3. The **2024/25 Annual Report** was presented and endorsed for board approval. The committee noted:
- The annual report consists of two parts: the performance report and the accountability report, developed in accordance with the Welsh Government Manual for Accounts.
 - The board had an opportunity to review the report in draft form previously and it has undergone scrutiny by Audit Wales and Welsh Government.
 - There are plans to start the report preparation earlier next year to streamline the process and reduce duplication. There is also an intention to coordinate with other end-of-year reports and consider creating an easy-read version for better accessibility.
 - All those involved in the development of this substantial report, showcasing the excellent work of the Trust in 2024/25 was recognised and commended.
4. A **non-compliance with Standing Orders** was reported and is brought to the board's attention. This related to the approval of settlement agreements for two employees in respect of Employment Tribunal cases. Due to an internal oversight, approval in each of these cases was not sought from the Chief Executive, Remuneration Committee or Welsh Government prior to entering into settlement negotiations. Retrospective approval was provided by the Remuneration Committee at its 3 June 2025 meeting. Adjustments have been made to internal controls to avoid future issues.
5. There was one **limited assurance internal audit** presented (Start of Shift Procedure – see paragraph 12).

ADVISE

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

6. A **pre-meet** was held with Audit Wales, Internal Audit and the committee Chair ahead of the meeting.
7. The **No PO No Pay Policy** was received and will be presented to the Finance & Performance Committee for approval in line with the separate delegations set out in the Terms of Reference for financial policies and those for financial procedures. The national policy changes are intended to enhance compliance and streamline processes.



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8. Members **reflected** that the high standard and quality of work and presentations reflect the professionalism and dedication of the staff involved. Members emphasised the importance of collaborative effort and the professionalism demonstrated by all participants, highlighting the effective teamwork across different roles and departments. They acknowledged the difficulty in achieving a balance between detail and conciseness in the reports and congratulated the team for striking this balance effectively, making the reports both comprehensive and accessible.

ASSURE

(Detail here any areas of assurance the Committee has received)

9. The Audit **Wales** update report was received. The 2025/26 Structured Assessment brief has been agreed and work is underway, with the deep dive for 2025/26 being a review of the arrangements to manage estates (due to be reported in March 2026). The 2024/25 deep dive review of investment in digital systems to support service resilience and transformation is due to be reported to ARAC in November.
10. The **WAST Urgent and Emergency Care – Arrangements for Managing Demand** report was presented by Audit Wales and will be before the board at its July meeting. The UEC work by Audit Wales examined different aspects of the urgent and emergency care system in three parts:
- Part One: Flow out of hospital (not applicable to the Trust)
 - Part Two: accessing urgent and emergency care (this report)
 - Part Three: national arrangements and leadership structures

The committee heard that the report highlighted the positive changes made by the Trust in managing urgent and emergency care demand, but members acknowledged the importance of collaboration with Health Boards to address systemic challenges and improve patient outcomes, expressing concern about the number of patients coming to harm due to handover delays and the need for urgent action. Members noted the need to consider a formal engagement plan to enhance communication and coordination within the wider system and noted the ongoing challenge of fragmented data systems, stressing the need for integrated data to have full visibility of patient pathways. The Committee noted the issue of Health Boards' legal responsibility to trigger the Duty of Candour for patients harmed by handover delays and that the triangulation of the data available could inform future audit activities.

11. The **2024/25 Head of Internal Audit Opinion** was received, and the committee commended the reasonable assurance rating, meaning that the Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Members were assured that sufficient audit work was undertaken during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards. The Head of Internal Audit Report is attached at **Annex 1**, and the board will note there were two substantial assurance audits, 13 reasonable with assurance, and four with limited assurance. Additionally, there was one advisory review. All service performance indicators for 2024/25 were green and members commended both management and Internal Audit for this achievement and for fostering strong, collaborative working relationships.



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12. The following Internal Audit reviews were completed during the quarter and presented to the Committee. Members reviewed the action plans that accompanied the audits and were assured (subject to a clarification on the seasonable forecasting and modelling audit) they were appropriate and timely. There is one review that was slightly delayed (111 Wales Website) which is in draft and will be presented to the next meeting:

- **Start of Shift Procedure – Limited Assurance.** The purpose was to assess compliance with the Shift Start and Finish Standard Operating Procedure (SOP), including the preparation of vehicles and to ensure that key equipment and medicines are available.

The SOP sets out an agreed process for staff during the commencement and completion of operational shifts, which includes coverage to comply with the requirements of the Road Traffic Act 1998. These arrangements exist to ensure increased efficiencies at the commencement of each shift and clearly set out the requirements that should be followed by staff when they start their shift.

The existing vehicle accident management task and finish group will be expanded to address the findings from this audit, given the correlation with the vehicle daily inspection forms. Members heard that vehicle checks are being done, but improvement was needed on the recording and reporting thereof. The task and finish group will work on an alternative system for recording and reporting. Time constraints and the immediate need to respond to calls were identified as barriers to recording checks. The task and finish group will explore solutions to improve efficiency.

One objective was classified as substantial assurance (staff book onto the MDT immediately at the commencement of shift), two as reasonable, and three as limited. Two high and three medium priority management actions were raised. The Finance and Performance Committee has an oversight of the audit actions and will receive this report at its July meeting.

- **Follow Up Audit 2024/25 – Reasonable Assurance.** The purpose of this review was to provide assurance on the status of implemented recommendations on the audit tracker and review the systems and arrangements the Trust has in place to monitor progress with the implementation of actions.

Whilst there was a need to seek further evidence of closure for some actions during the review, testing confirmed that 18 of the 18 recommendations tested as part of the review were appropriately classified as complete on the tracker. The Trust's closure rate in quarter 3 2024/25 of 67.9% is higher than the All-Wales average of 65.1%. There were no recommendations made as part of this review. There will be a new approach to this annual follow up audit in 2025/26, with the review taking place throughout the year.

- **Contract Management – Advisory Review (therefore no rating applied).** The purpose of this review was to assess whether appropriate contract management arrangements were in place within the Trust. This was an all-Wales review and compared the appropriateness of contract management arrangements across eight health bodies, with common issues and challenges noted.



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The Trust used this opportunity to assess its own contract management practices, and to develop a centralised contract register in readiness for the audit - the only health body to do so. While a centralised contract management system will not be pursued due to resource implications, the review identified strong pockets of good practice in higher-risk areas. For example, the Digital Directorate has a well-defined supplier contract SOP, and the Finance & Corporate Resources Directorate maintains a comprehensive capital contracts register. These areas demonstrated more advanced and structured contract management processes, reflecting their financial and reputational risk exposure.

The report also highlights the significant role of NWSSP Procurement Services in supporting all-Wales improvements. NWSSP is expected to lead on the development of consistent guidance, training, and education to strengthen contract management capabilities across NHS Wales bodies. In the meantime, a joint Siren Notice from the Finance and Corporate Governance Directors will reinforce key principles locally, including the need for designated contract managers, directorate-level registers, and clear reporting and escalation mechanisms.

ARAC noted these local actions and the continued collaboration with NWSSP on centralised improvements and will revisit this in nine months' time.

- **Seasonal Forecasting and Modelling – Reasonable Assurance.** The purpose was to assess the Trust's approach to forecasting and modelling, including a focus on winter resilience planning.

A forecasting and modelling group, established during the COVID-19 pandemic, has become a permanent fixture, coordinating activities across the trust. Management acknowledged the findings and noted that while the structures and culture are strong, the processes need improvement. The desire to have a written framework and SOPs was discussed to ensure the quality and reliability of forecasting and modelling outputs, as well as the need to formalise the analysis of actual performance against forecasted models, which is currently done informally. Further clarity was sought by members as to whether further managerial capacity is required to address the recommendations fully and this will be revisited in September.

Two objectives in the audit were rated reasonable assurance and one limited. Seven medium priority recommendations were raised. The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.

- **Emergency Nurse Communications System Implementation (ECNS) – Reasonable Assurance.** The purpose was to provide assurance that benefits realised reflect those identified at the outset of the ECNS implementation.

A significant backlog of audits was noted, with over 400 audits pending completion. An uplift of six auditors is expected in Q2 to address this backlog. There were discrepancies in monitoring tools and a lack of routine audits for clinicians, with 44% not receiving monthly audits as expected. No post-implementation review had been conducted, resulting in the absence of an evaluation of benefits realized and identification of lessons learned. There was no evidence of escalation of ECNS non-compliance, which could impact the trust's accreditation status. Reporting arrangements have been refreshed but need time to mature. Management acknowledged the findings and noted that the uplift in auditors and improved processes will address many of the key findings. Members were assured that the benefits of ECNS were realized



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upon implementation and that the project plan pathway framework and templates will help ensure consistent benefits realization and monitoring across projects.

The need for formal evaluation and post-implementation reviews has been a common theme in previous audits, highlighting the importance of pausing to assess the effectiveness and benefits of projects. Oversight of these audit actions are with the Finance and Performance Committee, who are requested by ARAC to discuss further the role that committee has in monitoring the process of such evaluations in the Trust.

Three objectives were rated reasonable assurance, with two being limited. The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.

- **Capital Systems – Reasonable Assurance.** The audit was focused on the selection, appointment and contractual arrangements applied at Capital and Estates projects. The audit provided substantial assurance for value for money, indicating effective use of resources in capital projects

The audit reviewed the control framework, systems, and processes in place to manage discretionary EFAB and other capital estates funded schemes. While several processes support capital project progression, they are not fully documented, affecting consistency and standardization, and there was a lack of evidence for declarations of interest and non-collusion, particularly from shared services procurement office. One project lacked a signed contract, and contract amendments were not consistently annotated as accepted by both parties. The retention period within the NHS Wales Records Management code of practice is insufficient to cover the liability period for contracts executed as deeds.

Similar reviews at other NHS Wales organizations revealed consistent issues with declarations of interest, non-collusion, and contract retention periods. Management acknowledged the findings and emphasised the need for improved processes with shared services procurement. Actions are in place to address the identified issues. The audit findings will be shared with shared services procurement to ensure compliance and mitigate risks. The policy is due for review in July, and the findings will be reiterated in the updated version.

Two objectives were rated reasonable and one substantial (value for money). The Finance and Performance Committee has oversight of the audit actions and will receive this report at its July meeting.

13. The Trust continues to progress its **Integrated Governance Programme**, which aims to streamline and unify governance structures and practices from 'floor to board'. Following the initial framework and tiering principles presented to ARAC in March 2025, the programme has moved into its next phase, focusing on practical tools and cultural improvements to enhance governance consistency, clarity, and accountability across the organisation.

Key deliverables for 2025/26 include standardised templates and guidance for board and committee papers (Q1), meeting etiquette and a house style for minutes (Q2), an Accountability, Assurance and Governance Handbook (Q3), and the introduction of AI tools to support governance processes (Q4). The programme builds on strong foundations established through previous structured assessments



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and committee effectiveness reviews, with further assurance updates scheduled for December 2025 and March 2026. Members are asked to note progress and the planned timeline for deliverables.

14. The **Losses and Special Payments** were reviewed for the period from 01 April – 31 May 2025 and noted as being -£1.248 million. The total net losses and special payments made during the period 01 April 2024 to 31 March 2025 amounted to £0.668. The committee acknowledged the importance of learning from these incidents to prevent future occurrences and emphasised the need for robust processes to manage and mitigate such losses.

15. The committee received the **Q4 2024/25 Audit Tracker update**, noting strong progress with 51% of internal audit actions closed 0 up from 27% in Q3, and 89% of remaining actions scheduled for closure by September 2025. Revised deadlines have decreased, and the ELT has removed the option for third extensions. 85% of external audit actions were also closed. One ARAC-related action remains open, due by Q2.

Four actions remain open from the 2023/24 Electronic Patient Clinical Records (ePCR): Clinical Compliance internal audit and are on their third and final date. These actions, originally assigned to the Clinical Directorate, were transferred in March 2025 to the Digital Directorate. They relate to training validation, competency testing, module engagement, and data structure improvements. While interface enhancements have been made, clinician feedback highlighted usability issues, prompting the development of a new learning module. A review meeting between the Digital Directorate and Internal Audit was held just prior to this committee meeting with some deadline extensions and reframing of actions for the committee to review in September.

16. The Committee's **cycle of business monitoring report** was reviewed with no matters to escalate. Its priorities are on track.

17. In private session the Committee received **the Local Counter Fraud Service Annual Report** for 2024/25, the update report and work plan for 2025/26. The annual report and workplan for 2025/26 were approved by the committee. **The tender update and single tender awards** were also received, as was the audit tracker related to the Technical Resilience and Cyber Security Internal Audit recommendations.

RISK MANAGEMENT

18. The risk report was received which describes key elements of the **2025/26 risk management work programme** for committee's oversight. Members were assured in respect of the **Trust's principal risks** with no material changes this period. The full Board Assurance Framework (BAF) is available in the reading room.

19. The discussion primarily focused on the **repositioning of Risks 223 and 224** which separates the controls, assurances and gaps into internal and external themes and categories. There are plans to score the effectiveness of internal controls and assurances, which have been mapped against the three lines of assurance, and to introduce internal and external risk scores to demonstrate the impact of actions taken to mitigate the risk. Members were assured about the new approach, which supports the early identification of any gaps, and any escalations required, and which has already supported more



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focused discussions on Risk 223 particularly in the areas of assurance. This approach could be implemented for other principal risks such as the Decarbonisation risk.

20. The **risk appetite statements** are being finalised in readiness for sign off by the Board and the development of a strategic BAF will be the focus for this year, including the creation of one or two strategic risks to be piloted in readiness for the Board Development Session in February 2026.
21. Interviews for the **Risk Manager** are scheduled for 11 July 2025 with the aim to support the enterprise risk management programme and to **explore digital solutions** for risk management as key pieces of work.
22. New tools have been developed to support continued effective risk management including dashboards describing trend data and mitigating actions impacting target scores.
23. Members agreed to support flexibility on the outline timings for the risk management work programme whilst new ways of working, processes and outputs are explored.

COMMITTEE AGENDA FOR MEETING IN JUNE

Internal Audit: - Head of Internal Audit Opinion - Follow Up Audit - Contract management audit - Seasonal modelling and forecasting audit - Start of shift procedure audit - ENCS implementation audit - Capital systems audit	Audit Wales Report Urgent and Emergency Care Review	Risk management report
Audit tracker	Losses and special payments	NHS Wales No PO no pay policy
Integrated Governance Programme	Non-Compliance with SO	2024/25 Annual Accounts and Annual Report

COMMITTEE ATTENDANCE

Name	1 May 2025 ¹	24 Jun 2025 ²	2 Sep 2025	2 Dec 2025	2 Mar 2026	
Peter Curran						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Chris Turley						
Audit Wales	Fflur Jones	Fflur Jones				
Julie Boalch						
Judith Bryce	Jon Sweet					
Christian Fox						
Carl Kneeshaw						

¹ The chairs of the Finance and Performance Committee (Jayne Beeslee) and QUEST (Bethan Evans) were in attendance for the committee effectiveness reviews

² Jason Killens, CEO, joined for the presentation and endorsement of the annual report and audited accounts



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COMMITTEE ATTENDANCE

Name	1 May 2025 ¹	24 Jun 2025 ²	2 Sep 2025	2 Dec 2025	2 Mar 2026	
Osian Lloyd						
Trish Mills						
Liam Williams		Wendy Herbert				
Carl Window						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

Head of Internal Audit Opinion & Annual Report 2024/25

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

Contents

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Report status:	Final
Draft report issued:	23 May 2025
Final report issued:	12 June 2025
Author:	Osian Lloyd, Head of Internal Audit
Audit, Risk and Assurance Committee:	June 2025



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Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



1. Executive Summary


1.1 Purpose of this Report

Welsh Ambulance Services University NHS Trust (the Trust) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation’s objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2024/25

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board’s own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2024/25 is:

Reasonable assurance		<p>The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.</p> <p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved.</p>
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1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit, Risk and Assurance Committee (the ‘Committee’). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2024/25 year, was presented to the Committee in March 2024. Changes to the plan have been made during the year and these changes have been reported to the Audit, Risk and Assurance Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NHS Wales Shared Services Partnership (NWSSP), Digital Health & Care Wales (DHCW), and the new NHS Wales Joint Commissioning Committee (JCC) that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, stated we 'Fully Conform', and our own annual Quality Assurance and Improvement Programme (QAIP) confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2024/25. We can state that our service 'conforms to the Institute of Internal Auditors' professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the substantial and reasonable areas in the table below.

Where we have given Limited or Unsatisfactory Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2024/25

Substantial Assurance	<ul style="list-style-type: none"> • 111 Wales Digital Operations • Estates Assurance: Energy Management
Reasonable Assurance	<ul style="list-style-type: none"> • Risk Management and Board Assurance Framework • Follow Up of Internal Audit Recommendations • Integrated Quality Performance and Management Framework • Seasonal Modelling and Forecasting • Exposure to Fumes • Patient Experience and Community Involvement • Rollout of Pentrox • Overtime Controls • Emergency Nurse Communications System Implementation • Data Quality • Occupational Health and Wellbeing Support • Speaking Up Safely • Capital Systems

Limited Assurance	<ul style="list-style-type: none"> • Vehicle Accident Management • Start of Shift Procedure • 111 Wales Website (draft) • Resourcing Policy
Unsatisfactory	N/A
Advisory/Non-Opinion	<ul style="list-style-type: none"> • Contract Management

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year and other information obtained during the year that we deem to be relevant to our work (see section 2.4).

2. Head of Internal Audit Opinion

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation’s objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Trust’s risk management process and system of assurance should bring together all the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit, Risk and Assurance Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Trust. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Audit, Risk and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Welsh Ambulance Services University NHS Trust which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators, including Healthcare Inspectorate Wales, in assessing compliance with the Health and Care Quality Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2024/25 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.


This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4).

2.4 Head of Internal Audit Opinion

Scope of opinion

As noted already, the scope of my opinion covers both those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee, and other information obtained during the year that we deem to be relevant to our work. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable assurance		<p>The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.</p> <p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved.</p>
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This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised from reviews.

Focus should be placed on the agreed response to any Unsatisfactory and Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there were four in 2024/25) as well as addressing implementation of recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2024/25, and reported to the Audit, Risk and Assurance Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit, Risk and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.5).
- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the leadership standard.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key Committee meetings; meetings with Executive Directors, senior managers and Non-Executive Directors; the results of *ad hoc* work

and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Trust.

In reaching this opinion we have identified some reviews during the year concluded positively with effective control arrangements operating in some areas.

From the opinions issued during the year, two were allocated Substantial Assurance, thirteen were allocated Reasonable Assurance, four were allocated Limited Assurance with none allocated an Unsatisfactory assurance opinion. One advisory or non-opinion report was also issued.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit, Risk and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Trust's activities that we had previously used to structure our strategic and one-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

Reasonable assurance was awarded in respect of the two reviews undertaken in this area.

- **Risk Management and Board Assurance Framework (BAF):** The key finding from our review is that the BAF is essentially the Corporate Risk Register, but in more detail. The Trust are aware of this and are working with external consultants to develop a new BAF that will focus more explicitly on its strategic objectives. Notwithstanding this concern, the reporting of the current key risks through the Board and its Committees continues to work effectively.
- **Follow-up of Internal Audit Recommendations** - this audit reviewed the systems in place to monitor progress with the implementation of actions in response to internal audit reports. We also validated the stated position for a sample of recommendations within the tracker See section 2.5.
- A review of the draft **Annual Governance Statement** highlighted that it was generally consistent with our knowledge of the Trust through the audit work performed in the Internal Audit plan and a review of other organisational documents.

Strategic Planning, Performance Management & Reporting

Reasonable assurance was awarded in respect of the two reviews undertaken in this area.

- The audit of the Trust's **Integrated Quality and Performance Management Framework** highlighted the need to embed the framework to ensure its successful

delivery. Key recommendations include enhancing oversight, refining communication plans, and ensuring timely, measurable progress across the framework's implementation.

- The **Seasonal Modelling and Forecasting** audit identified that while processes are embedded in operations, key gaps exist in documentation, governance, and evaluation. Improvements are needed to clarify roles and responsibilities and to ensure there is sufficient oversight, quality assurance, and organisational learning to enhance winter resilience planning, and alignment with strategic priorities and performance expectations.

Financial Governance and Management

We have undertaken two reviews in this area.

- The advisory review of **Contract Management** compared and contrasted the appropriateness of contract management arrangements across eight organisations, with common issues and challenges noted. Recommendations focus on clarifying roles and responsibilities and improving procedures, training provision, contract registers, and performance monitoring and oversight. Collaborative action with other NHS Wales bodies and NWSSP Procurement Services is advised to enhance consistency and mitigate risks.
- Limited assurance was provided in relation to **Vehicle Accident Management**. Key issues include lack of guidance, underreporting of incidents leading to a lack of investigation, poor data integration, and limited oversight. Recommendations focus on improving reporting systems, training, documentation, and analysis to reduce incidents and enhance accountability and learning. The report also recognised that the cost of vehicle accidents to the Trust is low and it is currently in a position to better defend claims made against it.

Quality & Safety

Reasonable assurance was awarded in respect of the three reviews undertaken in this area.

- **Exposure to Fumes:** The audit provided reasonable assurance on managing staff exposure to diesel fumes at Emergency Departments as a result of handover delays, reflecting positively on the actions being taken by the Trust. Key issues include the need to update guidance and improve data collection, a lack of a work programme in place for the cyclical completion of risk assessments, staff not complying with guidance, and delayed committee reporting.
- The **Patient Experience and Community Involvement** (PECI) review provided reasonable assurance on the Trust's engagement practices, highlighting effective frameworks and meaningful initiatives. However, improvements are needed in survey design, public engagement tracking, and impact reporting. Recommendations focus on the need to better define and coordinate the PECI Team's activities, increasing feedback response rates, and ensuring service changes reflect public input for better healthcare outcomes.
- The audit of the **Rollout of Pentrox** highlighted that while policies and training provision were in place, issues included incomplete training compliance, protocol breaches, limited access primarily for Community First Responders, and lack of

impact reporting. Recommendations focus on improving monitoring, training, access, and evaluating the analgesic's effectiveness and benefits.

Information Governance & Security

We have undertaken three reviews in this area, one of which is work in progress, but is planned for inclusion within the 2024/25 opinion.

- The **111 Wales Website** (draft) review assessed whether the 111 Wales website enables secure and effective provision of patient services. Limited assurance was reported, with high priority matters raised to strengthen the position. It is recognised that development of the website, and updated symptom checkers, remain a priority for the Trust, but could not be delivered in 2024/25 as funding has not yet been agreed. However, this has rolled forward into the Trust's 2025/28 Integrated Medium-Term Plan (IMTP).
- Substantial assurance was provided following our review of **111 Wales Digital Operations**. We found that the new system is secure, resilient, and well-managed. Staff received comprehensive training, and performance is effectively monitored. While implementation was rapid, lessons were learned. No significant issues were identified, and risk management, system performance, and user support were all deemed effective.
- The **Data Quality** audit provided reasonable assurance on the Trust's processes. The focus within the Trust, due to capacity, has been on the Emergency Medical Services Computer-Aided Dispatch System (EMS CAD), which is the main driver of national reporting, however, there is recognition that there is a need to strengthen data quality processes and controls across the other data sets and systems. While EMS CAD data is well-managed, gaps exist in training, policy updates, incomplete information asset registers, and assurance reporting. Key recommendations include improving digital literacy, formalising data quality reporting, updating policies, and enhancing oversight across all systems to ensure consistent data integrity.

Operational Service and Functional Management

We have undertaken three reviews in this area.

- The review of **Overtime Controls** provided reasonable assurance. Processes for allocation, authorisation, and payment were generally sound. Key improvements include better documentation of allocation changes and exploring automation of the payment process to reduce manual input. While overtime was mostly within budget, some local variances and inefficiencies in reporting and payment processes remain.
- **Start of Shift Procedure**: This audit assessed compliance with the Start of Shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available, and was provided limited assurance.
- Reasonable assurance was reported in relation to **Emergency Nurse Communications System Implementation**: While benefits were broadly achieved, no post implementation review has been undertaken. In addition, gaps remain in benefit definition and tracking, coverage of audit arrangements, and performance monitoring. Delays in quality assurance, inconsistent feedback, and lack of formal action plans risk accreditation. Improved governance, reporting and

escalation, and resource allocation are also recommended to strengthen oversight and outcomes.

Workforce Management

We have undertaken three reviews in this area.

- Limited assurance was provided following our review of the Trust's **Resourcing Policy**. Key issues include outdated policy, inconsistent application across services and regions, working time breaches not reviewed or reported on, unclear time off in lieu processes, and lack of performance reporting. Recommendations focus on the need to undertake a significant process mapping exercise to inform policy updates, standardising procedures, improving monitoring, and enhancing reporting to ensure compliance and operational consistency.
- **Occupational Health and Wellbeing Support:** We evaluated the programmes in place at the Trust to improve the Occupational Health and Wellbeing services and promote staff wellbeing and provided **reasonable** assurance. We found that while key strategies and support programmes are in place, improvements are needed in performance monitoring, trend analysis, and outcome evaluation. Enhanced data use and clearer measurement frameworks are recommended to better assess effectiveness and impact, and guide proactive interventions.
- The audit report on the **Speaking Up Safely** framework within the Trust provided reasonable assurance. While progress is evident, improvements are needed in action planning, feedback collection, enhanced training for managers, data capture and triangulation, and reporting. Strengthening these areas will enhance staff confidence, ensure timely resolution of concerns, and support a culture of openness and psychological safety.

Capital & Estates Management

We have undertaken two reviews in this area.

- Substantial assurance was provided following our review of the Trust's **Energy Management arrangements**. Strong governance, monitoring, and sustainability initiatives were noted. Minor issues included reliance on estimated meter readings, manual invoice approvals and display of educational media across Trust premises. Recommendations focus on expanding smart meter rollout, improving energy awareness communications, and streamlining invoice processing to enhance efficiency and accuracy.
- **Capital Systems:** While procurement and contract award processes were generally sound, resulting in reasonable assurance being awarded, gaps were noted in formal procedures, contract documentation, and retention practices. Recommendations include developing standardised project procedures, improving contract annotation and retention, and ensuring declarations of interest and non-collusion are consistently documented and retained.

2.5 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

However, it remains the role of Audit Committees, as reiterated within the Trust's Audit Handbook, to scrutinise the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

The Trust's recommendation tracking process continued during 2024/25. The Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to the Audit, Risk and Assurance Committee. The Trust also continues to refer relevant extracts of the audit tracker to each Board Committee to support oversight and scrutiny of recommendations relating to their remit. The Audit, Risk and Assurance Committee scrutinises the progress of audits recommendations overall, escalating to the Board any issues or concerns. The Trust is also developing a more automated tracker system, with support from Digital Health Care Wales.

We have undertaken work towards the end of the year to validate the stated position for a sample of recommendations within the tracker. We were able to confirm the recorded position for all sampled recommendations and therefore provide the Audit, Risk and Assurance Committee with additional assurance around the accuracy of the tracker.

2.6 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.7 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Trust, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2024/25 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Trust's Annual Report and accordingly will be completed and reported to management and the Audit, Risk and Assurance Committee after this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.8 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2024/25.

2.9 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023 who concluded we 'Fully Conform' with the Standards.

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at the Trust in conformance with the Public Sector Internal Audit Standards for 2024/25.

Our conformance statement for 2024/25 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2024/25 which will be reported formally in the Summer of 2025; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2024/25 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Trust's audit programme for 2024/25.

The Head of Internal Audit has unfettered access to the Chief Executive, Chair of the Audit, Risk and Assurance Committee and Chair of the Trust.

2.10 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to consider other assurances and risks when preparing their Statement. These sources of assurances will have been identified within the Board’s own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. Other work relevant to the Trust

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation’s audit programme, will cover activities relating to other health bodies. These are set out below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales; and
- NHS Wales Joint Commissioning Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NWSSP, a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Trust. These audits of the systems operated by NWSSP, processing transactions on behalf of the Trust, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To review the adequacy of the systems and controls in place for key risk areas in the accounts payable process, including progress in implementing the actions agreed with management to address the issues identified in the previous audit report.

Payroll	Substantial	To evaluate the design and operation of the systems and controls in place within payroll services.
Recruitment Services	Substantial	To review the adequacy of systems and controls in place for Recruitment Services.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. All audits in this programme are reported to the Velindre University NHS Trust Audit Committee for NWSSP. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Trust. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Financial Sustainability	Substantial	To review the financial management arrangements in place to ensure the ongoing sustainability of services and project delivery, with a particular focus on sustainable funding requirements for projects (e.g. DPIF, WASPI).
Programme Management	Reasonable	To establish the effectiveness of the portfolio management model used by DHCW and the controls that are in place to ensure it operates across the range of active projects.
Mission One – National Data Resource	Reasonable	To provide assurance over the National Data Resource (NDR) Platform programme of work, including progress towards implementing local datastores, and reference, demographics and medicines data.
Mission One – Cloud Services	Substantial	To provide assurance over the programme of work to move live services from datacentres into the cloud.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

NHS Wales Joint Commissioning Committee (JCC)

The work at the JCC is undertaken as part of the Cwm Taf Morgannwg University Health Board internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline scope
Mental Health Quality Commissioning arrangements	Reasonable	The purpose of the review was to assess the effectiveness of the arrangements in the JCC to oversee the quality and safety aspects of the commissioning of mental health and learning disability placements.
Governance	Advisory	To assess the arrangements that have been put in place at the JCC for embedding the statutory governance framework and the establishment of operational governance arrangements to provide effective oversight in the new organisation.
Financial arrangements (draft)	Reasonable	To consider the financial arrangements in relation to financial management and budgetary control, procurement and income.
Review of Traumatic Stress Wales (draft)	Limited	The purpose of the review was to provide information to assist the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups within the JCC to determine the optimum delivery mechanism for the national objective of Traumatic Stress Wales (TSW), by review of the adequacy of the systems and controls in place within TSW and the JCC in relation to its management of TSW. The review sought to provide assurance to the Chief Commissioner via the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups, that TSW is operating effectively, systems are being managed appropriately, and there is clarity on the purpose and objectives of TSW within the new arrangements for the JCC.

While these audits do not form part of the annual plan for the Trust, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the JCC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. Delivery of the Internal Audit Plan

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported, but are reflected within this Annual Report, will be reported alongside audits from the 2024/25 operational audit plan.

The audit plan approved by the Committee in March 2024 contained 20 planned reviews. As reported to the Audit, Risk and Assurance Committee, no changes have been made to the plan.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Trust. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit, Risk and Assurance Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	March 2024	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2024/25	G	100% (20/20)	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	80% 16/20	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to discussion & draft report [15 working days]	G	74% (14/19)	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% (19/19)	80%	v>20%	10%<v<20%	v<10%

Key: v = percentage variance from target performance

5. Risk based audit assignments

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 20 audit reviews were reported during the year. Figure 1 below presents the assurance ratings, and the number of audits derived for each.

Figure 1 Summary of audit ratings

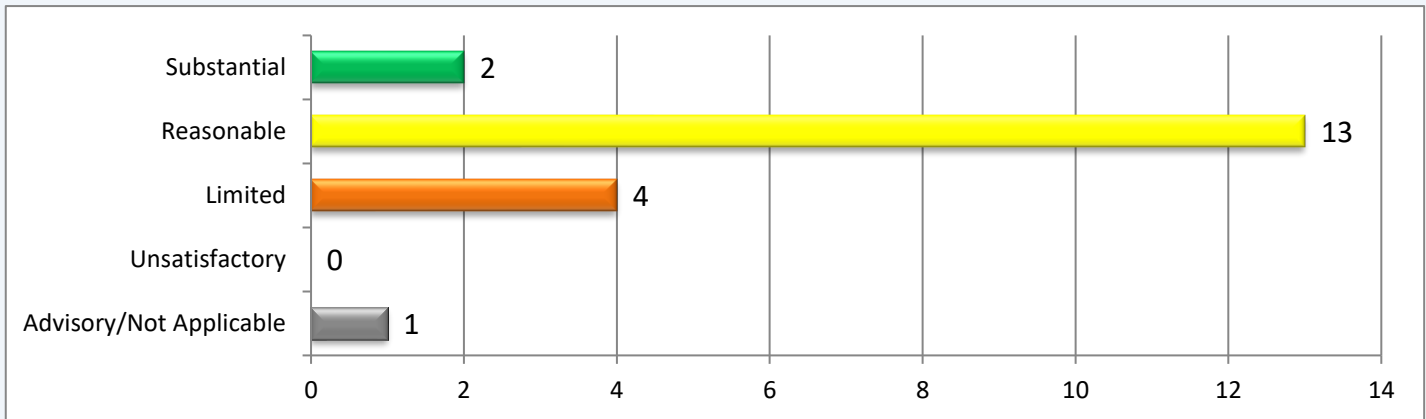


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the NHS Wales JCC.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Dark Green)



In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
111 Wales Digital Operations	To assess whether the digital operation of 111 is safe and effective, with mitigation plans in place for any weaknesses identified and tracked to resolution.
Estates Assurance: Energy Management	The audit was undertaken to determine the adequacy of, and operational compliance with, the established systems for the management and control of energy consumption within the Trust and

Review Title	Objective
	also considered other supporting regulatory and procedural requirements.

5.3 Reasonable Assurance (Light Green)



In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Risk Management and Board Assurance Framework	The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risk through the Board Assurance Framework and the Corporate Risk Register.
Follow Up of Internal Audit Recommendations	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.
Integrated Quality and Performance Management Framework	To review the deployment of the Quality & Performance Management Framework (Framework) and assess the extent it is being embedded across the Trust.
Seasonal Modelling and Forecasting	To assess the Trust's approach to forecasting and modelling, including focus on winter resilience planning.
Exposure to Fumes	To evaluate the actions being taken by the Trust to ensure the health and wellbeing of staff exposed to fumes as a result of delays in handovers of care at hospital.
Patient Experience and Community Involvement	To provide assurance on compliance with the Health and Social Care Quality Engagement Act and alignment with the Trust's IMTP.
Rollout of Pentrox	To assess the impact of the rollout of Pentrox on patients and staff, following the recent announcement that it can be administered by ambulance crews and Community First Responders.

Review Title	Objective
Overtime Controls	To provide assurance on the adequacy of the processes in place to control and monitor the level of overtime allocation, in line with the Trust's Financial Savings Plan.
Emergency Nurse Communications System (ECNS) Implementation	To provide assurance that benefits realised reflect those identified at the outset of the system's implementation.
Data Quality	To review the structures and processes for ensuring data quality and accurate reporting within the Trust.
Occupational Health and Wellbeing Support	To evaluate the programmes in place at the Welsh Ambulance Services University NHS Trust (the Trust) to improve the Occupational Health and Wellbeing services and promote staff wellbeing, and the arrangements in place to monitor effectiveness.
Speaking Up Safely	To review the implementation of the framework and assess its impact in promoting a culture that enables staff to raise concerns.
Capital Systems	These audits review the control framework, systems and processes in place to manage discretionary, EFAB or other capital / estates funded schemes – ensuring compliance with minimum requirements.

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Vehicle Accident Management	To assess the management of accidents relating to Trust vehicles, and the mitigating actions being taken to reduce the rate of occurrence.
Start of Shift Procedure	To assess compliance with the Start of Shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available.

Review Title	Objective
111 Wales Website (draft)	To assess whether the 111 Wales website enables secure and effective provision of patient services.
Resourcing Policy	To review the Trust's Resourcing Policy, its compliance with national terms and conditions, and to assess its application as an enabler for effective resource production.

5.5 Unsatisfactory (Red)



No reviews were assigned an 'unsatisfactory' opinion.

5.6 Advisory/Assurance Not Applied (Grey)



The following review was undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for this review is deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Contract Management	To assess whether the Trust has appropriate contract management arrangements in place.

6. Acknowledgement

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2024/25 plan.

Osian Lloyd

Pennaeth Archwilio Mewnol/Head of Internal Audit

Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services

Partneriaeth Cydwasaethau GIG Cymru/NHS Wales Shared Services Partnership

June 2025

Appendix A Conformance with Internal Audit Standards

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing Orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit, Risk and Assurance Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit, Risk and Assurance Committee Chair. There have been no impairments to our independence during 2024/25.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. An EQA was undertaken in 2023.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit, Risk and Assurance Committee.

	Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk-based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	<p>Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit, Risk and Assurance Committee.</p> <p>An annual report and opinion is produced for the Audit, Risk and Assurance Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.</p>
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit, Risk and Assurance Committee. In addition, audit reports are followed up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management, it would be discussed and will be escalated to Board level for resolution.

Appendix B Audit Assurance Ratings

Assurance Opinion

	<p>Substantial</p>	<p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.</p>
	<p>Reasonable</p>	<p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.</p>
	<p>Limited</p>	<p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved.</p>
	<p>Unsatisfactory</p>	<p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.</p>
	<p>Advisory</p>	<p>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.</p>

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 and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Prioritisation of Findings

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

Public Sector Internal Audit Standards

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



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





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FINANCE AND PERFORMANCE COMMITTEE HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	31 July 2025
Committee Meeting Date	21 July 2025
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

Finance

1. The Committee was assured via the usual reports and papers that the trust expected a balanced position at year end albeit with the active management of some risks and elements of uncertainty. Members were then updated on two external factors that had emerged during June 2025, which present an increased risk to the Trust delivering a year-end balanced financial position for 2025/26. The most up to date position will be discussed at Trust board and the committee took the opportunity to gain a deeper understanding of these critical emerging issues and risks.
2. The first is that the Welsh Risk Pool has substantially increased its previous forecast of in year spend, which would require an increased contribution from all Welsh NHS bodies. For WAST this could require an increased contribution of c£829K in year.
3. Secondly, Welsh Government (WG) has recently advised that it is not now able to cover the full costs associated with the increase in employers' National Insurance contributions (NICs). This is due to a gap in the funding provided for this from UK Treasury for the public sector in Wales. This gap for the Trust, which at month 3 was estimated as c£300k could now be over £1m in year, based on updated detail received in month 4.
4. If confirmed, these issues may mean the financial position worsens throughout the year and further consideration will need to be given to month 4 becoming a deficit forecast. The Trust is intending to use some its contingency, held for in year pressures such as this, to offset some of the impact; but if both issues crystallise at the current levels, the total in-year pressure could approach £2M. The Executive Leadership Team (ELT) will be discussing possible mitigations in the coming weeks and will continue to discuss the issues with government to understand the extent of the additional costs, particularly with reference to the Welsh Risk Pool. The Committee appreciated early sight of the risk and were assured that the Trust was taking all appropriate action. It further noted that such a



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position for the Trust – in recent years – is unprecedented.

Emergency Preparedness, Resilience and Response (EPRR)

5. Board members will note in paragraph 15 of this AAA that the Trust has shifted its assurance position in the EPRR submission to WG, indicating that some Civil Contingency Act 2004 (CCA) principles are only partially met rather than fully met, reflecting learning from the Manchester Arena Inquiry (MAI).

ADVISE

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

6. The updates to the **All Wales No PO No Pay Policy** was approved.
7. The **Operations Update for Q1 2025/26** was received, with the following of note for the board:
 - All teams were congratulated and thanked on the go-live of the new Ambulance Performance Framework.
 - Handover delays have significantly decreased, with June showing the lowest lost hours in some time. This improvement is being closely monitored, especially at sites like Royal Glamorgan and Morriston, where targeted actions have been implemented.
 - Non-Executive Director (NED) members noted that the positive impact on staff of decreased delays accords with their recent visits variously to Barry, Ceredigion and Rural Wales, Prince Charles and Royal Glamorgan Hospitals. Further discussions ensured during the MIQPR paper on the relationship of this and the average jobs per shift.
 - MAIT, which enables electronic transfer of CAD incidents between services, went live with two police agencies in mid-June. There is early positive staff feedback, and it is anticipated this move will reduce telephony activity between agencies. The rollout will expand to other police forces and eventually fire services, with the greatest benefits expected during major incidents due to improved, auditable inter-agency communication.
 - The team is providing planned support to Yorkshire Ambulance Service while they transition their 999 triage system. WAST is handling 100–150 calls per day for Yorkshire, and members were assured that this support has not negatively impacted performance and brings income benefits to the Trust.

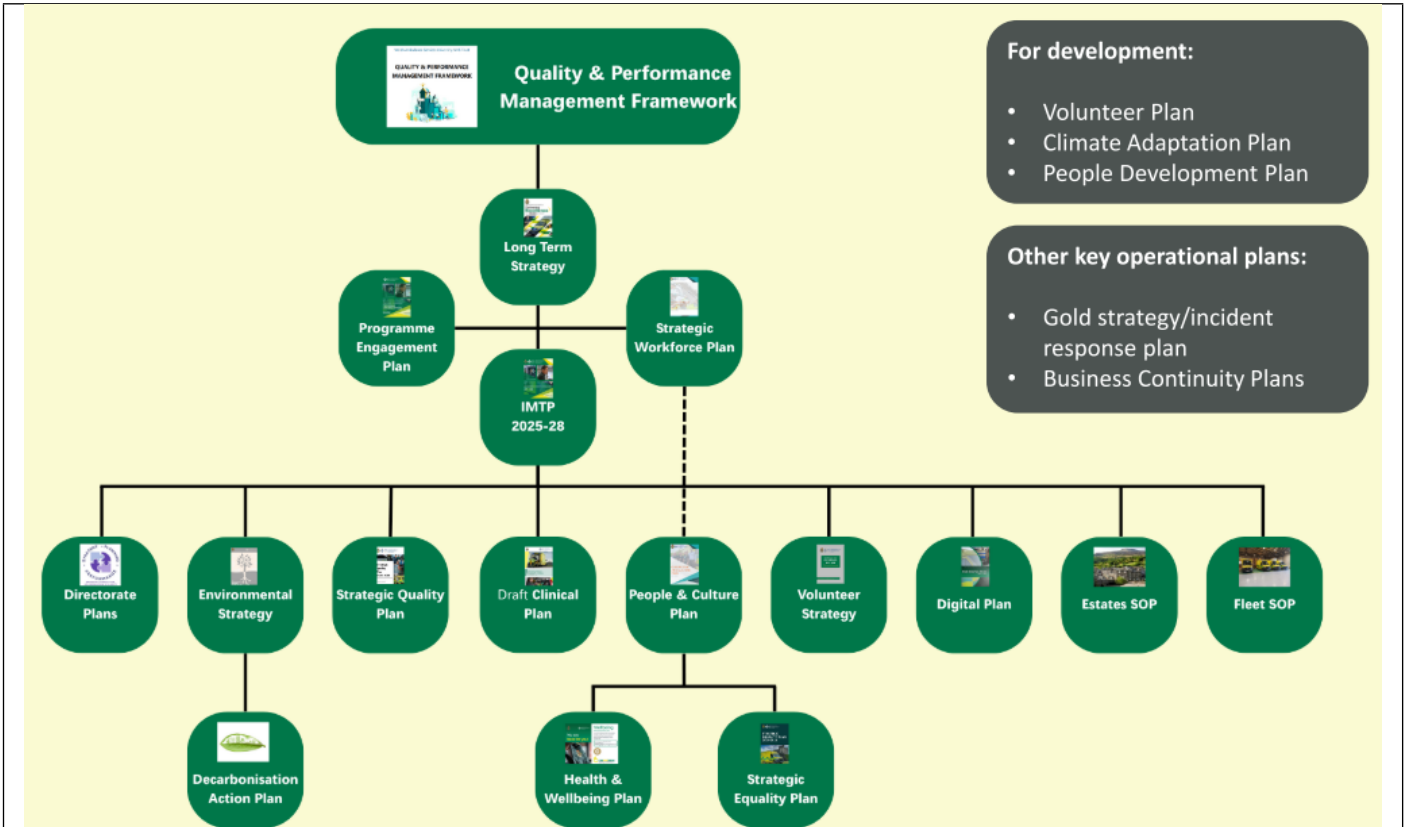
Members agreed that while the data and anecdotal evidence of handover times is encouraging, it is essential to monitor for sustainability, especially as summer progresses and activity may increase. The group stressed the need for ongoing vigilance and not losing sight of the ultimate goal to further reduce handover delays.

8. The IMTP is a key plan underpinning the delivery of the long term strategy 'Delivering Excellence'. However, there are further enabling plans which also support the strategy. The Committee requested an **organogram showing the relationship between these plans, the IMTP and the strategy**. Members found this a useful reference and it is replicated below for the board's reference:



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9. Members **reflected** that the 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.

ASSURE
(Detail here assurance items the Committee receives)

The following items will also be presented to board at their 31 July meeting however members may benefit from the following points of discussion from the committee:

10. With respect to the **financial position for months 2 and 3 2025/26**. The month 2 position was noted, and the committee took assurance from the update. Capital expenditure plans are being finalised with a view to be fully achieved in year; the Public Sector Pay Policy is on track with performance against a target of 95%, and 99.3% of the value of non NHS invoices being paid within 30 days. The Trust reported a small revenue surplus for month 2 at £5K and in line with the balanced financial plan submitted with the 2025-2028 IMTP, was forecasting to breakeven within 2025/26. As above, this position has been superseded by recent events in month 3 however; which present an increased risk to the 2025/26 year-end position. This position has been presented in the 'alert' for the board's attention.



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11. The bi-monthly update on the **Financial Sustainability Programme (FSP)** was also provided, and whilst not included in board papers in detail is set out here for flow with the financial position papers. Of note for the board:

- Early performance against a savings target of £8.5m shows a slight overachievement, but there remains a reliance on non-recurrent savings.
- A revised delivery framework has been introduced, and a project resourced secured.
- Recruitment for the Head of Commercial Development is complete, with onboarding expected soon. This role will drive income generation and commercial initiatives and align to the FSP. It was confirmed that whilst there is no level of income assumed for 2025/26 to give the individual time to embed and identify further opportunities, SMART objectives would be required to assure the committee that WAST could develop some momentum.
- A Task and Finish Group has been established with Trade Union partners to developed recommendations for Emergency Ambulance crew composition. An options paper has been submitted to ELT for consideration, with a further iteration to come back shortly.
- An administration review was initiated in 2023 however capacity constraints, staff turnover, and competing priorities have delayed progress. A new lead has been appointed to re-energise delivery.
- 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.

Members welcomed the timely shift from insight to action in light of the challenging financial position.

12. With respect to the **Monthly Integrated Quality and Performance Report (MIQPR)** for May/June of note:

- As noted above, the Trust lost 15,278 hours to handover in June 2025 (30-days), one of the lowest levels for 4 years.
- A discussion followed on why average jobs per shift (all resource types) remains below expectations despite reduced handover delays. It was acknowledged that this metric is 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, is needed to better understand the correlation. Staff feedback, including from NED visits, indicated an improved ability to reach more patients, but the group emphasised the need to maintain momentum to eliminate avoidable harm. Further analysis will be undertaken to disaggregate data and explore the impact of resource type on job cycle efficiency.

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

13. The Committee received the **Integrated Medium Term Plan (IMTP) Delivery and Assurance Report** for Q1 2025/26. Of note:

CMT Programme (Clinical Model Transformation):

- The CMT programme is 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.

- Members thanked the teams for this effort, recognising the shift that this change will bring to our patients and our people.
- The programme is 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 is an improvement from amber in the previous period.
- Five balanced scorecards for benefits and outcomes have been developed for the programme, supported by more detailed logic benefits maps..
- Internal feedback has led to improvements in communications and digital tools, and the programme is now using Microsoft Project and Planner for better management.
- 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 is introduced.

Cabinet Secretary Priorities:

- Progress on Cabinet Secretary priorities is good, with no red-rated items reported.
- The priorities are being tracked and reported alongside the CMT and directorate IMTP actions.

Directorate-Led IMTP Deliverables:

- Quarter 1 saw 12 deliverables, three are complete, three are on target, one is yellow, and five are red.
- The red items are due to capacity issues and have been reprogrammed to later in the year, which was considered reasonable by the committee.
- 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 agreed that assurance against 'what good looks like' within the IMTP will be presented bi-annually, commencing with the September meeting. The importance of supporting staff and managing change fatigue was emphasised throughout the discussion, and members found the communications on the new framework informative and well-pitched.

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

Highlights

- Recruitment across Digital is progressing well.
- There has been a successful soft launch of the NHS 111 Wales Virtual Assistant chatbot, supporting multilingual access and improved user experience.
- A technical go-live of video consultation for 111 clinicians on 8 July.
- Phase 2 of the Microsoft Copilot pilot began on 1 July, with 150 licences distributed.
- Refresh of ePCR app in development, aiming to reduce on-scene times and improve data quality
- Cyber Resilience Unit audit completed.
- Significantly contribution by the digital team to the go-live of new call categories on 1 July.

Lowlights



- iPad replacement programme paused pending agreement on charitable donation scheme for existing devices.
- Video Compliance Progress delayed due to competing priorities.
- Enhanced IVR (111) deprioritised due to CMT development demands.
- Reporting of new 999 CAD metrics is currently reliant on a temporary solution; full CAD upgrade is still unplanned.

Red Flags

- Sustained pressure on the IG team due to urgent asks from across the CMT programme.
- All-Wales data sharing via the National Data Resource (NDR) remains unresolved, with legal and regulatory risks under active review by WAST's DPO and IG team.
- Unknown requirements for 2025/26 and 2026/27 under the CMT programme pose a capacity risk to the Digital Directorate, potentially impacting delivery of the local Digital Plan.

15. Members enjoyed a **deep dive on digital**, where the five pillars of the digital plan: everyday essentials, digital pioneers, digital transformation, security/safety/cyber, and data/information insights, were laid out in more detail, including the 2025/26 priorities. This highlighted the breadth of digital's impact, particularly on the CMT, and the proactive approach to AI governance.
16. The **Information Governance (IG) Report** highlighted key updates, which included alerts regarding Data Protection Impact Assessment (DPIA) non-compliance, Artificial Intelligence risks, cyber risks, and an update regarding the ePCR 'copy and paste' functionality. Other key risks noted were that of the formal corporate risk, Risk 623 'failure to comply with data protection legislation', the risks regarding physical security, and the risks associated with not complying with the Freedom of Information Act 2000.
17. The annual package of **Emergency Preparedness Resilience and Response (EPRR)** assurance reports and plans were presented to this meeting. Members were assured as to the robustness of the plans and activities that have taken place:
 - With respect to the **Manchester Arena Inquiry (MAI)**, the Trust submitted its response to the recommendations to both WG and the Joint Commissioning Committee (JCC) in August 2024. Assurance meetings with commissioners took place in March and April, allowing scrutiny of the Trust's submission. Feedback from Commissioners is expected in August. There is some slippage on recommendations, which has been previously reported to the Trust Board. Additionally, an internal audit is underway to review governance and project management of the MAI recommendations, with findings expected to be reported in September.
 - The **Annual Hazard Area Response Team (HART) KPI report** for Q4 was presented, having been submitted to WG. Notably, one day in in March 2025, HART was unable to provide full team cover due to short-notice absences. This incident highlights the importance of the MAI recommendation to increase the HART team size from six to eight operatives to enhance resilience. 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; WG has allowed budget carryover to address this. The training programme to reach the new SORT staffing level is expected to complete within the calendar year. The main future challenge



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identified is skill retention and ongoing testing as the team expands, another element picked up in the MAI submission.

- The **Annual Welsh Government Emergency Planning Report (attached at Annex 1 in the reading room in Ibabs)** has been developed using the new WG template. It includes updates on national inquiries, outlines progress against priorities and sets forward-looking objectives. Members noted that this year, the Trust shifted its assurance position in the EPRR submission, indicating that some CCA principles are only partially met rather than fully met, reflecting learning from the MAI. The committee were assured that progress on these partially met elements now depends on meeting the MAI recommendations (see above), and this change was signalled to WG last year. The assurance section highlights dependencies and a move away from previous years' full assurance statements.
- The **Annual Business Continuity Report (attached at Annex 2 in the reading room in Ibabs)** includes a new governance structure implemented in November 2024 to strengthen oversight and embed business continuity planning across directorates. Members were assured that the Trust remains compliant with the CCA and that the new business continuity software, which is cloud based for additional cyber security, is expected to be fully rolled out by October 2025.
- The **Resource Escalation Action Plan (REAP)** triggers have been updated to align with the new Ambulance Performance Framework effective 1 July 2025. Key changes include new triggers for Purple Arrest, Red Emergency, and Amber categories, as well as inclusion of 999 call handling rates and Clinical Navigator UHP. The number of escalation triggers remains at four to ensure stability in operational response. A further review will take place to prepare for phase two of the framework.
- The **Incident Response Plan** was taken in closed session due to its sensitivities.

18. The Committee received a report on Commissioning, which is within its delegated responsibilities. Members noted the ways in which the Trust's 111 patient pathway, 999 patient pathway and Non-Emergency Patient Transport Service (NEPTS) patient pathways were all **commissioned by the JCC** and are subject to specific commissioning frameworks. This update was welcomed, setting out as it did the high-level arrangements and acknowledged the importance of the Trust's relationship with the JCC.
19. The **Audit Wales Urgent and Emergency Care – Arrangements for Managing Demand Report** was presented, following its extensive discussion at the Audit, Risk and Assurance Committee (ARAC) in June (see their AAA report in this board pack). This report provides a timely assessment of the Trust's response to ongoing pressures in urgent and emergency care and confirms that robust plans are in place and beginning to deliver improvements, though a full evaluation of the broader transformation is pending. Key developments include 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 are also promising. However, challenges persist, 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 recommends improving the accuracy of 111 Wales website



content and maintaining up-to-date service directories to support staff referrals. Both recommendations have been accepted, with business cases drafted and discussions underway with WG to secure support. Overall, the report validates the Trust's strategic direction and underscores the importance of continued collaboration to reduce avoidable harm and build a more integrated, resilient care model. At the meeting Audit Wales noted that the fieldwork engagement with Trust colleagues was very positive and added that the Trust has been and continues to do everything within its control to improve patient outcomes.

20. A number of **internal audit reports** were received at this meeting as set out below given that their subject matter is within the committee's remit.

- Capital systems – reasonable assurance
- Contract management - advisory
- Emergency communication nurse system (ECNS) implementation – reasonable assurance
- Forecasting and modelling – reasonable assurance

The audit reports had been presented by Internal Audit at the June ARAC (see their AAA report in this board pack) and the audits helpfully included the extensive discussions held there. All actions will be tracked for oversight by this committee.

21. The **Quality & Performance Management Framework (QPMF) logic benefits map** was presented to the committee. The QPMF sets out an integrated approach to helping the Trust improve the quality of its services and outcomes for patients and achieve its ambitions and objectives by monitoring and improving the performance of people, teams, and the organisation. The logic benefits map was developed to clarify how the framework delivers value and how success will be measured. Further work will be done to clarify flows between inputs, activities, outputs and benefits etc.; however, it was acknowledged that this was a strong first version and would be refined over time. Assurance was provided on governance structures and processes for feedback loops, audits and tracking benefits.

22. In **closed session** members received the update on the cyber KPIs, cyber audit actions and the cyber risk 260. The closed session also considered and endorsed the business case for the Bangor Fleet Workshop Project. All items taken in closed session were done on the basis of commercial or security sensitivity and will be reported to the open session of the board in due course.

23. The committee's **annual priorities** were reviewed and are progressing well. The cycle of business monitoring report noted that the Value Based Healthcare Report, due in May has been deferred and will be the subject of a board development session to draw out the issues as they relate to WAST.

RISKS

The committee received the **Risk and Board Assurance Framework report** noting that all risks have undergone their quarterly review, with no changes in scores. It was emphasised that the highest rated risks are considered when setting the agenda ensuring that these are integrated into the papers and discussions throughout the meeting.

It was noted that **Risk 542 Decarbonisation** is a complex and multifaceted risk and challenging to



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mitigate given its nature and external dependencies; however, there is an aspiration to reduce this from a score of 16 to 8. NEDs met with management recently to review this risk and the ambition is to reframe it to focus on what is within the Trust's control, similar to the approach to risks 223 and 224.

Risks raised in the finance reporting were also discussed and are set out above.

COMMITTEE AGENDA FOR MEETING		
Operations update Q1 2025/26	Financial position M2 and M3 2025/26	Financial sustainability programme
2025/26 Commissioning	IMTP Progress report	MIQPR
QPMF logic benefits map	Emergency preparedness, resilience and response (EPRR) annual reports	Digital reporting
Information governance report	Risk management and board assurance framework	Internal audits: - Capital systems - Contract management - ECNS - Forecasting and modelling
NHS Wales no purchase no PO policy	UEC report on arrangements for managing demand	Committee cycle and priorities update

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

	Attended
	Deputy attended
	Apologies received
	No longer member



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WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

MINUTES OF THE OPEN MEETING OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST HELD ON THURSDAY 1 MAY 2025 IN CARDIFF MRD AND VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Rhiannon Beaumont-Wood	Non-Executive Director and Vice Chair of the Trust Board
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Jayne Beeslee	Non-Executive Director (Left after Item 20/25)
Julie Boalch	Assistant Director of Corporate Governance and Risk
Bethan Evans	Non-Executive Director (Left after item 20/25)
Christian Fox	Trade Union Partner
Fflur Jones	Audit Wales
Angela Lewis	Director of Culture Change (Item 21/25 only)
Osian Lloyd	Head of Internal Audit, NWSSP
Trish Mills	Director of Corporate Governance/Board Secretary
Carl Kneeshaw	Director of People
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Jessica Price	Head of Financial Accounting
Felicity Quance	Internal Audit
Jonathan Sweet	Head of Service OD
Yvonne Thomas	Audit Wales
Lisa Trounce	Head of Compliance and Assurance
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing (Left after item 22/25)

OBSERVERS:

Skye Banks	Compliance Administrator
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APOLOGIES:

Judith Bryce	Assistant Director of Operations
Damon Turner	Trade Union Partner
Carl Window	Local Counter Fraud Manager

19/25 PROCEDURAL MATTERS

The Chair welcomed all to the meeting, noting the apologies of Judith Bryce, Damon Turner and Carl Window.

Minutes: The Minutes of the Audit, Risk and Assurance Committee (ARAC) meeting held on 6 March 2025 were approved.

Action Log:

Action Number: 3/25 - Internal Audit Report: Roll out of Pentrox. The environmental benefits of reducing Entonox use were discussed, with Pentrox contributing to a lower carbon footprint. *Ceri Jackson queried if the carbon footprint impact was being captured and were there any indicators being taken to the Finance and Performance Committee (FPC).* It was agreed that in terms of reporting medical gases, Ed Roberts advised this was reported through the Decarbonisation Action Plan. In terms of the metrics being reported to FPC it was agreed this would be investigated further and an update provided for the next ARAC meeting. This was part of the decarbonisation report, which was reported through FP&C and the use of Entonox has reduced following the introduction of Pentrox. Agreed that the action was closed.

Action Number: 3/25a – Internal Audit Reports: Trish Mills suggested that it would be helpful to lift out specific sections of the triple-A reports from committees like Finance and Performance (F&P) and share them with the Audit, Risk, and Assurance Committee (ARAC) to ensure that discussions on internal audit reports are transparent and integrated across committees. This approach would also involve informing other committees, such as Quest, about discussions that took place in ARAC. This suggestion was agreed upon to enhance the flow of information and ensure comprehensive oversight. *This will be taken forward by the Corporate Governance Team where reports have already been received by a committee, to ensure that the discussion/outcome was fed into subsequent committees.* As this was in the work programme it was proposed for closure. Agreed that the action was closed.

Action Number: 6/25 – Audit Tracker: Revised Audit Dates: Trish Mills agreed to discuss with the Executive Leadership Team whether to remain with three revised dates, reduce them to two, and then report back to the Audit and Risk Assurance Committee (ARAC). *The preference from the ELT was that the maximum permitted revised dates should be two, as opposed to three. The Audit Tracker format will be adjusted from 2025/26 onwards.* Given the position has been reached, subject to the ARAC being content with the position, this action was proposed for closure. Agreed that the action was closed.

Declarations of Interest: No other declarations of interest were added to those already on the register.

Committee AAA Report: March 2025: The Committee AAA report dated 6 March 2025 was received.

RESOLVED: The Committee:

- (1) **Noted the apologies of Judith Bryce, Damon Turner and Carl Window**
- (2) **Approved the Minutes of 6 March 2025.**
- (3) **Noted the update on the actions as described.**
- (4) **Noted there were no further declarations of interests recorded other than those listed on the Register of Interests.**
- (5) **Received the committee AAA dated 6 March 2025.**

20/25 ANNUAL BOARD AND COMMITTEE EFFECTIVENESS REVIEWS 2024/25 (ALL COMMITTEES)

Trish Mills presented the Annual Committee Effectiveness Reviews for 2024/25.

Trish Mills stated that the Trust Board will receive a report on the effectiveness of its committees (and its own effectiveness) at its 29 May meeting, as well as all committee annual reports and terms of reference for approval. All the committees' terms of reference have been amended to include a specific strategic development and delivery section.

Part one

This update included the finalised 2024/25 annual report for the Audit, Risk and Assurance Committee (ARAC), and its amended terms of reference and cycle of business for 2025/26 following a review of these at the 06 March 2025 meeting. Updates to these documents following that meeting included discussions on its effectiveness in the meeting and changes to terms of reference and operating arrangements as a result. These documents were for the committee's approval and presentation to the board on 29 May 2025. Members were asked to consider priorities for the committee for 2025/26.

Following a discussion ARAC members welcomed the continuous review through ARAC Non- Executive Director (NED) meetings as opposed to the more formal review completed in previous years. Members also acknowledged the huge amount of work involved. They also noted that the approach to committee effectiveness was thorough, positive and constructive. Members approved the changes to the terms of reference, the 2024/25 annual report and the cycle of business for 2025/26, for the ARAC.

Members considered and discussed ARAC's priorities for 2025/26 which included a focus on the further work to streamline the committee structure, and the relates changes to the Trust's Board Committee framework, during 2025/26.

Part two

Trish Mills advised that part two provided an overview of the effectiveness of the other committees. This was in line with the ARAC's purpose to advise and assure the Trust Board and the Accountable Officer on whether effective arrangements were in place to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives.

Each committee had reviewed its terms of reference and assurance reporting arrangements, alongside benchmarking against committee structures in other UK ambulance services. Following this comprehensive review it has been concluded that the areas of oversight and scrutiny delegated by the board were appropriate for the Trust's size and complexity. Annexes five to 10 were presented, with Annex 11 detailing the learning from these reviews. This will be incorporated into the Governance Directorate's Local Directorate's Plans (LDP) so that progress is monitored. It was noted that Annex 11 would be reviewed again by ARAC in September to track progress. All committees were effective in the way in which they operated, noting they all met as scheduled, that each meeting met quorum, delivered extensively and diligently on their delegated responsibilities, and have reflected on changes that would make them more effective and add value. All committees have endorsed their terms of reference for 2025/62, approved their annual reports for 2024/25, and their cycles of business for 2025/26. It was noted that within the extensive annual review across the committee framework, there were no material changes proposed at this time with regards to the number or remit of the committees. There are opportunities for development of the Board Committee framework however, with reference to the Academic Partnership Committee (APC).

It was noted that in Q1 and Q2, further work will be undertaken on the opportunities for development. This will include a fresh look at the spread across committees to affect material change to frequency and volume, and to address areas of concern related to quoracy and resilience. A core group, including ARAC NEDs, the Executive Director of Finance and Corporate Resources, and the Director of Corporate Governance/Board Secretary, will guide this work with the results reported back to ARAC in September 2025.

In addition to the Chair of ARAC, Chairs of the Finance and Performance Committee (FPC), Quality, Patient Experience and Safety Committee (QuEST) Committee, Charity Committee (CC) and People and Culture Committees (PCC) were in attendance to speak to their annual reports and the outputs of the annual effectiveness reviews, as well as to provide their views on the process and outputs of this year's reviews.

The Chairs welcomed the shift in terms of reference to a more strategic overview and recognised the nuances and responsibilities of each committee. It was suggested there could be a focus on identifying specific areas within the committees that warranted a deeper dive; with the aim to apply appropriate scrutiny to these issues while

maintaining the natural rhythm of the committee's agenda. The new approach of facilitated discussions using MENTIMETER was very effective and positive, fostering open conversations where people could share and explore ideas.

Trish Mills added that themed agendas at the commissioning stage have proven effective, creating a cohesive "golden thread" throughout. This approach helped maintain focus and structure. Going forward, the aim was to continue this practice, ensuring themes ran through committee work and incorporating deep dives as needed.

From the PCC perspective, Carl Kneeshaw added it was valuable to hear from people about their lived experiences, whether positive, negative, or neutral. Furthermore, involving Trade Union (TU) partners in these committee discussions was crucial for effective partnership working.

Liam Williams added that compiling the agendas, particularly for QuEST, involved ensuring that the most relevant and appropriate items were included, despite the volume of submissions. He made the point that at every QuEST Committee meeting it began with a patient's story, highlighting the care involved in working with the family and colleagues.

In terms of the Remuneration Committee, Trish Mills advised it was primarily reactive, dealing with annual objectives and eligibility, as well as unpredictable changes, especially at the executive level and exit settlements. Previously, meetings were infrequent, leading to a backlog of minutes. Now, the committee meets quarterly, ensuring meetings were short, effective, and papers were succinct.

Ceri Jackson accepted that while the Equality Quality Impact Assessment (EqIA) process was generally robust, added that timing can sometimes be an issue. She had noted during her review of the effectiveness review it became clear that capturing this as a priority was essential and sought clarity on the process involved. It was agreed that Trish Mills would provide further guidance on the completion of EqIAs as a substantive item at the next meeting.

Following a query on the well-being objectives, Trish Mills explained that the Strategic Transformation Board ensured a long-term view of the three main well-being objectives. The Trust's new report front covers – which will be implemented in the coming weeks - includes reference to both Trust's overarching strategic and well-being objectives, which will aid the audience's reading of papers going forward as it requires report authors to indicate the relevant objectives.

Trish Mills reported that the Welsh Ambulance Services Partnership Team (WASPT) annual effectiveness review conducted in March, that the outcome confirmed the committee remained effective and has not undergone significant change.

Committee members thanked the Corporate Governance Team, Chairs and all members of committees for their engagement in this important work. Audit Wales and Internal Audit also commended the transparent approach and thoroughness of the reviews. Fflur Jones, Audit Wales Auditor, noted that she had taken a keen interest in the discussions today for information which will inform the 2025 Structured Assessment. Fflur praised the Trust's open-minded approach to effectiveness reviews and the assurance that this gives the Trust Board regarding the effectiveness of the operation of the Board Committees. Fflur noted the Trust's willingness to take consider fundamental changes rather than just making tweaks and noted the positive integration of well-being objectives throughout the work of the committees. It was noted that Audit Wales would be considering the inclusion of well-being objectives within the 2025 Structured Assessment.

RESOLVED: The committee:

- (1) Reviewed and approved changes to ARAC's terms of reference at Annex 2 and its operating arrangements as set out in its annual report.**
- (2) Discussed and agreed the committee's priority for 2025/26.**
- (3) Approved the committee's annual report at Annex 1.**
- (4) Approved the committee's cycle of business at Annex 3.**
- (5) Noted the future work to be carried out on streamlining committees in Q1 and Q2.**
- (6) Noted the changes to the operating arrangements at Annex 11 and terms of reference at Annexes 5 to 10 for:**
 - **Charity Committee**
 - **Finance and Performance Committee**
 - **People and Culture Committee**
 - **Quality, Patient Experience and Safety Committee**
 - **Remuneration Committee****and endorsed these and the annual reports for onward approval by the Trust Board and Corporate Trustee (for Charity Committee).**
- (7) Noted the progress against the changes to operating arrangements agreed following the 2023/24 effectiveness reviews and further work on conducting board visits pan-Wales.**

21/25 INTERNAL AUDIT REPORTS

Osian Lloyd gave an update on the Internal Audit Progress Report explaining that out of 20 planned reviews, 13 were completed and included in today's papers, with reasonable outcomes with seven reviews still in progress.

The 111 Wales review has been delayed due to technical issues however, this will not affect the ability to provide an opinion to the Trust.

In terms of Key Performance Indicators there has been an Improvement in the manager response indicator from Red to Amber, but a slight dip in the report turnaround indicator from Green to Amber. Efforts were ongoing to return this to Green.

Risk Management and Board Assurance Framework –Reasonable Assurance

Felicity Quance explained that the purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of the strategic and key operational risk through the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). The key finding was that the current BAF would develop in 2025 into a strategic BAF that will focus more explicitly on its strategic objectives.

All six objectives in the audit were rated 'reasonable assurance.' The only matter requiring management attention was the need to ensure risk management documentation was updated to reflect the changes in approach that were envisaged in the coming months.

Trish Mills explained that in terms of the remaining Risk Appetite Statements, these were being finalised. Furthermore, the recruitment for a Risk Manager has been challenging, and once filled, will create more capacity to focus on the BAF.

Julie Boalch welcomed the pragmatic approach to this audit highlighting that key risks were being reported effectively through board committees. Despite challenges with the electronic system (Datix Risk Module), mechanisms were in place to support reporting.

Occupational Health and Wellbeing Support – Reasonable Assurance

Felicity Quance explained that the purpose of this review was to evaluate the programmes in place at the Trust to improve the Occupational Health and Wellbeing services and promote staff wellbeing, and arrangements in place to monitor effectiveness.

Despite efforts to achieve a 6% sickness absence target, the Trust's rates remained higher than NHS England Ambulance Services, with recent figures showing an 8% sickness rate compared to NHS England's 6.5%. The implementation of the Health and Wellbeing Plan approved in November 2024 and the occupational health and wellbeing referral system, aimed to improve the timeliness of the support provided.

All four objectives in the audit were rated 'reasonable assurance' and there were four medium priority management actions raised. These included the need for detailed deliverables in the Health & Wellbeing Plan, enhanced performance reporting, improved reporting to assess the quality and impact of initiatives, and regular feedback from managers on attendance management training sessions.

Members noted the importance of addressing musculoskeletal issues, particularly for staff in sedentary roles, and the need for leadership and management to encourage physical breaks away from desks. Additional assurance was provided on proactive measures, including increased physiotherapy referrals and improved performance for referral to first contact.

Carl Kneeshaw commented that the PCC had an oversight of the audit actions. The next steps included a continued focus on proactive health and wellbeing measures and regular updates to PCC on metrics and deep dives into absence management and occupational health usage.

Rhiannon Beaumont-Wood raised the issue of musculoskeletal (MSK) issues involving staff, particularly those whose roles were primarily sedentary and if there was a management focus on prevention. Liam Williams confirmed there were several measures in place in respect of MSK, which included encouraging staff in these roles to take regular breaks.

Speaking Up Safely– Reasonable Assurance

Felicity Quance commented that the purpose of this audit was to review the implementation of the framework and assess its impact in promoting a culture that enabled staff to effectively and openly raise concerns.

The NHS Wales Speaking Up Safely (SUS) Framework (WHC/2023/036) highlighted the importance of fostering a culture where individuals could raise concerns without fear of victimisation or detrimental treatment. The Trust has implemented several measures to support this, including the appointment of a lead Guardian and the use of the Work in Confidence (WIC) platform to record and manage concerns. Following high-profile cases, the Welsh Government (WG) has mandated NHS organisations to undertake self-assessments against the framework and develop action plans to address any gaps.

Three objectives in the audit were rated 'reasonable assurance' and one (review and analysis of recurring themes and trends) was rated limited assurance. There were five medium, and one high priority management action raised. Those actions included developing an action plan to address gaps identified in the self-assessment.

The committee discussed the challenges of auditing cultural impact and noted significant progress in this area. It was recognised that the Trust has made progress in addressing concerns and taking proactive action in problematic areas, noting there has been an increase in the NHS staff survey related to colleagues feeling able to raise concerns.

Angie Lewis acknowledged this audit highlighted challenges in assessing the cultural impact of the SUS framework. Angie Lewis added that the appointment of a guardian

was unique in NHS Wales, and it followed the National Guardian model used by ambulance services in England, to enhance the culture of SUS.

Angie Lewis further commented that since the audit conducted from December to January, significant progress has been made. Lessons learned will continue to be addressed, and themes will be identified in the first annual report.

Rhiannon Beaumont-Wood sought clarity if there was a sense of assurance regarding the resolution of concerns raised through this route. Angie Lewis explained she was confident concerns were being raised due to the framework being embedded and the Guardian being appointed.

Christian Fox commented that the process has become smoother and more efficient, which was a positive step. Building staff confidence and trust in the team will take time, but as the process continued to evolve, it should help in gradually building that trust.

Following a query on staff resources, Angie Lewis updated the Committee on the current staffing levels, adding that recruitment was underway for a further Speaking Up Safely Guardian, to support the existing Guardian Lizzie O'Shea. The intention is that this person would support the work of the Speaking Up Safely Guardian.

Trish Mills clarified the point on Recommendation six. The ARAC oversees whistleblowing arrangements, but SUS falls under the PCC. An annual report on SUS was not appropriate for ARAC; instead, it will be presented to PCC every six months and then to the Trust Board. The discussion from this meeting will be captured and included in a front cover to accompany the report, ensuring continuity and crossover.

RESOLVED: The committee received the following Internal Audit reports: Risk Management and Board Assurance Framework, Occupational Health and Wellbeing Support and Speaking Up Safely.

22/25 AUDIT WALES REPORTS

The Audit Wales progress report and Audit Plan for 2025/26 were received from Fflur Jones and Yvonne Thomas respectively.

The performance audit update included the review of Urgent Emergency Care, which was currently in clearance. Fieldwork was due to begin on the review of Digital Systems to support transformation, with the project brief now issued and agreed. The 2025 Structured Assessment associated deep dive on managing estates and local review of Non-Emergency Patient Transport service would begin later in the year.

Audit Plan for the financial accounts:

In presenting the report Yvonne Thomas outlined the risks identified during planning which included the risk of management override, which was a mandated risk included in all audit plans. Specific risks for the Trust included property, plant, and equipment and intangible assets. The audited accounts are due to be presented to the board on 26 June 2025 and the Auditor General scheduled to sign off the accounts on 27 June 2025. There were no significant issues to highlight to the board at this stage. The audit fee has been slightly increased this year due to the potential for additional work around property, plant, and equipment and intangible assets.

Chris Turley explained that the Finance team have reviewed the detailed final audit plan and found no concerns. A slight variance in the fee needs to be managed, but it was not material. The draft accounts will be submitted by the deadline, and detailed audit work will start after the bank holiday.

Ceri Jackson asked in respect to the transfer and discharge work whether the commissioning context was considered. Fflur Jones advised that as part of the unscheduled care it would consider it from the Joint Commissioning Committee perspective.

RESOLVED: The Committee received the Audit Wales update reports and the detailed audit plan.

23/25 SELF-ASSESSMENT AGAINST THE CORPORATE GOVERNANCE CODE FOR CENTRAL GOVERNMENT DEPARTMENTS 2017 - 2025 REVIEW

Trish Mills gave assurance that the Trust was compliant with all elements of the Corporate Governance Code for Central Government Departments 2017 as stated in the Trust Annual Report that would come to Board in June. There were no elements currently showing as 'explain'. Trish Mills verified that this was another element of the effectiveness review, which the board will have sight of.

Trish Mills added that it will be referred to in the AAA and agreed it would be sent to the Chair of the Board.

RESOLVED: Members Reviewed the 2024/25 self-assessment against the Corporate Governance Code for Central Government Departments 2017, ahead of confirming compliance with the Code in the 2024/25 Accountability Report.

24/25 REGISTERS

The following two Registers were presented to the Committee by Trish Mills:

Annual Report on Board Member Register of Interests 2024/25

The Trust's Standing Orders provision 8.1 requires all Board Members to declare any personal or business interests they may have which may affect or be perceived to affect the conduct of their role as a board member.

Gifts, Hospitality & Sponsorship Register 2024/25

Standing Order 8.7 requires the Director of Corporate Governance/Board Secretary "on behalf of the Chair, to maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members.

The Registers will now be made publicly available on the Trust website. The increase in reporting gifts and hospitality requests was noted. This importance of transparency, especially with suppliers, and the efforts to improve communication around gifts, hospitality, secondary employment, and sponsorship was recognised.

The committee recognised that it was a requirement of Trust's Standing Orders and the Committee's Terms of Reference that the Registers be received by the Committee at least once annually.

RESOLVED: The Committee confirmed receipt of the Trust Board Register of Interests as at the 31 March 2025 and confirmed receipt of the Gifts, Hospitality, Sponsorship Register as at the 31 March 2025.

25/25 RISK REPORTING SCHEDULE - 2025/26

Julie Boalch explained that the 2025/26 schedule considered the six Board meetings ensuring there was no duplication of reporting at any Board or Committee so that all forums were receiving the most up-to-date information and was here for approval. The committee approved the revised risk reporting schedule for 2025/26.

RESOLVED: The revised Risk Reporting Schedule for 2025/26 was approved.

26/25 REFLECTIONS AND SUMMARY OF ACTIONS

Members reflected that the particular focus on the annual board and committee effectiveness review demonstrated the substantial, excellent work delivered by the Board Secretary and the wider Corporate Governance Directorate. The outputs of this provided significant assurance to the committee of the effectiveness of the current board and committee arrangements. Members commented on the positive, constructive and collaborative nature of the meeting, noting the excellent collaboration with Internal and External Auditors.

Meeting concluded at 12:30

Date of next meeting: 24 June 2025



GIG
CYMRU
NHS
WALES

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

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

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

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

APOLOGIES:

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

OBSERVERS:

Skye Banks	Compliance Administrator
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30/25 PROCEDURAL MATTERS

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

Minutes: The minutes of the open session held on 18 March 2025 were considered by the committee and confirmed as a correct record.

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

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

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

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

The Committee highlight report dated 18 March 2025 was received.

The Committee RESOLVED TO:

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

31/25 OPERATIONS UPDATE

Lee Brooks highlighted key points from the Operations Report.

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

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

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

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

The Committee RESOLVED TO note the update.

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

MONTH TWELVE 2024/25

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

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

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

The Committee RESOLVED TO:

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

MONTH ONE 2025/26

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

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

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

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

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

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

Hugh Bennett provided details on the following points:

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

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

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

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

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

The Committee RESOLVED TO:

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

34/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

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

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

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

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

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

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

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

RESOLVED: The Committee RESOLVED TO:

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

35/25 INFORMATION GOVERNANCE REPORTING

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

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

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

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

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

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

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

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

The Committee RESOLVED TO note the contents of the report.

36/25 DIGITAL REPORTING

Jonny Sammut updated the committee on the following points:

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

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

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

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

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

The Committee RESOLVED TO note the update.

38/25 INTERNAL AUDIT REPORT: ENERGY MANAGEMENT

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

The Committee RESOLVED TO note the report.

39/25 REPORT ON COMMISSIONING

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

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

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

40/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

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

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

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

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

The Committee RESOLVED TO note the contents of the report.

41/25 AUDIT TRACKER -Q4

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

The Committee RESOLVED TO:

- (1) Receive assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.**
- (2) Note the progress reported against the remaining 2024/25 Data Quality Internal Audit recommendations.**

42/25 POLICIES FOR APPROVAL

Information Risk Policy

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

The Committee approved the Information Risk Policy.

The Committee RESOLVED TO approve the Information Risk Policy.

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

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

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

Committee Priorities

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

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

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

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

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

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

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

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

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

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

The Committee RESOLVED TO:

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

44/25 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

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

Meeting concluded at 12: 45

Date of Next Meeting: 22 July 2025

**Confirmed Minutes of the
NHS Wales Joint Commissioning Committee Meeting
held in public on
Tuesday 20 May 2025**

Microsoft Teams and In Person at Willowford

Members:

Ian Green (Chair)	(IG)	Lay Member, NHS Wales JCC (In Person)
Abigail Harris	(AH)	Chief Executive Officer, Swansea Bay University Health Board, (In Person)
Philip Kloer	(PK)	Chief Executive Officer, Hywel Dda University Health Board
Paul Mears	(PM)	Chief Executive Officer, Cwm Taf Morgannwg University Health Board
Nicola Prygodzicz	(NP)	Chief Executive Officer, Aneurin Bevan University Health Board (In Person)
Carol Shillabeer	(CB)	Chief Executive Officer, Betsi Cadwaladr University Health Board
Hayley Thomas	(HT)	Chief Executive Officer, Powys Teaching Health Board
Suzanne Rankin	(SR)	Chief Executive Officer, Cardiff and Vale University Health Board (part meeting)
Mandy Rayani	(MR)	Lay Member, NHS Wales JCC (In Person)
Nia Roberts	(NR)	Lay Member, NHS Wales JCC
Paul Worthington	(PW)	Lay Member, NHS Wales JCC (In Person)
Susan Elsmore	(SE)	Lay Member, NHS Wales JCC (In Person)
Shameem Nawaz	(SN)	Lay Member, NHS Wales JCC (In Person)

Associate Member:

Stacey Taylor	(ST)	Director of Finance and Value and Deputy Chief Commissioner (In Person)
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In Attendance:

Anita Louise-Rees	(ALR)	Service Manager, M&B Unit Tonna, Swansea Bay University Health Board (part meeting)
Carole Bell	(CB)	Director of Nursing & Quality, NHS Wales JCC (In Person)
Adrian Clarke	(AC)	Interim Director for Commissioning and Mental Health, NHS Wales JCC (In Person)
Iolo Doull	(ID)	Medical Director, NHS Wales JCC
Georgina Galletly	(GG)	Director of Corporate Planning and Strategy (In Person)
Claire Harding	(CH)	Interim Director of Planning, NHS Wales JCC
Victoria Legrys	(VL)	Programme Director, Strategic Clinical Redesign, Cardiff and Vale University Health Board

Jacqui Maunder	(JM)	Committee Secretary & Deputy Director of Corporate Governance, NHS Wales JCC (In Person)
Rachel Marsh	(RM)	Executive Director of Strategy, Planning and Performance, Welsh Ambulance Service University NHS Trust
Angela Mutlow	(AM)	Director of Operations, Llais
Ross Whitehead	(RW)	Director of Commissioning for Ambulance and 111 Services, NHS Wales JCC (In Person)
Helen Tyler	(HT)	Head of Governance and Risk, NHS Wales JCC
Observing:		
Yasmin Fraser	(YF)	Member of the Public (partial attendance)
Apologies:		
Huw George	(HG)	Chief Commissioner, NHS Wales JCC
Jason Killens	(JK)	Chief Executive, Welsh Ambulance Service Trust
Mel Wilkey	(MW)	Director of Commissioning for Specialised Services
Nick Wood	(NW)	Deputy Chief Executive NHS Wales, Welsh Government
Minutes:		
Maxine Evans	(ME)	Corporate Governance Officer, NHS Wales JCC

The meeting opened at 9:30am

Min Ref	Agenda Item
JCC25/001	<p>1.1 Welcome and Introductions</p> <p>The Chair, Ian Green (IG) welcomed members, attendees and observers to the Joint Committee (JC) Public meeting and introductions were made.</p> <p>Adrian Clarke (AC) was welcomed to his first meeting as Interim Director of Commissioning for Mental Health & Vulnerable Groups.</p> <p>There were no objections to the meeting being recorded and it was confirmed that the recording would be available on the NHS Wales Joint Commissioning Committee (NWJCC) website following the meeting. It was noted that a quorum had been achieved.</p>
JCC25/002	<p>1.2 Apologies for Absence</p> <p>Apologies for absence were noted as listed above.</p>
JCC25/003	<p>1.3 Declarations of Interest</p>

Min Ref	Agenda Item
	<p>There were no additional declarations of interest relating to the items for discussion on the agenda.</p> <p>The Chair highlighted that each Health Board (HB) had an interest in the approval of the Foundation Plan and in relation to Item 3.1 the NWJCC is required to work with all its partners and stakeholders in the best interests of the population of Wales and it is recognised that each HB member must discharge its collective duty for the population of Wales.</p> <p>For Item 4.2.3 Individual Patient Funding Requests (IPFR) – it was noted that Paul Worthington is a lay member advisor on the ABUHB IPFR Panel.</p> <p>Members noted that IG was no longer Chair of the Salisbury NHS Foundation Trust. As of 1 July 2025, he will be the new Chair of the Shropshire Integrated Commissioning Board.</p>
JCC25/004	<p>1.4 Minutes of Meeting held on 18 March 2025 and Matters Arising</p> <p>The minutes of the Joint Commissioning Committee (JCC) meeting held on 18 March 2025 were received and approved as a true and accurate record of the meeting.</p> <p>There were no matters arising.</p>
JCC25/005	<p>1.5 Action Log</p> <p>Members noted the progress on the actions outlined on the action log and agreed the completion of the actions marked as 'closed' noting that several items were proposed to be closed as they were covered on the agenda.</p> <p>In relation to Action 76, Gender Services, the need for a deep dive, focussing on the provision of services to children and young people through the contract with NHS England was discussed members advised that the matter had not been addressed fully at the JC Strategy session on 15 April 2025. It was agreed that the action remain open until the JC members had received a specific session on gender at a future JCC strategy session.</p>
JCC25/006	<p>2.1 Learning from Patient Experience</p> <p>AC introduced the video of a former patient (Jessica Hill) who shared her personal experience of being a patient at the Tonna Mother and Bay Unit. It was noted that the video had been previously presented to the JCC Quality, Safety and Outcomes sub-committee. Jess shared her experience and members noted:</p>

Min Ref	Agenda Item
	<ul style="list-style-type: none"> • she had been a patient for six months and experienced challenges she faced as a mother with physical health disabilities, and it had been important to receive additional support from staff and to be with her baby during her recovery; and • that she had faced unique challenges as the first physically disabled mum treated on the Unit, including the need for specific equipment and adaptations to be put in place. <p>Anita Louise-Rees described the improvements and learning taken from patient's experience, including the implementation of a partner support pathway to provide named support for partners during admission. Efforts to address financial needs were also highlighted to ensure families had access to appropriate financial support during and post discharge.</p> <p>AC advised that funding was available to help carers with travel costs and any other support required. The recurring money aimed to alleviate some of the financial burdens faced by families.</p> <p>The service was exploring methods to minimise anxiety for patients being admitted to the Unit such as providing booklets with photographs of the unit and phone calls to introduce staff to discuss the admission process. An online video tour had also been commissioned for patients to be able to view the unit prior to admission and will be made available on the NWJCC and all Health Board (HB) websites.</p> <p>Mandy Rayani (MR) highlighted that there was a bigger issue in considering physical disabilities across all services, not just mental health services and suggested that the carer needs assessment should be implemented as a standard for any service.</p> <p>Abigail Harris (AH) advised that a new purpose-built unit was included in the long-term plan to consolidate all mental health services within Swansea Bay University Health Board (SBUHB) as a permanent solution. In the interim, AH suggested that members were welcome to visit the current Unit in small groups.</p> <p>ACTION: AC to liaise with SBUHB to arrange for JC members to visit the mother and baby unit at Tonna hospital in small groups.</p> <p>The positive learning from the patient's story was noted. The Chair requested that AH thank Jess for her willingness to share her experience with the NWJCC.</p> <p>The Joint Commissioning Committee resolved to:</p>

Min Ref	Agenda Item
	<ul style="list-style-type: none"> • Note the patient story.
JCC25/007	<p>2.2 Chair’s Report</p> <p>The Chair’s report was received, and members noted the key meetings attended in the last period and the updates provided.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report.
JCC25/008	<p>2.3 Chief Commissioner’s Report</p> <p>The Interim Chief Commissioner’s report was received, and members noted:</p> <ul style="list-style-type: none"> • the updates provided on the transition work, • the Collaborative Commissioning Leadership Group (CCLG). • The advisory internal audit to review to assess the arrangements that had been put in place at the NWJCC for embedding the statutory governance framework and the establishment of operational governance arrangements since the NWJCC was established on 1 April 2024. • The Chief Commissioners designated Accountable Officer (AO) status from 1 April 2025 until 31 March 2026 and the personal responsibility for the propriety and regularity of the public finances of the NWJCC and the responsibilities outline in the AO Memorandum for the Chief Commissioner of the NWJCC; and • changes to the senior leadership team. <p>Stacey Taylor (ST) highlighted the advisory internal audit on governance concerning the establishment of the NWJCC of governance framework was positive, and that the recommendations had made related to strengthening and developing internal meeting groups.</p> <p>Members noted the 29% vacancy rate and George Galletly (GG) advised members that there was a prioritised recruitment plan in place to and the timeline for interviews should be concluded by the end of July 2025.</p> <p>Hayley Thomas (HT) queried the reference to the CCLG and its quoracy, highlighting the need of Executive Directors to attend. Jacqui Maunder (JM) advised that the Terms of Reference (ToR) explicitly referenced that Executive Directors would need to attend to ensure quoracy, and that to date deputies had been attending meetings which did not enable full quoracy. Members agreed to ensure that Executive Directors attend in future.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report.

Min Ref	Agenda Item
JCC25/009	<p>2.4 Director of Commissioning Ambulance Services and 111 Report</p> <p>The Commissioning report from the Director of Commissioning for Ambulance Services and 111 was received and members noted the updates provided.</p> <p>Ross Whitehead (RW) gave an update on the Cabinet Secretary for Health & Social Care's announcement concerning the revised performance standards for ambulance services which will go live on 1 July 2025. RW gave an assurance that all of the necessary work had been undertaken to deliver against those standards. Members noted that the 45-minute handover standard was being driven through the Clinical Led National Ambulance Improvement Delivery Group, which was key for mitigating the risk concerning the commissioning of ambulances on the NWJCC risk register.</p> <p>Members noted that the NWJCC had held four workshops with HB representatives concerning the Manchester Arena Inquiry. The workshops had provided an opportunity to meet with HBs and WAST to discuss the assessment provided. Scrutiny will take place in June 2025 with HB representatives and alongside that, independent legal advice had been sought in addition to an independent individual to provide a further level of assurance.</p> <p>Members discussed Non-Emergency Transport Service (NEPTS) acknowledging that the complexity of patient mobility was increasing, therefore the number of patients that could be transported per vehicle was reducing. In addition, there had been a growth in cost from external providers and HB service changes had led to some longer journeys, as well as an increasing demand for both transfers and discharges.</p> <p>Members noted that WAST had been asked to undertake a deep dive into 111 service performance to provide a better understanding of the NWJCCs view and ambition for the 111-service moving forward as part of the HBs urgent care service offer.</p> <p>The Chair suggested that it would be good to understand what were the building blocks that needed to be put in place in terms of sustainability for the service and the broader productivity challenges in the system. He suggested a future discussion on how the NWJCC could Commission the service in the future would be helpful.</p> <p>ACTION: An update on NEPTS and the 111 service to be brought to the Joint Committee scheduled for 15 July 2025.</p>

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	<p>Rachel Marsh (RM) supported the Joint Committee looking at the service in more detail and highlighted that there were ongoing conversations through the six goals programme around the development of an urgent care strategy. She suggested that a collective discussion would be beneficial. This was echoed by Phil Kloer (PK).</p> <p>ACTION: Arrange a dedicated session for a deep dive of the 111 service for a future Joint Committee Strategy session.</p> <p>Members noted that the outcome of the judicial review for the Emergency Medical Retrieval Transport Service (EMRTS) was delayed as the Judge had been unwell and that an update was expected later this month.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report.
JCC25/010	<p>2.5 Director of Commissioning of Specialised Services Report</p> <p>The Commissioning Director report from the Director of Commissioning of Specialised Services was received.</p> <p>In the absence of Melanie Wilkey, ST presented the report including risks and highlights from the Commissioning Teams.</p> <p>ST advised members that following assurance provided to the CCLG, it was proposed that the Syndrome Without a Name (SWAN) service should not be decommissioned at this stage and that funding should continue until the end of the financial year, at which point long term investment would be considered as part of the 2026/27 prioritisation process. It was noted that all but one dissenting HB was supportive of this proposal.</p> <p>HT queried when further information would be received on the cochlear service and the work being undertaken and it was agreed to provide an update outside of the meeting.</p> <p>ACTION: An update on timescales for the cochlear service to be provided outside the meeting.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the specialised commissioning updates summarised in this report; and • Approve the recurrent funding for the SWAN service; and • Note the summary of specialised risks described, mindful that these are managed by means of the organisational risk

Min Ref	Agenda Item
	<p>register and that risks and services in escalation are reported to the JCC Quality, Safety and Outcomes sub-committee (QSOC) for detailed scrutiny.</p>
JCC25/011	<p>2.6 Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups Report</p> <p>The Commissioning report from the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MHLDVG) was received.</p> <p>AC presented the report and members noted updates on the perinatal service advising that the demand and capacity report on the utilisation of beds and the future modelling had been completed and was now published on the NWJCC website. The report demonstrated that the NWJCC was commissioning the right number of beds in Wales, acknowledging the further consideration needed to be given on the future provision including potential investment in community services to enable a reduction in beds and travel distance for patients.</p> <p>The Chair referenced the helpful presentation received in the JCC development session on Mental Health services in April 2025 and queried if the actions and proposed transformation work had been built into the current work plans. AC provided an assurance and advised that specific updates will be included within the report to the next JC meeting in July 2025.</p> <p>Members discussed Glanrhyd hospital and were interested in the impact on both low and medium secure beds and whether there were plans to continue with the decant arrangements, or if there were other options being considered recognising that the timescale for the repair work had increased to 18 months. AH assured members that a record was being kept on the number of patients affected.</p> <p>The Chair highlighted the need for the JC to be sited on a longer-term solution and the options that were being considered, which would provide assurance to members. It was agreed to bring an update to the next meeting.</p> <p>ACTION: An update on the Glanrhyd Hospital 18-month plan to be brought to the next JC meeting in July 2025</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report.

Min Ref	Agenda Item
JCC25/012	<p>3.1 The Development of the Joint Commissioning Committee Strategy</p> <p>The presentation on the development of the NWJCC Strategy was received and George Galletly (GG) provided an update on the development of the strategy, including strategic objectives, values, and timelines for engagement and formalisation.</p> <p>Members noted that the key components of the strategy were highlighted which when brought together would ensure the NWJCC had a decision-making framework to help support prioritisation, manage risk, and focus investment to meet population need.</p> <p>The Chair asked members if the key components were those they will expect to see within the strategy, and that from the NWJCC perspective were they the correct areas of priority to focus on.</p> <p>Members made several helpful comments including where public value and the use of resources would fit into the strategy, what primacy would be given to prevention, and the need to articulate the specialist services we want to deliver within Wales as opposed to the services that might be better placed outside Wales due to critical mass and service fragility.</p> <p>GG confirmed that the strategy will cover all services that were currently within the scope of the NWJCC's Standing Orders and acknowledged the importance of aligning the strategy with those of the HBs through the process of development. In addition, public health involvement to support the population needs assessment will be critical.</p> <p>The timing of whether it should be a 5 or 10 year strategy was still to be determined and members were asked for their views.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the presentation.
JCC25/013	<p>4.1 NWJCC 2025/2026 Foundation Plan - Implementation Framework</p> <p>The report providing an update on the framework in place detailing the implementation arrangements for the NWJCC's 2025/2026 Foundation Plan was received.</p> <p>Members noted that the foundation plan was approved by the JC on 18 March 2025.</p>

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	<p>The Chair advised that he was pleased to see both NWJCC leadership and HB leadership within the implementation plan, providing accountability in driving this forward.</p> <p>Vacancy issues within the NWJCC were flagged as an inherent risk to delivery and support from HB members to reach out for additional capacity to help with delivering the key priorities will be important. Members noted that HG was in discussion with colleague's currently around potential support, and how the work of the clinical networks could be better interlinked with the NWJCC commissioning teams acknowledging the synergies in work plans.</p> <p>PM suggested taking a proactive approach around promoting opportunities for HB staff to spend time within the NWJCC to broaden their skills and experience.</p> <p>MR was pleased to see the reference to a maturity matrix, particularly in the context of a centre of excellence, and asked about the aspirations of the plans moving forward and the link to capital expenditure, and how that could impact on the overall delivery. ST responded that there was an upcoming meeting with Welsh Government to talk about capital expenditure more broadly and the role of the NWJCC.</p> <p>The Chair reflected that further prioritisation will be required and what resources will be needed whilst holding vacancies to deliver the implementation framework. If there were barriers or delays encountered, these should be brought back to the NWJCC to ensure they are dealt with promptly.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the framework for the implementation of the NWJCC's 2025/2026 Foundation Plan; and • Note and support the collaborative approach with HBs to leading and contributing on the strategic priority areas; and • Note the urgency to secure capacity in, or working with the NWJCC by end Q1 to support delivery of the milestones identified within the framework.
JCC25/014	<p>4.2 Financial Performance Report - Month 12</p> <p>The financial performance report providing the month 12 financial position of NWJCC for the 2024-2025 financial year was received. The financial position was reported against the 2024-2025 baselines following approval of the former Welsh Health Specialised Services Committee (WHSSC) Integrated Commissioning Plan (ICP) and former Emergency Ambulance Services Committee (EASC) IMTP by their respective Joint Committees of the 7 HBs in March 2024.</p>

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	<p>The final month 12 position closed at £6.987m overspend largely supported by Welsh Government funding which came in quite late in the year.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the month-end financial position.
JCC25/15	<p>4.3 Combined NWJCC Operational Performance Report</p> <p>The Combined NWJCC Operational Performance Report was received.</p> <p>The report presented a consolidated view of the JCC's operational performance and delivery against the adopted 2024/25 plans and included detailed insights reflecting progress across Ambulance and NHS 111 Wales, Mental Health and Vulnerable Groups, Specialised Services, and other portfolios.</p> <p>ST advised that further development of an integrated performance report would take some time, however it was a priority for the team and will be monitored through the Planning, Performance and Finance (PPF) Sub-Committee.</p> <p>Services in escalation were highlighted, and members noted that one of which was in Welsh Government escalation. Specific discussion took place around Plastic Surgery, Bariatric Surgery and Positron Emission Tomography (PET) services. Members noted that the Prostate Specific Membrane Antigen (PSMA) supply issue had been resolved. However, this had created a waiting time issue of around 6 weeks, with the target being 10 days. This position had been recovered and resilience within the PET service was being held.</p> <p>Members noted that formal performance discussions around plastic surgery were being held with the two Providers in North and South Wales to ensure the NWJCC was aligned to any application of funding that was available from Welsh Government. The wider issue of whether this service was handed back to HBs due to no longer being a specialist service was noted as a priority for reaching a conclusion in 2025/26. The Chair reflected on the challenges of getting the balance correct between fulfilling the responsibilities as a commissioner but also supporting the provider and suggested that a collective discussion on fragile services would be beneficial.</p> <p>ACTION: Future JCC strategy session to focus on what improvements need to be made for fragile services.</p>

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	<p>NP commented on bariatric surgery as a growing issue and highlighted the opportunities around weight loss medication and prevention, looking at the whole pathway.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Discuss the performance information for services commissioned by the NHS Wales Joint Commissioning Committee contained within the appendix; and • Note the on-going work to align indicators and metrics into an integrated performance report for the JCC.
JCC25/16	<p>5.1 Joint Commissioning Committee Scheme of Reservation and Delegation of Powers</p> <p>The report requesting approval for the adoption of the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the NHS Wales Joint Commissioning Committee (NWJCC) to the Chief Commissioner (and other Officers as appropriate) all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs, the updated financial scheme of delegation and the financial authorisation limits was received.</p> <p>Members noted that:</p> <ul style="list-style-type: none"> • the seven HBs approved the NWJCC Standing Orders (SOs), the Scheme of Reservation and Delegation of Powers and Standing Financial Instructions at their respective Board meetings in March 2024; • The documents were subsequently adopted by the NWJCC in April 2024 and were included as a schedule to each of the HBs own SOs. The JCC also approved the NWJCC Transitional Delegated Financial authorisation matrix in April 2024; • At the time of approval, it was recognised that the documents would need to be updated further during the transition phase to reflect the developments concerning delegated matters to the JC, the Chief Commissioner, Directors, and the new sub-committees as they were established. • <p>The Joint Commissioning Committee resolved to:</p>

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	<ul style="list-style-type: none"> • Note the development of the NWJCC's governance framework, as a key component of the Health Board's governance framework; and • Discuss and Approve the adoption of the updated Scheme of Delegation and Reservation of Powers for the matters further delegated from the NWJCC to the Chief Commissioner (and other Officers as appropriate) all of which must be formally adopted by the Joint Committee and approved by LHB Boards as a schedule to their own SOs; and • Discuss and Approve the financial delegations outlined within the updated financial authorisation matrix; and • Note that each Director will receive a letter outlining their responsibilities as budget holder and will receive the appropriate training to support them in financial management; and • Note the financial authorisation matrix will need to be endorsed by the NWJCC and approved by the 7 X Health Boards; and • Note the Handling of Interest Guidance developed to support the members of the Joint Committee and NWJCC Officers in discharging their roles effectively.
JCC25/17	<p>5.2 Individual Patient Funding Request (IPFR) Policy</p> <p>The report presenting the outcomes from the engagement process with key stakeholders to review the All Wales Individual Patient Funding Request (IPFR) Policy and to seek approval for the proposed changes to the policy was received.</p> <p>Iolo Doull (ID) highlighted changes to the criteria of the policy, including the ToR which had been instigated following a successful judicial review and recommendations as an outcome of that. The revisions aimed to clarify wording and ensure consistency across Wales. This included the demonstration of significant clinical benefit compared to conventional treatment, and value for money.</p> <p>Members discussed the need to be better informed of IPFR decisions and it was suggested that a six-monthly report on IPFR decisions and expenditure be brought to the JC.</p> <p>ACTION: Six monthly reports on NWJCC IPFR panel decisions to be brought to the Joint Committee / QSO sub-committee.</p> <p>The Chair raised the need for clarity on how the NWJCC IPFR panel operated in terms of current practice, and for a broader conversation to be undertaken on how that might be developed, making sure that there was an alignment to the individual HBs.</p>

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	<p>ACTION: The IPFR panel process to be included on a future JC strategy workshop.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report; and • Approve the updated All Wales Individual Patient Funding Request (IPFR) policy; and • Note that once the Joint Committee have approved the policy it will be presented to the 7 x Health Boards (HBs) and Welsh Government for final approval and adoption from 1 July 2025.
JCC25/018	<p>5.3 Recovered Plasma from Whole Blood Donations for Medicines</p> <p>The report seeking support for the Velindre UNHST Welsh Blood Service (WBS) to commence the supply of plasma recovered from whole blood donations (recovered plasma) for the manufacture of Immunoglobulin and Albumin products for clinical use in Wales under the terms of a UK-wide contract with Octapharma AG was received.</p> <p>IG welcomed Matthew Bunce (MB) to the meeting. The report was taken as read and MB opened the floor to questions.</p> <p>Members noted that the WBS were proposing to use the price savings from the UK-wide Octapharma contract compared to the commercially sourced equivalent NHS Wales contracts, to cover the additional costs of testing, processing, warehousing and logistics of recovered plasma, as well as income lost from supply of plasma to diagnostic industry. Once a break-even point had been reached, VUNHST will share future savings with HB commissioners.</p> <p>Members noted that there were no financial implications to HBs, the proposal should provide a financial benefit down the line, and there are no new risks to patients because of the changes proposed.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Approve that the Velindre University NHS Trust (VUNHST) / Welsh Blood Service (WBS): <ul style="list-style-type: none"> - commence supply of plasma recovered from whole blood donations for the manufacture of Immunoglobulin and Albumin products for clinical use in Wales under the terms of a UK-wide contract with Octapharma AG; and - use the price savings from the UK-wide Octapharma contract compared to the commercially sourced equivalent NHS Wales contracts, to cover the additional costs and lost income.

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JCC25/019	<p>5.4 Improving Patient Flow, Oversight and Repatriation in Mental Health Hospitals</p> <p>The report recommending actions that support NWJCC cost reduction in MH, LD & VG, improves patient experience and reduces vacancies in commissioned services was received.</p> <p>AC presented the report, highlighting that this had been discussed at the JCC Strategy session in May 2025 where there had been an appetite to reduce the length of stay of the notification period for Delayed Transfers of Care (DeToC) from 3 months to 1 month and to consider extending the scope to include other NWJCC commissioned services.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report; and • Approve the reduction of the DeToC timescale from 3 months to 1 month and expand the scope to include other JCC commissioned inpatient MH/LD services.
JCC25/020	<p>5.5 Joint Commissioning Committee Risk Register – March 2025</p> <p>The NWJCC risk register was received and members noted:</p> <ul style="list-style-type: none"> • that as at 31 March 2025 there were 13 risks in total, comprising of 12 commissioning risks and 1 corporate risk, • One new risk has been added relating to Type A Aortic Dissection, • One risk had been de-escalated relating to a Lack of Paediatric Intensive Care Beds • and one risk had been closed relating to Financial Break-Even 2024-2025 and that a new risk will be added in April 2025 for the financial year 2025/26. <p>Members noted that several activities occurred in April 2025 which might enable the NWJCC to review and adjust the risk ratings and mitigation plans for some of the risks.</p> <p>Members noted that risk appetite statement will be considered in Quarter 3 to align with the development of the NWJCC Strategy.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report; and • Approve the JCC risk register as at 31 March 2025.
JCC25/021	<p>5.6 Corporate Governance Report</p> <p>The Corporate Governance Report was received.</p> <p>Members noted that the draft accountability report will be presented</p>

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	<p>to the CTMUHB Audit, Risk and Assurance Committee (ARAC) on 22 May 2025 as part of their Draft Accounts and Annual Report and the final documents will be presented to the ARAC meeting on 25 June 2025 for recommendation for Board Approval on 26 June 2025 prior to being submitted to Audit Wales and Welsh Government.</p> <p>Members noted and discussed the new timeframe for issuing papers timing for publishing papers outlined in Welsh Governments Welsh Health Circular "(WHC/2025/007) - Amendments to Model Standing orders for LHBs, Trusts and SHAs", and the proposal to adopt and adhere to the same revised timelines for HBs as 5 clear days before a formal Board meeting as opposed to 7 calendar days.</p> <p>The Chair agreed that, as a minimum, it was sensible to follow the SOs established for HBs, however emphasised that the earlier papers could be published would be helpful recognising the significant number of reports and information to be digested prior to meetings.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report; and • Approve the draft Accountability report 2024-2025 for submission to the CTMUHB Audit & Risk Committee (ARAC) on 22 May 2025 as part of CTMUHBs Draft Accounts and Annual Report; and • Endorse that the NWJCC adhere to the new "5 clear days" timeframe" timeframe for issuing formal Joint Committee papers to align with the new model for HBs, Trusts and Special Health Authorities (SHA's) and note that this will be formally adopted when we receive the new Welsh Government model SOs for the JCC; and • Approve the Annual Plan of Committee business for 2025-2026; and • Note that as the Joint Committee's new sub-committees only met once during 2024-2025, and that assurance reports were provided to the Joint Committee meeting in March 2025 sub-committee annual reports will not be required for 2024-2025, and will instead be presented for the 2025-2026 after a full year of meetings has taken place; and • Note the NWJCCs attendance at Health Board meetings in 2024-2025 to provide assurance on the work of the NWJCC, • Note that details on the NWJCC Register of Interests is included in the Accountability report 2024-2025 and will be published on the JCC website in June 2025; and • Approve the responses to the Audit Wales enquiries letter in readiness for submission to the CTMUHB Audit & Risk

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	<p>Committee on 22 May 2025 for assurance, and to Audit Wales; and</p> <ul style="list-style-type: none"> • Note that the results of the NWJCCs Annual Committee effectiveness survey will be presented to the meeting on 15 July 2025.
JCC25/022	<p>6.1 Blueteq Electronic Prior Approval System</p> <p>The report providing an update on the extension of the procurement contract for the Blueteq® electronic prior approval system to ensure business continuity for purchasing High-cost Drugs (HCD) for NHS Wales was received.</p> <p>ID described the Blue Tech Electronic Prior Approval System for high-cost drugs, explaining its role in managing high-cost drugs and ensuring compliance with NICE guidelines. Members noted that the Blueteq licence was due for renewal in April 2025 and there was a need to extend this for 2025/26 to ensure business continuity and compliance with managed access agreements.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the report.
JCC25/23	<p>6.2 Highlight Reports from the Joint Sub-Committees</p> <p>The highlight reports from the following Joint Sub-Committees were received:</p> <p>6.2.1 Quality, Safety and Outcomes Sub-committee (QSO) Highlight Report</p> <p>The highlight report from the meeting held on 31 March 2025 was received. MR highlighted the importance of focusing reports on quality and outcomes going forward, and the powerful patient story shared during the meeting. She also expressed how pleasing it was to see several of the actions agreed progressing well.</p> <p>The point of equity was also touched upon and how that pervades the experience of almost every patient that accesses these services because they are often centralised due to their specialist nature, and that focus will continue to be pursued through the sub-committee.</p> <p>6.2.2 Planning Performance and Finance Sub-committee (PPF)</p> <p>The highlight report from the meeting held on 8 April 2025 was received. PW commented that a key focus of the sub-committee is to maintain an overview of the risks and providing assurance ahead of the JCC committee. This will be a critical piece of work for the sub-committee.</p>

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	<p>6.2.3 Individual Patient Funding Request (IPFR) Panel The highlight report from the meeting held on 16 April 2025 was received. MR suggested that the IPFR reports are taken through the QSO sub-committee for discussion ahead of the JCC committee meetings. The Chair responded that time to consider the delegated responsibilities within the sub-committees would be useful.</p> <p>The Chair queried if the lay member vacancies for the IPFR panel had been advertised and noted that this needed to be progressed.</p> <p>6.2.4 Welsh Kidney Network (WKN) The highlight report from the meeting held on 16 April 2025 was received. Members noted that conversations had taken place with Ian Phillips, Chair of the WKN around the governance review which was currently concluding and will be brought to the next JC meeting in July 2025.</p> <p>Members discussed what assurance the JC required from sub-committees and groups and it was suggested that a review be undertaken.</p> <p>ACTION: Undertake a review of what assurance the Joint Committee needs to receive from the legacy groups, sub-committees, IPFR panel and the WKN.</p> <p>The Joint Commissioning Committee resolved to:</p> <ul style="list-style-type: none"> • Note the highlight reports.
JCC25/24	<p>7.1 Any Other Business There were no other matters of business to discuss.</p>
JCC25/25	<p>7.2 Review of Meeting The Chair asked for members to provide any reflections on the meeting. The following comments were received:</p> <ul style="list-style-type: none"> • Reports need to be specifically focussed on what was required of the JC; and • Not all issues brought to the JC were being taken through the sub-committees prior to the JC meeting; and • Reports need to be clear on which meeting(s) the issues have been discussed and scrutinised at on behalf of the JC; and • A significant number of red risks had not been given time for discussion although they were noted in the reports.

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	It was agreed that report writing training be given to report authors and that the structure of the meeting agenda be reviewed to focus on the NWJCC's risk profile.
JCC25/26	<p>7.3 Date of Next Meeting</p> <p>The next routine meeting was scheduled for the 15 July 2025 and the JCC Strategy Session on 17 June 2025.</p>

The meeting concluded at 12:41.

Chair's Signature:

Date:

CONFIRMED

ACRONYMS BUSTER

ABBREVIATION	TERM
AAA	Alert, Assure, Advise Report
ACA1/2	Ambulance Care Assistant
ADLT	Assistant Directors' Leadership Team
AfC	Agenda for Change
AGM	Annual General Meeting
AMR	Antimicrobial Resistance
APC	Academic Partnership Committee
APPs	Advanced Paramedic Practitioners
AQIs	Ambulance Quality Indicators
ARAC	Audit, Risk and Assurance Committee
ARWAP	Anti Racist Wales Action Plan
BAF	Board Assurance Framework
BI	Business Intelligence
CVUHB	Cardiff and Vale University Health Board
CAS	Clinical Assessment System
CASC	Chief Ambulance Services Commissioner
CC	Charity Committee
CCC	Clinical Contact Centres
CFRs	Community First Responders
CHARU	Cymru High Acuity Response Unit
CIAT	Clinical Intelligence and Assurance Team
COPI	Control of Patient Information Regulations
COSHH	Control of Substances Hazardous to Health
CPD	Continual Professional Development
CPR	Child Practice Reviews
CardioPR	Cardiopulmonary Resuscitation
CRM	Clinical response Model
CRR	Corporate Risk Register
CQGG	Clinical Quality Governance Group
CSD	Clinical Support Desk
CTP	Clinical Transformation Programme
DAP	Decarbonisation Action Plan

ACRONYMS BUSTER

ABBREVIATION	TERM
DEEE	Diesel Engine Exhaust Emissions
DPIA	Data Protection Impact Assessment
EAP	Emergency Ambulance Practitioner
EASC	Emergency Ambulance Services Committee
EDs	Emergency Departments
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
ELT	Executive Leadership Team
ePCR	Electronic Patient Care Record
EPRR	Emergency Preparedness Resilience and Response
ESR	Electronic Staff Record
GRS	Global Rostering System
HART	Hazardous Area Response Team
HEIW	Health Education and Improvement Wales
HIW	Health Inspectorate Wales
FPC	Finance and Performance Committee
FReM	Government Financial Reporting Manual
FTE	Full-time Equivalent
HSE	Health and Safety Executive
ICAP	Integrated Commissioning Action Plan
ICO	Information Commissioner's Office
IMTP	Integrated Medium-Term Plan
IPC	Infection Prevention Control
IRP	Incident Response Plan
JCC	Joint Commissioning Committee
JESIP	Joint Emergency Services Interoperability Principles
JIF	Joint Investigations Framework
JOL	Joint Organisational Learning
LCFS	Local Counter Fraud Service
LRF	Local Resilience Forum/Fora
MACA	Military Aid to Civil Authorities
MAI	Manchester Arena Inquiry

ACRONYMS BUSTER

ABBREVIATION	TERM
MDS	Minimum Data Set
MHRV	Mental health response vehicle
MIQPR	Monthly Integrated Quality and Performance Report
NEPTS	Non-Emergency Patient Transport Service
NHSDW	NHS Direct Wales
NQP	Newly Qualified Paramedic
NRIs	National Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
PADRs	Performance and Development Reviews
PCC	People and Culture Committee
PENNA	Patient Experience National Network Awards
PECI	Patient Experience and Community Involvement
PPE	Personal Protective Equipment
PSOW	Public Service Ombudsman for Wales
QIA	Quality Impact Assessment
QMG	Quality Management Group
QPMF	Quality and Performance Management Framework
QuEST	Quality, Patient Experience and Safety Committee
Q1, Q2, Q3, Q4	Quarter (of the financial year)
RemCom	Remuneration Committee
RCRP	Right Care Right Person
RCS	Rapid Clinical Screening
REAP	Resource Escalation Action Plan
RICS	Remote Integrated Care Service
RPE	Respiratory Protective Equipment
RPB	Regional Partnership Boards
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
RIF	Regional Integration Fund
ROSC	Return of spontaneous circulation from cardiac arrest
SCIF	Significant Clinical Incident Forum
SDECs	Same Day Emergency Care Centres

ACRONYMS BUSTER

ABBREVIATION	TERM
SI	Statutory Instrument
SOP	Standard Operating Procedure
SORT	Specialist Operational Response Team
STB	Strategic Transformation Board
STEMI	ST segment elevation myocardial infarction
SUS	Speaking Up Safely
The Trust	Welsh Ambulance Services University NHS Trust
TRiM	Trauma and Risk Management
TU	Trade Union
UCRS	Urgent Community Response Service
UCS	Urgent Care Service
UHP	Unit Hour Production
UTS	University Trust Status
WASPT	Welsh Ambulance Services Partnership Team
WHSCC	Welsh Health Specialised Services Committee
WRP	Welsh Risk Pool
WTEs	Whole-time equivalents