Bundle Trust Board (Public Session) 26 November 2026

Agenda attachments
- Agenda Public Trust Board 26 November 2026
- Agenda Public Trust Board 26 November 2026-en-cy-C

0 09:30 - OPENING ITEMS

1 Chair's welcome, apologies and quorum

2 Declarations of interest
- Item 02 Board Member Register of Interests 18 November 2026

3 Minutes of the previous meetings:

3.1 3.1 AGM - 30 July 2026
- Item 03.1 2026-07-30 AGM Minutes draft

3.2 3.2 Trust Board - 24 September 2026
- Item 03.2 2026-09-24 Public Trust Board Minutes draft

4 Action log and matters arising
- Item 04 Trust Board (Public) Action and Decisions Log

5 09:35 - Chair and Vice-Chair's report
- Item 05 Chair and Vice-Chair Report - November 2026

6 09:45 - Chief Executive's report
- Item 06 Chief Executive's Report November Final

7 10:00 - Questions from members of the public

7.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

8 10:05 - Patient experience: Chontelle Owen
- Item 08 Updated Experience Story tracker - Chontelle Owen final

9 10:35 - Finance report month 7 2026/27
- Item 09 Finance Report Month 7 26-27 Final

9.1 10:50 - COMFORT BREAK

10 11:05 - Integrated Medium Term Plan (IMTP) 2026/27 Q2 progress update
- Item 10 Trust Board IMTP Q2 26.27 Delivery & Assurance Report_Nov 2026 Final
- Item 10 Appendix 1 - Welsh Government IMTP Approval Letter_FINAL
- Item 10 Appendix 2 - WAST IMTP Accountability Conditions FINAL WG
- Item 10 Appendix 3 - IMTP 26-29 Progress Update Quarter 2 SO4 v0.3 FINAL

11 11:20 - Monthly Integrated Quality and Performance Report (MIQPR)
- Item 11 MIQPR SBARN TB August September 2026
- Item 11 Annex 1 MIQPR TB August September 2026 TB

12 11:40 - Board committee AAA highlight reports:

12.1 18 September 2026: Academic Partnership Committee
- Item 12.1 Academic Partnership Committee report 18 September 2026

12.2 5 November 2026: QuEST Committee
- Item 12.2 Quest Committee Highlight Report 5 November 2026
- Item 12.2.1 HIW Review of Progress October 2026
- Item 12.2.2 HIW Improvement Plan October 2026

12.3 10 November 2026: People and Culture Committee

Item 12.3 People and Culture Committee AAA Highlight Report 10 November 2026
Item 12.3.1 Annex 1 WES organisation-level report
Item 12.3.2 Annex 2 WASPT Annual Report draft 2025-26 post WASPT 210926
Item 12.3.2 Annex 3 WASPT ToR 2026-27 amended post WASPT 210926, for TB approval 261126

12.4 17 November 2026: Finance and Performance Committee
Item 12.4 FPC Highlight Report 17 November 2026 Public

13 12:10 - Governance report
Item 13 Governance Report November 2026

13.1 12:15 - CLOSING ITEMS

14 Reflections

15 Any other business

16 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).

17 Date and time of next meeting: 28 January 2027 at 9.30am

18 Acronyms
Item 18 Acronyms

Length of Meeting:	02:50	Agenda Status: AGREED	PUBLIC TRUST BOARD: 26 November 2026 (VPH)					Deadline for papers: 17 November 2026	
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	n/a
		2	Declarations of interest	To State Conflicts	Standing	Verbal	n/a	Chair	n/a
09:30	00:05	3	Minutes of the previous meetings: 3.1 AGM - 30 July 2026 3.2 Trust Board - 24 September 2026	Approval	Standing	Paper	n/a	Chair	n/a
		4	Action log and matters arising	Discussion	Standing	Paper	n/a	Chair	AnnaMaria Williams
09:35	00:10	5	Chair and Vice-Chair's report	Information	Standing	Paper	CorGov	Chair, Vice Chair	Alex Payne, AnnaMaria Williams
09:45	00:15	6	Chief Executive's report	Information	Standing	Paper	CEO Office	Emma Wood	Keith Ellingham
10:00	00:05	7	Questions from members of the public	Discussion	Standing	Verbal	Partnerships	Estelle Hitchon	n/a
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
10:05	00:30	8	Patient experience: Chontelle Owen	Assurance	Standing	Presentation	QSPE	Andy Swinburn	Alison Kelly, Leanne Hawker
10:35	00:15	9	Finance report month 7 2026/27	Assurance	Standing	Paper	FinCor	Chris Turley	Ed Roberts
10:50	00:15		COMFORT BREAK						
11:05	00:15	10	Integrated Medium Term Plan (IMTP) 2026/27 Q2 progress update	Assurance	Standing	Paper	SPP	Rachel Marsh	James Houston
11:20	00:20	11	Monthly Integrated Quality and Performance Report (MIQPR)	Assurance	Standing	Paper	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Georgia Tizzard. Melanie O'Connor
		12	Board committee AAA highlight reports:	Assurance	Standing	Paper	CorGov	Various	n/a
		12.1	18 September 2026: Academic Partnership Committee	Assurance	Standing	Paper	CorGov	Hannah Rowan	Sarah Harland
11:40	00:30	12.2	5 November 2026: QuEST Committee 12.2.1 HIW report (Review of progress following HIW reviews, October 2026) 12.2.2 HIW Improvement Plan	Assurance	Standing	Paper	CorGov	Bethan Evans	Sarah Harland
		12.3	10 November 2026: People and Culture Committee 12.3.1 Workforce Race Equality Standards report 2026 12.3.2 WASPT annual report 2025/26 and 2026/27 terms of reference (approval)	Approval	Standing	Paper	CorGov	Ceri Jackson	Sarah Harland
		12.4	17 November 2026: Finance and Performance Committee	Approval	Standing	Paper	CorGov	Jayne Beeslee	AnnaMaria Williams
12:10	00:05	13	Governance report	Approval	Standing	Paper	CorGov	Trish Mills	AnnaMaria Williams
			CONSENT ITEMS The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so. There are no consent items						
			CLOSING ITEMS						
		14	Reflections	Discussion	Standing	Verbal	n/a	Chair	n/a
		15	Any other business	Discussion	Standing	Verbal	n/a	Chair	n/a
12:15	00:05	16	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	n/a
		17	Date and time of next meeting: 28 January 2027 at 9.30am	Information	Standing	Verbal	n/a	Chair	n/a
		18	Acronyms	Information	Standing	Paper	n/a	Chair	n/a
12:20	**02:50**		**CLOSE**						

LEAD PRESENTERS

Name	Position
Phil Berrington	Chair of the Trust Board, Non- Executive Director
Emma Wood	Chief Executive
Jayne Beeslee	Non-Executive Director, Chair of Finance and Performance Committee
Peter Curran	Non-Executive Director, Chair of the Audit, Risk and Assurance Committee
Bethan Evans	Non-Executive Director, Chair of the Quality, Patient Experience and Safety Committee
Estelle Hitchon	Director of Partnerships and Engagement
Ceri Jackson	Non-Executive Director, Chair of People and Culture Committee
Rachel Marsh	Deputy Chief Executive
Trish Mills	Director of Corporate Governance/Board Secretary
Hannah Rowan	Non-Executive Director, Chair of Academic Partnership Committee
Andy Swinburn	Chief Clinical Officer
Chris Turley	Executive Director of Finance and Corporate Resources

Hyd y cyfarfod:	02:50	Statws yr agenda: CYTUNWYD ARNI	BWRDD CYHOEDDUS YR YMDDIRIEDOLAETH: 26 Tachwedd 2026 (VPH)					Dyddiad cau ar gyfer papurau: 17 Tachwedd 2026	
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	Ddim yn berthnasol
		2	Datganiadau o Fuddiant	Datgan gwrthdaro	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd	Ddim yn berthnasol
09:30	00:05	3	Cofnodion y cyfarfodydd blaenorol: 3.1 Cyfarfod Cyffredinol Blynyddol - 30 Gorffennaf 2026 3.2 Bwrdd yr Ymddiriedolaeth - 24 Medi 2026 (Cadarnhad o ddileu recordiad/trawsgrifiad y cyfarfodydd blaenorol)	Cymeradwyaeth	Sefydlog	Papur	Ddim yn berthnasol	Cadeirydd	Ddim yn berthnasol
		4	Cofnodion gweithredu a materion sy'n codi	Trafodaeth	Sefydlog	Papur	Ddim yn berthnasol	Cadeirydd	AnnaMaria Williams
09:35	00:10	5	Adroddiad y Cadeirydd a'r Is-gadeirydd	Gwybodaeth	Sefydlog	Papur	Llywodraethu Corfforaethol	Cadeirydd, Is-gadeirydd	Alex Payne, AnnaMaria Williams
09:45	00:15	6	Adroddiad y Prif Weithredwr	Gwybodaeth	Sefydlog	Papur	iwyddfa'r Prif Swyddog Gweithredo	Emma Wood	Keith Ellingham
10:00	00:05	7	Cwestiynau gan aelodau'r cyhoedd	Trafodaeth	Sefydlog	Ar lafar	Partneriaethau	Estelle Hitchon	Ddim yn berthnasol
			EITEMAU AR GYFER CYMERADWYAETH, SICRWYDD A THRAFODAETH						
10:05	00:30	8	Profiad y Claf: Chontelle Owen	Sicrwydd	Sefydlog	Cyflwyniad	nsawdd, Diogelwch a Phrofiad y Cl	Andy Swinburn	Alison Kelly, Leanne Hawker
10:35	00:15	9	Adroddiad cyllid mis 7 2026/27	Sicrwydd	Sefydlog	Papur	Cyllid ac Adnoddau Corfforaethol	Chris Turley	Ed Roberts
10:50	00:15		EGWYL						
11:05	00:15	10	Diweddariad cynnydd ar gyfer Ch2 y Cynllun Tymor Canolig Integredig (IMTP) 2026/27	Sicrwydd	Sefydlog	Papur	trategaeth, Cynllunio a Pherfformia	Rachel Marsh	James Houston
11:20	00:20	11	Adroddiad Ansawdd a Pherfformiad Integredig Misol (MIQPR)	Sicrwydd	Sefydlog	Papur	trategaeth, Cynllunio a Pherfformia	Rachel Marsh	Hugh Bennett, Mark Thomas, Georgia Tizzard. Melanie O'Connor
		12	Adroddiadau ar y prif bwyntiau o bwyllgorau'r Bwrdd:	Sicrwydd	Sefydlog	Papur	Llywodraethu Corfforaethol	Amrywiol	Ddim yn berthnasol
		12.1	18 Medi 2026: Y Pwyllgor Partneriaethau Academaidd	Sicrwydd	Sefydlog	Papur	Llywodraethu Corfforaethol	Hannah Rowan	Sarah Harland
11:40	00:30	12.2	5 Tachwedd 2026: Pwyllgor Ansawdd, Profiad a Diogelwch - Adroddiad AGIC	Sicrwydd	Sefydlog	Papur	Llywodraethu Corfforaethol	Bethan Evans	Sarah Harland
		12.3	10 Tachwedd 2026: Y Pwyllgor Pobl a Diwylliant 13.3.1 Adroddiad Safonau Cydraddoldeb Hil y Gweithlu 2026 (cymeradwyaeth) 13.3.2 Cylch gorchwyl adroddiad blynyddol WASPT 2025/26 a 2026/27 (cymeradwyaeth)	Cymeradwyaeth	Sefydlog	Papur	Llywodraethu Corfforaethol	Ceri Jackson	Sarah Harland
		12.4	17 Tachwedd 2026: Y Pwyllgor Cyllid a Pherfformiad	Cymeradwyaeth	Sefydlog	Papur	Llywodraethu Corfforaethol	Jayne Beeslee	AnnaMaria Williams
12:10	00:05	13	Adroddiad Llywodraethu	Cymeradwyaeth	Sefydlog	Papur	Llywodraethu Corfforaethol	Trish Mills	AnnaMaria Williams
			EITEMAU AR GYFER CYDSYNIAD At ddibenion gwybodaeth yn unig y mae'r eitemau canlynol. Os bydd aelod yn dymuno trafod unrhyw un o'r eitemau hyn, gofynnir iddo/iddi hysbysu'r Cadeirydd fel y gellir neilltuo amser i wneud hynny. Nid oes unrhyw eitemau ar gyfer cydsyniad						
			EITEMAU I GLOI						
		14	Myfyrdodau	Trafodaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd	Ddim yn berthnasol
		15	Unrhyw fater arall	Trafodaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd	Ddim yn berthnasol
12:15	00:05	16	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 Cyrff Cyhoeddus (Derbyn i Gyfarfodydd) 1960).	Cymeradwyaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd	Ddim yn berthnasol
		17	Dyddiad ac amser y cyfarfod nesaf: 28 Ionawr 2027 am 9.30am	Gwybodaeth	Sefydlog	Ar lafar	Ddim yn berthnasol	Cadeirydd	Ddim yn berthnasol
		18	Acronymau	Gwybodaeth	Sefydlog	Papur	Ddim yn berthnasol	Cadeirydd	Ddim yn berthnasol
12:20	**02:50**		**DIWEDD Y CYFARFOD**						

PRIF GYFLWYNWYR

Enw	Swydd
Phil Berrington	Cadeirydd Bwrdd yr Ymddiriedolaeth, Cyfarwyddwr Anweithredol
Emma Wood	Prif Weithredwr
Jayne Beeslee	Cyfarwyddwr Anweithredol; Cadeirydd y Pwyllgor Cyllid a Pherfformiad
Peter Curran	Cyfarwyddwr Anweithredol, Cadeirydd y Pwyllgor Archwilio, Risg a Sicrwydd
Bethan Evans	Cyfarwyddwr Anweithredol, Cadeirydd y Pwyllgor Ansawdd, Profiad y Claf a Diogelwch
Estelle Hitchon	Cyfarwyddwr Partneriaethau ac Ymgysylltu
Ceri Jackson	Cyfarwyddwr Anweithredol, Cadeirydd y Pwyllgor Pobl a Diwylliant
Rachel Marsh	Dirprwy Brif Weithredwr
Trish Mills	Cyfarwyddwr Llywodraethu Corfforaethol/Ysgrifennydd y Bwrdd
Hannah Rowan	Cyfarwyddwr Anweithredol, Cadeirydd y Academic Partnership Committee
Andy Swinburn	Chief Clinical Officer
Chris Turley	Cyfarwyddwr Gweithredol Cyllid ac Adnoddau Corfforaethol

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Date Left Trust
AHMAD, Umar Afthab DR	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	GP Partner at Plains View Surgery, Nottingham	Financial Interest	2014		
		Primary Care Network Clinical Director for Arrow Health, Nottingham	Financial Interest	2019		
		Non-executive Director (appointed company director) for Primary Integrated Community Services Ltd, Nottingham and small shareholder [Company number 08763136]	Financial Interest	2023 and 2016		
		Owner and company director of Travel Jab Guru Ltd – online medical travel advice [Company number 14685908]	Financial Interest	2023		
		Local Medical Committee Member	Financial Interest	2019		
		Nottingham Integrated Care Board Cardiovascular Disease and Stroke Prevention Clinical Design Authority Lead	Financial Interest	2025		
		Associate Non-executive Director Nottinghamshire University Hospital Trust (non-voting member of the board)	Financial Interest	2024		
BEESLEE, Jayne	**Non-Executive Director** * Chair of Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment fro interim assignments via Public Sector Resourcing (an agency) regarding the rev iew of major UK Government programmes (remunerated nex of tax via an umberella company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Governor on the Finance and General Purposes Committee of Cardiff and Cale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel and Development	Non-Financial Personal	01 April 2006		
BERRINGTON, Phil	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Shareholdings: Remaining shares in former employer: IBM <£10,000	Financial Interest	2010		
		Remaining shares in former employer: The Hackett Group <£5,000	Financial Interest	2008		
		Secondary employment: Deputy Chair Portsmouth Hospitals University NHS Trust and Isle of Wight NHS Trust	Directorships	2019	18 October 2026	
		Fellow Chartered Institute of Management Accountants	Non-Financial Personal	1981		
		Chartered Management Consultant	Non-Financial Personal	2021		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Cmgr FCMI - Chartered Manager and Fellow of Chartered Management Institute (UK)	Loyalty			
		CPMgr FIML - Certified Practising Manager and Fellow of Institute of Managers and Leaders (Aus/NZ)	Loyalty			
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Trustee of Action for Children Pension Board	Position in Charity or Voluntary Organisation	22 May 2023		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Chair - Taff Housing Association	Any Other Interest	17 July 2025		
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Non-Financial Professional	01 March 2024		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Date Left Trust
		Independent Member - Kaplan Open Learning (including member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Group Chair of South Central Ambulance Service NHS Foundation Trust and South East Coast Ambulance Service NHS Foundation Trust	Directorships	27 March 2026		30 September 2026
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		30 September 2026
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		30 September 2026
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		30 September 2026
DURRANT, Penny	**Deputy Director of Nursing, Quality and Governance**	Nil Declaration		30 May 2026		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Companty Director - Springfield Property Lettings Ltd	Directorships	16 August 2022		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	Directorships	12 March 2020		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	Directorships	27 April 2022		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
		Longhope Property Ltd	Directorships	12 February 2026		
		My Choice Healthcare England Ltd	Directorships	26 August 2025		
		My Choice Healthcare Ltd	Directorships	26 August 2025		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Date Left Trust
		Glyncornel Care Ltd	Directorships	16 August 2022		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025		
		Consultant Advisor to the FASAR Trial, Nottingham Trent University	Financial Interest	25 March 2026		
		Charity Trustee, UK Paruresis Trust	Non-Financial Personal	24-Aug-26		
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		
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		28 June 2026
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Chartered Fellow of the CIPD		2005		31 October 2026
MARSH, Rachel	**Deputy Chief Executive/Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
NESTOR, Alex	**Chief People Officer**	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		
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	17 June 2028	
		CHIME (College of Healthcare Information Management Executives) Digital Health Fellowship - UK Cohort 2026	Non-Financial Professional	07 May 2026		
		Author of the book: '*Working With AI, Not Against It*' ~ commerically published and generates royalty income from sales.	Financial Interest	24 February 2026		
		Family member appointed to a post within Digital Directorate but will not be line managed by Director [appointment accepted 24/07/2026]	Any Other Interest	24 July 2026		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Nil Declaration				
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		29-May-26
		Member Royal College Nursing	Any Other Interest	01 August 2022		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Date Left Trust
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		
WOOD, Emma	**Chief Executive (from 01 October 2025)**	Chartered Fellow of CIPD (Chartered Institute of Personnel and Development)	Non-Financial Professional	2000		
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025		
		Part-time Yoga Teacher at Burnham Swim and Sports Academy Leisure Centre	Financial Interest	July 2025		
		Sub/Relief Yoga Teacher at Omni Studio, Worle, North Somerset	Financial Interest	04 April 2026		
		Board Director, Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	August 2026		
		Appointment as Employer Representative of the Social Partnership Council for Wales	Non-Financial Personal	01 December 2026	30 November 2029	

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

MINUTES OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST ANNUAL GENERAL MEETING HELD ON THURSDAY 30 JULY 2026 IN THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

The meeting started at 9.30am

ATTENDEES:

Colin Dennis	Chair of the Trust Board
Emma Wood	Chief Executive Officer
Dr Umar Ahmad	Non-Executive Director
Jayne Beeslee	Non-Executive Director
Lee Brooks	Executive Director of Operations
Peter Curran	Non-Executive Director
Bethan Evans	Non-Executive Director
Estelle Hitchon	Director of Partnerships and Engagement
Professor Hayley Hutchings	Non-Executive Director
Ceri Jackson	Non-Executive Director
Angela Lewis	Director of Culture Change
Trish Mills	Director of Corporate Governance/Board Secretary
Hugh Parry	Trade Union Partner
Hannah Rowan	Non-Executive Director
Jonny Sammut	Director of Digital
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources

APOLOGIES:

Rachel Marsh	Deputy Chief Executive
Damon Turner	Trade Union Partner

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1. CHAIR'S WELCOME

1.1 The Chair welcomed everyone to the Annual General Meeting of the Welsh Ambulance Services University NHS Trust, noting that it was being livestreamed and was a public meeting where members of the public were encouraged to ask questions.

2. ANNUAL REPORT AND ACCOUNTS OVERVIEW 2025/26

2.1 Emma Wood, Chief Executive Officer, provided an overview of the Trust's performance during 2025/26 and shared several key highlights as below.

2.2 The Welsh Government Ambulance Performance Framework has been introduced, which has shifted performance assessment away from a primary focus on response times and towards clinical outcomes and patient care.

2.3 Progress has been made in Clinical Model Transformation (CMT), with changes beginning to improve how demand is managed and how patients access appropriate care.

2.4 Approximately 60% of 999 callers now receive remote clinical assessment, supporting the aim of providing the right care in the most appropriate setting and reducing unnecessary hospital attendance.

2.5 There has been strong partnership working with health boards, Welsh Government, local authorities, commissioners and third-sector organisations, including initiatives such as single points of access, same-day emergency care and falls pathways.

2.6 There has been a continued focus on improving hospital handover performance and reducing the length of time ambulance crews spend waiting outside emergency departments.

2.7 The first year of the Trust's Well-being of Future Generations pledge has been supported by three wellbeing objectives and the Trust's role as an anchor organisation in Wales.

2.8 The Trust has maintained strong governance and financial stewardship, met all statutory duties and continued to invest in its workforce.

2.9 There is ongoing investment in staff wellbeing, leadership and organisational culture, recognising that patient care depends on a supported workforce.

3. AUDITED FINANCIAL ACCOUNTS 2025/26

3.1 Chris Turley, Executive Director of Finance and Corporate Resources, presented the key highlights from the Trust's audited 2025/26 annual accounts and reported that the Trust had met all statutory financial duties.

3.2 The Trust submitted its draft accounts on time and underwent a detailed audit by Audit Wales. The accounts received an unqualified audit opinion, with very few adjustments required and no uncorrected misstatements.

3.3 The accounts were considered through the Trust's governance arrangements, including at the Audit, Risk and Assurance Committee on 23 June 2026, before being approved by Trust Board on 25 June 2026 and signed off by the Auditor General for Wales on 26 June 2026.

3.4 The Trust achieved an effective break-even financial position, delivering a small retained surplus while spending broadly in line with the income received.

3.5 In addition to achieving revenue financial balance, the Trust met its Capital Expenditure Limit and complied with the Public Sector Payment Policy, paying invoices within required timescales.

3.6 Total income and expenditure were just under £350 million, with approximately 75% of expenditure (£260 million) related to staff costs, reflecting the Trust's workforce-intensive nature.

3.7 Non-pay expenditure was around £50 million, with the largest areas being:

- Transport costs (approximately £18 million), including fuel, maintenance and repairs of vehicles.
- Premises costs (just under £17 million), covering the operation and maintenance of around 120 sites across Wales.
- Clinical and general supplies required to deliver ambulance services.

3.8 The Trust invested £32.3 million in capital projects during 2025/26, with around £24 million spent on fleet replacement. This enabled 141 vehicles to be replaced during the year, the largest vehicle replacement programme undertaken by the Trust. A similar level of funding has been secured for 2026/27, supporting the replacement of a further 160 vehicles.

3.9 Investment in the Trust's estate through the year includes:

- A new fleet workshop in Bangor.
- A refurbished and converted ambulance station in Dolgellau.

- A major refurbishment of the station in Monmouth.
- Additional improvement works at Abergavenny, and at the Matrix, Swansea, which enabled the closure of Thanet House.

3.10 Future investment is planned in sites including Wrexham, Swansea, Carmarthen, Pembroke Dock, various North Wales locations and Vantage Point House, Cwmbran.

3.11 Capital investment is increasingly focused on sustainability through the installation of technologies such as solar PV panels, battery storage, air-source heating and electric vehicle charging infrastructure. The Trust is continuing to expand the use of electric and lower-carbon vehicles, particularly within single responder and Non-Emergency Patient Transport Services (NEPTS) fleets, where technology and affordability permit.

4. IN REVIEW OF 2025/26

4.1 Presentations shared at the AGM were structured around the four NHS Wales operating and accountability pillars of finance, delivery/performance, quality, workforce and the domain of well-led. The presentation showcased achievements and challenges in 2025/26, as well as priorities for the year ahead.

Delivery/Performance – Clinical Performance

4.2 Andy Swinburn, Executive Director of Paramedicine, provided an overview of clinical performance during 2025/26 and outlined several key highlights.

4.3 The Ambulance Performance Framework (APF) was introduced in two phases during 2025, replacing the previous response-time based categories with a model that better reflects patient need and clinical outcomes. The framework supports the Trust's clinical model by enabling remote clinicians to assess how quickly a patient requires face-to-face care, what type of clinician is needed, and whether alternatives to hospital attendance are appropriate.

4.4 Return of Spontaneous Circulation (ROSC) is the principal clinical outcome measure for cardiac arrest patients. The Trust has seen a gradual improvement in cardiac arrest survival outcomes, with performance trends comparing favourably with other UK ambulance services.

4.5 The work of Save a Life Cymru has included:

- Increasing bystander cardiopulmonary resuscitation (CPR) rates.
- Improving access to public access defibrillators.
- Supporting CPR and defibrillator training initiatives.

- Enhancing the readiness and effectiveness of Wales' defibrillator network.
- Providing support programmes for those affected by cardiac arrest.

4.6 The APF measures the effectiveness of clinical interventions through outcome indicators. These measures provide evidence of the clinical impact of ambulance interventions rather than simply how quickly a response arrives, and include:

- Oxygen saturation improvement for patients with breathing difficulties, showing an average improvement of around 7% during episodes of care.
- Pain management, demonstrating reductions in patients' pain scores following treatment.
- National Early Warning Score measures, showing that clinicians are generally stabilising or improving patients' conditions during treatment.

4.7 The Trust's most significant performance challenge is stroke and ST-Elevation Myocardial Infarction (STEMI) call-to-door times. While some improvements have been seen, patients are still taking too long to reach specialist treatment. The primary issue is the time taken to reach the patient, rather than time spent on scene, which remains comparable with other ambulance services. Contributing factors include:

- Call handling times.
- Dispatch processes.
- Ambulance availability.
- Distance travelled to patients.

4.8 Priorities for 2026/27 include improving call-to-scene times and reducing delays for stroke and heart attack patients. Separate workstreams are underway to address each element of the patient journey and improve overall outcomes.

Delivery/Performance – Operational Performance

4.9 Lee Brooks, Executive Director of Operations, provided an overview of operational performance across the Trust's emergency and non-emergency services, highlighting both improving access to care and the ongoing pressures affecting ambulance availability.

4.10 During 2025/26, the Trust received approximately 549,000 emergency 999 calls, equating to around 420,000 incidents. Although incident demand reduced by around 3% compared with the previous year, demand remained high and regularly exceeded available capacity during periods of system pressure.

4.11 Access to the 999 call service remained strong, with a median call answer time of one second, and improvement in the longest waits experienced by callers.

4.12 The Trust maintained its International Academy of Emergency Dispatch Centre of Excellence accreditation.

4.13 Significant progress was made in remote clinical assessment, with almost 60% of 999 callers receiving clinical assessment remotely, compared with around 30% the previous year. This enabled more patients to receive advice, referral or alternative care pathways without requiring an ambulance response.

4.14 NHS 111 Wales handled over 1 million telephone calls and more than 5 million digital interactions during the year. Demand for the service remained consistently high, particularly during evenings, weekends and times of seasonal pressure.

4.15 There have been ongoing challenges with call abandonment rates, with independent modelling showing that commissioned staffing levels were insufficient to consistently achieve historic performance expectations. The Trust has undertaken workforce and service planning work and continues discussions with commissioners regarding longer-term solutions.

4.16 Regarding Emergency Ambulance Response, demand for the most serious incidents has increased significantly in recent years, although growth started to stabilise during 2025/26. There has been a move from the former 'Red' category to the new 'Purple Arrest'' and 'Red Emergency' categories under the APF. Performance for 'Red Emergency' patients remained below the level the Trust would like to achieve, with response times still presenting challenges.

4.17 Hospital handover delays is one of the most significant operational challenges affecting ambulance services. Delays in transferring patients to emergency departments remove ambulances and crews from the community, reducing available capacity and impacting response times. The Trust has expanded remote assessment and improved productivity, but handover delays continue to have a major impact on performance. Encouragingly, national focus through the 'Handover 45' programme has led to:

- Reduced lost ambulance hours.
- Fewer extremely long handover delays.

- Greater system-wide recognition of the risks associated with delayed handovers.

4.18 NEPTS remained a vital service supporting access to renal dialysis, oncology, outpatient appointments and discharge journeys. During 2025/26, the service managed over 745,000 bookings and travelled more than 11 million miles. Demand for the service became increasingly complex, with more patients requiring stretcher transport and longer-distance journeys.

4.19 Capacity pressures resulted in approximately 33,000 cancelled journeys, more than double the previous year, which had negatively affected patient experience. Patient feedback remained positive; satisfaction with transport services remained above 92% and courtesy and professionalism scores for staff were consistently between 97% and 99%.

4.20 Future priorities include:

- A dedicated NEPTS Improvement Programme being established, focusing on eligibility, digital capability, efficiency, reporting and workforce improvements.
- A fleet replacement programme to replace 65 NEPTS vehicles which will improve both staff experience and service delivery.

Delivery/Performance – Digital Performance

4.21 Jonny Sammut, Director of Digital Services, outlined progress against the Trust's Digital Strategy, which is structured around five strategic pillars:

- Transformation
- Digital Pioneers
- Security, Safety and Cyber
- Data, Information and Insight
- Everyday Essentials

4.22 Progress has been monitored through clear performance measures and reported regularly to the Finance and Performance Committee, providing assurance on delivery, benefits realisation and value for money.

4.23 The Trust has continued to improve patient choice, accessibility and efficiency through AI-enabled services. Highlights included:

- The launch of AI-supported functionality within 111 Wales Online
- SMS appointment cancellation services

- Enhanced language and accessibility support for patients accessing digital services

4.24 The Trust has continued to support new models of care through:

- Intelligent digital signposting
- Remote triage
- Digital pathway development
- Automation of processes

4.25 Work has continued to strengthen Cyber Security and Information Governance arrangements, including cyber resilience and core digital infrastructure. The importance of ensuring patient information remains secure and that critical services continue to operate safely and reliably is core to the strategy.

4.26 Investment has been made in improving the Trust's use of data and analytics to support operational and clinical decision-making, improve planning and strengthen performance monitoring across the organisation.

4.27 Continued investment has been made in digital capability and innovation. The Trust has strengthened partnerships across NHS Wales to accelerate the adoption of technologies that improve patient care and workforce productivity.

4.28 Future priorities include:

- Expanding the use of AI-enabled services.
- Increasing digital integration across health and care organisations.
- Enhancing the use of data and predictive analytics.
- Working with NHS Wales organisations, government and industry partners to identify and deliver shared digital solutions.

Quality

4.29 Penny Durrant, Interim Director of Nursing and Quality, provided an overview of the Trust's quality agenda, focusing on strengthening patient experience, learning from concerns and incidents, and creating a more integrated approach to quality assurance and improvement.

4.30 Three key areas of progress were highlighted:

4.301 <u>Strengthening People's Experience</u>
The Trust has developed its People's Experience Framework, bringing together patient stories, complaints, compliments and wider engagement

and feedback. This approach is helping the Trust better understand what matters most to patients and families and use that insight to shape services.

4.302 Turning Learning into Improvement

The Trust is increasingly bringing together intelligence from incidents, concerns, legal claims and inquests. Rather than treating these as separate processes, they are being triangulated to identify recurring themes, emerging risks and opportunities for improvement. This approach also underpins the Concerns Management Recovery Programme, with a focus not only on improving response times but also on improving the quality of investigations, strengthening organisational learning and embedding improvement across the Trust.

4.303 Investing in People and Quality Infrastructure

Continued investment has been made in professional standards, clinical supervision, safeguarding, infection prevention and control and governance systems. The Trust achieved national recognition for its safeguarding work and continued to contribute to national infection prevention initiatives. Work has also begun to integrate professional regulation, safeguarding and governance arrangements into a more joined-up quality framework.

4.31 Challenges remain around concerns management and timeliness of responses however significant progress has been made in strengthening the foundations for quality improvement and developing a more proactive learning culture.

4.32 The Trust's quality framework supports Strategic Objective 5, "Being Quality Driven and Clinically Led," with key themes including:

- Putting patients, families and communities at the centre of improvement.
- Using patient experience and feedback as a key source of intelligence.
- Fulfilling the statutory Duty of Quality through continuous improvement of services and outcomes.
- Strengthening clinical governance and patient safety arrangements.
- Supporting staff through professional development, supervision and workforce assurance.
- Using intelligence from multiple sources to identify system-wide opportunities for improvement rather than responding only to individual events.
- Providing stronger assurance to the Board through integrated reporting on patient experience, safety, workforce, professional standards, complaints, claims, coronial learning and performance.

Workforce

4.33 Angie Lewis, Director of Culture Change, highlighted the Trust's work during 2025/26 to strengthen workforce sustainability, culture, inclusion and partnership working. Three areas where partnership working had been particularly important were:

4.331 Future Skills Mix Model
The Trust worked closely with Trade Unions, Health Education and Improvement Wales (HEIW), universities and Welsh Government to develop its future workforce and skills mix requirements.

4.332 Workplace Safety
Significant work was undertaken to improve speaking up, sexual safety, and the management of violence and aggression towards staff, with the aim of creating a safer working environment.

4.333 Sickness Absence
The Trust continued to work with ambulance services and wider public sector organisations to better understand the pressures experienced by emergency service staff and identify ways to improve attendance and wellbeing.

4.34 The importance of social partnership was acknowledged, with continued investment in joint development programmes for trade union representatives and managers to strengthen local working relationships.

4.35 A range of initiatives aimed at improving organisational culture and inclusion were outlined, including more than 350 leaders completing training through the Our WAST Way Leadership Framework, progress made against the Trust's Strategic Equality Objectives, including improvements in workforce diversity data, and the gender pay gap reducing from 5.3% to 4.5%.

4.36 Staff and volunteer networks were expanded, supporting greater allyship and inclusion and significant focus was placed on sexual safety and speaking up, with a full-time Speaking Up Safely Guardian appointed.

4.37 Improvements were achieved in relation to the Welsh Language, with better accessibility of services supported.

4.38 There were positive results from the NHS Wales Staff Survey, including improved scores relating to a compassionate and inclusive culture and an increase in overall survey participation from 35.2% to 43%, demonstrating higher levels of workforce engagement.

4.39 Sickness absence remained above target, although a downward trend was achieved. There has been ongoing investment in wellbeing services, clinical psychology and post-trauma support, with the challenging nature of frontline ambulance work acknowledged.

4.40 PADR compliance remained below target, but work was undertaken to improve the quality of appraisal conversations rather than focusing solely on compliance.

4.41 Staff turnover reduced during the year. A new 'Moving On' interview process was introduced, enabling the Trust to better understand why staff leave and to use that learning to improve workforce retention and experience.

Well-Led (accountability report)

4.42 Trish Mills, Director of Governance, presented the Trust's Accountability Report for 2025/26, providing an overview of the Trust's governance, risk, assurance and internal control arrangements.

4.43 The Trust Board maintained oversight of quality, patient safety, workforce, performance, finance and risk through established governance structures and systems of internal control. The board remained satisfied that effective governance, risk management and control arrangements were in place across the Trust.

4.44 Independent sources of assurance remained positive throughout the year, including an overall 'reasonable assurance' opinion from Internal Audit, and positive findings from the Audit Wales Structured Assessment.

4.45 Improvements are still required in concerns management, with additional oversight and governance arrangements introduced to strengthen performance in this area.

4.46 The Trust's Board Assurance Framework will continue to mature, supported by the introduction of Risk Appetite Statements during 2025/26 to help guide decision-making and risk management across the organisation.

4.47 Governance improvements are ongoing and will be driven by the Integrated Governance Programme and actions arising from the recent Good Governance Institute Board Effectiveness Review.

5. FORWARD LOOK

5.1 Estelle Hitchon, Director of Partnerships and Engagement, outlined the Trust's strategic priorities for 2026/27, setting these within the context of the Trust's Integrated Medium-Term Plan (IMTP), financial pressures and changing service demands. Priorities include:

- Maintaining a strong focus on clinical outcomes, patient experience and reducing harm.
- Evaluating the benefits delivered through the CMT Programme and new Ambulance Performance Framework to ensure they are improving patient outcomes and experiences as intended.
- Demonstrating productivity, efficiency and value for money within a challenging public sector financial environment.
- Focusing resources on a smaller number of priorities that will deliver the greatest benefit for patients, staff and the organisation.
- Developing new income generation opportunities, supported by an emerging commercial strategy and newly established commercial function.
- Remaining agile in responding to future Welsh Government priorities and policy developments.

5.2 Strategic Objective 1: Providing the Right Care or Advice, in the Right Place, Every Time

5.21 Plans being put in place to meet this objective include:

- Further embed the APF and CMT.
- Strengthen clinically led prioritisation and earlier clinical advice for patients.
- Develop the digital front end for NHS 111 Wales, providing additional ways for people to access services.
- Improve NEPTS reliability, scheduling and reductions in avoidable cancellations.
- Strengthen emergency preparedness and resilience arrangements.
- Continue providing national leadership across NHS Wales in urgent and emergency care.

5.3 Strategic Objective 2: Enabling Our People to Be the Best They Can Be

5.31 Plans being put in place to meet this objective include:

- Continuing to improve culture, engagement and speaking up safely.
- Addressing workforce challenges, including the oversupply of newly qualified paramedics.

- Expanding apprenticeships and career development opportunities.
- Reducing sickness absence, burnout and work-related stress.
- Strengthening proactive workforce health and wellbeing support.

5.4 Strategic Objective 3: Being at the Forefront of Innovation and Technology

5.41 Plans being put in place to meet this objective include:

- Replacement of the Trust's Computer Aided Dispatch (CAD) system.
- Further development of digital access to services, including SMS functionality for patients.
- Progressing electronic patient record improvements.
- Enhancing data linkage and integration across NHS Wales.
- Continuing to invest in core digital infrastructure while delivering innovation.

5.5 Strategic Objective 4: Developing Services in Collaboration

5.52 Plans being put in place to meet this objective include:

- Begin reviewing and refreshing the Trust's Long-Term Strategy beyond 2030.
- Work more closely with health boards and system partners.
- Provide leadership across urgent and emergency care pathways.
- Explore alternative clinical models and pathways that meet the needs of Wales' diverse urban and rural communities.

5.6 Strategic Objective 5: Being Quality Driven and Clinically Led

5.61 Plans being put in place to meet this objective include:

- Introducing a more compassionate, person-centred approach to concerns management.
- Strengthening the Patient Voice network.
- Using patient feedback to shape future service design.
- Bringing together quality improvement, change management and project management approaches to support organisational improvement.

5.7 Strategic Objective 6: Delivering Exceptional Value and Sustainability

5.71 Plans being put in place to meet this objective include:

- The Trust has agreed a balanced financial plan for 2026/27, supported by £9 million of savings and a commitment to deliver 2% productivity improvements.

- A £31 million capital programme will be delivered during the year.
- A Trust-wide Financial Sustainability Programme has been established.
- The Trust has launched a new commercial function to explore alternative income generation opportunities and strengthen long-term financial sustainability.

6. QUESTIONS FROM THE PUBLIC

6.1 Questions were received from the public prior to and during the meeting and were answered as follows.

6.2 The Annual Report acknowledges that Non-Emergency Patient Transport Services are having to cancel transport on the day, and that data collection on this matter is not complete. This results in unused hospital appointments and is detrimental to patients - plus wasted staff time if it involves a care home. What actions will the Trust take to better monitor this problem and reduce the number of last-minute transport cancellations? (Stephen Senior, MS)

6.3 In response, it was acknowledged that short-notice cancellations can be distressing for patients and families and may result in missed hospital appointments; apologies were offered to those who had experienced poor service. The Trust's objective is to reduce avoidable cancellations wherever possible, but where cancellations cannot be avoided, the priority is to provide earlier notice, clearer communication and a more sustainable and efficient service for patients.

6.4 Cancellations arise for several reasons, including transport capacity constraints, patients no longer requiring transport and hospital appointments being changed or cancelled by healthcare providers. The Trust has now established a dedicated NEPTS Improvement Programme, which will focus on:

- Reviewing patient eligibility criteria to ensure transport is prioritised for those with the greatest clinical need.
- Improving how demand and capacity are managed, including the use of planned activity limits when demand exceeds available resources.
- Improving data, reporting and analytics to identify service pressures earlier.
- Working with health boards to improve appointment booking and cancellation processes and to reduce avoidable late changes.
- Introducing digital solutions to improve communication with patients and provide better visibility of transport arrangements.

6.5 Patient feedback had consistently highlighted the greatest frustration being the lateness of cancellation. As a result, the Trust is focusing on giving patients as much notice as possible when transport cannot be provided, improving communications and public information and using engagement activities to involve patients in shaping future service improvements.

6.6 *What is the total cost of your electrification plan and, related to that, what is the cost of your de-carbonisation ambition? What is the planned spend over the next financial year? (Anonymous)*

6.7 In response, it was emphasised that sustainability is now embedded within the Trust's capital planning and investment decisions. Estate developments and refurbishment schemes routinely incorporate decarbonisation measures where affordable and practical, including:

- Solar photovoltaic (PV) panels.
- Battery storage.
- Air source heat pumps.
- Electric vehicle (EV) charging infrastructure

6.8 The cost of these measures varies significantly between sites due to local factors such as geography, electricity supply requirements and National Grid infrastructure, making it difficult to provide a single overall programme cost.

6.9 The Chair thanked attendees and all those who had sent in questions.

The meeting closed at 10.45am

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

MINUTES OF THE PUBLIC MEETING OF WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST, TRUST BOARD ON THURSDAY 24 SEPTEMBER 2026 HELD IN VANTAGE POINT HOUSE, CWMBRAN AND VIA TEAMS

The recording of this meeting can be viewed here

The meeting started at 9.30am

MEMBERS:

Ceri Jackson	Non-Executive Director and Vice Chair *(chair of the meeting, deputising for Colin Dennis)*
Emma Wood	Chief Executive Officer
Dr Umar Ahmad	Non-Executive Director
Jayne Beeslee	Non-Executive Director
Peter Curran	Non-Executive Director
Keith Dorrington	Assistant Director of Digital (for Jonny Sammut)
Bethan Evans	Non-Executive Director
Estelle Hitchon	Director of Partnerships and Engagement
Professor Hayley Hutchings	Non-Executive Director
Angie Lewis	Director of Culture Change
Rachel Marsh	Deputy Chief Executive
Trish Mills	Director of Corporate Governance/Board Secretary
Angela Mutlow	Director of Operations, Llais
Hugh Parry	Trade Union Partner
Andy Swinburn	Chief Clinical Officer
Chris Turley	Executive Director of Finance and Corporate Resources
Paul Underwood	Deputy Director of Operations (for Lee Brooks)

APOLOGIES:

Lee Brooks	Chief Operating Officer
Colin Dennis	Chair of the Trust Board
Hannah Rowan	Non-Executive Director
Jonny Sammut	Director of Digital
Damon Turner	Trade Union Partner

SECRETARIAT:

Alex Payne	Corporate Governance Manager
AnnaMaria Williams	Corporate Governance Officer

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OPENING ITEMS

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

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

2. DECLARATIONS OF INTEREST

2.1 There were no other declarations recorded.

3. MINUTES OF PREVIOUS MEETINGS

3.1 The minutes of the public meetings of the Trust Board held on 30 July 2026 were received and approved.

4. ACTION LOG AND MATTERS ARISING

4.1 The action log was reviewed and discussed, with updates added to the log.

5. CHAIR AND VICE CHAIR'S REPORT

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

5.1 The report was received and noted by the board.

6. CHIEF EXECUTIVE'S REPORT

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

6.1 The report was received and noted by the board. Emma Wood acknowledged that this would be the last board meeting for both Colin Dennis and Angie Lewis. She thanked Colin, in his absence, for his leadership and contribution during his time as Chair, and thanked Angie for her significant contribution and leadership of the Trust's people and culture agenda.

6.2 Members discussed winter planning and system risk management, including how risks can be shared across the system. Members were advised that NHS Wales Performance and Improvement (NHSW P&I) had recently sought greater understanding of how organisational risks align

with wider system risks. Work is underway nationally to collate and assess risks and mitigations across Wales to provide a more integrated view of system risk. Members were assured that the Trust had already differentiated between risks that could be directly managed and those that could only be monitored and influenced, positioning the organisation well to contribute to these discussions.

6.3 Members discussed whether the new Welsh Government was driving any noticeable change in behaviour, accountability or sanctions within the NHS and were advised that recent discussions with NHSW P&I reflected a more directive and collaborative approach to system accountability. It was noted that the Welsh accountability framework does not currently include the same incentives and consequences seen within NHS England and that the Trust had provided feedback suggesting stronger rewards for high performance and clearer intervention mechanisms for underperformance.

6.4 Members asked whether ministers or Members of the Senedd had been invited to visit the Trust to see its work first hand and were advised that they had. The publication of the new programme for government, with an increased focus on organisational performance, leadership and delivery, was noted.

6.5 Members noted the development of a winter urgent and emergency care (UEC) dashboard, as requested by NHSWP&I and discussed whether this could create additional resource burdens. Members were advised that a national UEC dashboard was already in operation, providing daily oversight of system performance including emergency department waits, bed occupancy, handover delays and call handling performance. The new winter dashboard would focus on demonstrating organisational contributions to system flow and winter resilience and assurance was provided that reporting would utilise existing datasets and would not create additional administrative burden or duplicate performance reporting requirements.

6.6 The Trust has prepared a winter dashboard that will follow an agreed governance route through the Joint Commissioning Committee (JCC) before being shared with NHSWP&I, ensuring consistency of reporting and oversight.

7. QUESTIONS FROM MEMBERS OF THE PUBLIC

7.1 Members were advised that two questions had been received from members of the public, Mr Brian Price and Mr Owen Pullman-Slater, both concerning specific patient cases. It was therefore felt not appropriate for

detailed discussion on these to take place in a public board meeting because of confidentiality considerations.

7.2 Estelle Hitchon explained that both questions related to the handling of concerns, including the integrity, timeliness and effectiveness of the concerns management process. On behalf of the board, Estelle apologised to the individuals concerned, noting that they felt their concerns had not been managed appropriately.

7.3 Andy Swinburn acknowledged that the complainants had not received the standard of response they deserved and provided an update on improvement work within the Listening to People service and the Trust's concerns management arrangements. He advised that the Trust had recognised shortcomings in its concerns management processes and had established a significant improvement programme to strengthen capacity, increase senior clinical oversight, improve communication and timeliness, engage earlier with people raising concerns and ensure that learning from complaints drives service improvement.

7.4 Learning from concerns and complaints is now captured and used to drive changes in patient care and patient experience. The programme is focused on achieving compliance with the Listening to People Regulations while promoting a more person-centred, compassionate and learning-focused approach to concerns management. It was emphasised that this work is intended not only to meet statutory requirements but to provide a better experience for patients and members of the public who place their trust in the service.

7.5 Members discussed and noted that the Trust's Quality, Patient Experience and Safety Committee (QuEST) had given considerable scrutiny to the Trust's performance in relation to concerns management. The Chair of that committee, Bethan Evans, confirmed that members had been assured that progress was being made and that significant improvements had already been delivered, however recognised that further improvements were required. These included responses to complainants being more person-centred, meaningful and compassionate, and less scripted and technical in nature. Members received assurance that significant work was underway to improve the experience of people raising concerns with the Trust.

ITEMS FOR ASSURANCE, DISCUSSION OR APPROVAL

8. STAFF EXPERIENCE: SOPHIA SEABOURNE (INCLUSIVE WORKSPACE)

Sophia Seabourne and Pema Richards joined the meeting at 10.08am

8.1 The board welcomed Sophia Seabourne, Resource Centre Co-ordinator, and her line manager, Pema Richards, Resource Supervisor, to the meeting and received a presentation from them in which they shared their experiences of workplace inclusion and disability support within the Trust.

8.2 Sophia explained that she works at Vantage Point House and has worked for the Trust for nearly 13 years. Sophia has multiple sclerosis and she experienced a spinal cord injury in 2021, resulting in her becoming a full-time wheelchair user. Through a video and personal testimony, Sophia described how physical access can significantly affect the working experiences of disabled staff.

8.3 Sophia reflected on her return to work after spending more than a year in hospital and admitted that she initially had concerns about whether she could continue working full-time because of her disability and health condition. However, she described receiving significant support from managers and colleagues, which helped remove much of her anxiety and enabled her to return successfully to employment. Challenges can include the availability and location of accessible parking spaces, building access difficulties, including heavy doors, thresholds and swipe-card entry systems and workplace layouts that do not always fully consider wheelchair users. Sopha explained that these barriers can have a cumulative impact on an employee before they even start their working day.

8.4 Sophia emphasised that her disability does not prevent her from working, but that environmental barriers can create unnecessary obstacles. She stressed that accessibility is not simply about buildings and facilities but about mindset, planning ahead and being willing to listen and respond when barriers are identified.

8.5 Pema, Sophia's line manager, explained the practical steps she had taken before Sophia returned to work. Pema researched multiple sclerosis and spinal cord injuries to better understand the potential impact on Sophia and the support she might need, familiarised herself with symptoms such as fatigue and mobility challenges, walked through the workplace from the perspective of a wheelchair user to identify potential barriers and worked with Estates colleagues to assess physical accessibility before Sophia started. Pema also reviewed Trust policies and procedures, including display screen equipment assessments, attendance management arrangements and occupational health support, to ensure she understood the available support mechanisms. She said her aim was to create an environment where Sophia would feel comfortable discussing any difficulties and confident that support would be available when required.

8.6 Sophia described her overall experience of returning to work as overwhelmingly positive, whilst recognising that accessibility improvement is an ongoing process. Several physical improvements have been made, including the installation of automatic doors at VPH, additional disabled parking spaces and improved signage and accessibility arrangements. This has allowed Sophia to focus on performing her role rather than worrying about practical obstacles.

8.7 Members thanked Sophia and Pema for sharing their experiences and reflected on the importance of accessibility and inclusion, highlighting the value of understanding lived experience. Progress made by the Trust was acknowledged, while noting that barriers continued to exist for disabled people. The importance of continued investment in estates, workplace accessibility and organisational culture was highlighted, with the Trust aspiring to achieve the highest possible standards of inclusion and accessibility and with accessibility remaining a priority within the estates agenda.

8.8 Members noted Pema's compassionate and proactive leadership, emphasised the need for consistent support across the organisation, and stressed that reasonable adjustments should be determined by need and not constrained by local budgets.

8.9 Members discussed whether the Trust involves people with lived experience of disability when planning building works and refurbishments and were advised that major refurbishment and new-build projects routinely involve building users through project boards. The Trust is increasingly seeking to learn from lived experience and to embed accessibility considerations earlier in the design process, with these becoming a more prominent feature of estates planning.

8.10 The role of the Trust's Purple Space Network in providing lived experience and informing organisational improvements for colleagues with long-term health conditions and disabilities was also highlighted. Members heard that managers are encouraged to engage with the network as allies, to increase understanding of the experiences of disabled colleagues.

8.11 In response to a question about what more the Trust could do to change mindsets and promote inclusion, Sophia highlighted the importance of sharing lived experiences, encouraging open conversations and creating opportunities for staff to ask questions and learn from one another. She noted that understanding often develops through direct interaction with colleagues and emphasised that increased visibility of lived experiences helps challenge assumptions and drive cultural change. Members reflected on the value of experiential disability awareness training in improving

understanding and on opportunities to further strengthen learning and awareness across the organisation.

8.12 Members thanked Sophia and Pema for sharing their experiences and for their positive examples of inclusion in practice.

Sophia Seabourne and Pema Richards left the meeting at 10.31am

8.13 PREVIOUS STORY FOLLOW UP: PATIENT EXPERIENCE, LUCY BURROWS ON BEHALF OF AJ

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

8.14 Members received an update on learning arising from Lucy Burrows' presentation at the July board meeting and heard that AJ's story had been shared at the Leaders Connect conference and incorporated into organisational learning sessions to support wider staff development. Feedback had been provided directly to the staff involved in AJ's care, recognising the positive impact of their actions.

8.15 It was confirmed that patient stories would continue to be used as learning tools across the organisation, with work underway to develop more systematic approaches for capturing and sharing patient and family experiences to support person-centred care and service improvement.

9. FINANCE REPORT MONTH 5 2026/27

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

9.1 The board received the finance report, noting that it had received detailed scrutiny at the Finance and Performance Committee meeting held on 15 September 2026 as noted in their AAA report. Members were provided with assurance that performance against the balanced financial plan and the budget approved by the board in March was currently being maintained and that the Trust was aligned to deliver the approved financial position. Capital expenditure was progressing ahead of previous years, reflecting earlier approval of fleet replacement funding and improved planning of capital schemes.

9.2 The Finance and Performance Committee had also considered the Welsh Government financial governance and control self-assessment, which identified a number of positive areas whilst recognising opportunities for further improvement. Members were advised that many improvement actions were already underway prior to completion of the assessment. The

self-assessment and evidence of board budget approval had been submitted to Welsh Government and NHSWP&I as part of increasing national financial governance scrutiny.

9.3 Members were reminded that the Trust's financial forecast continues to assume Welsh Government support for Welsh Risk Pool costs. Assurances had been received on this, with confidence in the funding assumption remaining high, however the funding mechanism cannot be fully confirmed until year-end and therefore remains recorded as a financial risk. Members were assured that these assumptions would continue to be monitored through the Trust's financial forecasting process.

9.4 Members discussed the ongoing volatility of fuel prices and the associated financial risk. Members were assured that the Trust retained sufficient contingency to manage the pressure and that detailed month 6 forecasting would further test assumptions and available flexibility. Whilst fuel had created a significant in-year pressure, the impact was expected to be materially lower than the worst-case scenario due to fluctuations in market prices and the Trust remained on course to deliver its financial plan, while continuing to monitor fuel costs closely.

9.5 The board noted and gained assurance in relation to the month 5 revenue financial position and performance of the Trust as at 31 August 2026. The board noted the delivery of the 2026/27 savings plan, and the context of this within the overall financial position of the Trust, noted the initial capital programme for 2026/27 and noted the month 5 Welsh Government monitoring return submission.

10. MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT (MIQPR)

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

10.1 The board received and considered the MIQPR report for June/July 2026 and were reminded that the board is now the only forum that considers the full range of MIQPR metrics, with committees considering the metrics relevant to their remit rather than the complete performance picture. The board noted that these reviews were also provided in each committee's AAA report.

10.2 Angela Mutlow welcomed the reported improvements in ambulance handover times and asked whether this corresponded to improvements in the patient experience, and whether patient feedback was being used to inform service improvement. Andy Swinburn explained that the improvements were expected to improve patient experience through greater ambulance availability, with reductions in cancellations and

improvements in the longest patient waits likely be the first observable benefits. Patient experience will be monitored through both direct patient feedback and information gathered through Handover 45 meetings. Angela asked about the difference that patients and families should realistically notice in the next twelve months if the improvements are successful and was advised that better ambulance availability should also support faster call-to-door times for stroke and STEMI (ST-elevation myocardial infraction) patients.

10.3 Members were advised that handover delays remained volatile however, highlighting the need for continued partnership working between the Trust and health boards. The Trust was also reviewing its own operational practices and culture to maximise the benefits of improved handover performance.

10.4 Members emphasised the importance of the Trust continuing to strengthen its ability to demonstrate the impact of improvement initiatives on patient outcomes and experience. Members welcomed the assurances received regarding improvement activity and delivery plans, noting there is also a need to model and evidence the performance gains that patients should expect to see from those interventions. Members were advised that work was underway through the call flow optimisation programme and the review of orange now pathway activity to develop performance trajectories and expected improvement outcomes through to November and year-end. It was agreed that this work would be brought back to the board to provide assurance regarding the anticipated impact on patient experience and operational performance.

10.5 The board was asked to approve the pausing of reporting on the neck of femur fracture metric given the focus on call to door times for stroke and STEMI, due to limited resources. Members sought assurance on whether this metric would be picked up in the future and were assured that the measure had been paused rather than discontinued. Once progress had been achieved in the priority areas of stroke and STEMI call-to-door performance, which were areas of greater patient risk, work would recommence on developing the neck of femur fracture metric and associated improvement programme.

10.6 Members noted that the national reportable incidents (NRI) chart showed fluctuations, with one month showing a far higher incident level than the others. Members sought clarification regarding the level of occurrence for NRIs the Trust might reasonably expect within a complex healthcare system. Members were advised that the measure was one of activity rather than a performance target and that the Trust had not established a specific expected level of activity. It was agreed for the Quality, Safety and Patient Experience Committee (QuEST) to review the NRI metric in greater detail,

including trend analysis, learning and appropriate contextual information, and to provide assurance regarding whether the reported levels are within expected parameters. This request will be transferred to the QuEST committee public action log.

10.7 Members discussed the assumptions underpinning the forecast for emergency ambulance hours produced, observing that the forecast appeared to indicate lower workforce hours during the forthcoming winter period compared with the previous year. Members also sought clarification on the role of overtime within the forecast and whether reduced overtime assumptions could affect operational capacity during a period of anticipated increased demand.

10.8 Members were advised that overtime continued to be used to address vacancies and operational pressures, with staffing capacity reviewed and resources directed across the wider response model to support ambulance availability, performance and patient experience. Additionally, the executive team had reviewed the longstanding 95% production target and identified a range of contributory factors, including vacancies, financial constraints and changes in workforce deployment. It was agreed that Rachel Marsh would work with operational colleagues to review the reporting of the emergency ambulance production metric and the longstanding 95% production target and would bring forward proposals for a revised approach to reporting these metrics.

11. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

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

11.1 The board received the risk report, noting that, as was evidenced in their AAA reports, the Trust's committees had already undertaken detailed scrutiny of the Trust's principal risks and that the board had previously agreed a more strategic approach to risk reporting. The paper therefore focused primarily on reputational risks, which the board had specifically agreed to retain within its direct oversight.

11.2 Members were assured that risks continue to be subject to regular executive and committee review and that the Trust's strategic board assurance framework was continuing to develop. This was reiterated by Peter Curran as chair of the Audit, Risk and Assurance Committee. A board development session will be held in December to review and refresh risk appetite statements, with the strategic board assurance framework due to be fully operational early in the next financial year.

11.3 The board received and discussed the Trust's two reputational risks relating to stakeholder relationships and patient experience. They were assurance on the effectiveness of the arrangements in place to manage and monitor these risks.

11.4 It was agreed that oversight of risk 201b, relating to poor patient experience be transferred to QuEST to provide more integrated and detailed assurance, given that this was the forum where those controls and mitigations are already scrutinised in greater detail.

12. BOARD COMMITTEE AAA HIGHLIGHT REPORTS

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

12.1 6 August 2026: Quality, Patient Experience and Safety Committee

12.1.1 Bethan Evans, Chair of QuEST presented the highlight report and drew attention to the patient story shared by Anna Jenkins, who described supporting her neighbour while awaiting an ambulance response.

12.1.2 Members heard that the story prompted significant discussion, particularly around perceptions of highly scripted organisational responses and comparisons with the more flexible response received from the Fire Service. While the committee received assurance regarding improvement activity already underway, the story reinforced the importance of ensuring that organisational processes remain person-centred, compassionate and responsive to individual circumstances.

12.1.3 Members noted the report and particularly welcomed the committee's recognition of the progress made within the concerns management improvement programme. It was noted that the position remained fragile, with sustainable recovery not yet fully achieved and with meaningful and lasting improvement likely to take time due to the scale and complexity of the issues being addressed.

12.2 11 August 2026: People and Culture Committee

12.2.1 Ceri Jackson, Chair of the People and Culture Committee, presented the highlight report, noting that both the Welsh Language Annual Report 2025-26 and the Strategic Equality Plan Annual Report 2025/26 had been endorsed by the committee.

Melfyn Hughes joined the meeting at 11:42

12.2.2 Melfyn Hughes joined the meeting and presented the Welsh Language Annual Report 2025-26 to members bilingually. Members were advised that the Trust remained compliant with the Welsh Language Standards, with a recent internal audit review also providing reasonable assurance. Members were pleased to see the significant progress and improvements that had been made across the Trust in the Welsh language agenda.

12.2.3 Members received assurance from the Speaking up Safely Annual Report, while recognising that further work remained to strengthen organisational culture and confidence in speaking up.

The board approved the Welsh Language Annual Report 2025-26 and the Strategic Equality Plan Annual Report 2025/26.

Melfyn Hughes left the meeting at 12:12pm

12.3 3 September 2026: Audit, Risk and Assurance Committee

12.3.1 Peter Curran, Chair of the Audit, Risk and Assurance Committee, presented the highlight report and items for board approval.

12.3.2 Members were advised that the committee had reviewed the proposed amendments to the Scheme of Reservation and Delegation of Powers and had endorsed and recommended them for approval.

12.3.3 Members were advised that a review of delegated financial limits had also been undertaken, following a request from the Finance and Performance Committee. No changes to delegated financial thresholds were proposed however, following benchmarking against comparable NHS organisations.

The board approved the Scheme of Reservation and Delegation amendments to reflect current executive role titles, portfolio responsibilities and interim executive arrangements and retrospectively approved the application of the delegations previously assigned to the Director of People, to Angela Lewis, Director of Culture Change, from 28 June 2026.

12.4.1 Members were advised that the committee had reviewed and scrutinised the Good Governance Institute (GGi) board effectiveness review action plan and the associated governance changes arising from that review, was satisfied that the proposed maturity levels

and delivery timescales were realistic and endorsed the plan and the implementation approach.

12.4.2 The committee had endorsed the strategic reporting and assurance framework for board committees and the revised approach to the board agenda, recommending their approval by the board.

12.4.3 Members were assured that the revised reporting and assurance framework would support implementation of the review recommendations and strengthen the board's focus on strategic delivery, strategic outcomes and strategic risk. Members were advised that committee work programmes and terms of reference would be reviewed to align with this approach, with future board meetings increasingly focusing on the relationship between IMTP delivery, organisational performance and strategic risk. The GGi improvement actions would be incorporated into routine governance arrangements, with future effectiveness reviews used to assess progress against the agreed maturity objectives.

The board approved the strategic reporting and assurance framework for board committees and the revised approach to the board agenda.

12.4.4 The committee had endorsed a proposal to reduce the frequency of Charity Committee and Corporate Trustee meetings from four meetings per annum to two meetings per annum with immediate effect, reflecting the revised strategic direction approved by the Corporate Trustee. The board's approval was sought for that proposal.

The board approved the revised meeting schedule for Charity Committee and Corporate Trustee meetings and associated decision-making arrangements.

12.4 15 September 2026: Finance and Performance Committee

12.4.5 Jayne Beeslee, Chair of the Finance and Performance Committee, presented the highlight report, noting that this was the first time that the Manchester Arena Inquiry recommendations had been discussed in public, with previous discussions held in private due to confidentiality considerations.

12.4.6 The committee considered the implications of future national events, including UEFA Euro 2028 and the Tour de France, and received assurance that early planning discussions were already underway with relevant partners.

13. GOVERNANCE REPORT

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

13.1 The board noted the report and **approved the application of the Trust seal to**:

- The lease renewal document for Unit C Trecenydd Business Park, Caerphilly. The relevant parties to the document were Callowgate Limited and the Welsh Ambulance Services University NHS Trust.
- Six documents which relate to one overarching transaction in reference to units four and five of the Heart of Wales Business Park, Llandrindod Wells, Powys, LD1 5AB. The relevant parties to the transactions were Clive William Jones, Susan Elizabeth Mary Jones, Julie Anne Jones Freire and Garrabost Ltd and the Welsh Ambulance Services University NHS Trust.

CLOSING ITEMS

14. REFLECTIONS

14.1 Members thanked Alex Payne for her hard work in preparing the new board meeting venue.

15. ANY OTHER BUSINESS

15.1 Members were reminded that the next staff survey goes live on 5 October 2026.

15.2 The Chair of the meeting formally thanked Colin Dennis, Chair of the Trust Board, in his absence, for his contribution over the last four years, noting that he will be leaving the Trust on 30 September 2026.

15.3 The Chair of the meeting formally thanked Angie Lewis, Director of Culture Change, for all her work over the years, noting that this would be her last board meeting. Members recognised her outstanding contribution to organisational culture, inclusion, psychological safety, sexual safety and staff engagement. Particular tribute was paid to her values-led leadership, willingness to challenge difficult issues and role in embedding a culture where staff feel listened to and valued. The board acknowledged the significant national recognition she had received for her work and expressed its gratitude for the lasting impact she had made across the Trust.

16. EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC

16.1 The board resolved that, pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960), the press and public be invited to leave the meeting because of the confidential nature of the business about to be transacted.

17. DATE AND TIME OF THE NEXT MEETING

17.1 The next meeting will be held on 26 November 2026 at 9.30am

The meeting closed at 12.34pm

ACTION LOG
WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST BOARD

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
10/240926	24 September 2026	**Monthly Integrated Performance Report (MIQPR)**	**ACTION REQUEST FROM TRUST BOARD TO QUEST** It was agreed for the Quality, Safety and Patient Experience Committee (QuEST) to review the NRI/serious incidents metric in greater detail, including trend analysis, learning and appropriate contextual information, and to provide assurance regarding whether the reported levels are within expected parameters. This request will be transferred to the QuEST committee public action log.	**Andy Swinburn**	25 March 2027	**Update at 5 November 2026 meeting (QuEST)** Penny Durrant confirmed that the work remained in progress, with teams contributing to its development on a weekly basis. The sprint within the Concerns Management Programme had moved to NRIs, which was expected to support progress. Andy Swinburn confirmed the position, and the Committee noted that the work was on track. The action would therefore remain open pending completion. **Update from Penny Durrant 15 October 2026 (QuEST)** This remains a work in progress, with a number of interdependent elements still developing. Nationally Reportable Incidents will form the next sprint within the Concerns Management Improvement Programme, bringing a concerted focus to this area. Further dashboard development will support improved visibility of trends, trajectories and recovery over time. This is therefore an evolving assurance picture, with the level of detail sought by QuEST, and STB being developed progressively rather than delivered in a single step. **Propose leaving on agenda and revisiting at the February QuEST agenda setting meeting.** **Update received 18 November 2026** This has been incorporated into the QuEST agenda for the February meeting. The AAA from the meeting will set out the review in more detail. Propose closing this item. **25 September 2026:** Added to QuEST action log.	Not due
10.1/240926	24 September 2026	Monthly Integrated Quality and Performance Report (MIQPR)	Paul Underwood committed to bringing analysis back to the board to provide assurance regarding anticipated improvements in patient experience and operational performance. Members were advised that work was underway through the call flow optimisation programme and orange now pathway improvement work to model expected performance trajectories through to November and year-end.	Lee Brooks	26 November 2026	Update 18 November 2026 This will be circulated to board members. Propose closing the action.	Complete
10.3/240926	24 September 2026	Monthly Integrated Quality and Performance Report (MIQPR)	It was agreed that Rachel Marsh would work with operational colleagues to review the reporting of the EA production metric and the longstanding 95% production target, and will bring forward proposals for a revised approach to reporting these metrics.	Rachel Marsh	26 November 2026	Update 18 November 2026 Analysis has been undertaken and has been discussed with ELT. Next steps will be to discuss implications with commissioners. This issue will be considered further as part of the EMS Demand and Capacity Review. Propose closure of the action.	Complete
11/240926	24 September 2026	Risk Management and Board Assurance Framework report	It was agreed that oversight of risk 201b, relating to poor patient experience, be transferred to QuEST to provide more integrated and detailed assurance, given that this was the forum where those controls and mitigations are already scrutinised in greater detail.	Trish Mills	26 November 2026	QuEST secretariat notified of the decision. Propose for closure.	Complete

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

Agenda Item No.	5

REPORT TITLE

Chair and Vice-Chair's report: November 2026

MEETING

Name of meeting	Trust Board
Date of meeting	26 November 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Phil Berrington, Chair of the Trust Board Ceri Jackson, Vice-Chair of the Trust Board
Author(s) of report	Alex Payne, Corporate Governance Manager AnnaMaria Williams, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

CHAIR'S REPORT

1. Since joining the Trust on 1 October, I have welcomed opportunities to deepen my understanding of its services, people and strategic priorities. The WAST National Volunteer Conference, Chief Executive roadshows and visits, including to Dobshill with Ceri Jackson, have provided valuable opportunities to listen directly to colleagues and volunteers and better understand the challenges staff want to see addressed. Meeting staff and former staff at the openings of the Bangor workshop and Dolgellau Ambulance Station has also helped me appreciate the Trust's history and its connection with local communities. Alongside these conversations, introductions and service inductions, board development and committee attendance has strengthened my knowledge of the Trust's operational, quality, workforce and financial priorities. Networking with fellow chairs and chief executives, together with attendance at the Welsh NHS Alliance conference, has broadened my understanding of the wider NHS Wales context and the importance of partnership working. These experiences are helping me connect the Trust's strategic ambitions with the day-to-day experiences of its people and will inform my contribution as Chair of the Trust Board.

2. The Trust Board met for its bi-monthly board development day on 29 October 2026. The day focused on progress against the ambitions set out in the Trust's long-term strategy 'Delivering Excellence – Our Vision for 2030' and development of the Integrated Medium-Term Plan and financial plan for 2027-28. An overview of the emerging financial position and early priorities was shared with board members. A further board development session with an AI focus was held on 2 November, facilitated by Gartner and Digital Directorate colleagues. Outcomes from this session will be further discussed at the next board development day on 17 December.

3. Since joining the Trust on 1 October 2026, I have undertaken the following activities: -
    - Introductory meetings and briefings with executives, non-executive directors and board members
    - Attended the WAST National Volunteer Conference
    - A two-day NHS Wales induction programme for board members on 13 and 14 October
    - A meeting between Welsh Government Health and Care Ministers and NHS Leaders on 6 October
    - Staff roadshows in Pontypridd, Wrexham and Carmarthen in mid-October
    - Visiting Dobshill Ambulance Station with the Vice Chair on 19 October
    - NHS Wales Chairs and Vice Chairs peer group meetings
    - Meeting with the Chair of Health Education and Improvement Wales
    - Attended board development sessions and a non-executive directors' meeting

- Attended the Quality, Patient Experience and Safety Committee on 5 November, the People and Culture Committee on 10 November and the Finance and Performance Committee on 17 November
- Started Welsh lessons with the Welsh Language Services Manager
- The Welsh NHS Alliance (previously the Welsh NHS Confederation) annual conference, exhibition and dinner in Cardiff on 3 and 4 November
- Attended the opening of the workshop in Bangor and of Dolgellau Ambulance Station
- Inductions to Emergency Medical Service Centre, 999 and 111 services, the Operational Delivery Unit, and Non-Emergency Patient Transport
- Meeting with Internal Audit

VICE-CHAIR'S REPORT

4. Since our last meeting I have been busy with the following activity: -
   - The Community by Design event in Cardiff Bay on 1 October
   - A meeting of the sub-group of the Audit, Risk and Assurance Committee (ARAC) members on 7 October
   - NHS Wales Vice Chairs peer group meeting on 14 October
   - Staff roadshows in Pontypridd and Wrexham
   - Visiting Dobshill Ambulance Station with the Chair on 19 October
   - Meeting with Vice Chair, Digital Health and Care Wales
   - NHS Wales Chairs and Vice Chairs peer group meeting
   - Attending board development sessions.
   - The Welsh NHS Confederation annual conference exhibition and dinner in Cardiff on 3 November
   - Attending the Quality, Patient Experience and Safety Committee on 5 November and the People and Culture Committee on 10 November
   - Held routine meetings with Mental Health Lead.
   - Held routine meetings with the Chair of the Trust Board
   - Held routine meetings with people and culture colleagues and Trust executives
   - Held routine meetings with the Speaking up Safely Guardian
   - Attended routine meetings with trade unions
   - Attended routine monthly meetings with non-executive director colleagues

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Trust Board is requested to: 1. Receive and note the report.

ADDITIONAL PAPER(S)

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

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
n/a	

Ymddiriedolaeth Brifysgol GIG
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Welsh Ambulance Services
University NHS Trust

Agenda Item No.	6

REPORT TITLE

Chief Executive Report: November 2026

MEETING

Name of meeting	Trust Board
Date of meeting	26 November 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Emma Wood, Chief Executive Officer
Author(s) of report	Emma Wood, Chief Executive Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This report is presented to the Trust Board to provide awareness of the Chief Executive's activities and key service issues since the last Trust Board meeting held on 24 September 2026. It is intended to provide a briefing as linked to our strategic objectives.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Trust Board is requested to: 1. Discuss and note the content of this report

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
None

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
The report references updates which are relevant to the following risks. Risk 139 - Failure to deliver our statutory financial duties in accordance with legislation. Risk 223 - The Trust's inability to reach patients in the community, causing patient harm and death. 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. Risk 671 – Unauthorised or inappropriate use of AI technologies Risk 690 – SAR and disclosure of records compliance Risk 700 - Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying 'Listening to People' guidance

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

SITUATION

1. This report provides an update to the Trust Board on recent key activities, matters of interest and material issues since the last report dated 26 September 2026.

BACKGROUND

2. This report is presented to the Trust Board to provide awareness of the Chief Executive's activities and strategic issues relevant to the Trust. For assurance the Board is asked to note:

- WAST remains at Tier 1 under the NHS Wales accountability framework;
- The Integrated Medium Term Plan (IMTP) accountability conditions have been provided from Welsh Government;
- Financial stewardship is strong with a breakeven position maintained;
- 2027/28 IMTP and financial planning are underway with a focus on sustainability;
- WAST continues to participate in national programmes of work and policy direction;
- WAST's winter plan is active and work continues to manage the risks related to handover 45 not being consistently met (risks 223 and 224);
- The NEPTS eligibility criteria engagement exercise is now closed and assessment of feedback is underway;
- WAST welcomed Cabinet Minister for Health and Care, Mabon ap Gwynfor, for an informal visit to our control centre in Cwmbran and to officially open Dolgellau ambulance station;
- The Board connected with colleagues in the month of October during the CEO road shows meeting several hundred people.

ASSESSMENT

Strategic update

Cabinet Minister for Health and Care visits

3. We were delighted to welcome Cabinet Minister for Health and Care, Mabon ap Gwynfor, on an informal visit to Vantage Point House in October. Mr ap Gwynfor had the opportunity to see at first hand the work undertaken in both our 999 and 111 contact centres, as well as chatting to teams across our services and understanding more about how our refreshed clinical model and the ambulance performance framework are improving the way we support our patients.

4. In November, our Chair, Phil Berrington, formally opened two excellent new facilities, our new fleet workshops in Bangor and our new ambulance station in Dolgellau. Both facilities were long overdue and thanks to the dedicated work of our capital and estates teams, have been completed to a superb standard, making a real difference to the working lives of our people.

5. We were delighted that, once again, the Cabinet Minister for Health and Care was able to join us, this time at Dolgellau, which falls within his Gwynedd Maldwyn constituency. Mr ap Gwynfor spent time talking to crews and guests and recognised the importance of investing in our local communities, building confidence in our services and providing better facilities for staff.

IMTP accountability conditions and future planning

6. Welsh Government has provided the accountability conditions for WASTs IMTP. They include:

    - maintaining financial balance;
    - demonstrating the improved clinical outcomes as a result of our new clinical model;
    - improving response times;
    - improving mental health response and conveyance;
    - improving cardiac arrest and ROSC (return of spontaneous circulation) rates;
    - reducing unavoidable conveyance.

7. These conditions will be assessed, measured and managed through existing governance processes into Board committees and Trust Board.

8. Development and prioritisation of next year's IMTP is well underway which has included a mid-point assessment review and key prioritisation workshops. Current work is focused on the development of a consolidated set of IMTP deliverables and key planning information (milestones, risks, metrics) in readiness for a collaborative dependency mapping workshop planned for late November. WAST will present the IMTP and financial plan to the Joint Commissioning Committee at a workshop on 8 December 2026 ahead of final contracting in the new year.

Welsh Government accountability meeting

9. On 29 October the Executive Team met with the NHS Wales leadership team for the Trust's latest accountability meeting. The meeting provided a valuable opportunity to reflect on progress and achievements over the previous six

months, including the positive impact of the new clinical model and improvements in return of spontaneous circulation (ROSC), while also considering priorities for the period ahead. The board will note that ROSC rates for October 2026 have further increased to 28.64%

10. The discussion was open about the challenges that remain, including long community waits and ambulance handover pressures, as well as the need to strengthen the management of complaints, incidents and concerns. Particular emphasis was placed on maintaining a strong quality focus through the winter period and ensuring clinicians have sufficient opportunity to contribute to investigations, statements and audit activity as part of learning from harm and concerns.

11. Overall, the meeting was positive, with recognition of the progress made and the direction of travel, alongside a clear acknowledgement of those areas where further grip and improvement are required. The Trust is awaiting the formal feedback from the meeting and the next meeting, which is in public, will be on 29 April 2027.

National programmes

Strategic Service Change

12. The planning team remains heavily engaged in strategic service changes across NHS Wales. A key area of focus over the last few months has included close collaboration with Powys Teaching Health Board in support of an extensive period of public consultation on the Health Boards Clinical Services Plan proposals.

Community by Design (CbD)

13. A workshop in October brought together stakeholders to discuss the key enablers for implementation of the new models of care.

14. The final description of the CbD model was presented to the CbD Board on 13 November.

15. WAST continues to engage in the design of elements of the programme more recently preparing a consultation response to draft prevention standards. The premise of these standards is to create an all Wales framework that makes prevention a core NHS function rather than a distinct programme of work. It covers population led planning, prevention in every contact, equity, intelligence, governance, measurement and continuous improvement. The draft is health

board centric and WAST have attended webinars to understand implications and offer feedback. Formal feedback is being led by WAST's Associate Medical Director – community care.

System Performance and Urgent and Emergency Care delivery

Urgent and Emergency Care (UEC) Programme Board

16. Whilst in its infancy the UEC Programme Board is seeking to drive the national UEC improvement plan. This plan sets out the priorities, delivery and assurance expectations needed to stabilise and improve urgent and emergency care in Wales. To this effect the programme board is measuring the delivery plan for three inter-related pillars namely:

    - responsive community based services to prevent admission;
    - front door care at acute hospitals and up to the first 72 hours of stay;
    - in hospital flow and discharge.

17. The UEC Programme Board receives updates on core operational models, winter resilience and trajectory management with the priorities being:

    - handover delays;
    - 12 hour breaches in ED;
    - corridor care;
    - flow and discharge.

18. Of note the Board approved the All Wales Release Protocol which will support the implementation of handover 45 and tested winter plans.

Handover 45 Programme

19. There was an increase in handover lost hours in September 2026, with the Trust losing a total of 13,071 hours, a marked increase from the 9,737 lost hours in August 2026. A total of 4,809 handovers took longer than 45 minutes, against the Welsh Government ambition of none. While there is some comparative improvement, year on year, it remains more than double the 6,000 hours built into the Trust's 2019 rosters. The remaining delay was estimated to have prevented the Trust from responding to approximately 4,217 additional patients.

20. Variation across Wales continues, with Cwm Taf Morgannwg and Cardiff and Vale maintaining lower levels of handover lost hours and Aneurin Bevan demonstrating improvement. However, Swansea Bay, Hywel Dda and Betsi Cadwaladr are not yet progressing against their agreed trajectories.

21. Recent handover 45 reviews have identified stronger partnership working, governance and admission-avoidance pathways, although these have not yet delivered the sustained improvement in handover performance required. As winter pressures increase it is foreseeable that handover delays may continue to absorb ambulance capacity challenging our ability to provide a timely response to those patients who need us most.

22. There have been signals of broader system pressure through declarations of incidents and points of escalation. In September and October 2026, the organisation has spent 62.5% of time at REAP Level 2 and 37.5% of time at REAP Level 3. Across health boards, formal incidents have been declared; namely Critical Incident at Aneurin Bevan and Business Continuity Incidents at Cardiff and Vale, Swansea Bay and Hywel Dda.

Operations

Winter Plan

23. The Executive Leadership Team approved the Trust's Winter Plan in August, with onward submission to Welsh Government. The Plan is now live and includes 38 actions across 111, 999 and Ambulance Care, including relevant transformation actions e.g. Respiratory Desk, along with the more regular operational actions e.g. vaccinations, review of planned production, escalation arrangements and so on. The Trust has also stood up its Senior Planning Team, which will meet weekly through the Winter Plan period with performance managed through our winter scorecards.

999/EMS Strategic Demand & Capacity Review

24. The Trust has decided to proceed in this financial year with a refresh of its strategic demand and capacity review of 999/EMS. Previous experience of demand and capacity reviews has demonstrated their value, enabling the modelling of required capacity to meet demand, using agreed performance expectations, benchmarks and productivity measures. The review will be undertaken in collaboration with the Joint Commissioning Committee, and trade union partners will also be members of the steering group overseeing the review.

Non-Emergency Patient Transport (NEPTS) Engagement – Application of Eligibility

25. The public consultation window on intended adjustments to how existing eligibility is to be applied opened on 16 September and closed on 4 November 2026, following a one-week extension agreed with Llais. A total of 1,333 survey responses were received. The approach to gathering themes and testing how this may or may not impact implementation is underway, the outcomes of which will progress through our governance process as usual, including any necessary revision of impact analysis. The outcomes, together with updated Quality and Equality Impact Assessments (QIA/EQIA), will be considered through the Strategic Transformation Board governance route before implementation proceeds.

Finance and Corporate Resources

26. The Trust has reported year-to-date financial position to Month 6 of the current financial year 2026/27 as breakeven and this is expected to remain the position for Month 7.

27. Focus is now on the emerging development of the 2027/28 financial plan to support the IMTP with regards to identification of cost pressures (recurrent and emerging) and the required savings and efficiency requirements being driven via the Financial Sustainability Programme. Whilst WAST is a commissioned service, the Welsh Government publication of the health boards allocation letter for 2027/28 is expected in December 2026 which will provide a strong indication of the outlook for 2027/28 and beyond.

28. The Programme Director for the financial sustainability programme joined the Trust in mid October 2026, reporting to the Deputy Chief Executive. The role will build on the programme's work to date and lead the next phase of delivery, aligned with next year's IMTP priorities. The focus will be on ensuring the Trust's resources are directed where they deliver the greatest value for patients and staff.

29. The Trust capital expenditure is on track, with expectation to achieve the current CEL of £31.428m by the 31st March 2027 with the 2027/28 Vehicle Procurement Business Justification Case to be received by closed Trust Board on 26 November for approval, and submitted to Welsh Government for funding consideration, if approved, on 27 November.

30. All estate schemes under the 2026/27 capital programme are currently on track, with the Carmarthen roof project now complete and the remaining schemes for Swansea, Rhyl, Pembroke Dock and Llandrindod Wells due for completion in Q4.

31. A newly enhanced and consolidated annual Estates Infrastructure report, covering estates condition, backlog maintenance, energy and waste management was well received by the Finance and Performance Committee in September.

32. The fleet replacement programme is on track with over 150 vehicles received or out for conversion.

People and Culture

33. Following the success of Leaders Connect 2026, which brought together 152 leaders from across WAST, we have launched LIFT, Leading Inclusive Frontline Teams, a nine-month pilot supporting 29 first-line leaders through ILM Level 4 development, WAST-specific learning, peer support and practical improvement projects.

34. Our first Workforce Equality Standard Report was presented to the Executive Leadership Team and People and Culture Committee, giving us greater insight into the experiences of colleagues with protected characteristics and how WAST compares across NHS Wales. The findings will help shape our integrated Equality, Diversity and Inclusion plan for 2027/28, with a particular focus on colleague experience and progression into senior roles.

35. We continue to build our internal education and development capacity while creating new development opportunities for operational colleagues. Four paramedics have been selected for the WAST Clinical Instructor development opportunity, with approval also secured for Ambulance Care Operational Instructor opportunities. Together, these will increase our capacity to support induction, learner development and wider workforce development, while enabling colleagues to broaden their skills and experience.

36. WAST has been recognised by Welsh Government for its leadership in Speaking Up Safely and is coordinating a review and reframing of the All Wales Speaking Up Safely Network. Work is also progressing on our Trust Speaking Up Safely policy, strengthening how colleagues are supported to raise concerns and helping ensure these are triaged and resolved as quickly and safely as possible.

37. And finally, WAST's education expertise continues to receive external recognition, with our Assistant Director for Education and Development appointed to the City

& Guilds Customer Advisory Board for a two-year term, giving WAST the opportunity to contribute to global curriculum development across the ILM Leadership and Management portfolio.

Quality and Safety

HIW quality review and report

38. HIW recently released the published outcome of their most recent inspection. The report provides a positive endorsement of the progress made by WAST since the original HIW reviews of 2020 and 2021. HIW concludes that the Trust is now in a "materially stronger position" and recognises substantial improvements across governance, leadership, workforce support, escalation processes, clinical decision-making and digital assurance.

39. Whilst recognising extensive implementation HIW's principal challenge is that evidence of impact is less developed. Further assurance is required that programmes of work are delivering sustained benefits for patients, staff and the wider urgent and emergency care system. HIW describes as the most significant remaining assurance concern is the prolonged waits as a consequence of delayed handovers.

40. The Executive team remain focused on the Quality agenda and how this can be further embedded across all staff groups and directorates.

Digital Update

41. WAST is delighted to report that Jonny Sammut, Director of Digital Services, has been named in the CIO (Chief Information Officers) 100 UK 2026, recognising him among the UK's leading digital and technology executives. Part of his leadership has been on improving cyber security and WASTs substantial rating in the Cyber Security Internal Audit was reassuring.

42. As part of our GGI Board effectiveness review and maturity assessment the Board recognised its need to improve digital awareness including AI. The Digital Directorate with support from Gartner developed a board session this month which focused on digital maturity in a healthcare organisation and on increasing confidence at Board level to steer strategic direction, assure safety and risk, and scrutinise performance.

Digital refresh

43. The wider refresh programme for WAST's electronic Patient Care Record application (TerraPACE) continues to progress well. A timeline has been agreed with the supplier, Terrafix, which includes clinical risk assurance, testing and staff training, with high confidence that the refresh will be deployed in Q4. WAST is the UK's official TerraPACE reference site, a significant recognition of the organisation's digital maturity and partnership with the supplier, providing WAST with early access to new platform capabilities.

44. A new Case Management System (CMS), to be known as "Records Path", is being built in-house for Records Management. It will help improve processes by bringing together all requests for records into one system, including police and solicitor requests, and Subject Access Requests. The system is expected to bring substantial benefits through far great clarity and oversight over workload and backlog. Subject to approval through appropriate governance channels, the system is expected to launch in November.

Local engagement

45. Since the last reported period the formal CEO road shows took place in Pontypridd, Wrexham and Carmarthen. This year the CEO road shows included regional winners of the WAST Awards, with categories aligned to Our WAST Way: Care, Connect and Value Everyone. It was a pleasure to see so many colleagues and engage with them on our future plans and connect with those in the stations of Bala, Dolgellau, Aberystwyth, Cardigan and Pembroke Dock Health Centre.

Colleague updates

46. And finally, a warm welcome is extended to Phil Berrington as Chair and Alex Nestor as Chief People Officer to this their first formal Board meeting.

RECOMMENDATION

47. The recommendations are as set out on the front cover above.

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Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
University NHS Trust



Trust Board 26 November 2026

Patient Story: Chontelle Owen
A Daughter's Thanks: Professionalism, Kindness and Person-Centred Care When It Mattered Most

peci.team@Wales.nhs.uk

Chontelle Owen

Summary of Experience Story – Chontelle Owen

https://youtu.be/nxnzgvu-WxE?si=D5LUreSv7HOzcp_g

Compliment received February 2026 describes Chontelle's experience of a traumatic emergency involving her father. She credits ambulance staff on how they acted quickly and compassionately and thanks them for their skill, care, compassion and emotional support. At the time of recording, Chontelle reported that her father had improved and regained awareness following treatment in intensive care.

Feedback highlighted:

- Compassionate and emotional support
- Effective communication
- Clinical excellence and life saving care
- Professionalism
- Timely response
- Positive patient outcome

The experience highlights high-quality, compassionate, and patient-centred care, combined with professionalism, strong communication, and staff going above and beyond expectations.

Background

Chontelle's father has type 1 diabetes; lives alone and has a history of poor management of his diabetes, so Chontelle keeps a close eye on him everyday. They message each other daily which is why, on failing to hear from her father, Chontelle called a neighbour to check on him.

Timeline:

- **20/02/2026**
  Call made to emergency 999 ambulance
- **24/02/2026**
  Compliment received and shared with staff
- **15/04/2026**
  Story recorded with Chontelle

Positive Impact Observed

- Chontelle's account provides a valuable example of timely, compassionate care and the difference clear communication and emotional support can make to a family during an emergency. It identifies positive practice that the Trust can recognise and share.
- Wider assurance about consistency requires these themes to be considered alongside other patient experience feedback, concerns, incidents and relevant clinical and operational information, with evidence of how learning informs improvement.

Organisational Enablers

- Capturing patient and family stories helps identify and share positive practice. Feeding compliments back to staff recognises their contribution and reinforces the behaviours people value.
- Positive experiences can shape how patients, families and the wider public perceive our services. Chontelle's account illustrates how kindness, professionalism and clear communication can build trust and confidence.
- Considering these accounts through quality governance supports reflection on what matters to patients and families. Comparing themes with wider feedback and safety information helps identify where practice is consistent and where improvement is needed.

Wider Learning: Communication and Support for Families

Chontelle's story highlights the value of clear communication, reassurance and emotional support alongside clinical care. When these are missing, patients and relatives may experience greater distress and reduced confidence in the service, even when clinical treatment is effective.

Potential risks when these needs are overlooked include:

*(*These are wider learning considerations, rather than failings identified in this story.):*

- Additional Distress and trauma for patients and relative/s
- Poor understanding of what is happening and what to expect
- Relatives feeling less able to support the patient
- Relatives feeling excluded or unsupported
- Reduced trust and confidence in the service
- Missed opportunity to provide holistic care
- Missed opportunities to recognise individual and family needs

Chontelle Owen

Assurance Themes and Actions

Learning Themes:

- Person-centred care
- Professionalism that builds trust
- Family involvement matters
- How compassion shapes families' experience and confidence in the service
- The reported 12-minute response was an important part of Chontelle's positive experience

Actions Taken / In Progress:

- Patient story recorded and shared through patient experience and quality governance routes.
- Positive practice highlighted through organisational learning channels.

Areas of Continued Focus:

- Embed person-centred care consistently across teams
- Continue promoting emotional support, empathy, and reassurance alongside clinical care
- Reinforce clear, calm, and compassionate communication with both patients and relatives
- Feed positive feedback back to staff, recognise good practice and share learning across teams
- Consider these themes alongside wider feedback and safety information to identify variation and improvement needs

Intended Outcomes:

- Greater consistency in compassionate care and positive patient and family experience
- Patients and relatives feel informed, reassured and supported alongside the delivery of clinical care
- Staff feel recognised for the difference their care makes

Chontelle's account illustrates how timely care, compassion and clear communication can build trust and reassurance. It provides positive practice to recognise and reinforce, with wider feedback needed to assess consistency across services.

Alignment with The People's Experience Framework (PEF) (NHS Wales):

A positive experience is shaped by **what matters most to the individual**, with person-centred care at the heart of every interaction.

The People's Experience Framework defines experience as '***the sum of all interactions, influenced by organisational culture, staff, and systems***'

Drivers of positive experience in this story:

Clear communication: Chontelle valued the information and reassurance provided by staff during a frightening emergency.

Compassion and professionalism: Staff kindness and emotional support were central to her positive experience.

Recognition of family needs: The care described recognised Chontelle's needs as a daughter alongside her father's clinical needs.

Clinical Context and Wider Learning:

Diabetes in Wales:

Public Health Wales reports that 230,371 people aged 17 and over were living with diabetes in Wales in 2025, an increase of 3.5% from 2024. This provides context for the importance of effective care and support for people living with diabetes.

Emergency assessment and care:

Ambulance services have an important role in assessing and treating diabetes related emergencies. Published research using Welsh ambulance data describes both treatment at scene and hospital conveyance, reflecting differences in patients' clinical needs.

Learning from Chontelle's experience:

Chontelle's account brings a family perspective to this clinical context. It highlights the value of timely care, clear communication and emotional support, particularly when a person lives alone and relatives play an important role in recognising that something is wrong.

Applying the learning more widely:

Sharing this feedback with staff recognises positive practice and reinforces the behaviours families value. Considering these themes alongside wider experience feedback and clinical and safety information helps assess consistency and identify opportunities for improvement.

Board Reflection, Learning and Assurance

What does this experience demonstrate?

- Chontelle describes professional, compassionate care that provided reassurance during a frightening emergency.
- Clear communication and emotional support were important alongside her father's clinical care.
- The experience left a lasting positive impression and strengthened her confidence in the service.

What should we learn and reinforce?

- Recognise the staff contribution and reinforce the behaviours Chontelle valued.
- Use positive feedback to support team reflection and share practical examples of compassionate care.
- Recognise relatives' needs and their role in supporting patients, particularly those living alone.
- Consider how individual experiences shape public trust and perceptions of our services.

What remains a focus?

- Understanding how consistently patients and families experience compassionate care across services.
- Demonstrating how learning from patient and family stories is shared and applied.
- Ensuring compliments reach the staff involved and inform wider team learning.
- Supporting a culture of appreciation, reflection and improvement.
- Triangulating experience themes with wider feedback, safety information and clinical and operational measures.

This story provides a valuable example of care that Chontelle experienced positively. The Board is invited to reflect on how these behaviours are recognised and reinforced, and what wider evidence demonstrates consistency of care and the impact of organisational learning.

Chontelle Owen

Wider Organisational Learning and Assurance

What positive experiences tell us

- Compassion, professionalism and clear communication shape how patients and families experience our services.
- Recognising emotional needs alongside clinical needs helps people feel informed, reassured and supported.
- Positive feedback identifies practice worth recognising and sharing.
- Individual experiences can leave lasting impressions and influence public trust and confidence.

Contribution to Trust Priorities

Trust Priority	Evidence from this story
Listening to People	Lived experience informs improvement.
Duty of Quality	Feedback translated into learning.
Patient Safety	Communication supports safer assessment.
Health Equity	Care adapted to individual needs.
Person-centred Care	Trust values demonstrated in practice.

Organisational Learning

•Feed compliments back to staff to recognise their contribution.
•Share specific examples of good practice through team reflection, education and governance.
•Identify recurring themes across positive feedback and concerns.
•Demonstrate how learning informs practice and assess its impact.

Learning and Assurance Summary

Positive patient and family experiences provide valuable organisational intelligence. Triangulating this feedback with incidents, concerns, legal claims, mortality reviews and clinical and operational information supports a fuller understanding of quality.

Wider assurance comes from demonstrating how learning is applied and whether people experience good care consistently across services.

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

Agenda Item No.	9

REPORT TITLE

Financial Performance as at Month 7 – 2026/27

MEETING

Name of meeting	Trust Board
Date of meeting	26 November 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This paper presents to the Board the latest Financial Performance Report of the 2026/27 financial year, the reported position as at Month 7 (October 2026). This builds on, and is consistent with, that presented to the meeting of the Finance & Performance Committee on 17 November 2026.

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

3. Key highlights from the report for the Board to note are:
   - The Trust is reporting a breakeven position for month 7 2026/27, but the assumptions made in doing so need to be noted;
   - Capital expenditure plans continue to be progressed, with plans to fully achieve in year;
   - In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust continues to forecast a breakeven position by the 2026/27 financial year end;
   - In line with the financial plans that support the IMTP, gross savings of £5.557m have been achieved in month 7 against a target of £4.638m;
   - Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.3% for the number, whilst slightly off track in terms of value at 93.8% of non-NHS invoices paid within 30 days.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Board is requested to:

1. **Note** and gain **assurance** in relation to the Month 7 revenue financial position and performance of the Trust as at 31 October 2026.

2. **Note** the delivery of the 2026/27 savings plan, and the context of this within the overall financial position of the Trust.

3. **Note** the capital programme for 2026/27.

4. **Note** the Month 7 Welsh Government monitoring return submission (as required by WG).

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
The Board is requested to receive the following: 1. Monitoring return submitted to Welsh Government for month 7 – as required by WG 2. Monitoring return letter submitted to Welsh Government for month 7 – as required by WG

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
17 November 2026	Finance & Performance Committee (presentation)

SITUATION

1. This report provides the Board with a summary of the revenue financial performance of the Trust as at 31 October 2026 (Month 7 2026/27), along with a brief update on the 2026/27 capital programme.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2026/27** (1 April 2026 – 31 October 2026) are that:

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

   - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of **£5.557m** have been achieved against a target of **£4.638m**;

   - Public Sector Payment Policy is on track with performance**, against a target of 95%, of 98.3% for the number,** whilst slightly off track in terms of value at **93.8% of the value** of non-NHS invoices paid within 30 days.

3. At the planning stage of the 2026/27 financial year the Trust assumed it would need to cover in full, the emerging cost pressure of the increase in the Welsh Risk Pool (WRP) costs. As such, the Trust strove to identify savings to cover the whole £2.355m estimated cost increase, as part of the original £9.000m total savings requirement. However, following the submission of the plan, Welsh Government (WG) confirmed that if organisations could deliver a balanced position other than for the WRP element then WG would fund this pressure. As such, the Trust is now assuming cover for this. This, therefore, is the basis of both the year to date and forecast financial position, and the residual in year savings delivery required, which now aligns to that which was identified as deliverable at the outset of the financial year (£7.800m). Following revised forecasts received from NWSSP in September, the total estimated cost has now increased to £3.220m (requiring funding support of £2.546m, an increase of £0.191m from original estimates)

4. In terms of the current reported position, this is further compounded by the cost pressure and volatility that has emerged following the completion of the plan in

relation to fuel price increases, primarily due to the impact of the conflict in the Middle East. Should prices remain as high as they have been throughout the financial year, this would translate into a c.£1.500m additional cost pressure not recognised in the original financial plan.

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

   - The ability to deliver a minimum of £7.800m in savings in year.
   - Assumed financial cover from WG for the increased WRP costs – at a value of £2.546m.
   - No other developments, enhancements or cost increases not currently funded within budgets will be able to be progressed until a confirmed funding source for them is found, or an agreed equivalent value of cost is stopped or reduced elsewhere.
   - The ability to manage any other in year cost pressures as they arrive, within the small contingency the Trust continues to hold, as per the IMTP / 2026/27 financial plan.
   - Income assumptions in opening financial plan are fully funded via commissioners and Welsh Government (i.e. pay awards / Employers National Insurance increases)

6. As we know, no plan, forecast or reported delivery at this stage of the financial year is risk free. The risks included in the Welsh Government Monitoring Return at Month 7 are set in line with the submitted IMTP and summarised later in this report. As we progress through the remainder of the financial year we will continue to scrutinise and amend accordingly, with mitigations and management plans in place.

ASSESSMENT

REVENUE FINANCIAL PERFORMANCE – MONTH 7 2026/27

7. The table below presents an overview of the financial position for the period 1st April 2026 to 31st October 2026.

Revenue Financial Position for the period 1st April - 31st October				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-342,363	-198,511	-198,835	-325
Expenditure				
Pay	253,005	146,487	145,299	-1,187
Non-pay	64,980	36,738	38,192	1,454
Total pay & non-pay expenditure	317,985	183,225	183,492	267
Depreciation & Impairments / interest payable & receivable	24,378	15,286	15,344	58
Total	0	0	0	0

Income

8. Reported Income against the initial budget set to Month 7 shows an overachievement of **£0.325m**.

Pay Costs

9. Overall, the total pay variance at Month 7 is an underspend of **£1.187m**.

Non-pay Costs

10. The non-pay position at Month 7 is an overspend of **£1.454m**. In addition, for reporting purposes Depreciation, Impairment and Interest is excluded from the above figure, which overspent by **£0.058m,** hence the total overspend to budget of **£1.512m**. Much of this is linked to, and in some cases driven by, the other variances and savings delivery being reported.

Savings

11. As above, the original 2026/27 financial plan identified that a minimum of £9.000m of planned savings (including income generation) were likely to be required to achieve financial balance in 2026/27. However, as detailed above, following the cover for the WRP being provided by WG, the initially unidentified savings of £1.200m are now assumed not to be delivered in the current financial year, with work progressing to ensure this can be further delivered recurringly.

12. Month 7 in month performance was, plan of £0.639m and £0.911m achieved, therefore an overachievement of £0.272m (as per the below table).

	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
BX01-Chief Executive Directorate	107	12	12	0	45	39	-6	107	105	-2
BX02-Corporate Governance	39	6	6	0	11	11	0	39	39	0
CX01-Partnerships & Engagement Directorate	40	3	4	1	23	23	0	40	40	0
DX01-Operations Directorate	4,337	339	377	38	2,649	2,803	154	4,337	4,434	97
FX01-Finance and Corporate Resources Directorate	1,064	94	200	107	620	867	247	1,064	1,321	257
HX01-Planning and Performance Directorate	267	26	24	-3	135	219	84	267	317	50
JX01-Quality, Safety and Patient Experience Directorate	420	27	79	51	191	304	112	328	446	118
KX01-Digital Directorate	720	60	97	37	420	581	161	720	829	109
PX01-People and Culture Directorate	402	37	79	41	307	519	212	494	696	202
RR01-Trust Reserves	20	2	2	0	12	12	0	20	20	0
UX01-Medical & Clinical Services Directorate	384	32	32	0	224	179	-45	384	339	-45
Totals	**7,800**	**639**	**911**	**272**	**4,638**	**5,557**	**919**	**7,800**	**8,586**	**786**

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

13. ***Appendix 1*** provides the overall detail for Month 7 by theme.

Financial Performance by Directorate

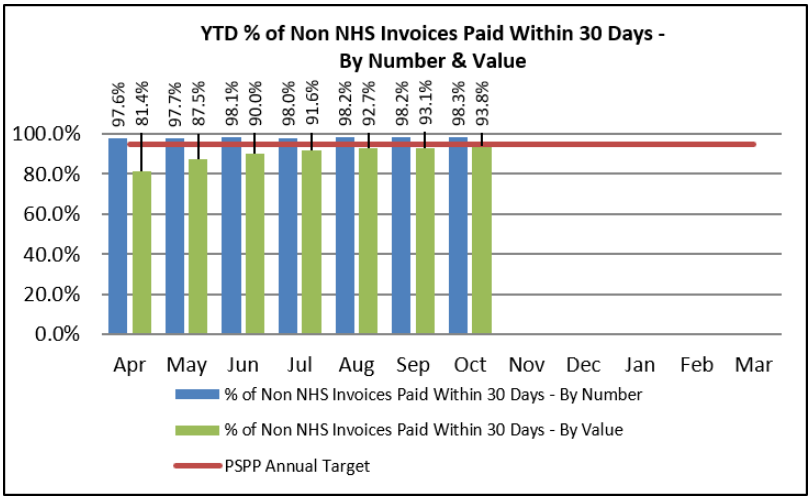
14. Whilst there is a breakeven position at Month 7, there are some variances between Directorates, as shown in the table below, when compared to the budgets set at the outset of the financial year. The majority of these are fairly minor in nature, other than the Trust reserves which included in month 4/12th of the £1.2m saving target and a provision for an income risk. The others will be continued to be closely monitored.

Financial position by Directorate @ 31st October	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	228,004	131,984	132,087	104	0.1%
Chief Executive Directorate	2,189	1,301	1,285	-16	-1.2%
Board Secretary	781	441	434	-7	-1.6%
Partnerships & Engagement Directorate	716	402	342	-61	-15.1%
Finance and Corporate Resources Directorate	38,696	22,800	22,909	110	0.5%
Planning and Performance Directorate	3,242	1,885	1,797	-88	-4.7%
Quality, Safety and Patient Experience Directorate	7,686	4,462	4,266	-196	-4.4%
Digital Directorate	17,070	9,681	9,486	-195	-2.0%
People and Culture	7,695	4,296	4,064	-233	-5.4%
Medical & Clinical Services Directorate	6,783	3,835	3,825	-10	-0.3%
Trust Reserves	2,869	50	642	592	1196.6%
Trust Income (mainly JCC)	-315,731	-181,136	-181,136	-0	0.0%
Overall Trust Position	**0**	**0**	**-0**	**-0**	

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

15. Public Sector Payment Policy (PSPP) compliance to Month 7 was **98.3%** against the **95%** WG target set for non-NHS invoices by number and **93.8%** by value.

16. Whilst the number is in line with the target, due to a payment processing issue, one large value invoice failed to process correctly in month 1, resulting in the 30 day target for value being missed. Due to the cumulative nature of this, it is expected that this delivery will recover as we progress through the rest of the financial year.



2026-27 CAPITAL PROGRAMME

17. The discretionary capital programme and resulting budgets have been finalised, and progress on these schemes is in line with expected delivery plans.

18. At Month 7, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2026/27 is **£31.428m**. This includes **£24.633m** of All Wales Approved schemes and **£6.795m** for Discretionary schemes.

	Actual £'000	Plan £'000
All Wales Capital Programme: Schemes:		
ESMCP - Control Room Solutions	57	181
MDVS	3	100
Welsh Ambulance Services NHS Trust – Vehicle Replacement Programme – 2026-27	3,990	23,110
TEF - Infrastructure	90	517
TEF - Decarbonisation	0	225
Digital Backlog Funding 2026-27	0	500
Sub Total	**4,140**	**24,633**
Discretionary:		
I.T.	176	1,028
Equipment	517	1,339
Statutory Compliance	0	0
Estates	322	3,745
Other	26	400
Unallocated Discretionary Capital	0	283
Sub Total	**1,041**	**6,795**
Total	**5,181**	**31,428**

RISKS AND ASSUMPTIONS

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

20. However, there are a small 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.

21. Given the current position around the savings, the Trust has removed the previously stated risk of £0.200m around energy prices. This will be constantly monitored over the coming months and reassessed as we move closer to the end of the financial year.

22. At this stage it is prudent to include a risk of the WRP funding not being provided by Welsh Government, as such a risk has been included for the full amount of **£2.546m**. However, given the assurance from WG that if we achieve our forecast, it will be covered in full, this is a low risk.

23. Given the positive reduction in the WRP, and that WG agreed to fund the uplift for WAST, the Trust has removed the previously unquantified risk around the WRP figure increasing.

24. As noted above, there are currently no individually assessed high financial risks. However, when this is considered alongside continuing significant service pressures and the likely need to balance financial risk against patient safety, quality and experience, it remains clear, as set out in the IMTP, that 2026/27 is likely to be another challenging financial year. This remains the case despite the initially reported Month 7 financial performance and the assumptions underpinning it.

RECOMMENDATION

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

NEXT STEPS

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

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

Appendix 1

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

Savings Performance by Theme 26-27

Reporting Month 7

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income Commercialisation Opportunities	150	17	0	-17	67	0	-67	150	50	-100
Non Pay Estates Efficiencies - Corporate	135	11	11	0	80	75	-5	135	135	0
Non Pay Fleet Efficiencies - Corporate	250	21	88	67	146	185	39	250	289	39
Non Pay Local Schemes - Corporate	471	39	32	-8	275	207	-68	471	347	-125
Non Pay Local Schemes - Operations	915	78	94	16	465	516	51	915	909	-6
Non Pay Local Schemes - Operations Contract Reviews	415	30	30	0	259	259	0	415	415	0
Non Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Agency Reduction	89	7	7	0	52	52	0	89	89	0
Pay Cost Management (Variable Cost reductions) - Operations	1,100	96	96	0	622	622	0	1,100	1,100	0
Pay End of Shift Overrun - Operations	110	9	31	22	65	168	103	110	213	103
Pay Skill Mix Modernisation - Operations	500	42	42	0	294	294	0	500	500	0
Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,368	204	396	192	1,369	2,235	866	2,368	3,242	874
Pay Vacancy Management - Operations	1,297	84	84	0	944	944	0	1,297	1,297	0
Totals	**7,800**	**639**	**911**	**272**	**4,638**	**5,557**	**919**	**7,800**	**8,586**	**786**

Savings Performance by Theme 26-27 - Recurrent

Reporting Month 7

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income Commercialisation Opportunities	150	17	0	-17	67	0	-67	150	50	-100
Non Pay Estates Efficiencies - Corporate	135	11	11	0	80	75	-5	135	135	0
Non Pay Fleet Efficiencies - Corporate	250	21	88	67	146	185	39	250	289	39
Non Pay Local Schemes - Corporate	471	39	32	-8	275	207	-68	471	347	-125
Non Pay Local Schemes - Operations	915	78	94	16	465	516	51	915	909	-6
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Non Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Agency Reduction	89	7	7	0	52	52	0	89	89	0
Pay Cost Management (Variable Cost reductions) - Operations	1,100	96	96	0	622	622	0	1,100	1,100	0
Pay End of Shift Overrun - Operations	110	9	31	22	65	168	103	110	213	103
Pay Skill Mix Modernisation - Operations	500	42	42	0	294	294	0	500	500	0
Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,368	204	396	192	1,369	2,235	866	2,368	3,242	874
Pay Vacancy Management - Operations	1,297	84	84	0	944	944	0	1,297	1,297	0
Totals	**7,800**	**639**	**911**	**272**	**4,638**	**5,557**	**919**	**7,800**	**8,586**	**786**

Savings Performance by Theme 26-27 - Non Recurrent

Reporting Month 7

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income Commercialisation Opportunities	0	0	0	0	0	0	0	0	0	0
Non Pay Estates Efficiencies - Corporate	0	0	0	0	0	0	0	0	0	0
Non Pay Fleet Efficiencies - Corporate	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Corporate	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Operations	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Operations Contract Reviews	0	0	0	0	0	0	0	0	0	0
Non Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Agency Reduction	0	0	0	0	0	0	0	0	0	0
Pay Cost Management (Variable Cost reductions) - Operations	0	0	0	0	0	0	0	0	0	0
Pay End of Shift Overrun - Operations	0	0	0	0	0	0	0	0	0	0
Pay Skill Mix Modernisation - Operations	0	0	0	0	0	0	0	0	0	0
Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Operations	0	0	0	0	0	0	0	0	0	0
Totals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Please note figures are rounded to the nearest whole number

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

Agenda Item No. 10

REPORT TITLE

Integrated Medium-Term Plan (IMTP) Development, Assurance & Delivery (Q2)

MEETING

Name of meeting	Trust Board
Date of meeting	26 November 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh, Deputy Chief Executive Officer
Author(s) of report	James Houston, Assistant Director of Planning and Transformation

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The purpose of this paper is to provide Trust Board with a concise update on internal planning related matters, including:

- Welsh Government approval of the 2026-2029 Integrated Medium-Term Plan (IMTP) & Accountability Conditions;
- High level assessment of Quarter 2 (Q2) progress and delivery against all IMTP deliverables, with a focus on Strategic Objective 4 (Developing services in collaboration) assigned for Board level oversight; and
- To provide an assurance update on the development of next year's IMTP (2027-2030);

2. The Trust has received formal approval of the 2026-2029 IMTP from Welsh Government and receipt of the annual Accountability Conditions.

3. Good progress is being made to deliver the 47 IMTP deliverables at the quarter 2 checkpoint. Three deliverables have been completed (7% completion rate) and 24 (51%) remain on track. There are 16 deliverables reported as Amber (monitor) status, of which three have a 'low' level of delivery confidence (these are stepped out in more detail in the paper).

4. A more detailed assessment of the IMTP deliverables reporting within Strategic Objective 4 'Developing Services in Collaboration' is included for Trust Board oversight. This reporting changes is aligned to the revised committee reporting approach introduced in the Q2 reporting cycle.

5. Work is progressing at pace to develop next year's IMTP (2027-2030) supported by a number of development workshops to determine key priorities and areas of focus.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

Trust Board is asked to:

1. **NOTE** progress reported in the paper.

ADDITIONAL PAPER(S)

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

- Appendix 1 – Welsh Government 2026-2029 IMTP Approval Letter
- Appendix 2 – Welsh Government Accountability Conditions
- Appendix 3 – Q2 IMTP Delivery & Assurance Report (Strategic Objective 4)

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.	
Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
28 October 2026	Executive Leadership Team
5 November 2026	QUEST Committee
10 November 2026	People & Culture Committee
17 November 2026	Finance & Performance Committee

SITUATION

1. The purpose of this paper is to provide Trust Board with a concise update on internal planning related matters, including:

   - Welsh Government approval of the 2026-2029 Integrated Medium-Term Plan (IMTP) & Accountability Conditions;
   - High level assessment of Quarter 2 (Q2) progress and delivery against all IMTP deliverables, with a focus on Strategic Objective 4 (Developing services in collaboration) assigned for Board level oversight; and
   - To provide an update on the development of next year's IMTP (2027- 30).

BACKGROUND

2. Following Trust Board approval, the organisation submitted its 2026-29 IMTP to Welsh Government on the 31 March 2026. The IMTP sets out the key organisational priorities and IMTP deliverables to be achieved over the next three-year planning cycle, mapped to the Trust's six strategic objectives as set out in the Long-Term Strategy 'Delivering Excellence'.

3. This update is received following considerable internal review and assurance aligned to the revised governance and assurance arrangements put into place from this quarterly reporting period (as set out in the Q1 update paper). The Q2 update has been reviewed by the Executive Leadership Team (ELT) on the 28 October followed by wider committee review of the associated IMTP deliverables organised by the Strategic Objectives assigned to each committee.

ASSESSMENT

Welsh Government IMTP approval and Accountability Conditions

4. The Trust's 2026-29 IMTP and financial plan received formal approval from Welsh Government in August (see appendix 1). This is a significant organisational achievement in light of the pressures & challenges facing the organisation and wider health system in Wales, reflecting confidence in the Trust to develop a robust medium-term plan that address both national & organisational priorities and ability to develop a financially balanced plan.

5. The Trust has also recently received the 2026/27 Accountability Conditions set by Welsh Government (see appendix 2). The refreshed conditions align closely to the key priorities set out in the IMTP and largely cover the areas expected. Work is

underway to embed the Accountability Conditions within the IMTP quarterly reporting process in readiness for formal progress reporting to Welsh Government from Q3 onwards.

6. The Trust is expected to receive formal feedback on last year's plan by the end of November which will be considered in the development of next year's plan.

IMTP 2026-27 Quarter 2 Delivery & Assurance

7. Formal transition of the 2026-27 IMTP deliverables has been completed alongside the changes to the committee wide assurance reporting arrangements commencing from Q2. The quarterly report continues to be strengthened with a focus on the alignment between IMTP delivery and improvement outcomes. The report now includes a summary of the linked Monthly Integrated Quality & Performance Report (MIQPR) aligned to each Strategic Objective.

8. The internal IMTP assurance and progress reporting approach continues to be strengthened to ensure effective governance and oversight arrangements are in place to monitor delivery. A key change implemented for the quarter 2 reporting cycle includes the wider distribution of the quarterly IMTP assurance report to key organisational committees (including Quest and People & Culture Committee) in addition to the routine reporting into Finance & Performance Committee.

9. This change will see committees receiving a bespoke IMTP assurance report covering the IMTP deliverables captured within the respective Strategic Objective aligned to the committees scope and remit (see table below).

Table 1: Overview of the new Committee reporting arrangements

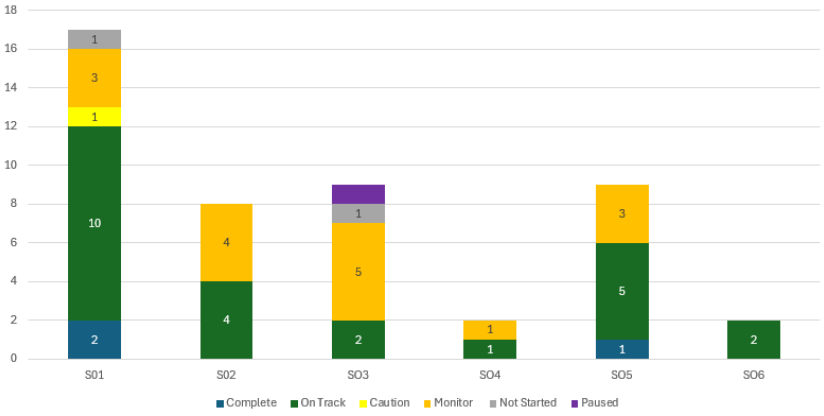
Strategic Objective	Receives
SO1 - Providing the right care or advice in the right place, every time	**Finance and Performance Committee** (SO1 also shared with QUEST for information)
SO2 - Enabling our people to be the best they can be	**People and Culture Committee**
SO3 – Being at the forefront of Innovation and Technology	**Finance and Performance Committee**
SO4 - Developing services in collaboration	**Trust Board**
SO5 - Quality driven and clinically led	**Quest**
SO6 - Value and Sustainability	**Finance and Performance Committee**
All Strategic Objectives - (high level overview)	**Trust Board**

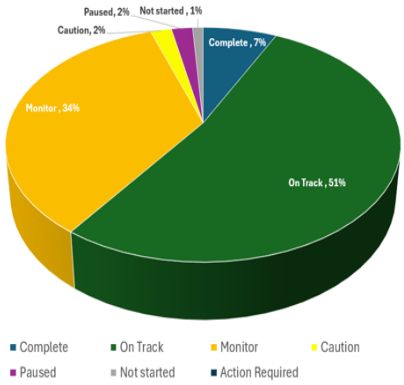
10. The Trust continues to make strong delivery progress at the Q2 delivery position. The tables below provide a summary of progress by strategic objective and associated RAG status across the 47 IMTP deliverables. See the supporting information section for an overview of the RAG descriptors. A more detailed progress and assurance report is appended to this paper for Strategic Objective 4 'Developing our Services in Collaboration' aligned to the new committee level assurance reporting approach (see appendix 3).

Table 2: IMTP delivery RAG status (Q2 position compared to Q1)

Deliverables Total		On Track	Caution	Monitor	Not Started	Complete	Paused
47	Q1	31	3	10	2	1	0
	Q2	24	1	16	2	3	1

Table 3: IMTP delivery RAG status by Strategic Objective (Q2 position)





11. Overall progress and delivery confidence remains high with 3 (7%) deliverables completed and 24 (51%) reported as on track at the end of Q2. More detail is included in the full IMTP Assurance & Delivery report which is available upon request.

12. There are no deliverables reported 'Red / off track' requiring urgent action or immediate mitigation. A total of 16 deliverables were assigned an Amber (monitor) status in Q2 whereby potential issues / delays have been flagged for early sighting and consideration, an increase of 6 from the 10 reported at the end of Q1. One deliverable was reported with a yellow (caution) status to flag an early potential issue to delivery. These are mapped out in table 4 overleaf.

Table 4: Amber (Monitor) + Yellow (Caution) reported deliverables in Q2

IMTP Reference	Deliverable Title	Q1 RAG	Q2 RAG	Confidence Level
1	Academic Evaluation	Monitor	Monitor	Moderate
2	Clinical Flows	On Track	Caution	Moderate
7	EA Skills Mix	Monitor	Monitor	Low
11	Advanced Practice	On Track	Monitor	Moderate
19	Absence Management	Monitor	Monitor	High
21	Our WAST Way	On Track	Monitor	High
23	Development for All	Monitor	Monitor	High
24	Recruitment Strategy	Monitor	Monitor	High
26	GRS Solution	On Track	Monitor	Moderate
29	AI Framework	On track	Monitor	High
30	CAD Replacement	Monitor	Monitor	High
32	EPCR Refresh	On Track	Monitor	High
34	All Wales Data Sharing	Monitor	Monitor	Low
35	Stakeholder Engagement	On Track	Monitor	High
37	QI Framework	Monitor	Monitor	Moderate
41	Listening to People (Concerns)	Monitor	Monitor	Moderate
44	Medicines Management Hub	Monitor	Monitor	Low

13. The Executive Leadership Team (ELT) undertook a detailed assessment of the full IMTP Q2 delivery and assurance report. A more detailed assessment of the 16 Amber reported deliverables was undertaken, with a focus on the 3 Amber deliverables reported with a 'low' level of delivery confidence. These are further detailed out in table 5 below. In addition to ELT review, these deliverables have been considered by the respective committees aligned to the enhanced committee level assurance reporting introduced in this reporting cycle.

14. It is important to note that organisational capacity remains a key challenge impacting IMTP delivery. To help mitigate this an exercise was undertaken in Q1 to review directorate level plans to identify, re-profile or stop any non-essential work to free up capacity. Furthermore, there is a greater focus on capacity planning as part of the development of next years IMTP with a detailed dependency mapping workshop planned for the 30th November.

Table 5: IMTP Deliverables Amber (Monitor) and Low Delivery Confidence

SO1 - Providing the right care or advice in the right place, every time						
Ref	**Deliverable**	**RAG**	**Priority**	**Confidence**	**Issue**	**Mitigations**
7	Operationalise the key recommendations of the **Emergency Ambulance (EA) skill mix review**	**Monitor**	**Must Do**	**Low**	Delivery Timescales off track: Further work required to explore the broader impacts of transitioning EMTs from Band 4 to EAP and Band 5, and ongoing work regarding the retire and return policy.	Work continuing to finalise the retire and return policy and wider work by the project team is to be undertaken regarding the transition and broader skills mix impacts linked to the new integrated clinical services model.

SO3 – Being at the forefront of innovation and technology						
Ref	**Deliverable**	**RAG**	**Priority**	**Confidence**	**Issue**	**Mitigation**
34	Strengthen information governance arrangements and technical development to enable WAST to continue to support the **all-Wales data sharing ambitions** via the National Data Resource.	**Monitor**	**Must Do**	**Low**	National legislation changes required: All Wales data sharing arrangements require national agreement with Welsh Government and legislative changes not anticipated for circa two years.	Some aspects of this work remain achievable irrespective of the national data sharing agreement being finalised.

SO3 – Being at the forefront of innovation and technology						
Ref	**Deliverable**	**RAG**	**Priority**	**Confidence**	**Issue**	**Mitigation**
44	Implementation of the **Medicines Management Hub** systems and processes, subject to funding.	**Monitor**	**Should Do**	**Low**	*Changes to Health Board Delivery Model:* - Omnicell business case submitted to FPC, however changes in Health Board medicines management approaches may impact WAST approach.	Contingency plan in place to continue current operating arrangements, accepting the existing challenges and decisions from Health Boards.

15. Also included in the full IMTP report is a quarterly update against the four key productivity improvements identified in the IMTP. Whilst these were not specific deliverables, they are being closely monitored within the Financial Sustainability programme governance, reporting through the Productivity Group workstream. It is noted that achievement of these improvements are linked to key IMTP deliverables. Work has been undertaken to develop the key outcome metrics assigned to each of the productivity improvements, and further work is being undertaken to commence monitoring of the non-cash releasing efficiency savings.

IMTP Development 2027-2030

16. The Trust's internal planning cycle is in full operation, and considerable work has been undertaken in Q2 to support the development of next year's plan.

17. The Trust is expecting to receive next year's NHS Wales Planning Framework & Technical Planning Guidance in late December alongside the financial allocation for 2027/28. It remains important for the Trust to continue at pace with IMTP development pre-receipt of next year's Planning Framework to inform an early

draft. It is recognised that any material changes to the WG planning approach / national priorities may require key adjustments to the emerging plan.

18. A detailed lessons learned activity has been undertaken to help strengthen the internal planning process. A detailed IMTP Mid-Point assessment was undertaken in September to consider the expected delivery position at the end of 2026/27 to help inform next year's priorities, noting next year is year 2 of the approved current IMTP whereby the vast majority of IMTP deliverables were planned as multi-year pieces of work.

19. A number of workshops and focussed development sessions have been undertaken with the Executive Leadership Team, Senior Leaders and Board members to review emerging organisational priorities for next year. This has focussed on prioritising the key areas of work and considering any new priorities to address emerging risks or opportunities. This process has centred on a further consolidation of organisational priorities and a reduction from the current 47 IMTP deliverables is anticipated. A high-level overview of the emerging IMTP deliverables for next year was considered at a Board Development session in October where there was a broad consensus supporting the direction of travel and key areas of focus.

20. Considerable internal activity is planned over the next few months to continue the development of the IMTP:

- *Deliverable Development (Nov):* key organisational leads are continuing to develop the proposed IMTP deliverables – mapping out the key milestones, prioritisation (based on the MOSCOW prioritisation tool), key dependencies and outcomes.
- *Future financial planning workshop (23rd Nov):* a collaborative internal workshop has been arranged to explore financial sustainability challenges and opportunities.
- *IMTP Dependency Workshop (30th Nov):* a collaborative planning session is planned to assess key organisational dependencies and organisational capacity.
- *ELT Session (10th Dec):* further review of IMTP Deliverables and financial planning.
- *Board Development Session (17th Dec):* Overview of current IMTP prioritisation and financial planning.
- *Early draft plan (anticipated by late Dec):* Skeleton framework and first draft content to be developed prior to IMTP planning guidance circulation.

21. The trust is in close collaboration with the Joint Commissioning Committee (JCC) to support the development and prioritisation of next year's plan. A session has been arranged for the 8th December to discuss strategic positioning, risks and financial planning.

22. Early work has commenced to support the development of the trust's 2027/28 financial plan. This has included a review of the current financial position, assessment of the potential financial requirements for 2027/28, review of key financial principles and exploration of early organisational saving opportunities for costing and consideration. Whilst the financial allocation has yet to be confirmed for next year, initial planning has assumed a potential 'flat cash' scenario at this early stage.

23. The Trust remains on track to deliver an approvable plan in readiness for submission by the end of March-27.

RECOMMENDATION

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

NEXT STEPS

25. Continue to refine and mature the IMTP quarterly reporting and assurance process and embed the Accountability Conditions; and

26. Continue key actions to develop next year's IMTP 2027-2029

SUPPORTING INFORMATION

Graphic 1: IMTP RAG and Delivery Confidence Descriptors

STATUS	DELIVERY POSITION	ACTION REQUIRED
GREY Not Started	**Not started** Delivery has not commenced or the agreed start date is in the future.	Confirm owner, scope, dependencies and start date.
GREEN On Track	**On track** Milestones, quality, resources and outcomes are progressing to plan.	No immediate action is necessary. Continue routine monitoring and manage emerging risks.
YELLOW Caution	**Caution - Early warning** A potential issue could affect progress, but delivery remains achievable.	Monitor closely and agree mitigating or contingency actions.
AMBER Monitor	**Off track but recoverable** Milestones or outcomes are at risk and corrective action is required.	Agree a time-bound recovery plan, owner and escalation route.
RED Off Track	**Significantly off track** A major issue materially threatens achievement of the agreed outcome.	Escalate immediately and re-plan scope, timing or resources.
BLUE Complete	**Complete** The deliverable or milestone is complete and supported by evidence.	Confirm acceptance, record evidence and close residual actions.
PURPLE Paused	**Paused** Delivery has been intentionally stopped following an agreed decision.	Record rationale, restart conditions, owner and review date.

Mabon ap Gwynfor AS/MS
Gweinidog Cabinet dros Iechyd a Gofal
Cabinet Minister for Health and Care

Llywodraeth Cymru
Welsh Government

Colin Dennis
Chair
Welsh Ambulance Services University NHS Trust
Vantage Point House
Vantage Point Office Park
Ty Coch Way
Cwmbran
Torfaen
NP44 7HF

colin.dennis@wales.nhs.uk

26 August 2026

Dear Colin

Thank you for submitting your trust's Integrated Medium-Term Plan (IMTP) for 2026-29, which I note has been approved by your Board on a three-year basis.

Following a robust assessment of your trust's plan, I am pleased to formally confirm that I have approved the IMTP. This approval is subject to accountability conditions that have been agreed by Jacqueline Totterdell, Chief Executive of NHS Wales.

The approval of the plan does not represent either my or Welsh Government's agreement to any service changes and business case proposals. Nor does the approval of the plan in principle confirm any validity in funding assumptions around additional revenue or capital funding. All service change and business case proposals must be subject to:

- compliance with extant requirements set out in guidance and in legislation including the detailed Guidance on Engagement and Consultation Changes to Health Services, and;

- business cases and bids being subject to the normal business case approval process, including capital, and Invest to Save bid approval process.

Welsh Government Offices, Cathays Park,
Cardiff. CF10 3NQ
Swyddfeydd Llywodraeth Cymru, Parc Cathays,
Caerdydd. CF10 3NQ

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Mabon.apGwynfor@llyw.cymru
Correspondence.Mabon.apGwynfor@gov.wales

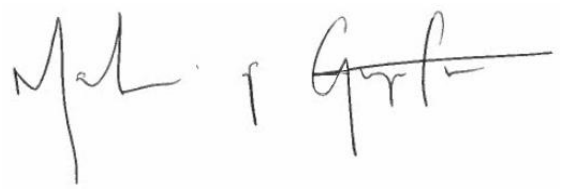
Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn yr iaith honno ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Officials will write separately to your Chief Executive setting out the conditions and expectations for the trust including continued monitoring. Please note that any deviation from the submitted plan may result in heightened monitoring and evaluation in accordance with the escalation and intervention protocols, or potentially lead to the revocation of the approved status of your plan.

I would like to take this opportunity to remind you that your Board will be held to account against the accountability conditions set out within the approval which will be tracked through the normal Accountability arrangements. I will be interested to discuss progress on the plan at our regular Chair discussions.

Yours sincerely,



Mabon ap Gwynfor AS/MS
Gweinidog Cabinet dros Iechyd a Gofal
Cabinet Minister for Health and Care

Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal ac Atal / Prif Weithredwr GIG Cymru

Director General Health, Health, Care and Prevention Group / NHS Wales Chief Executive

Llywodraeth Cymru
Welsh Government

Emma Wood
Chief Executive
Welsh Ambulance Services University NHS Trust

Emma.Wood5@wales.nhs.uk

2 November 2026

Dear Emma,

Integrated Medium Term Plan (IMTP) 2026-29

You will be aware that the Cabinet Minister for Health and Care wrote to your Chair formally on 26 August confirming the approval of the trust's IMTP 2026-29 in accordance with the NHS Wales Planning Framework and section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014).

I would like to recognise this as a significant achievement, especially in the complex and challenging planning environment, and I would also like to thank those involved in the development of the plan for their hard work.

Whilst the approval of your IMTP reflects the level of confidence in your organisation's response to the NHS Planning Framework, the plan does carry a number of risks which will need to be actively managed and mitigated. I have therefore set out a range of accountability conditions, which must be tracked and reported on throughout the year. The accountability conditions for the health board are set out in Annex 1.

These conditions should be viewed alongside your approved plan and existing statutory responsibilities. They represent the areas where national oversight, assurance and demonstrable progress will be particularly important during the coming year.

Meeting these conditions will require continued partnership working across NHS Wales, Welsh Government, local government and other key stakeholders.

The Cabinet Minister and I expect you and the Board to effectively scrutinise and monitor progress against your plan, to have accepted any risks within it, and have mechanisms to ensure delivery. The organisation should continue to submit quarterly updates on the implementation of your plan and progress against the accountability conditions to HCP.PlanningTeam@gov.wales and must be accompanied by a refreshed Minimum Data Set (MDS), clearly outlining any changes to trajectories and goals.

Progress against these conditions will form part of our routine performance and accountability arrangements throughout the year. We will work constructively with your team to monitor delivery, address emerging risks and support achievement of the agreed outcomes.

If any material changes to the plan are required during the year, these must be communicated to me in an 'Accountable Officer' letter.

As Chief Executive, I expect you to lead by example and with compassion, drawing on the full capability of your executive team to meet the accountability conditions, engage constructively with the Welsh Government, and deliver measurable improvements.

I trust this letter provides clarity on our expectations. However, should you have any questions, please do not hesitate to contact me.

I would like to thank you and your colleagues for your continued commitment and leadership. I look forward to working with you to deliver these priorities and improve outcomes for the people of Wales.

Yours sincerely



Jacqueline Totterdell

Cc: Colin Dennis, Chair, Welsh Ambulance Services University NHS Trust

Annex 1: Welsh Ambulance Services University NHS Trust - Accountability Conditions 2026-27

Your organisation's accountability conditions include:

Condition Ref:	Accountability Condition:
WAST#AC1	In line with your IMTP approval, as a minimum, deliver the financially balanced plan in full and progress ongoing development and realisation of opportunities, ensuring any adverse variance to trajectories/delivery is specifically highlighted within the regular monitoring arrangements. In addition, the trust is expected to demonstrate clear actions aimed at delivering further sustainable improvements towards the delivery of the Priorities set out in the Planning and Performance Frameworks, where relevant.
WAST#AC2	**Clinical Model** - Demonstrate clear delivery in line with the intent of the revised clinical response model, including: a) Provide evidence of impact, learning from formal evaluation, and actions to improve clinical outcomes and efficiency in line with the Performance Framework; b) Provide evidence of changes made in-year as evaluation findings emerge, including action to improve rapid clinical screening, by the end of November 2026; c) Produce an interim report which contains actionable recommendations resulting from the interim review of the first 12 months (phase 1) of delivery of the revised clinical model by the end of Q3; and Submit an academic led evaluation of the clinical model by the end of Q4.
WAST#AC3	Demonstrate credible, measurable and sustained improvement in emergency ambulance performance and clinical outcomes, underpinned by robust modelling, transparent reporting and explicit quarterly trajectories, by Q4. This includes: a) Reviewing whether a blanket 60-minute orange performance ambition as a stretch target is ambitious enough and provide Welsh Government with an update **by the end of January** given delays in response and access to definitive care for service users in this category presents a risk of avoidable harm; b) Improvements in median and 90th percentile response times, and the anticipated date by which compliance with Ambulance Performance Framework standards will be achieved and sustained **by the end of February**

WAST#AC4	Demonstrate ongoing and sustainable improvements in: • **Mental Health** response and conveyance, including mitigation of risks arising from changes to police conveyance under the Mental Health Act. • **Cardiac Arrest & ROSC Improvement -** delivery of out-of-hospital cardiac arrest improvement, with a more ambitious and measurable plan to improve ROSC outcomes and partner contributions, by Q4; and • **Conveyance** - reducing avoidable conveyance through stronger use of community-based alternatives, clinical remote assessment and health board pathways, by Q4.

Reporting arrangements

- The IMTP and summary explainer video must be published on your organisation's public facing website.
- Reporting must be submitted quarterly to provide a delivery update against the IMTP, as well as the conditions outlined above. There should be reporting against the key milestones associated with that quarter, an explanation of any delays/amendments to milestones, identification of next steps and the mitigation of any new/emerging risks.
- The Minimum Data Set (MDS) must be refreshed on a quarterly basis, supported by written narrative to explain the context to these changes.
- Any material changes must be communicated to the Director General for Health, Care and Prevention / NHS Wales Chief Executive, through an Accountable Officer letter.
- Quarterly updates on plan delivery should be submitted to HCP.PlanningTeam@gov.wales

Welsh Ambulance Services University NHS Trust

IMTP 2026-29
Quarterly Assurance & Progress Report

Quarter 2: July - Sept 2026
Trust Board Report: Strategic Objective 4 – Developing Services in Collaboration

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

IMTP Deliverables Q2 Update
Version Final
Released: October 2026

Planning & Performance
AMB_Planning_&_Performance@wales.nhs.uk

Introduction

Purpose of the report

- Provides a comprehensive Quarter 2 update on delivery of the IMTP 2026-29.
- Supports organisational oversight, assurance and informed decision-making through a combination of narrative updates, delivery confidence assessments and performance intelligence.
- To be read alongside the IMTP 'Plan on a Page' milestone document and MIQPR.

Reporting Approach

- Reporting incorporates all **47 IMTP deliverables**, aligned to the six strategic objectives
- Progress is assessed through a combination of milestone delivery, narrative assurance, performance measures and delivery confidence ratings
- The reporting cycle is fully embedded within routine governance and performance arrangements, providing a consistent Trust-wide view of progress

Enhancements delivered since Q1

- Full integration of detailed productivity reporting
- Embedding of change control requirements
- Enhanced delivery confidence and assurance reporting
- Continued alignment between IMTP and MIQPR performance measures
- Inclusion of Welsh Government Enabling Actions

Future enhancements

- Alignment of improvement expectations set out within the IMTP
- Integration of strategic risks
- Strengthened alignment between IMTP and MIQPR performance measures



Proposed Oversight Route

Proposed oversight route for IMTP 26-29 quarterly progress reports

Committee coverage

Principle

Route the right level of detail to each committee, while keeping STB and Trust Board sighted on the full delivery position.

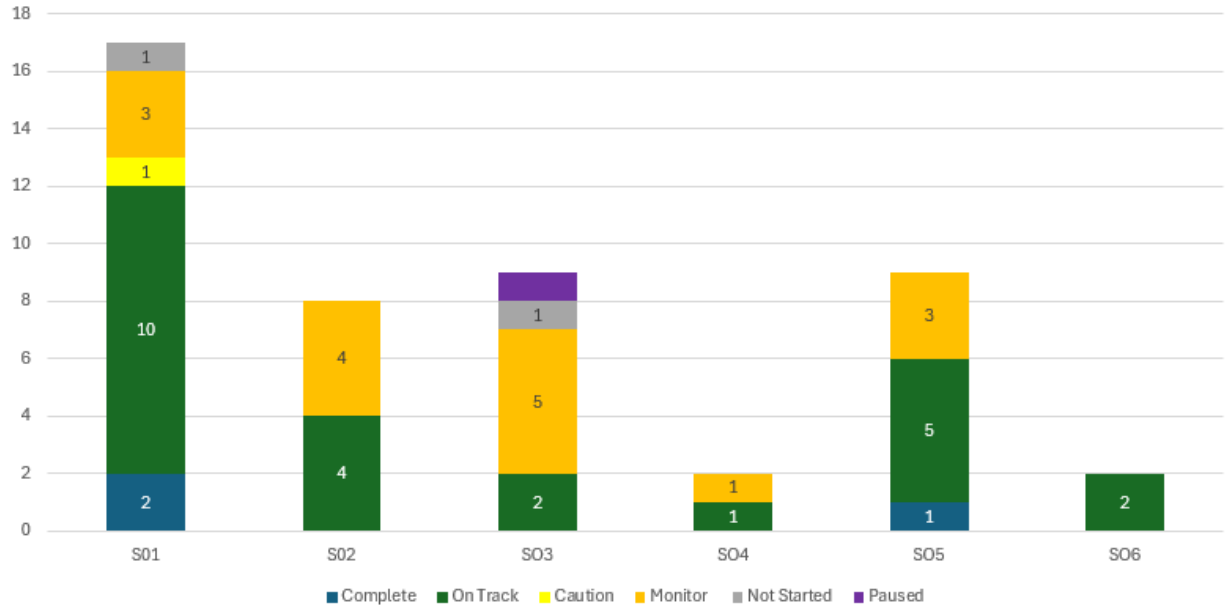
Strategic Objective	Receives
S01 - Providing the right care or advice in the right place, every time	**Finance and Performance Committee** (Shared with QUEST for information to cover clinical indicator outcomes)
S02 - Enabling our people to be the best they can be	**People and Culture Committee**
SO3 – Being at the forefront of Innovation and Technology	**Finance and Performance Committee**
SO4 - Developing services in collaboration	**Trust Board**
SO5 - Quality driven and clinically led	**Quest**
S06 - Value and Sustainability	**Finance and Performance Committee**
All Strategic Objectives - (high level overview)	**Trust Board**

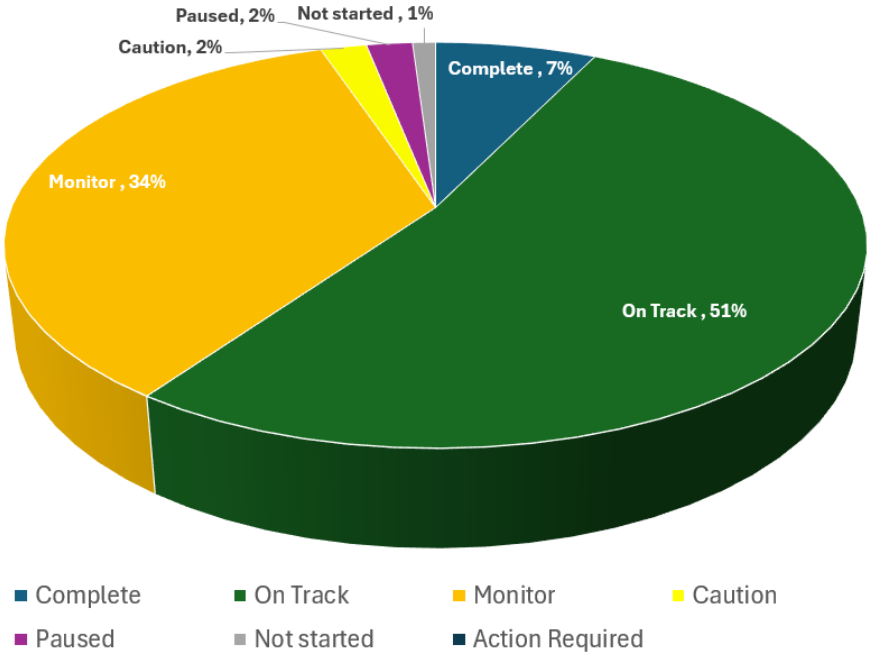
IMTP Assurance Overview (all IMTP Deliverables)

Quarterly Progress Comparison RAG status

Deliverables Total		On Track	Caution	Monitor	Not Started	Complete	Paused
47	Q1	31	3	10	2	1	0
	Q2	24	1	16	2	3	1

Quarter 2 Progress Overview by Strategic Objective (number & %'s)





Overall Summary Position

MOSCOW: 87% MUST, 7% SHOULD, 6% COULD

47 IMTP 26-29 deliverables

17 Deliverables reporting Amber + Yellow (Q2)

IMTP Reference	Deliverable Title	Q1 RAG	Q2 RAG	Confidence Level
1	Academic Evaluation	Monitor	Monitor	Moderate
2	Clinical Flows	On Track	Caution	Moderate
7	EA Skills Mix	Monitor	Monitor	Low
11	Advanced Practice	On Track	Monitor	Moderate
19	Absence Management	Monitor	Monitor	High
21	Our WAST Way	On Track	Monitor	High
23	Development for All	Monitor	Monitor	High
24	Recruitment Strategy	Monitor	Monitor	High
26	GRS Solution	On Track	Monitor	Moderate
29	AI Framework	On track	Monitor	High
30	CAD Replacement	Monitor	Monitor	High
32	EPCR Refresh	On Track	Monitor	High
34	All Wales Data Sharing	Monitor	Monitor	Low
35	Stakeholder Engagement	On Track	Monitor	High
37	QI Framework	Monitor	Monitor	Moderate
41	Listening to People (Concerns)	Monitor	Monitor	Moderate
44	Medicines Management Hub	Monitor	Monitor	Low

Summary overview

Q2 demonstrates **continued progress across all six strategic objectives** with delivery moving beyond mobilisation and planning into implementation, optimisation, evaluation and embedding. Across the 47 IMTP deliverables, the overall position remains positive, with the majority progressing in line with planned milestones. Key achievements include advancement of clinical transformation, workforce development, digital governance, financial sustainability and quality improvement programmes.

Whilst a small number of deliverables remain under monitoring due to external dependencies, capacity constraints and governance requirements, these are being actively managed through established arrangements and confidence remains in the overall delivery of the IMTP.

Several cross-cutting themes define the Q2 position:

- Clinical and operational transformation programmes are progressing from design into implementation, evaluation and optimisation, with a growing focus on productivity, operational resilience and patient outcomes.
- Workforce, leadership and organisational development programmes continue to gain momentum, supported by strong engagement and increasing organisational capability.
- Digital transformation is accelerating through strengthened governance, deployment of new digital solutions and advancement of strategic technology programmes.
- Partnership working and strategic collaboration continue to mature, supporting service improvement, long-term planning and system-wide delivery.
- Quality improvement activity is becoming increasingly embedded, with stronger governance, improved patient involvement and continued progress across mental health and concerns management programmes.
- Financial sustainability and productivity initiatives are now firmly established, with increasing organisational focus on recurrent efficiencies, commercial opportunities and long-term value.

Overall, **Quarter 2 reflects a positive and maturing delivery position.** Whilst some programmes face implementation challenges associated with the scale and complexity of transformation, there remains strong evidence of organisational momentum, effective governance and sustained progress against the ambitions set out within the IMTP 2026-29.

RAG and Delivery Confidence Level Descriptors

RAG shows the current delivery position. Confidence shows the level of assurance that delivery will be achieved as planned.

STATUS	DELIVERY POSITION	ACTION REQUIRED
GREY **Not Started**	**Not started** Delivery has not commenced or the agreed start date is in the future.	Confirm owner, scope, dependencies and start date.
GREEN **On Track**	**On track** Milestones, quality, resources and outcomes are progressing to plan.	No immediate action is necessary. Continue routine monitoring and manage emerging risks.
YELLOW **Caution**	**Caution - Early warning** A potential issue could affect progress, but delivery remains achievable.	Monitor closely and agree mitigating or contingency actions.
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RED **Off Track**	**Significantly off track** A major issue materially threatens achievement of the agreed outcome.	Escalate immediately and re-plan scope, timing or resources.
BLUE **Complete**	**Complete** The deliverable or milestone is complete and supported by evidence.	Confirm acceptance, record evidence and close residual actions.
PURPLE **Paused**	**Paused** Delivery has been intentionally stopped following an agreed decision.	Record rationale, restart conditions, owner and review date.

DELIVERY CONFIDENCE LEVELS

Current assurance that the deliverable will be achieved as planned, considering risks, dependencies, capacity and progress.



Plans are in place, resources are secured and no major risks are foreseen.



Some risks or uncertainties exist, but they are understood and manageable.



Significant challenges exist around planning, resources or dependencies.

Welsh Ambulance Services
University NHS Trust

IMTP 2026-29
Strategic Objective 4

Developing our services in collaboration



GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

SO4 – Developing Our Services In Collaboration

2 IMTP 26-29 deliverables

High Level Achievements

- Continued strengthening of partnership working across Health Boards and wider system partners
- Progress in developing strategic relationships to support service improvement and transformation
- Ongoing development of the foundations required to refresh the Trust's Long-Term Strategy

Key themes emerging across S04

- Strengthening collaborative working with Health Boards and system partners
- Increased focus on co-production and stakeholder engagement
- Supporting integrated service planning and transformation
- Development of the Trust's future strategic direction
- Building strong foundations for long-term system collaboration

SO								Total
SO4		1		1				2

Assurance narrative

- Quarter 2 has seen continued progress across SO4, with a strong emphasis on collaboration, partnership working and long-term strategic planning. Several initiatives have advanced through engagement and co-production with Health Boards, system partners and national stakeholders, supporting more integrated approaches to service delivery and transformation.
- Work to strengthen strategic relationships and influence across the wider health and care system has continued, alongside activity to support future service development and organisational planning. Progress has also been made in preparations for the Trust's Strategy refresh, helping to ensure future priorities remain aligned to the changing needs of patients, partners and the wider healthcare landscape.
- Overall, SO4 remains in a positive delivery position, with continued progress

SO 4 Deliverables – RAG Monitor

Ref	Deliverable	RAG	Priority	Confidence	Update
35	Create strategic opportunities for increased **Health Board engagement** and collaborative working	Monitor	Must Do	High	Options discussed and considered with executive colleagues outlining different approaches for stakeholder engagement (account management approach). The management approach remains under review and is due to be agreed on 22 October 2026. As it has not yet been finalised or agreed, implementation and embedding have not commenced.

SO 4 Deliverables – RAG On Track

Ref	Deliverable	RAG	Priority	Confidence	Update
36	Develop and deliver a robust approach to refresh the organisation's **Long-Term Strategy**, using an internally produced strategic development and engagement framework	On Track	Should Do	High	Early preparatory work has continued through Q2 to support the LTS refresh, including: Strategic Intelligence Gathering: Work has continued to capture key strategic intelligence. A first draft Mid-Point Progress Assessment of the current LTS has been undertaken and presented to STB in Oct. LTS Framework & Approach: Work has continued to develop the overarching framework and high-level engagement approach to support the strategy refresh in readiness for wider engagement and review. LTS Timelines: Agreement at STB in Sept to formally commence strategy refresh and begin initial engagement activity from Q1 27/28. Following further IMTP prioritisation discussions there may be a requirement to further delay / re-profile formal commencement and engagement to later in 27/28 (this is subject to wider discussion at a Board Development session in late Oct). This deliverable has therefore been marked as a cautionary 'Amber' progress status to reflect this position.

Agenda Item No.	11

REPORT TITLE

Monthly Integrated Quality Performance Report – August/September 2026

MEETING

Name of meeting	Trust Board
Date of meeting	26 November 2026
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report presents the August/September 2026 Monthly Integrated Quality and Performance Report, supported by the detailed dashboard at Annex 1.
2. The overall RAG profile remains challenging, with 18 indicators rated red overall.
3. The central pattern remains one of interdependency between patient access, ambulance response, hospital handover, workforce capacity, productivity and wider system flow. Improvement in one area is unlikely to be fully realised without sustained delivery across the others.
4. There are areas of improvement since the previous report. Return of spontaneous circulation rates following cardiac arrest reached the lower end of target at 25.7% in September and the number of ambulances that could not send and cancelled by patients was reduced, attaining ambition. NEPTS oncology performance remains above ambition; financial balance has been maintained; and statutory and mandatory training and turnover remain comparatively stable.
5. These improvements do not yet translate into consistent delivery against all ambitions. The highest-risk areas for Board consideration remain Emergency and Orange response performance, stroke and STEMI call-to-door times, hospital handover and H45 delivery, EMS unit hours production, sickness absence, PADR completion, APP productivity, consult and close performance, NEPTS cancellations and concerns/Joint Investigation Framework performance.
6. The Clinical Model Transformation Programme has been reprioritised for winter. Delivery is focused on additional remote clinical capacity through the respiratory desk; improving how patients are referred through local Single Points of Access (SPOAs); improving Advanced Paramedic Practitioner (APP) deployment and utilisation within the existing resource; maintaining the additional falls response vehicles funded this year; and optimising the flow of 999 calls from assessment through to response. These priorities are supported by stronger performance evaluation and benefits tracking.
7. The CMT reprioritisation concentrates limited transformation capacity on the changes most likely to improve patient flow, winter resilience, clinical outcomes and operational productivity, with a clearer basis for testing whether activity is translating into measurable impact.
8. A number of material improvements remain dependent on wider system action, particularly health board delivery of H45 trajectories, sustained improvement in urgent and emergency care flow, alternative pathway availability and the release of operational capacity back into the ambulance system.

9. The trajectories included in this iteration should continue to be treated as developing assumptions rather than definitive forecasts. Further work is required to strengthen the link between actions, milestones, expected impact and measurable delivery dates.
10. The report therefore presents a mixed assurance position: the key drivers are understood, there is clearer programme focus for winter, and some indicators are improving, but several core measures remain below ambition, and delivery continues to rely on both internal execution and wider system commitments.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Trust Board is requested to:

1. **Consider the August/September 2026 Integrated Quality and Performance Report and actions being taken and determine whether:**
    - The report provides sufficient assurance.
    - Whether further information, scrutiny or assurance are required, or
    - Further remedial actions are to be undertaken through Executives.

ADDITIONAL PAPER(S)

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

1. Annex 1 - Monthly Integrated Quality and Performance Dashboard

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
223 - The Trust's inability to reach patients in the community causing patient harm and death 224 - Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients 160 - High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service 558 - Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences 100 - Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience 139 - Failure to deliver our Statutory Financial Duties in accordance with Legislation

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
4 November 2026	Hugh Bennett – Assistant Director Commissioning & Performance
5 November 2026	Rachel Marsh - Deputy Chief Executive
11 November 2026	Executive Leadership Team

SITUATION

1. The purpose of this report is to provide the Board with an integrated view of performance against the 39 agreed key measures across Our Patients, Our People, Value and Partnerships/System Contribution. This report covers August and September 2026 and should be read alongside the detailed dashboard at Annex 1.

BACKGROUND

2. The Monthly Integrated Quality & Performance Report continues to evolve. Forecast trajectories are included for selected measures; further modelling is required before reliable forecasts can be presented for operational response measures following implementation of the new clinical model.

3. Three indicators remain under development or review:

- **Time to Integrated Care — Remote Integrated Care Service (RICS), 90th percentile:** definitions for this indicator were agreed at November's Clinical Model Transformation Board. The definitions are now with the Joint Commissioning Committee (JCC) for final approval and will then be switched on.

- **National Patient Reported Experience Measure:** new Beacon Measures are now included in the report, but the volumes are low with SMS surveying, designed to address the volumes issue, with Executives having recently discussed a way forward on a related IG issue.

- **Successful applicants from under-represented groups**: this metric is currently being further reviewed as it appeared to be double counting successes.

4. The main assessment is structured around the Trust's six strategic objectives. This is intended to help the Board consider performance, actions, risks and interdependencies through the lens of the organisation's agreed strategic framework.

Clinical Model Transformation Programme update

5. The Clinical Model Transformation (CMT) Programme has been reprioritised for winter to concentrate limited delivery capacity on the changes most likely to improve patient flow, operational productivity and winter resilience. Four

programme priorities have been agreed: deliver the respiratory model, including additional remote clinical capacity through a dedicated respiratory desk; test a proactive referral model into health board Single Points of Access (SPOAs) to reduce the number of patients waiting for remote clinical assessment; improve Advanced Paramedic Practitioner (APP) deployment and utilisation within the existing resource; and continue work to improve the flow of 999 calls, including breathing difficulties, Orange-category demand, time spent at scene, time from call to hospital arrival, clinical navigation and dispatch.

6. The additional falls response vehicles funded this year will remain a winter priority, providing a more appropriate response for patients who have fallen, supporting care in the community where clinically appropriate and helping to preserve emergency ambulance capacity for higher-acuity demand.

7. Remote clinical capacity and stronger performance, evaluation and benefits realisation arrangements are the principal enablers. Stable activity is being transferred into business as usual with clear ownership, while lower-priority or unaffordable work is being paused to protect delivery capacity through winter.

8. A New Year review will use evidence from winter to decide which interventions should be expanded, adapted, stopped or restarted, and to agree the next improvement priorities through the Trust's clinical improvement governance arrangements.

ASSESSMENT

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

9. **Emergency and urgent ambulance response: current position.** Time-critical and urgent ambulance outcomes and response times remain below ambition across several parts of the pathway. Average times from the initial call to arrival at hospital for stroke and ST-elevation myocardial infarction patients remain materially above the 1 hour 30-minute ambition; and response times for Emergency and Orange-category calls remain challenged. Performance is affected by the availability of ambulance hours, demand, hospital handover delays, the continuing development of the new clinical model and wider patient flow across the health system.

10. **Actions and dependencies.** The reprioritised Clinical Model Transformation Programme is the main improvement route, in particular, the Call Categorisation (3) Task & Finish Groups, with trajectories in place for each workstream, which are being reported on. It focuses on respiratory presentations, the flow of calls through the service, clinical navigation, remote assessment, referral through Single

Points of Access and use of Advanced Paramedic Practitioners (scheduling went live in early November, with the new rosters due to all be in place by mid-January). Work to improve outcomes following cardiac arrest also continues. The full benefits also depend on health boards reducing handovers over 45 minutes and improving wider urgent and emergency care flow.

11. **NHS 111.** The proportion of callers who ended their call before it was answered (call abandonment rate) has increased in recent months after achieving 15% and marginally hitting the upper limit of the modelled operating range in July 2026. Abandonment rate reached 21.5% in September 2026, which is the highest recorded abandonment rate since December 2025. However, higher demand, longer average call-handling times and staff time unavailable for call handling continue to constrain capacity. In particular, in relation to demand, it should be noted that demand is 19% higher in this financial year compared to the same period last year, which will materially affect ability to meet that demand with existing capacity. The Commissioners have sought further information on this matter together with an update on the actions being taken that are within the organisations gift.

12. **Actions.** Recruitment, revised rosters, greater use of the virtual queue, review of repeat callers for the same episode of care, and improvements to the Clinical Advice Line remain under Executive oversight with a clear action plan in place. Further modelling of what capacity is required to deliver performance is also now under consideration, given these significant increases in demand.

13. **Non-Emergency Patient Transport Service.** Transport for oncology patients remains above ambition, but only 75.1% of planned discharge and transfer journeys were collected within 60 minutes of their booked time, against a 95% ambition. Performance is affected by when journeys are booked and the capacity available at those times. Improvement is being pursued through the service improvement programme and discussions with health boards, with WAST wide performance largely driven by lower levels of performance within BCU.

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

14. **Current position.** Workforce capacity remains a material constraint on patient access and operational resilience. The Trust produced 88% of planned Emergency Medical Service ambulance hours in September against the 95% ambition — 115,780 actual hours compared with 131,834 planned. Sickness absence was 8.19%, including 5.5% long-term absence, and remains above the 6% ambition. Performance appraisal and development review (PADR) completion was 77.48% in September 2026, this is the highest figure recorded since June 2025, however,

remains below the 85% target. More stable measures include staff turnover remaining below target and statutory and mandatory training remaining above target.

15. **Actions.** Recruitment, options for additional overtime during winter (now actioned), tighter management of staff time away from operational duties, roster changes, occupational health support and the performance appraisal refresh remain the principal controls. Current forecasts do not yet show that the ambulance-hours, sickness or appraisal ambitions will be achieved.

SO3: Being at the forefront of innovation and technology

16. **Current position.** This remains the strongest-performing strategic objective, with continued use of the NHS 111 Wales virtual assistant, online symptom checkers and webchat. Reporting now needs to demonstrate whether these digital channels reduce telephone demand, improve outcomes and experience, and increase productivity.

17. **Actions.** Online symptom checkers and the virtual assistant are moving into routine service management. Alongside this, the Joint Commissioning Committee is working with the Trust on the future digital access model and the benefits expected from it.

SO4: Developing services in collaboration

18. **Current position.** This objective is dominated by patient flow across the wider health system and the Trust's reliance on partner organisations. There was an increase in notification to handover lost hours in September 2026, with the Trust losing a total of 13,071 hours, a marked increase from the 9,737 lost hours in August 2026. A total of 4,809 handovers took longer than 45 minutes, against the Welsh Government ambition of none. The remaining delay was estimated to have prevented the Trust from responding to approximately 4,217 additional patients. Health boards have now provided plans showing how they intend to reduce handovers over 45 minutes; progress will be monitored through the monthly Operations Performance, Demand and Capacity meeting.

19. **Pathway indicators.** The proportion of 999 incidents resolved through telephone assessment without an ambulance being sent (consult and close) has improved over the longer term but has fallen in recent months with a value of 16.8% in September, remaining below the 22% ambition. There has been a definitional issue with the consult & close metric, which is now resolved and with the JCC for final

approval, but the Trust estimates this change will only gain an additional one percentage point, so further analysis in this space is required. The proportion of verified incidents conveyed to a major emergency department was 34.37%, above the modelled ambition of 30%, while 10.4% of incidents were treated at scene. Together, these measures show that further improvement is needed so more patients can be safely managed by telephone, at scene or through community and alternative services. The Clinical Model Transformation priorities on Single Points of Access, respiratory care, Advanced Paramedic Practitioner deployment and remote clinical assessment are intended to support this shift.

20. **Actions and dependencies.** The Trust continues to support health board improvement work, escalate concerns through Executive routes and monitor delivery against plans to reduce handovers over 45 minutes. Within the Trust's control, the Clinical Model Transformation work on Single Points of Access, respiratory pathways, Advanced Paramedic Practitioner utilisation, clinical navigation and call flow is intended to reduce avoidable conveyance and improve access to community services. However, the full benefits for response times, productivity and patient experience depend on health boards sustaining reductions in handover delay and ensuring that alternative pathways are consistently available and responsive.

SO5: Being quality driven and clinically led

21. **Current position.** This objective should be read alongside the access, response and patient-flow position described under SO1 and SO4. Longer ambulance response times, delayed access to definitive care and extended hospital handovers increase the risk of patient harm and contribute to reportable incidents, complaints, investigations undertaken jointly with health boards, and cases where the Trust must formally apologise and explain what has happened under the Duty of Candour. In September the Trust recorded seven National Reportable Incidents with only three investigations shared with Health Boards for joint investigation as fewer SCIF meetings were held in September. Compliance with complaint response times was 38.0%, and two Duty of Candour cases missed the requirement for written follow-up within five working days. Evidence on patient experience remains limited pending implementation of the 999 text-message survey.

22. **Actions and dependencies.** The Concerns Management Improvement Programme is focused on resolving concerns earlier, clarifying ownership, improving tracking and reporting, and ensuring lessons lead to change. Controls for approving Duty of Candour correspondence are also being strengthened. These actions improve how the Trust responds and learns when care falls short, but reducing the underlying number of quality and safety events also depends on

faster ambulance responses, fewer hospital handovers over 45 minutes and better patient flow across the wider system.

SO6: Delivering exceptional value

23. **Current position.** The Trust was financially on plan at Month 4, but value must also be assessed through the effective use of staff and vehicles, patient flow and the sustainability of workforce arrangements. Emergency ambulances completed an average of 3.03 jobs per shift in September 2026, continuing an improvement seen since April 2025 as hospital handover delays reduced and vehicles became available sooner. The measure requires further review to ensure it reflects meaningful efficiency and does not encourage activity at the expense of appropriate care. Advanced Paramedic Practitioners completed an average of 2.72 jobs per shift against the 4.75 ambition, indicating that this specialist clinical capacity is not yet being deployed as effectively as intended

24. **Actions and dependencies.** Improving how Advanced Paramedic Practitioners are deployed and used within the existing resource has been prioritised within the winter (scheduling went live in early November, with the APP new rosters expected to be all in place by mid-January). Clinical Model Transformation portfolio. The immediate work will align capacity with demand and geography, improve allocation of suitable patients and increase community-based care. The digital scheduling solution has been deferred until after winter and the previously modelled improvement forecast should therefore be treated as provisional. Investment has supported additional falls response vehicles, which will remain a winter priority. These vehicles provide a more appropriate response for patients who have fallen, support care in the community where clinically appropriate and help preserve emergency ambulance capacity for higher-acuity calls.

25. In the Non-Emergency Patient Transport Service, 18.6% of planned activity was cancelled in September against an ambition below 10%. The improvement programme is addressing rosters, capacity, booking and planning, demand management and digital links, although cancellations by patients and hospitals remain partly outside the Trust's control. These changes are important to delivering the 2% productivity improvement commitment in the 2026/27 Integrated Medium Term Plan while maintaining financial balance and sufficient operational capacity.

OVERALL CONCLUSION

26. The overall position remains mixed. The principal drivers of performance are understood, and improvement actions are in place across patient access, the new clinical model, NHS 111, non-emergency patient transport, concerns management, workforce, productivity and hospital handovers.

27. Since the previous report: improvement trajectories have been developed for each of the Call Categorisation (3) workstreams, with early signs of improvement; the Trust has submitted its winter plan to NHS P&I, received feedback and is currently undertaking a final assurance check; APP scheduling has been live, definitions for RICS time to assessment have been agreed and a revised consult & close metric definition agreed; additional overtime monies have been made available to support CHARU and EA production through the winter; the NEPTS Improvement Programme continues to develop; the 111 rosters will go live in Q4 and an initial set of productivity metrics for the Trust has been developed.

28. Whilst there is a significant body of work in progress and delivering designed to deliver improved performance against the core metrics in this report, the Trust is now moving into the winter plan period, with system pressure already increasing.

RECOMMENDATION

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

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

Monthly Integrated Quality & Performance Report - TB

August/September 2026
Annex 1 – Top Indicator Dashboard

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

Version 1.0
November 2026

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Ambition 2026/27	Jul-26	Aug-26	Sep-26	2 Year Average	RAG
Our Patients (SO1&5)						
Return of Spontaneous Circulation (ROSC)	25-30%*	23.4%	19.7%	25.7%	21.7%	G
Stroke Call to Hospital Door Times	01:30	02:14	02:08	02:21	02:28	R
STEMI Call to Hospital Door Times	01:30	02:27	02:24	02:39	02:34	R
Arrest (Purple) Median	6-8 Minutes*	07:39	07:24	07:31	N/A	G
Arrest (Purple) 90th	<20 Minutes	18:27	18:27	17:56	N/A	G
Emerg. (Red) Median	6-8 Minutes*	09:13	09:01	09:32	N/A	R
Emerg. (Red) 90th	<20 Minutes	22:07	22:08	22:46	N/A	R
Now (Orange) Median	<60 Minutes	01:05	01:00	01:23	N/A	R
Time to Integrated Care RICS 1 90th Percentile	<60 Minutes					
Can't Send & Cancelled by Patient Volumes	<5,770	5,882	5,610	5,641	6,559	G
NHS111 Call Handling Abandonment Rates	<10-15%	15.0%	18.0%	21.5%	13.3%	R
Renal Repeat Cancellation +	Zero	N/A	N/A	1	N/A	A
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	>70%	75.3%	78.0%	77.0%	76.6%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	>95%	72.7%	74.2%	75.1%	77.6%	R
% of 111 call presented in Welsh, Answered in Welsh	>70%	43.2%	52.8%	49.6%	59.5%	R
National Patient Reported Experience Measure (average overall experience score)	85%	N/A	N/A	88%	N/A	G
Complaints Compliance with Required Response Timeframes	>75%	69.2%	57.5%	38.0%	N/A	R
Enactment of the Duty of Candour Total	100%	0%	0%	71%	N/A	R
National Reportable Incidents reports (NRI)	MOA	4	1	7	4	MOA
Joint Investigation Framework Referrals to HBs	<7	10	5	3	12	G

Monthly Indicators	Ambition 2026/27	Jul-26	Aug-26	Sep-26	2 Year Average	RAG
Our People (SO2)						
% of Under-represented Groups Offered	>7%					
EMS Hours Produced (Against Planned)	95%	86%	85%	88%	86%	A
Sickness Absence *(all staff)*	<6%*	8.17%	8.34%	8.19%	7.96%	R
Staff Turnover Rate	<10%*	8.42%	8.28%	8.18%	8.12%	G
PADR/Medical Appraisal	>85%	73.47%	73.40%	77.48%	73.79%	A
Statutory & Mandatory Training	>85%	89.08%	88.23%	90.39%	87.40%	G
Finance & Value (SO6)						
Average Jobs per Shift (EA)	>2.3	3.16	3.15	3.03	2.85	G
Average Jobs per Shift (APP)	4.75	2.43	2.47	2.72	2.85	R
NEPTS Activity Cancelled (by CMP, Patients & HBs)	<10%	18.4%	17.8%	18.6%	17.8%	R
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	100%	G
Partnerships / System Contribution (SO3&4)						
Number of Patients using Albot	MOA	5,328	5,247	5,399	N/A	MOA
Webchats as a % of Web Site Hits	>1.35%	1.65%	1.73%	1.78%	N/A	G
111 Outcomes (999 & ED)	MOA	16.4%	15.4%	15.0%	18.4%	MOA
Successful Consult & Close Outcome	>22%	15.8%	16.3%	16.8%	18.4%	R
% See & Treat & Alternative pathways (of verified activity)	>20%	10.1%	10.6%	10.4%	10.52%	R
Number of Handover Lost Hours	<6000	9,929	9,737	13,071	16,466	R
Number of Handovers over 45 mins	Zero*	3,681	3,498	4,535	5,252	R
Reduction in Number of Conveyances to ED as % of Verified	30%	34.35%	34.58%	34.37%	35.37%	R

RAG Indicates -

TBD: Status cannot be calculated (To Be Determined)

MOA – Measure of Activity

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

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

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

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

+ 4 weekly data

Delivering on our Strategic objectives

Overall strategic objective profile

STRATEGIC OBJECTIVE	DESCRIPTOR	RED	AMBER	GREEN	TBD	MOA
SO1 – Our Patients	Significant performance challenges	8	1	5	1	0
SO2 – Our People	Mixed performance	1	2	2	1	0
SO3 – Innovation & Digital Transformation	Strong performance	0	0	1	0	1
SO4 – Partnerships & System Contribution	Significant performance challenges	5	0	0	0	1
SO5 – Quality, Safety & Patient Experience	Mixed performance	2	0	3	0	1
SO6 – Finance, Resources & Value	Mixed performance	2	0	2	0	0

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

Since June/July: red indicators remain at 18 overall, with movement between objectives

SO1 | Patient measures
Red 7→8, Amber -2, Green +1

SO2 | Patient measures
Red 2→1, Amber +1

SO4 | System contribution
Red 4→5

SO5 | Quality & safety
Red -1; Amber -1; Green +3;

SO3 and SO6 unchanged

Activity at a glance

Demand across 111, 999 and non-emergency patient transport

111

93,649

CALL DEMAND

111 activity	
Website Visits	**303,496**
Albot Usage	**5,399**
Completed Symptom Checkers	**9,488**
Call Demand	**93,649**
999 / ED	**7,649**

Digital and telephone demand indicators

999

45,320

CALLS

999 calls & incidents	
999 Calls	**45,320**
Verified Incidents	**35,253**
Arrest Incidents	**782**
Emerg Incidents	**4,750**
Now Incidents	**11,868**
Soon Incidents	**5,492**
Planned Incidents	**1,414**
Cancelled by Patient	**5,246**
Consult & Close	**5,902**
See & Treat	**3,661**
Conveyed	**12,115**

Emergency activity and outcomes

NEPTS

45,113

COMPLETED JOURNEYS

NEPTS	
Completed Journeys	**45,113**

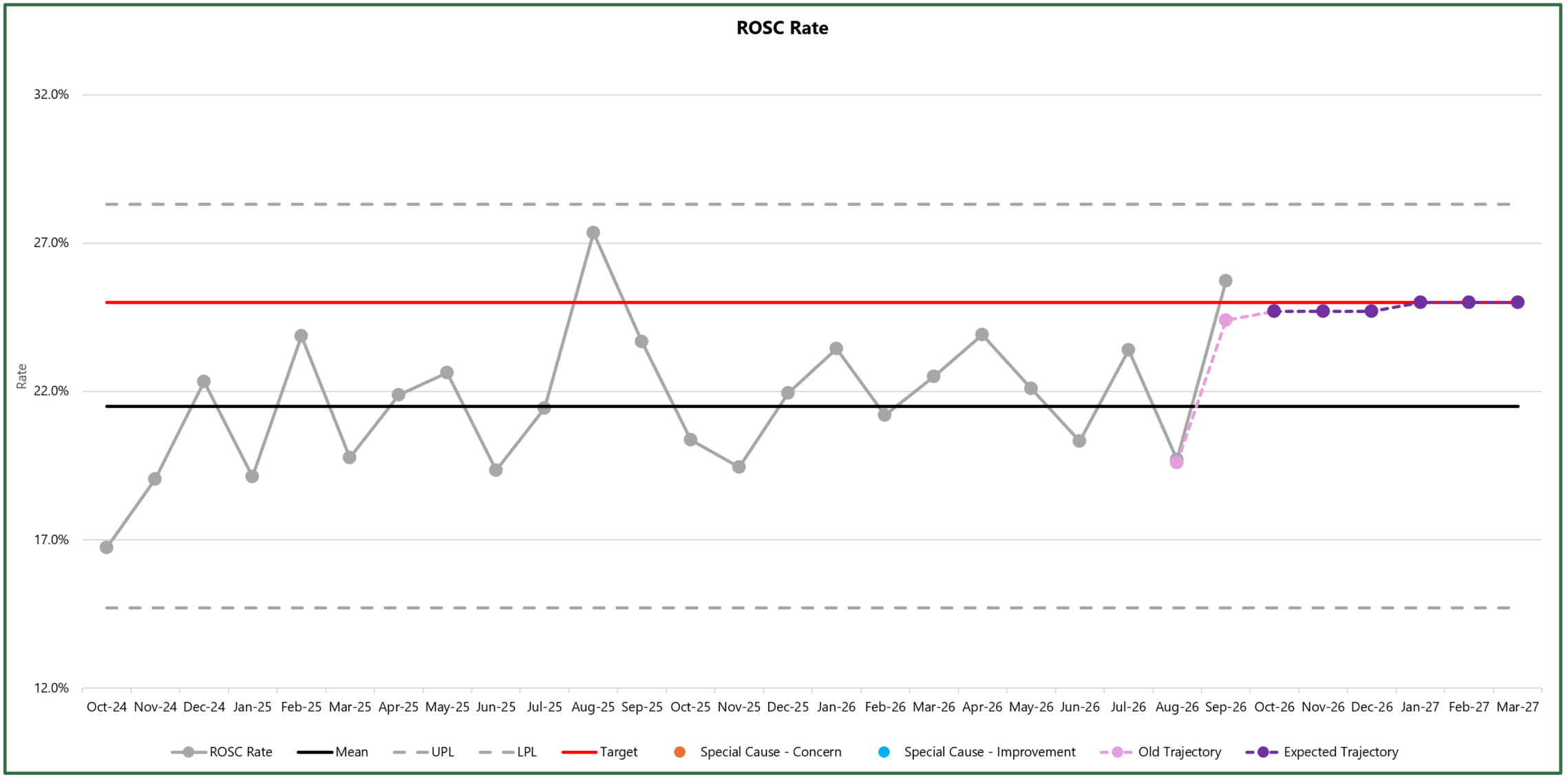
Non-emergency patient transport activity

Our Patients

Return of Spontaneous Circulation (ROSC)

Strategic Objective 1

ROSC
G



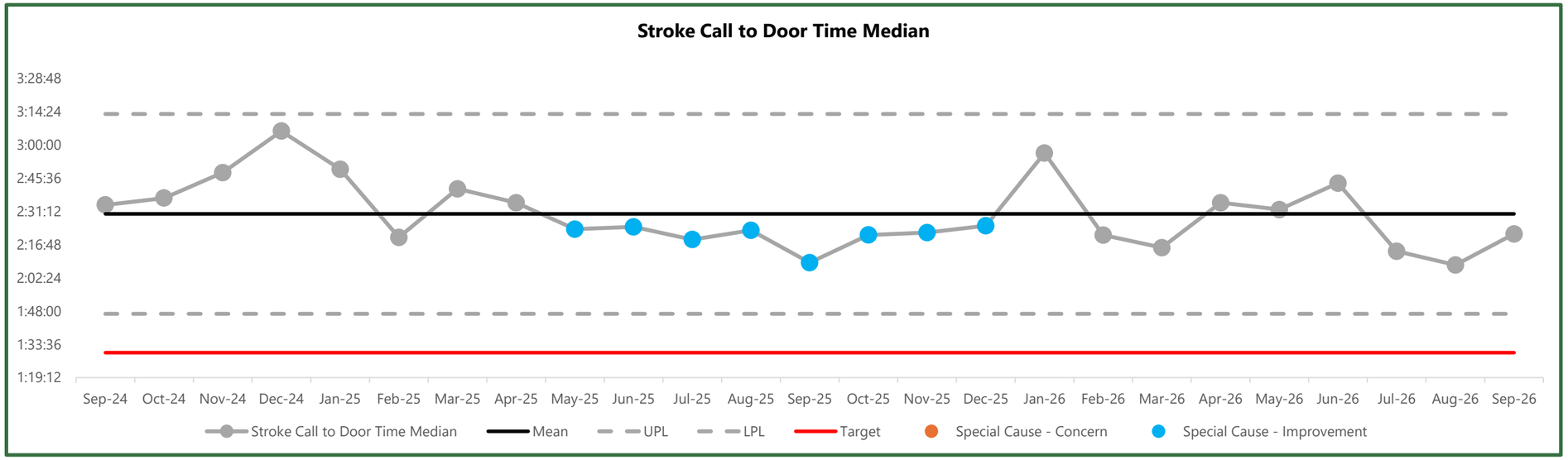
Our Patients

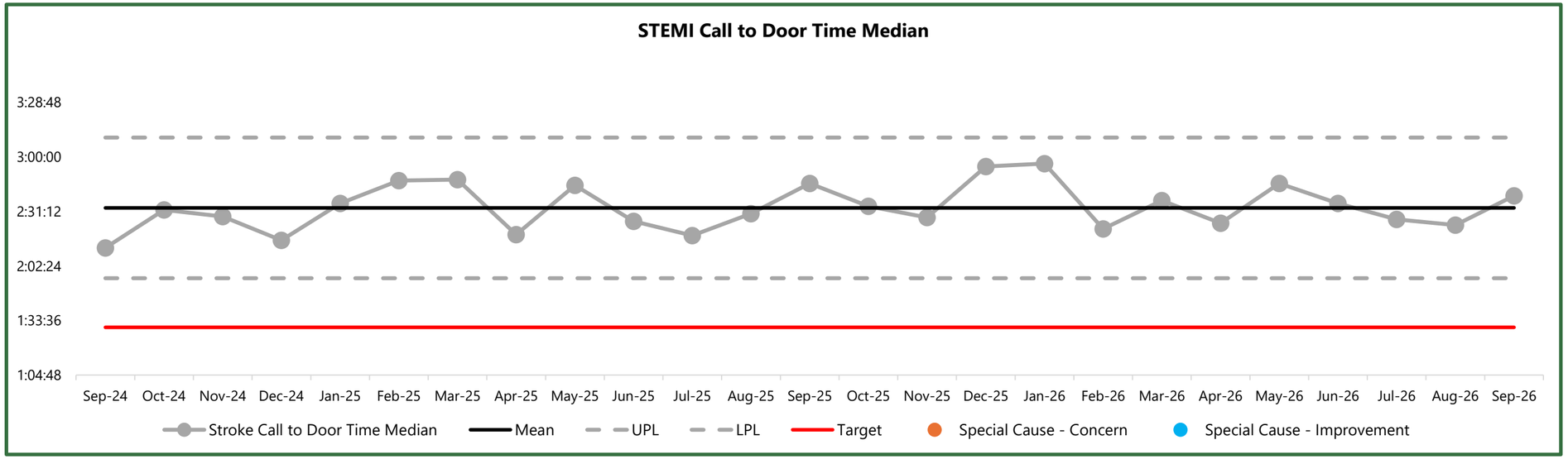
Stroke & ST-elevation myocardial infarction (STEMI) patients

Time-Based metrics

Strategic Objective 1

Stroke Call to Door	STEMI Call to Door
R	R





Analysis:

Stroke call-to-door times show special cause improvement in 2025, however, recent data has returned to common cause variation around the mean of 2 hours 30 mins.

STEMI call-to-door times demonstrate predominantly common cause variation, with performance fluctuating around the mean of 2 hours 33 mins. For both pathways, the processes remain stable but will not deliver the ambition of 1 hour 30 mins, and process improvement is required.

Remedial Plans and Actions:

The Trust's ambition is to improve the call to door times to 1.5 hours. Improvement actions include: reducing the Orange Now category ratio in the new model i.e. ensuring accurate categorisation of Orange demand, reducing on scene times, reducing call to allocation times for 28J incidents, the boosting of EA production through the winter plan and increasing APP utilisation (thereby avoiding EA dispatch to APP suitable incidents), with W45 also being a material factor in releasing EAs to respond.

Expected Performance Trajectory:

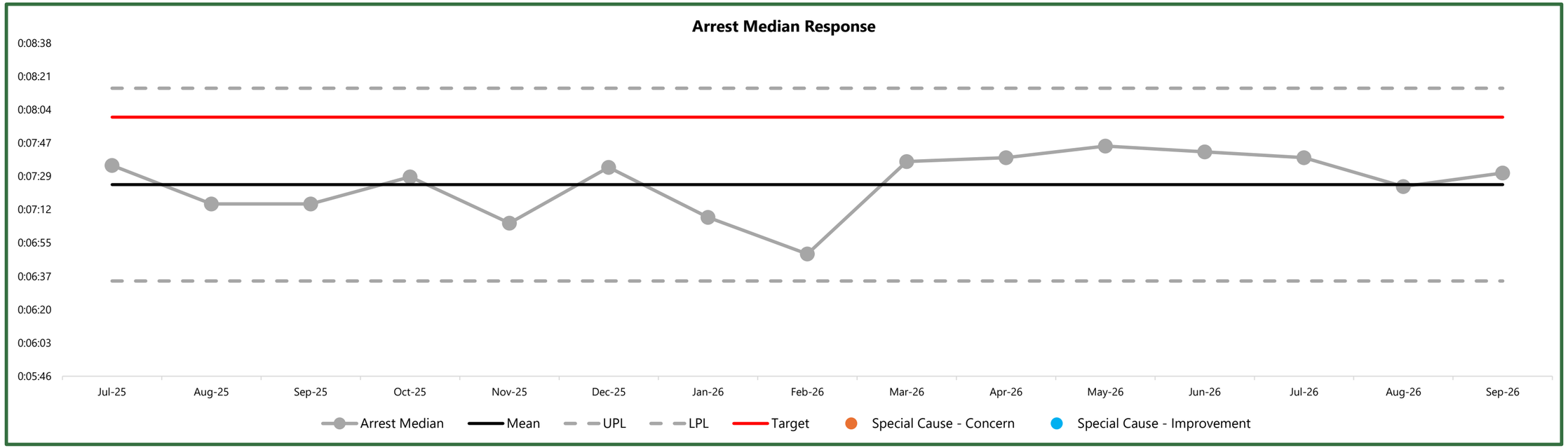
Improvement trajectories are in place for all of the above actions. It is difficult to determine the combined impact of these actions without modelling: simulation software currently being retuned.

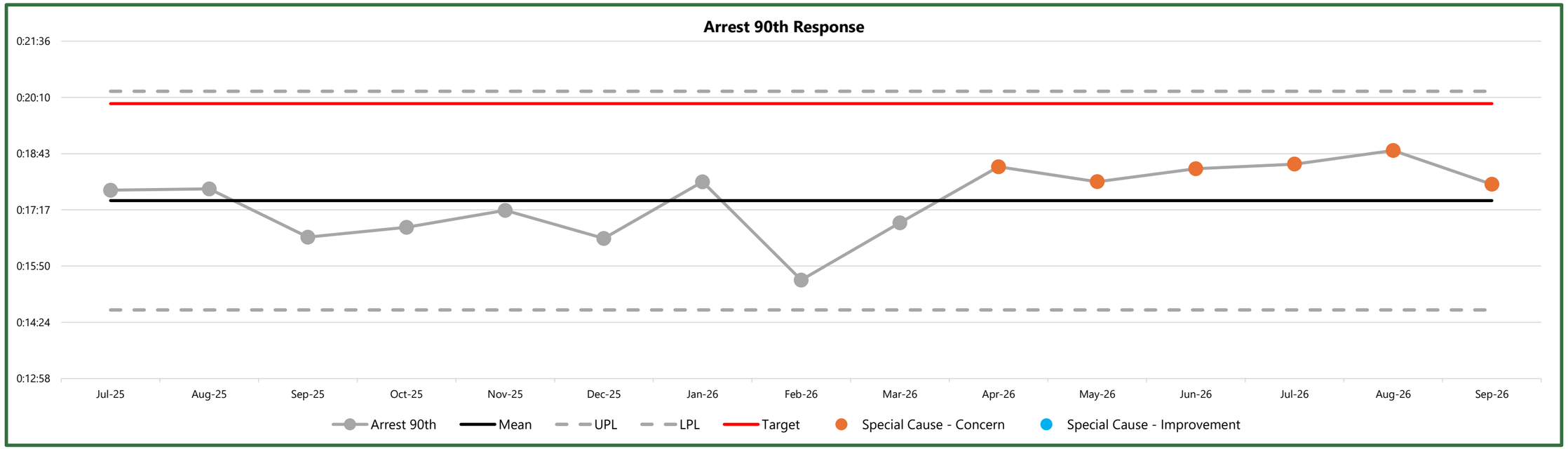
Our Patients

Arrest (Purple) Indicators

Strategic Objective 1

Arrest Median	Arrest 90th
G	G



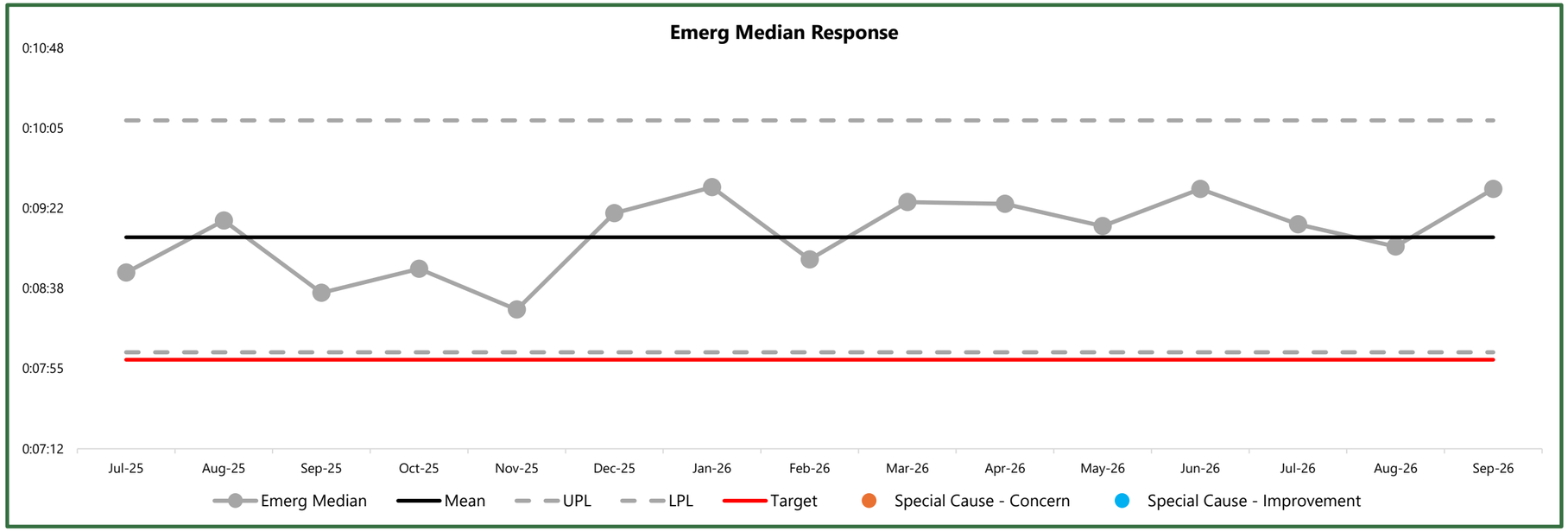


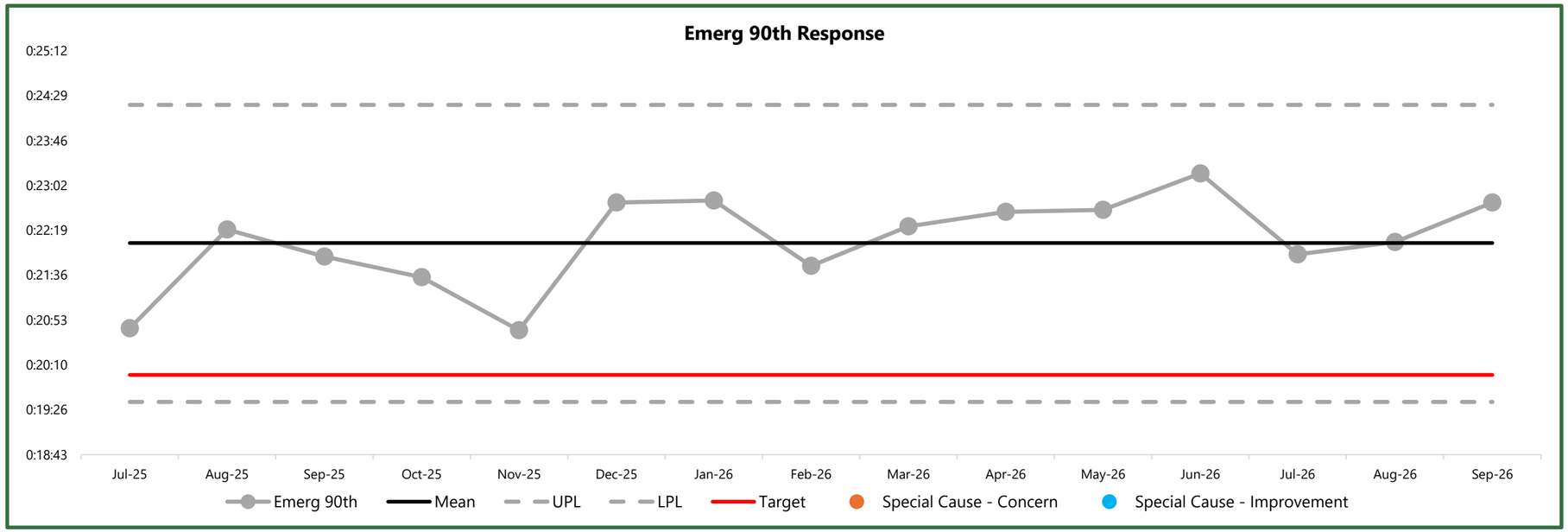
Our Patients

Emerg (Red) Performance Indicators

Strategic Objective 1

Emerg Median	Emerg 90th
R	R





Analysis

There were 4,750 incidents in September 2026, which is slightly below the mean of 4,860 since July 2025 when the new priority categories went live. This meant Emerg incidents accounted for 13.4% of all verified incidents during the month.

Performance is stable i.e. there is no special cause concern, however, response times are still failing to achieve performance targets and there is no special cause improvement evident at this stage. The median response time in September 2026 for Emerg incidents was 9 minutes 31 seconds. Aneurin Bevan health board had the lowest median time of 8 minutes and 1 second, narrowly missing the target, while Powys had the highest at 14 minutes and 18 seconds, although this is to be expected due to the geography of the area. The pan-Wales 90th percentile response time was 22 minutes 45 seconds.

Remedial Plans & Actions

As part of the Clinical Model Transformation Programme, a Call Categorisation (3) Flow Optimisation Task & Finish Group has been set up to work on improving the patient flows through the new model, in advance of winter.

Two of the six workstreams in this task & finish group are relevant to this indicator 1) breathing difficulties and 6) RCS/Clinical Navigators. The aim is to increase the number of RCS0 incidents that are screened, currently c60% are timing out and going back to the dispatch stack. The focus is on reducing clinical navigator activity and increase capacity (interim for winter with longer term modelling being completed by mid-November). Delivery of H45 will also be a key contributory factor.

Expected Performance Trajectory

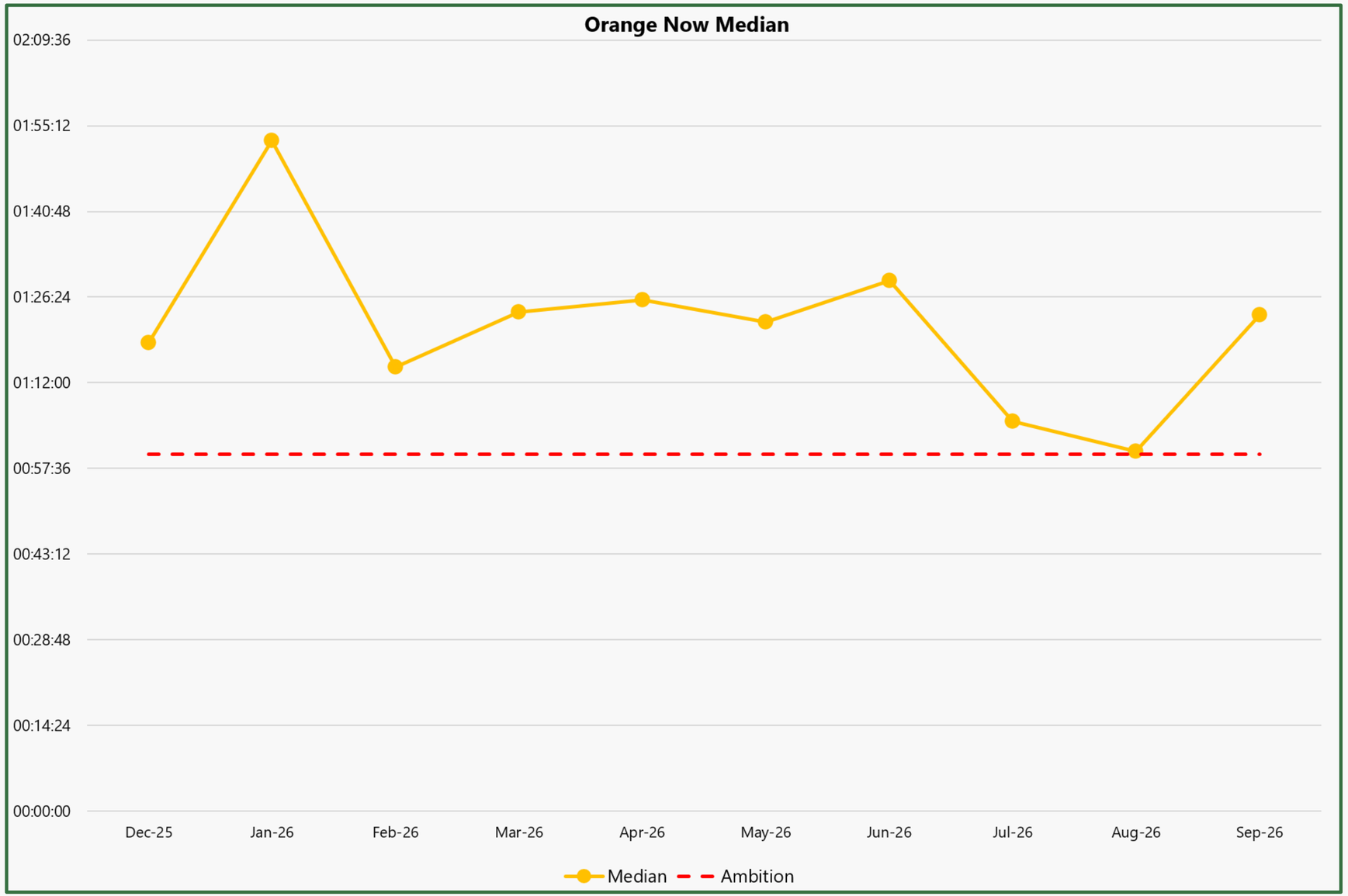
An expected trajectory will be included once the simulation software has been retuned to the new model. Retune underway.

Our Patients

Orange (Now) Performance Indicator

Strategic Objective 1

Now Median
R



Analysis

In December 2025 the existing Amber category, was replaced by Orange (now) and Yellow (soon).

The median response time in September 2026 for Orange (Now) incidents was 1 hour 23 minutes. This continues to be above the 1-Hour ambition response time.

Powys health board had the lowest median response time of 51 minutes, whilst Swansea Bay had the highest at 2 hours 54 minutes.

Remedial Plans and Actions

The Trust's ambition is to improve the Orange Now median to one hour. Improvement actions including: reducing the Orange Now category ratio in the new model i.e. ensuring accurate categorisation of Orange demand, reducing on scene times, reducing call to allocation times for 28J incidents, the boosting of EA production (slide 20) through the winter plan and increasing APP utilisation (slide 30) (thereby avoiding EA dispatch to APP suitable incidents), with W45 (slide 34) also being a material factor in releasing EAs to respond.

Expected Performance Trajectory

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

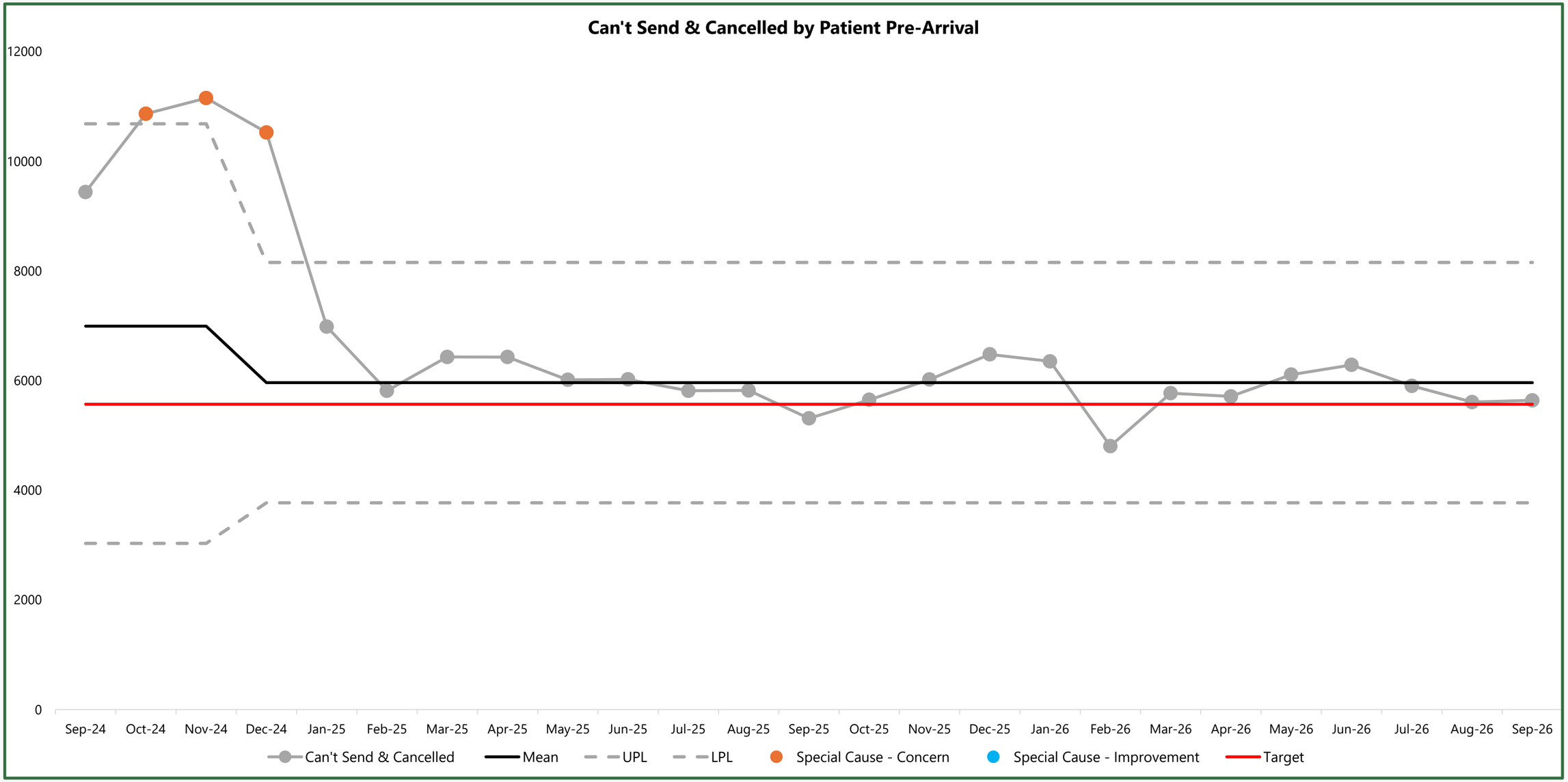
Modelling (based on forecast December demand) recently undertaken suggested that if total time at hospital was reduced to 42 minutes (which matches the average handover time in England of 27 minutes plus the 15 minutes currently allowed), the Orange median response time would reduce to under 50 minutes and therefore achieve the WAST ambition of under 1-hour. The modelling was also carried out based on W45, which indicated that Orange median response times would remain at just above the one-hour threshold.

Our Patients

No Send or Patient Cancellations

Strategic Objective 1

Can't Send
G

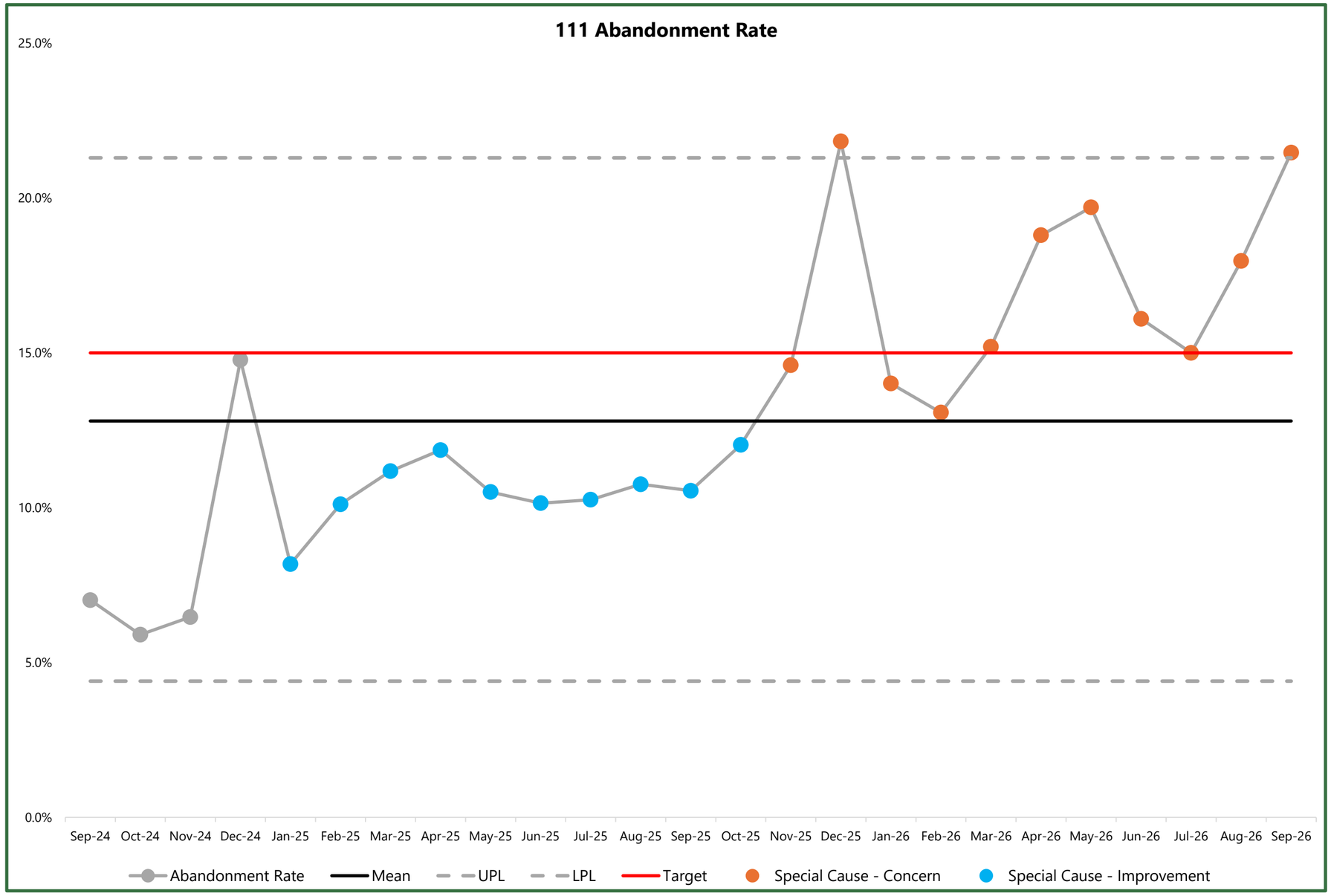


Our Patients

111 Call Abandonment Performance Indicators

Strategic Objective 1

Abandonment Rate
R



Analysis

The 111-call abandonment rate increased to 21.5% in September 2026. Based on the SPC chart, the service is not currently able to meet the target consistently. Performance has seen a decline since October 2025, which has seen the metric consistently above the mean and in two months, above the upper process limit. 111 call demand is 19% higher for this financial year to date, compared to the same period last year. Previous analysis has shown that current capacity can sustainably handle around 85,000 calls a month, however, once this figure increases over 90,000 there is a much stronger likelihood of increased abandonment rates. Call demand has been above 90,000 in every month of this financial year apart from Jun-26. Sickness absence is also tracking material above last year's levels with September's sickness abstraction at 13.74%, compared to 9.5% in September 2025. Average Handling Times (AHT) have also increased in recent months. During 2024/25 AHT was below 9.5 minutes, but during 2026 it has risen to over 10 minutes. Changes to some of the activity required within the Clinical Advice Line (CAL) has also reduced call handling hours, with CAL reducing capacity by 6% in September 2026.

Remedial Plans and Actions

A 111-re-roster review is underway, with new rosters expected to be in place by late Autumn (now revised to Q4 as a result of flexible working applications being mapped onto the 18 available roster patterns), which should help reduce sickness and turnover. Actions are also underway to increase the utilisation of virtual queuing and review the way patients who are re-accessing for the same care episode could be managed differently. The Trust is also working on new processes around the use of the Clinical Advice Line (CAL) by call handlers, designed to free up call handler and clinician time.

Expected Performance Trajectory

The independent modelling indicates that the Trust should expect to see a performance range of 10%-15% based on the current commissioned establishment and previous demand levels. JCC have sought further information arising from the deepdive

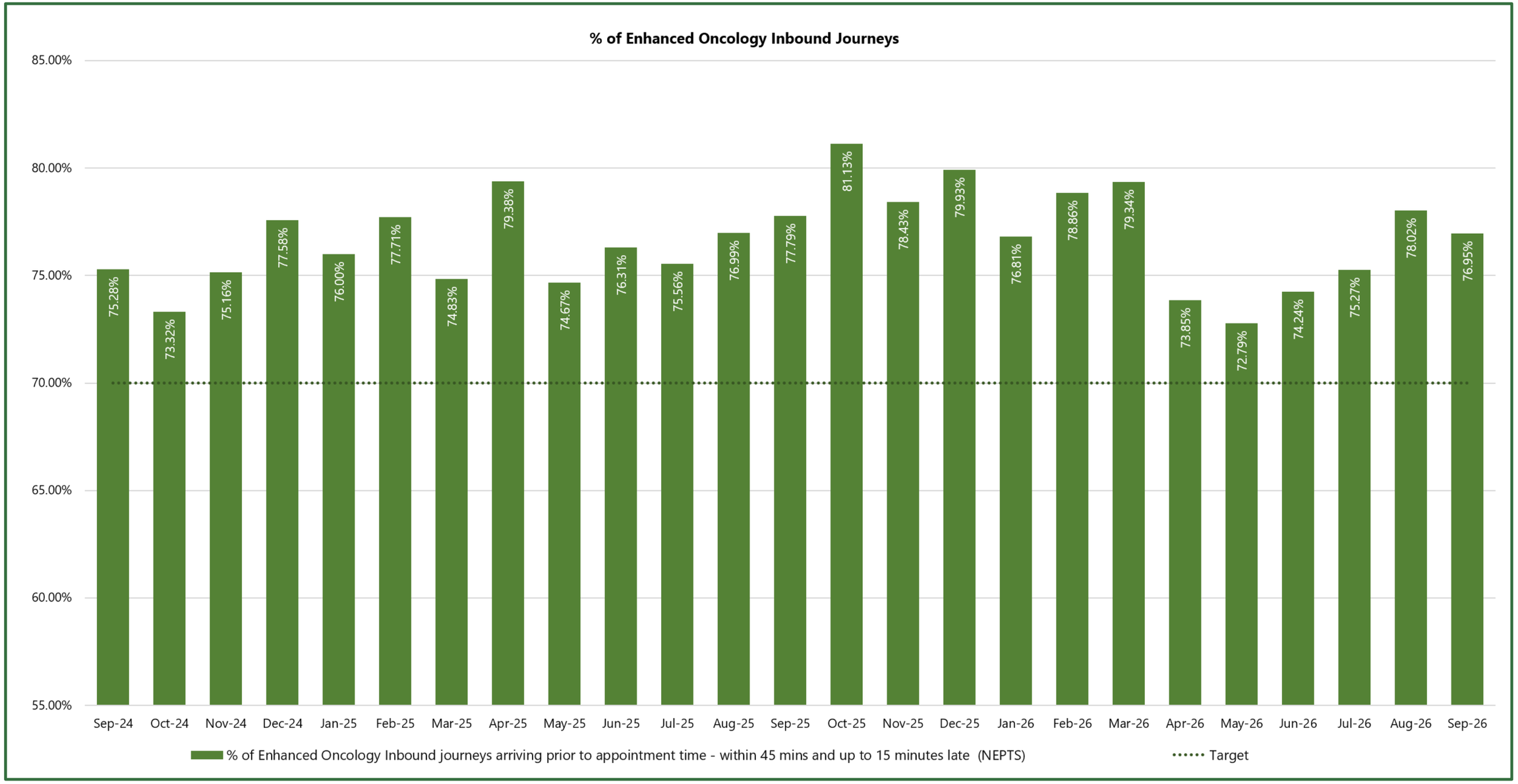
Our Patients

Ambulance Care Indicators - Oncology

Strategic Objective 1

Oncology

G

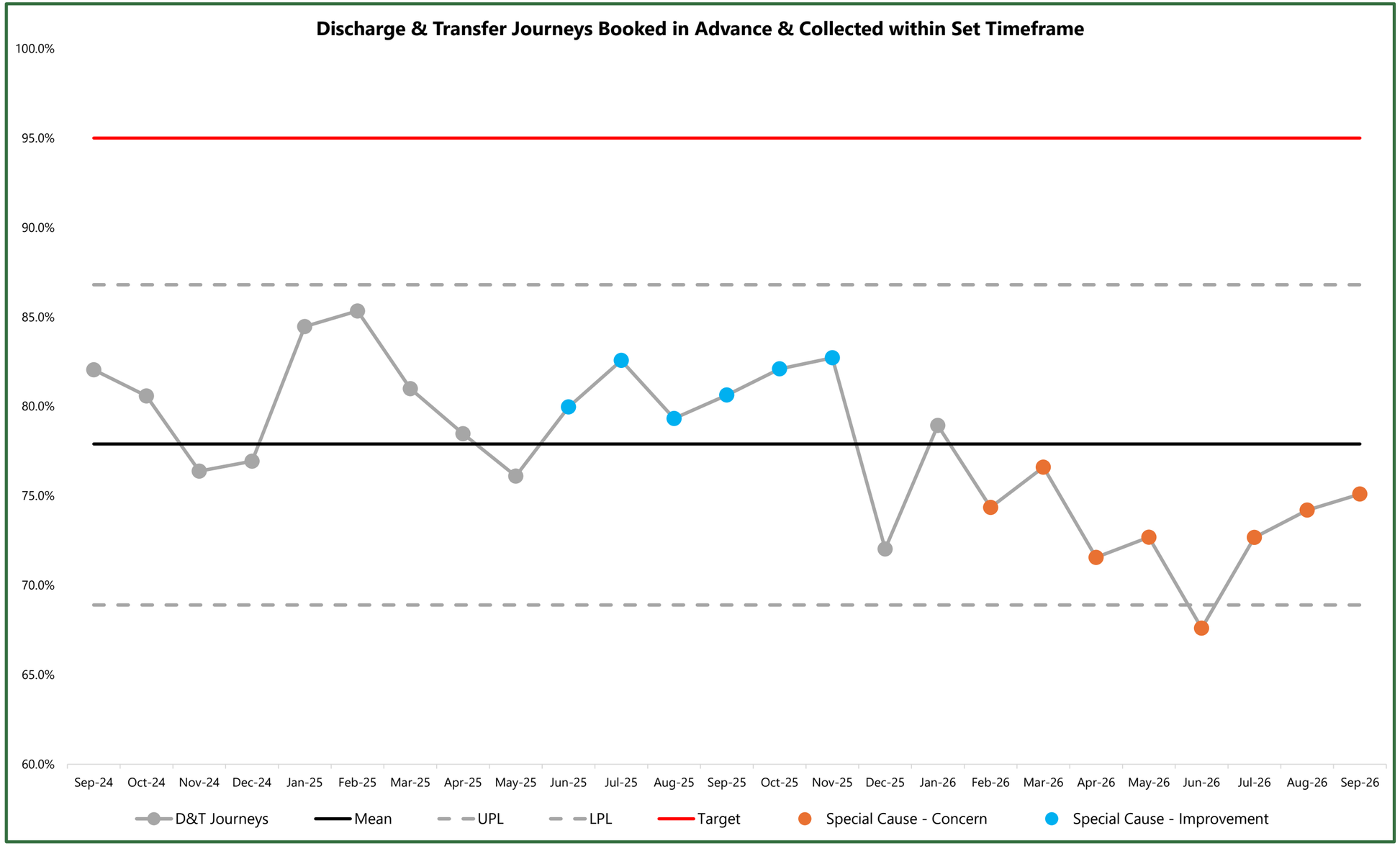


Our Patients

Ambulance Care Indicators – Discharge & Transfers

Strategic Objective 1

Advanced D&T
R



Analysis

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment time continues to increase in September 2026 to 75.1% but remains well below the 95% target.

The SPC shows three months of improvement in performance from the low of June 2026, when performance fell below the lower process limit in, however, performance remains below mean and is a special cause of concern.

Following performance becoming a special cause concern, considered to be due to an increase in early bookings in certain parts of Wales, meetings with Health Boards were put in place to have discussions around re-profiling resources at different times of the day. To date, no consensus has been reached on these, as resources available are still required. However, the team have adapted their planning approach to address this. Performance will continue to be tracked.

Remedial Plans and Actions

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

Expected Performance Trajectory

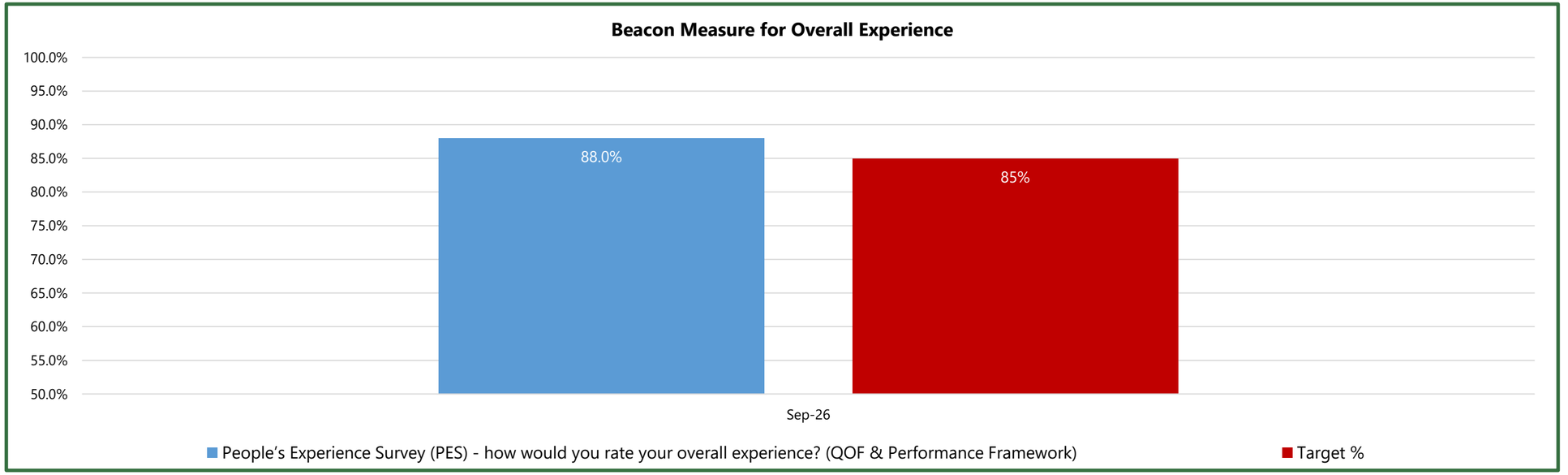
Dependent on options paper (to be developed in December).

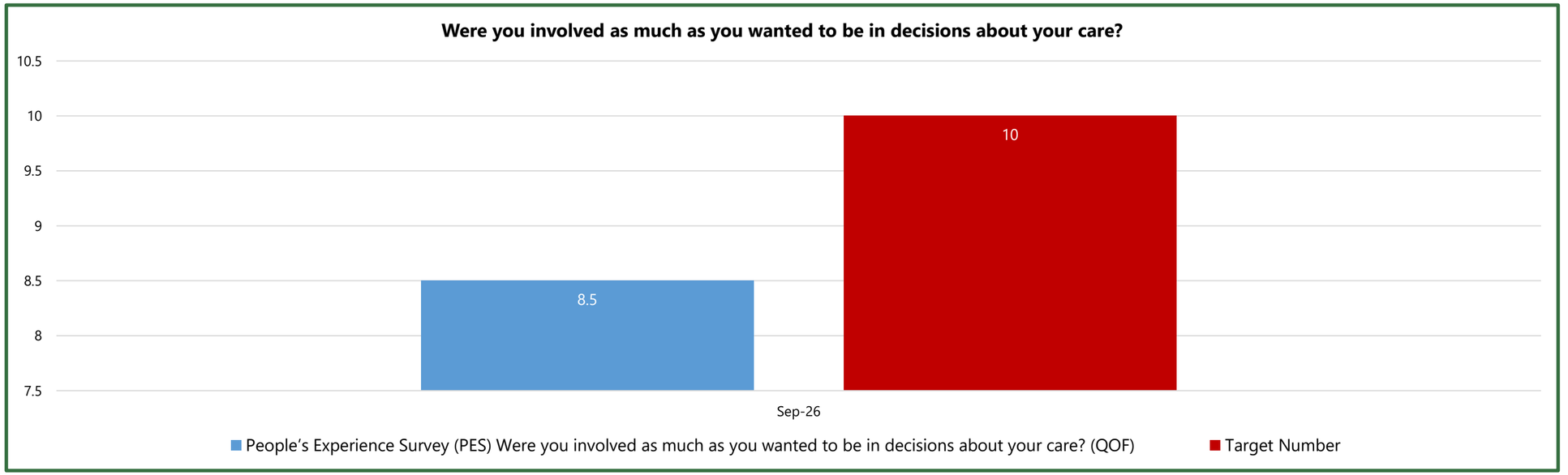
Our Patients

Patient Experience Surveys
NHS P&I Beacon Measures

Strategic Objective 5

G





Analysis

The score for 'Were you involved as much as you wanted to be in decisions about your care?' for the same period was 8.5. Currently there is no guidance of how this is to be measured, in the interim, the team are using the same as the Overall Experience measure (out of 10). The data needs to be treated with a degree of caution as the response rates are currently low e.g. 11 for 999.

Remedial Plans & Actions

The planned expansion of experiential reach out through the introduction of SMS survey in 999 and 111 services was expected to have gone live by now, however, an MPDS update and the associated information governance around this plus one difficult remaining information governance issue has delayed the go live. Go live is dependent on a decision around the IG issue. Once it is live in the 999 environment, the Trust can go onto explore the 111 SMS.

Expected Performance Trajectory

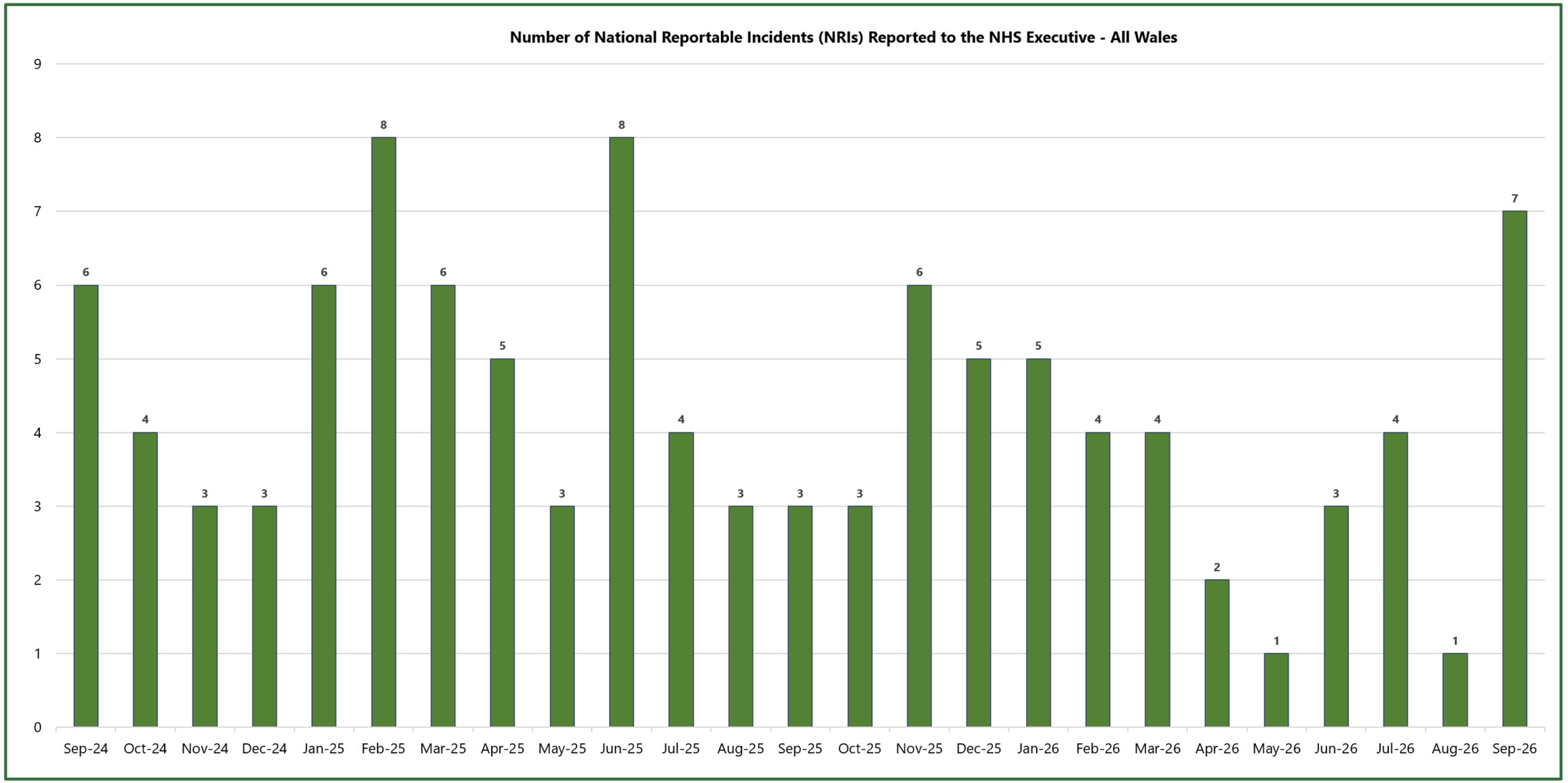
The expansion of survey approaches is expected to provide richer and more experiential intelligence improving the Trust's ability to identify themes and target improvement activity. However, the introduction of revised Patient Needs assessment, may result in a short-term deterioration in some experiential measures as service delivery and public expectations adjust.

Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents

Strategic Objective 5

NRIs
MOA



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

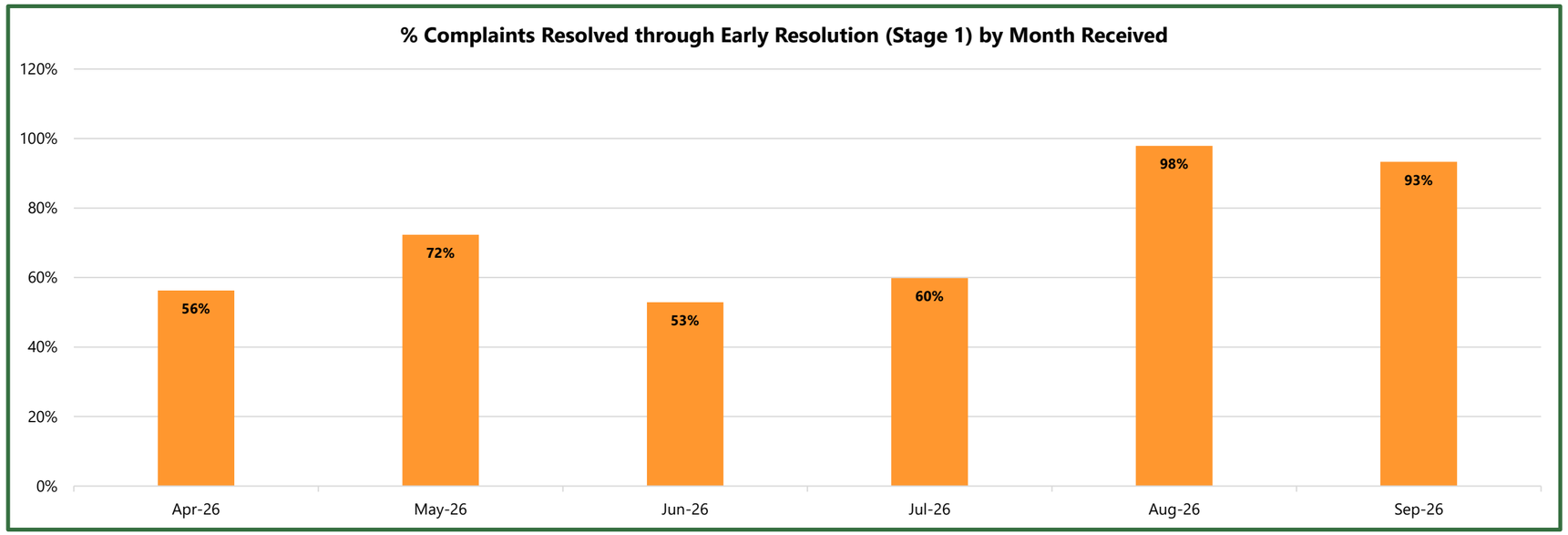
Our Patients: Quality, Safety & Patient Experience

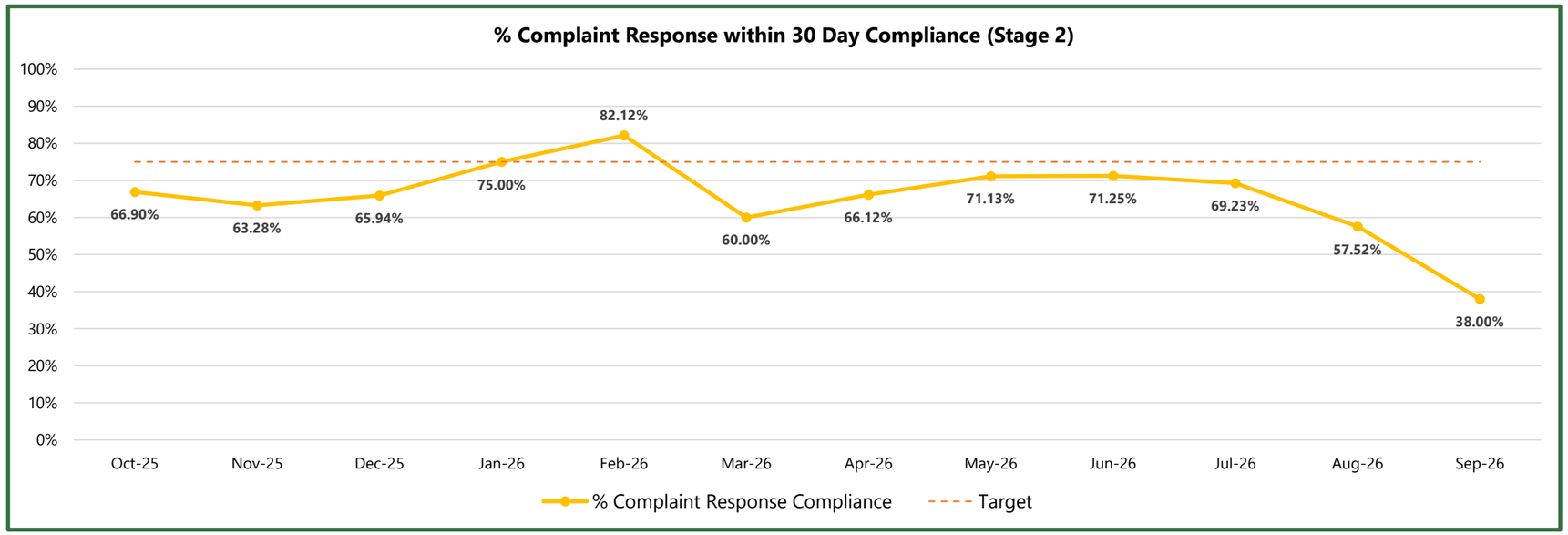
Concerns

NHS P&I Beacon Measures

Strategic Objective 5

R





Analysis

Revisions to the Concerns Regulations were implemented from 1st April 2026, with new statutory key performance indicators also introduced. The Trust is now able to replicate national reporting of these KPIs with the primary compliance metric being the percentage of complaints that the Trust has successfully resolved using an Early Resolution (Stage 1) approach, which as the graph indicates is performing well at 93% in September 2026.

The second graph shows the compliance from a formal complaint, not closed at Stage 1, within 30-days and this has seen a deterioration in recent months, falling to 38% in September 2026.

Remedial Plans and Actions

The 'sprint' approach adopted by the Planning and Delivery workstream of the Trust's Concerns Management Programme has focused on effective and timely resolution of Early Resolution (Stage 1) complaints. Improvements include enhanced senior clinically-informed triaging of complaints, a clear process for all elements of the pathway and detailed data tracking to enable caseload monitoring and deep-dives into areas of delay. Improvements are demonstrated across the sprint period with increased numbers of complaints resolved within statutory Early resolution timeframes, placing the Trust ahead of the 40% KPI target for Year 1 Listening to People Implementation.

Expected Performance Trajectory

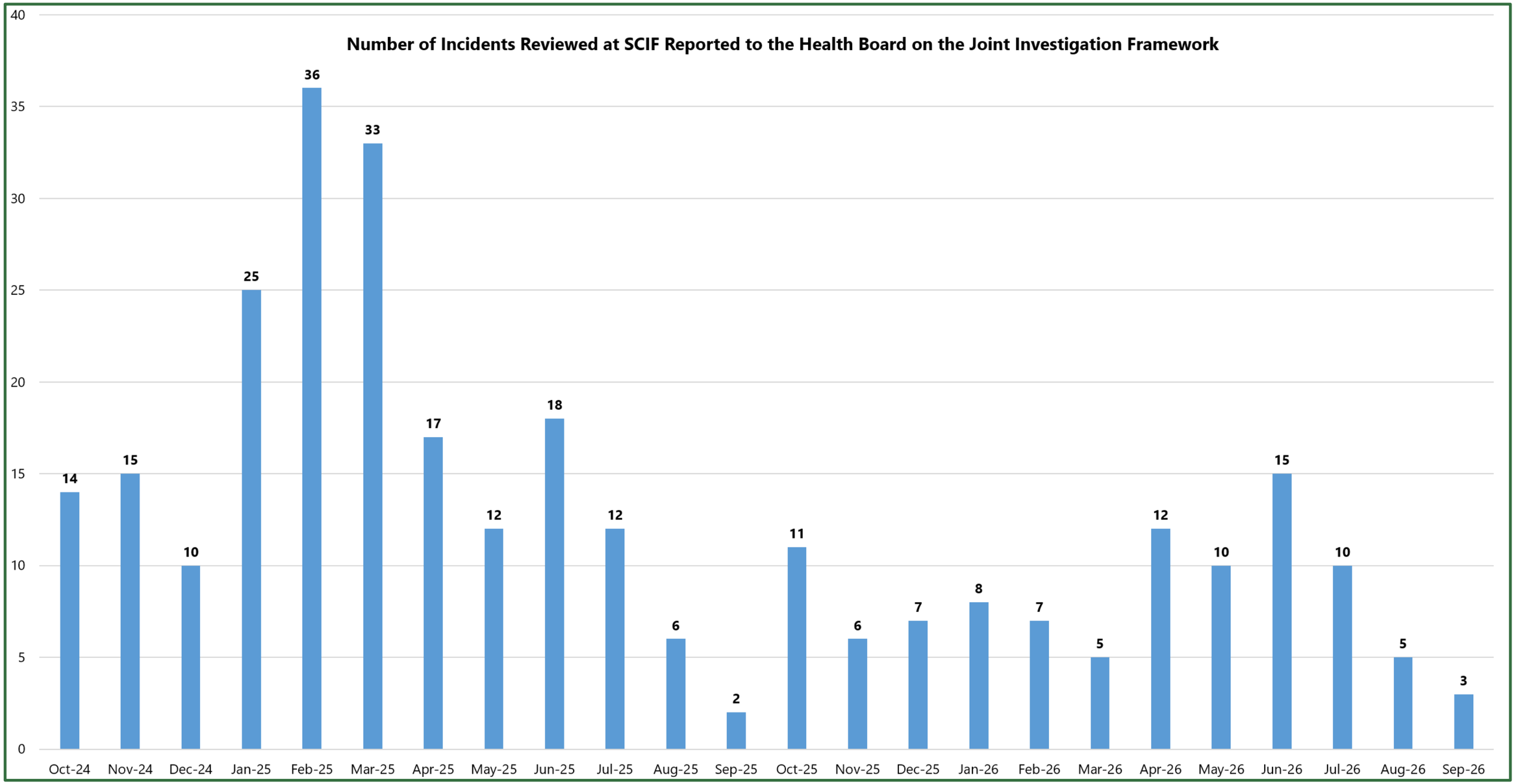
Early Resolution compliance can now be monitored through the development of a dedicated Listening to People dashboard and oversight of performance will be integrated into the Trust's Quality Management System. The signatory process for written Duty of Candour letters is being reviewed at a dedicated workshop event to improve the timeliness of issuing correspondence.

Our Patients

Joint Investigation Framework

Strategic Objective 5

JIF
G



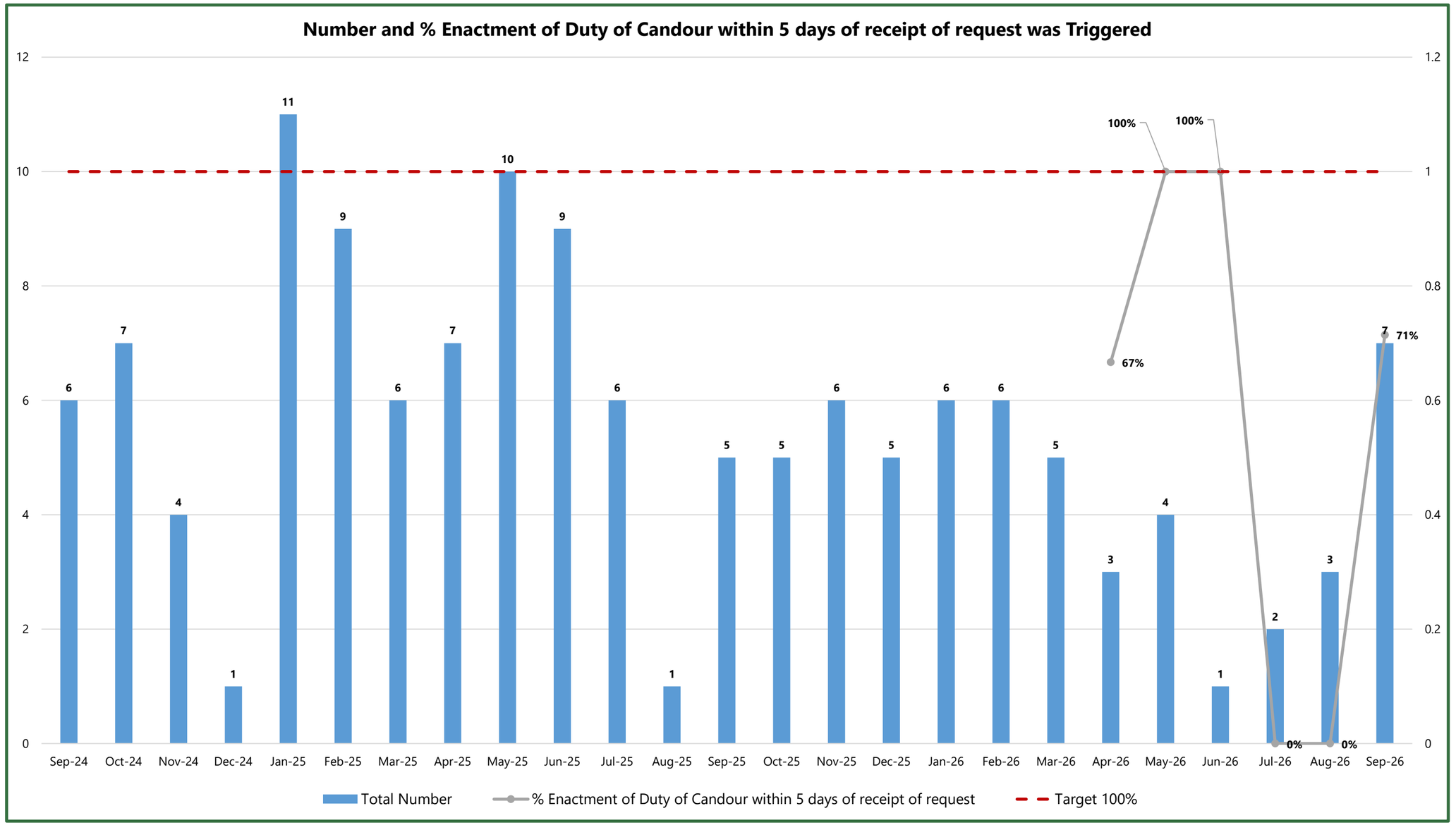
*NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change

Our Patients

Duty of Candour

Strategic Objective 5

R



Analysis

In September 2026, Duty of Candour was not enacted within five days of request receipt on two out of seven occasions.

The issuing of a written follow-up letter within 5 days of successful enactment remains low due to delays within the quality assurance and approvals process.

A new data capture process to assess bottlenecks during senior review and approval processes is being introduced to assist in addressing delays in quality assurance processes.

Remedial Plans and Actions

The Trust aims to improve quality of letters to promote efficient quality assurance.

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

Our People

Successful Applicants from Under-Represented Groups

Strategic Objective 2

This metric has previously been supplied, but ELT have determined that the metric needs further consideration, so have been removed from this report, pending review and replacement.

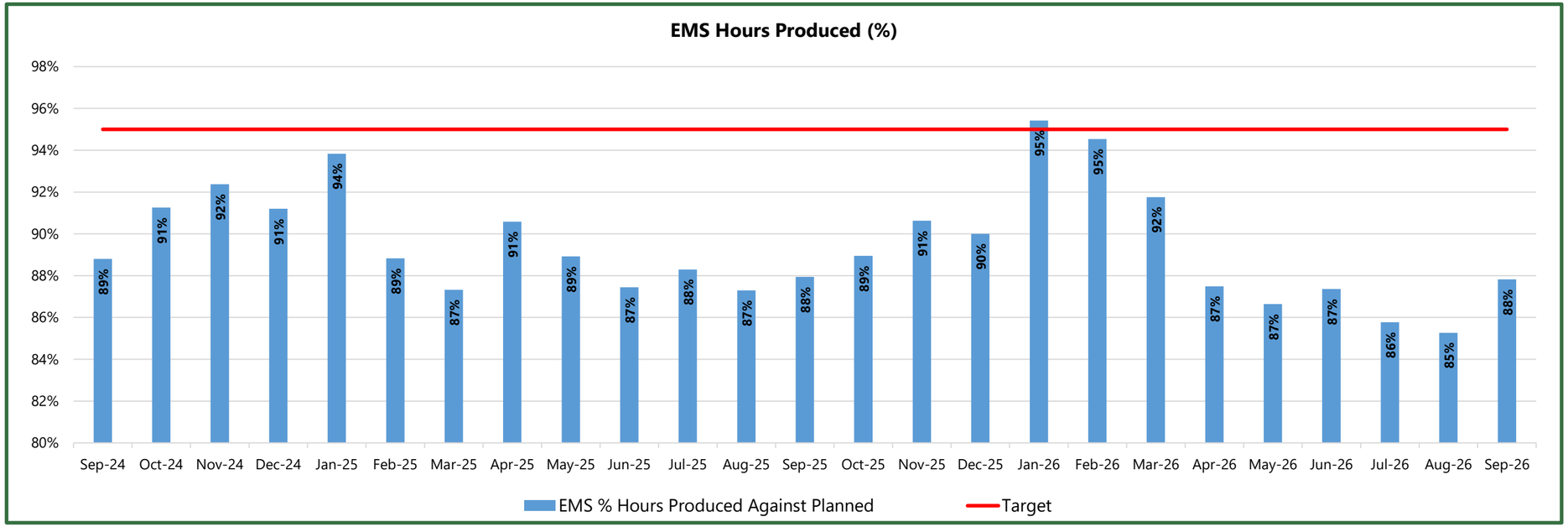
Our People

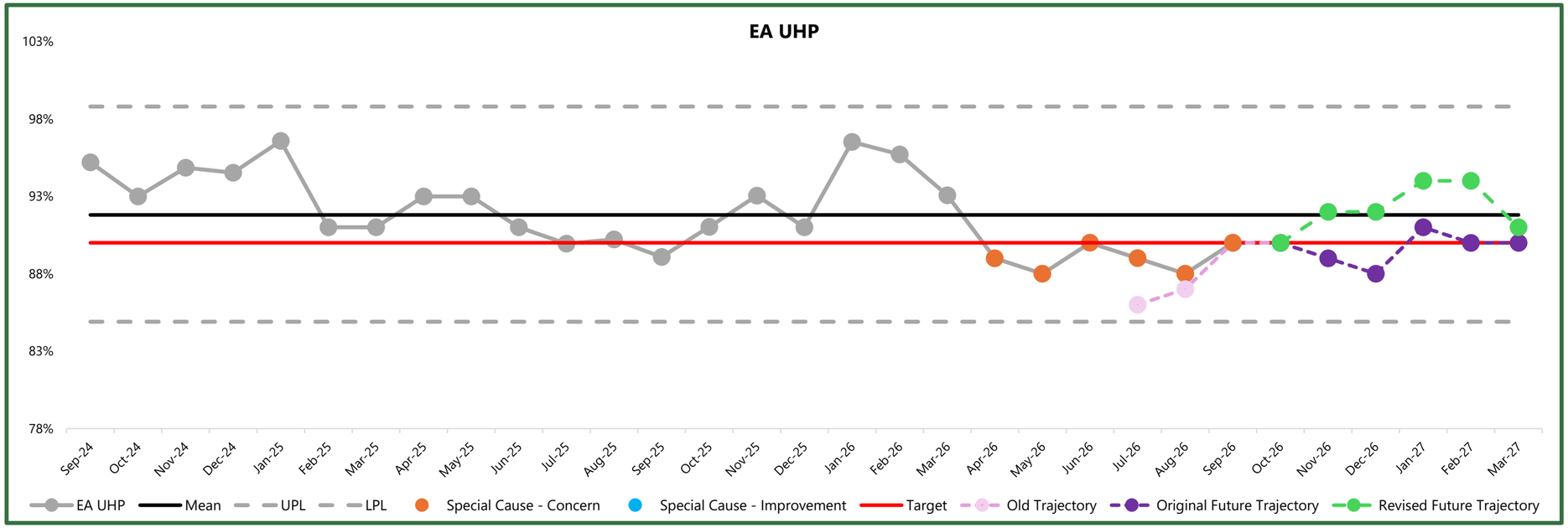
EMS Hours Production Indicators

EMS Production

A

Strategic Objective 2





Analysis

The total EMS hours produced is a key metric for patient safety. The SPC chart highlights that over the past two years this metric has stayed within normal process limits.

EMS Hours Produced achieved 88% in September 2026 which equated to 115,780 Actual Hours, against a planned total of 131,834, remaining below the 95% target, with reduced overtime availability linked to financial constraints a factor. It should be noted that the 95% target is currently under review to ensure it remains appropriate and reflective of current operational and financial conditions.

Remedial Plans and Actions

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

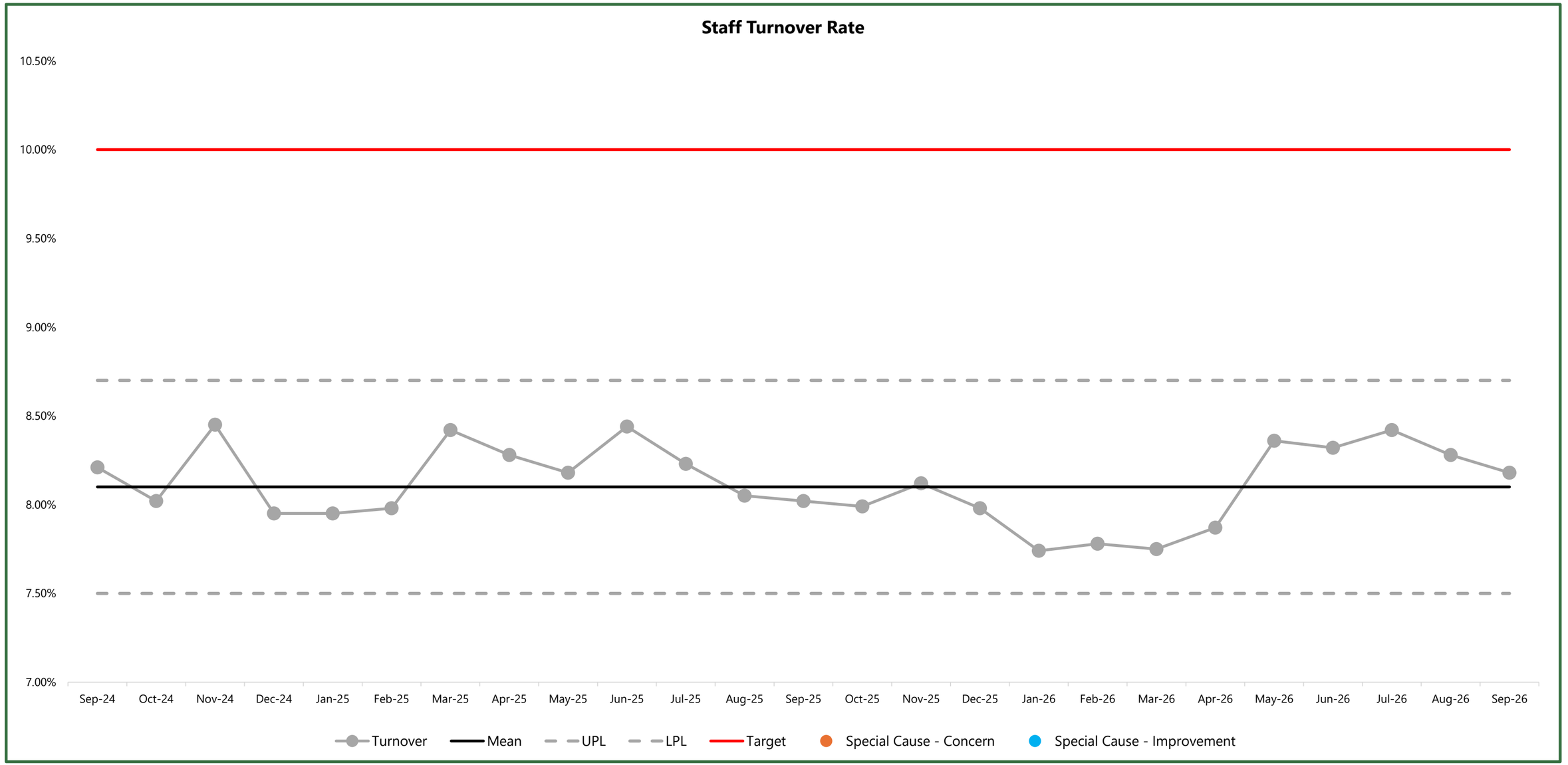
Expected Performance Trajectory

A UHP trajectory is being developed. The UCS recruitment gap is projected to close over this financial year, with a meeting arranged to consider how this can be sped up. The Trust maintains an ambition to reduce sickness to 6% and maintain abstractions to 30%. Reduced overtime availability will reduce future levels of production.

Our People
Turnover Indicators

Strategic Objective 2

Turnover
G

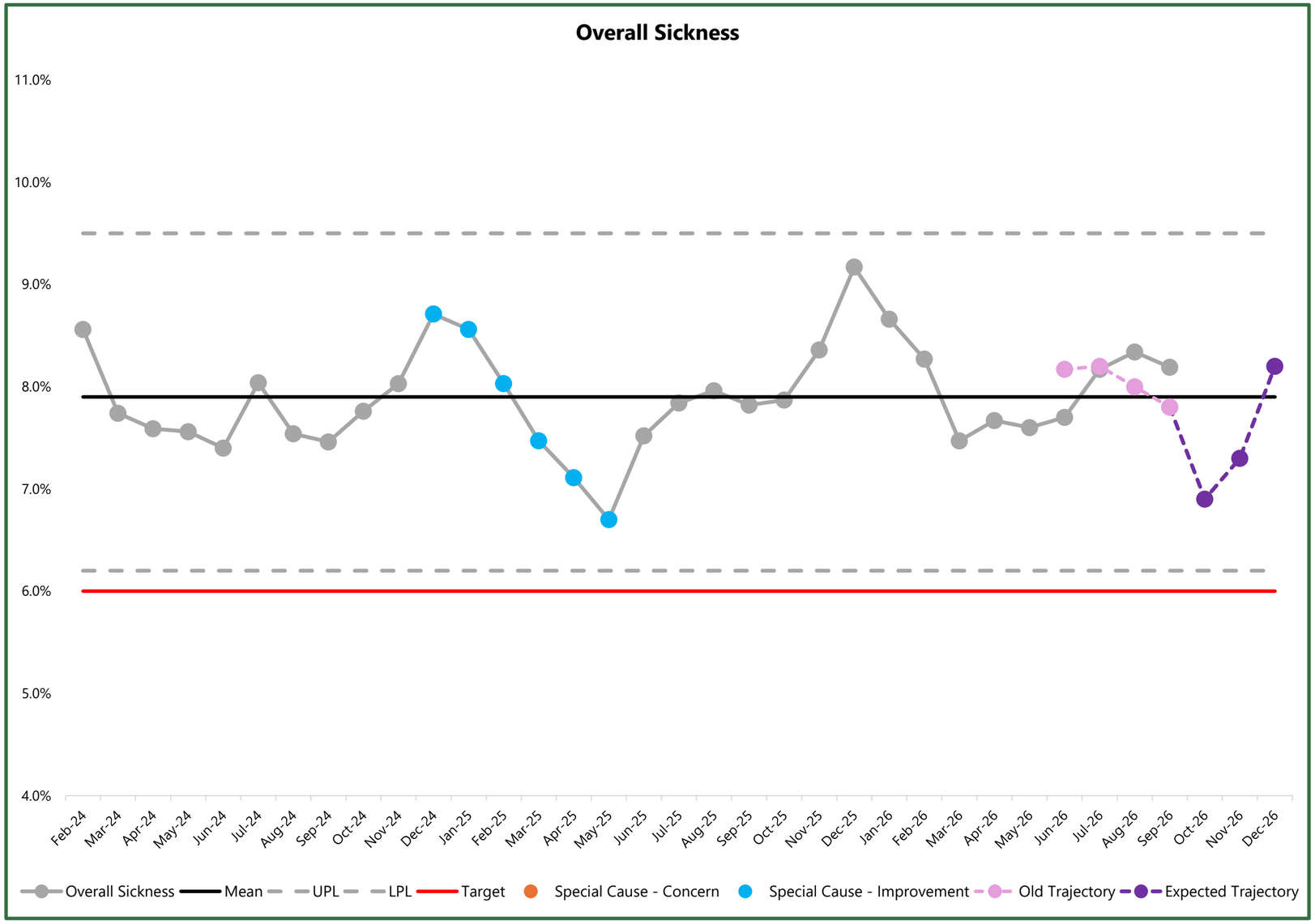


NB: Sickness data will always be reported one month in arrears

Our People
Sickness Absence

Strategic Objective 2

Sickness
R



Analysis

Sickness levels in September 2026 were at 8.19%. Long term absence was at 5.54%, and short-term absence was at 2.66%.

The highest reasons for absence in September 2026 were Anxiety/ Stress/ Depression, gastrointestinal problems, influenza and musculoskeletal issues.

The SPC chart shows that sickness absence remains in statistical control with variation occurring within expected limits. However, the process mean of 7.9% is well above the organisational target of 6.0% and the trajectory. No special-cause improvement is evident, so achieving the target will require fundamental changes to the factors driving sickness absence rather than continued monitoring of normal variation.

Remedial Plans and Actions

- Our Occupational Health Service Manager continues to offer specialised consultation to managers for sensitive and complex situations.
- This year's Flu Campaign is underway, with drop-in vaccination clinics available for staff and volunteers.
- The OH/Wellbeing team's work is guided by the Health and Wellbeing Plan 2025-29, with a focus on strengthening workplace relationships, enhancing organisational awareness on trauma, and addressing key health and wellbeing challenges while continuing to provide individual support.
- A review of all our external providers has been completed in preparation for the new financial year, and we are working with Procurement to ensure best value arrangements for these services.
- There are also expected changes to the rest break policy and the approach to managing overruns in EMS, all of which are anticipated to have a positive effect on overall sickness levels.

Expected performance

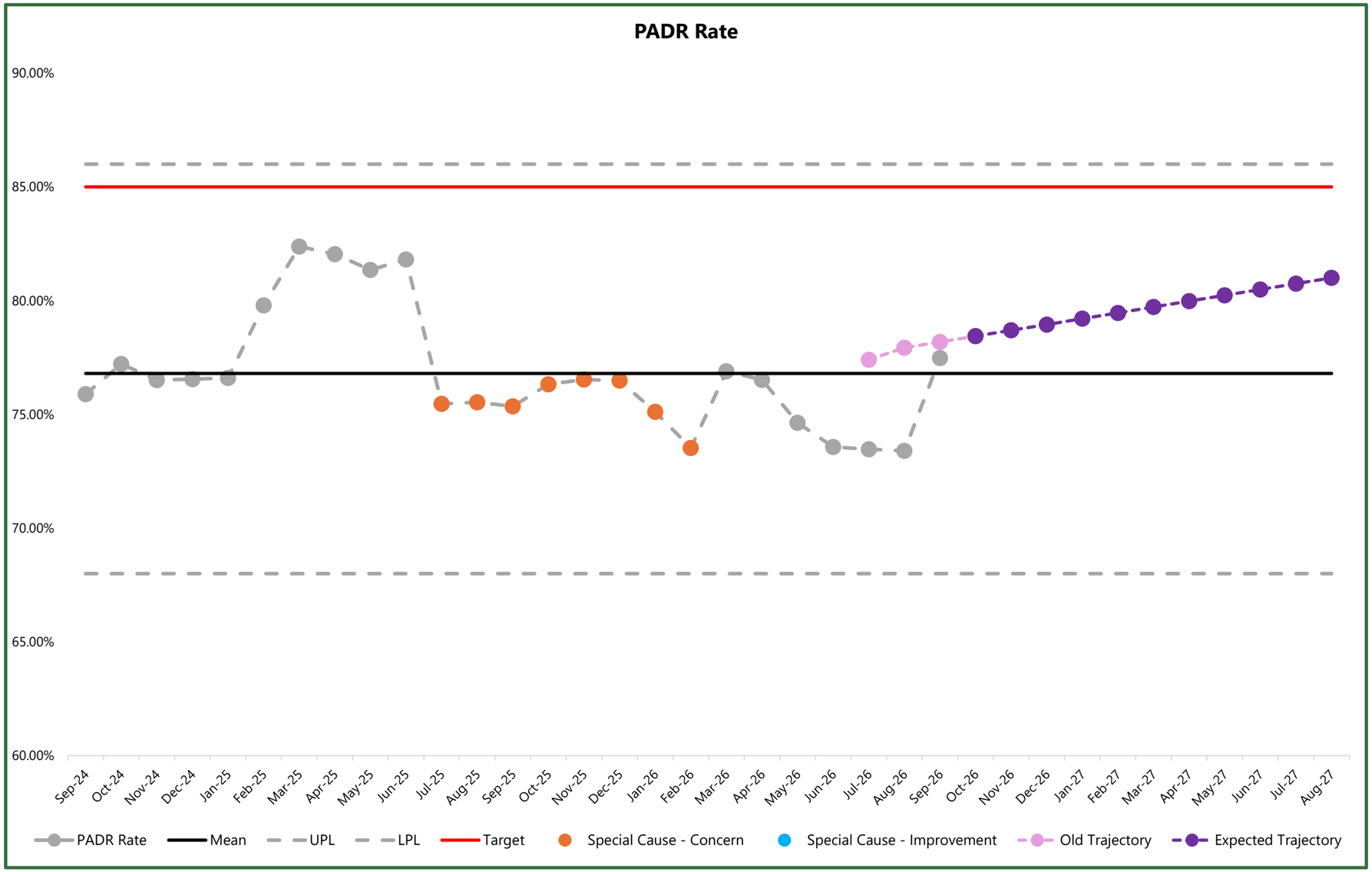
The purple line indicates expected trajectory over the remainder of the year, with sickness expected to follow normal seasonal patterns during the summer months but then decrease from September 2026 as changes to rosters, and potential changes to rest break policy and approaches to reducing overruns take effect.

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

Our People
PADR

Strategic Objective 2

PADR
A



Analysis

PADR rates were at 77.48% in September 2026 and while remaining below the 85% target, they have increased to the highest figure recorded since June 2025 and are now back near to the forecast trajectory.

However, it is still unlikely that the target will be achieved without further specific improvement action.

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.

Work on the PADR refresh is underway. The aim is to better reflect Our WAST Way and support meaningful, values-led conversations that have a genuine impact for our people. The proposed refresh seeks to simplify the process and embed a more continuous, constructive dialogue; provide practical tools and guidance to assist both managers and employees; and ensure PADRs are more clearly aligned with wellbeing, personal development, and individual career aspirations.

Expected Improvement

The purple line denotes the expected trajectory during the rest of the year, with rates anticipated to improve as awareness increases and momentum is maintained throughout the year with continued communication.

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

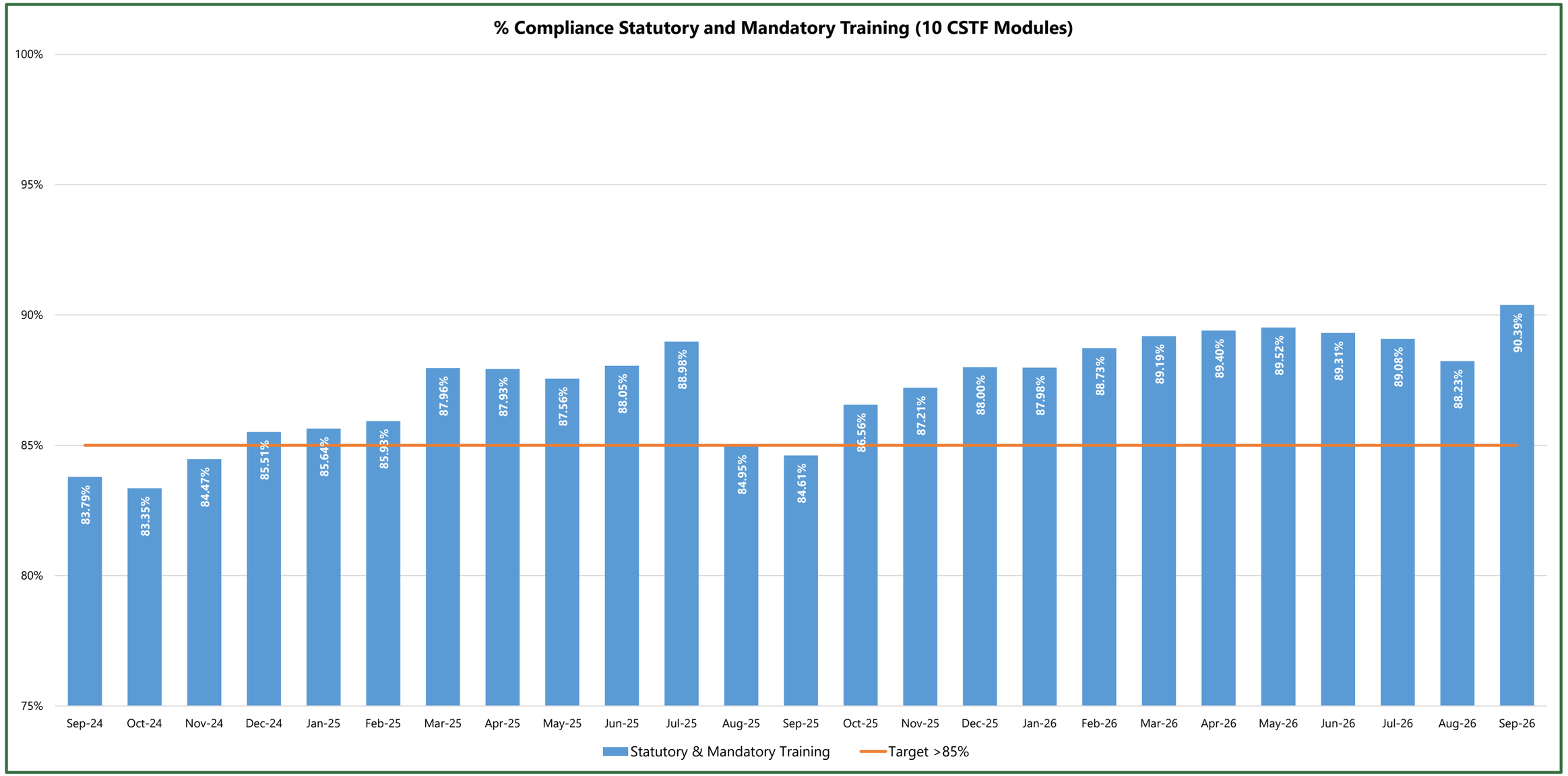
Our People

Training Rates Indicators

Strategic Objective 2

Stat & Mand

G



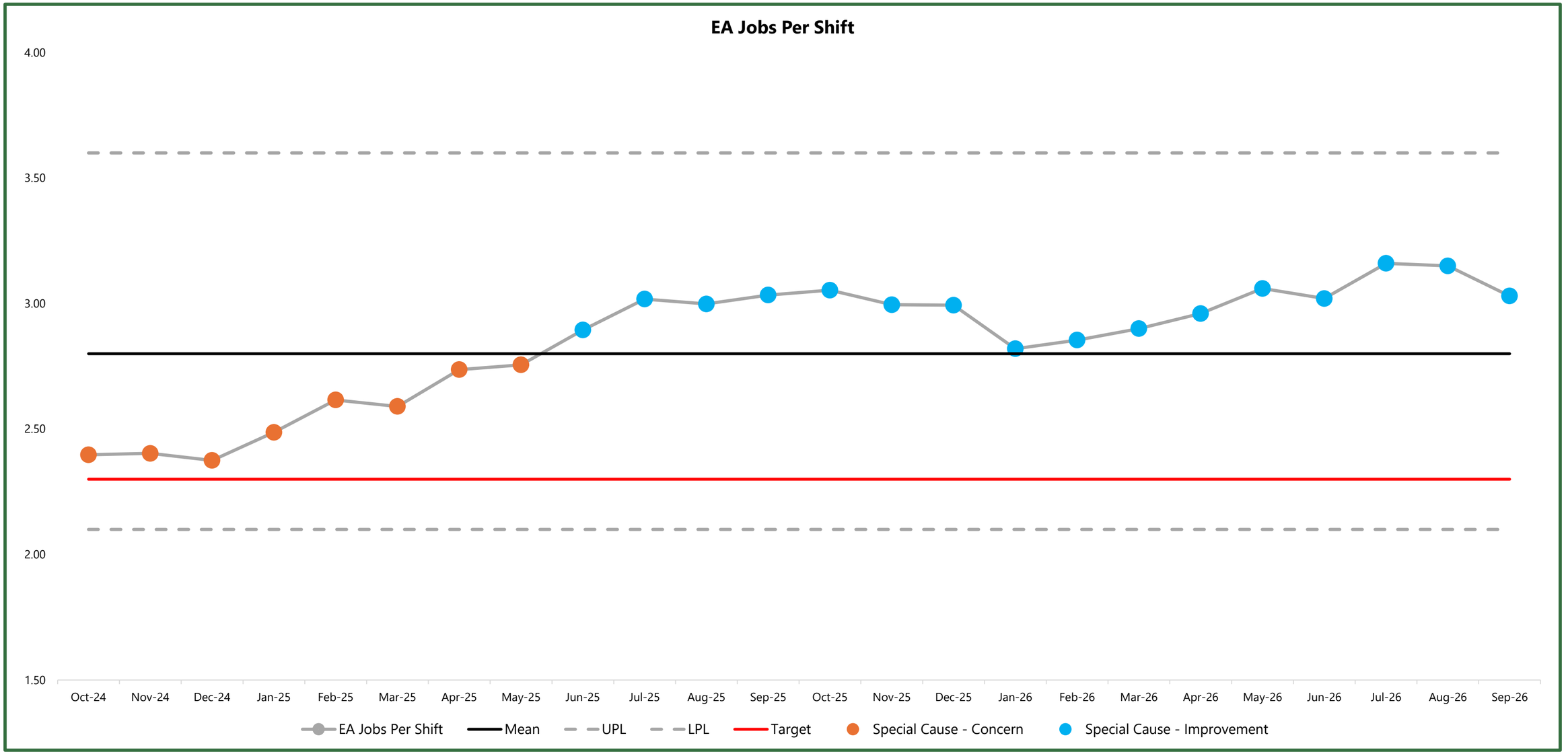
ESR Data correct at time of export.

Finance, Resources and Value

EA Average Jobs Per Shift

Strategic Objective 6

EA Jobs Per Shift
G

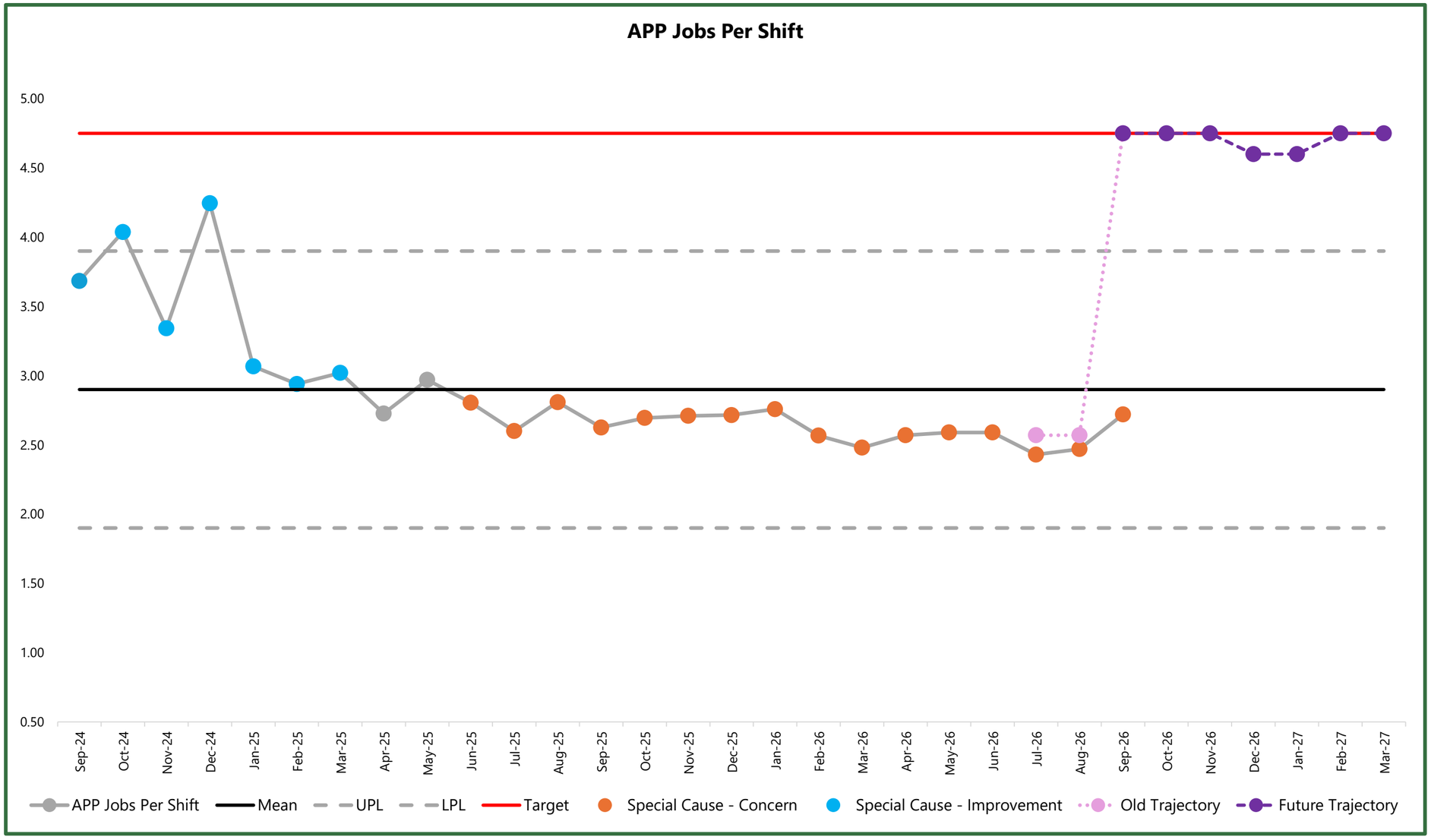


Finance, Resources and Value

APP Average Jobs Per Shift

Strategic Objective 6

APP Jobs Per Shift
R



Analysis

The SPC chart shows there has been a deterioration in this metric since mid 2025, with a sustained run of 16 points below the mean. APPs attended an average of 2.72 jobs per shift during September 2026, the highest on record since January 2026. Performance is still however well below the target (4.75) — indicating the current system is not capable of meeting this target.

Remedial Plans and Actions

There are three key actions underway for APPs a) scheduling (that is looking at the code set they are designed to focus and respond to); b) the APP re-roster, which is due to take place this year, and
c) Work has been undertaken to better identify jobs that are APP suitable and increase the code set and allocation to an APP at an earlier stage.

Expected Performance Improvement

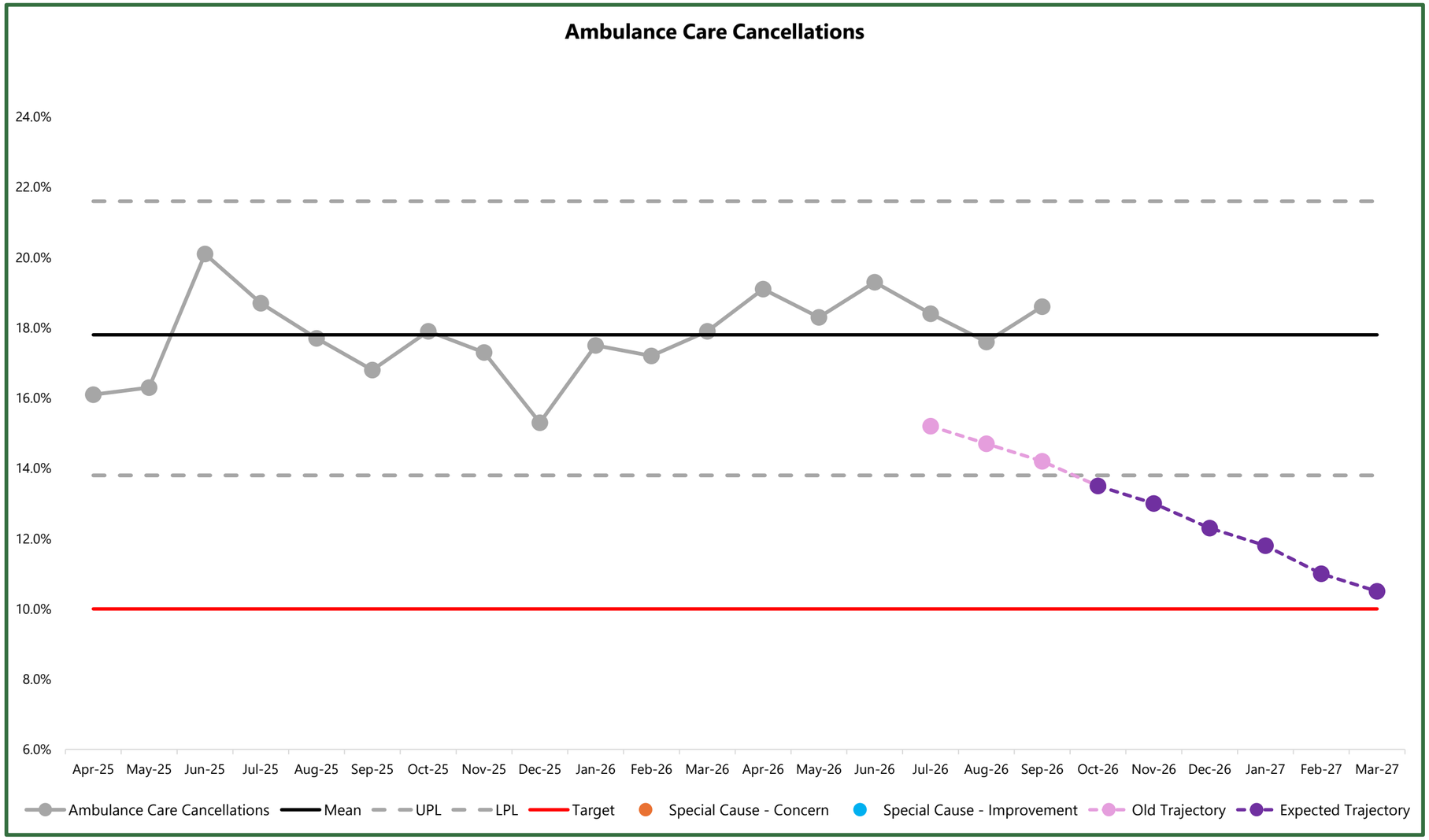
Both a), b) and c) above are expected to be in place by December, in line with the Winter Plan (scheduling is now live). Advanced simulation software has been used to develop the new APP rosters. The lilac future trajectory line, was the original improvement trajectory, with the purple trajectory line,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

Finance, Resources and Value

Ambulance Care Indicators

Strategic Objective 6

NEPTS Activity Cancelled
R



Analysis

The chart shows that Ambulance Care cancellations have remained within normal process limits over the past 12 months. However, in recent months, cancellation rates have been considerably above the target of less than 10%, ranging from 17-19%, with a rate of 18.6% recorded in September 2026.

The expected trajectory (purple line) indicates a predicted sustained improvement in cancellation performance over the next 12 months although current rates remain some way above this.

Remedial Plans and Actions

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

Capacity Management Plan improvements will be driven by increased available capacity due to re-rostering (five of seven health boards going live in November, with modelled efficiency gain of +315 journeys per week) and improvements in efficiency and reductions in demand through adjustments to journey booking and planning processes. Bookings cancelled by others (patients and hospitals) are not fully in the direct control of WAST and will require a change in both patient behaviour and Health Board process. Digital improvements such as system integration and additional messaging will also be key.

Expected Performance Improvement

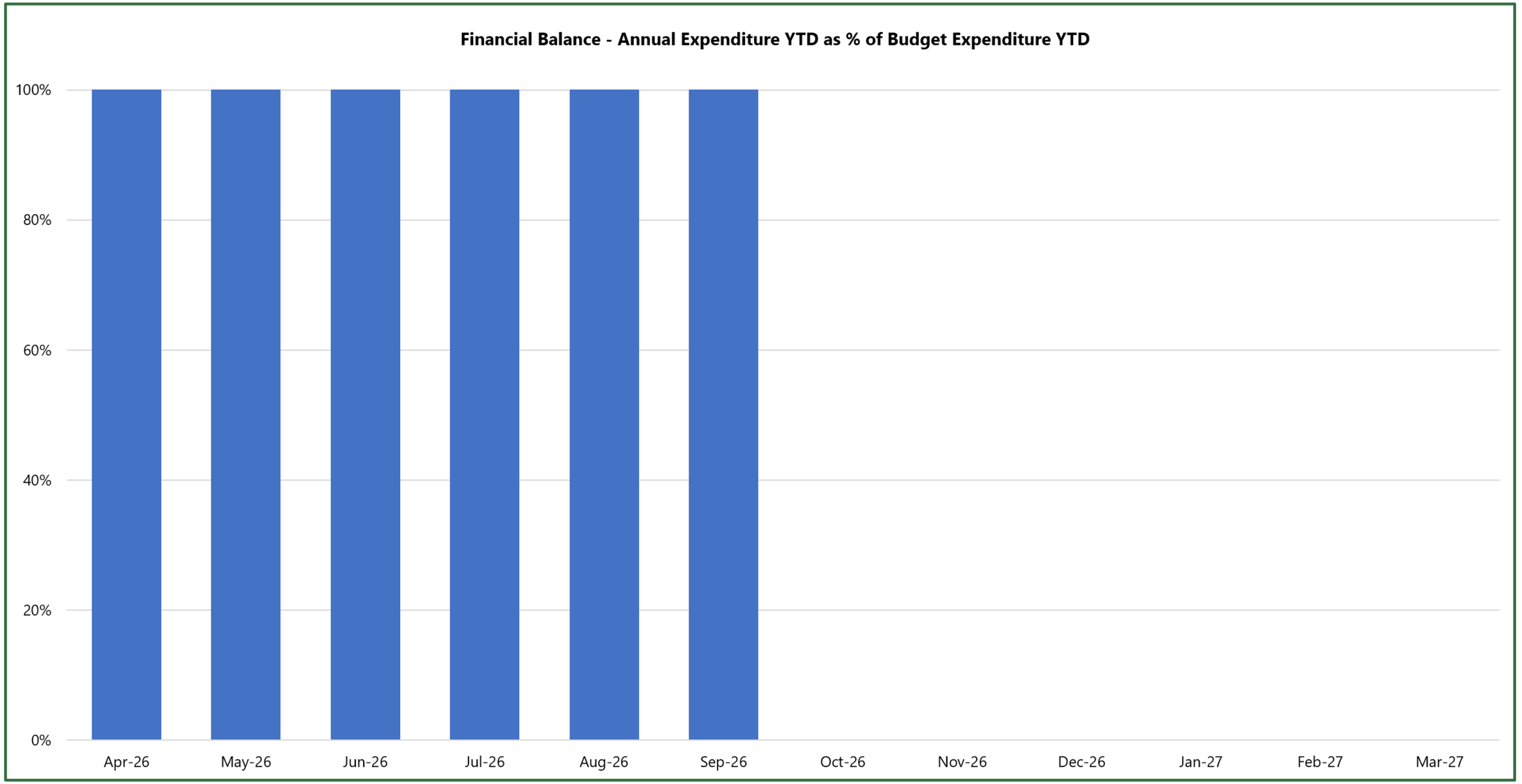
The chart illustrates the expected performance improvement, but the ambition of moving from 19% to less than 10%, needs to be reconsidered, in the light of a revised metric for this indicator.

Finance, Resources and Value

Financial Balance

Strategic Objective 6

Balance
G

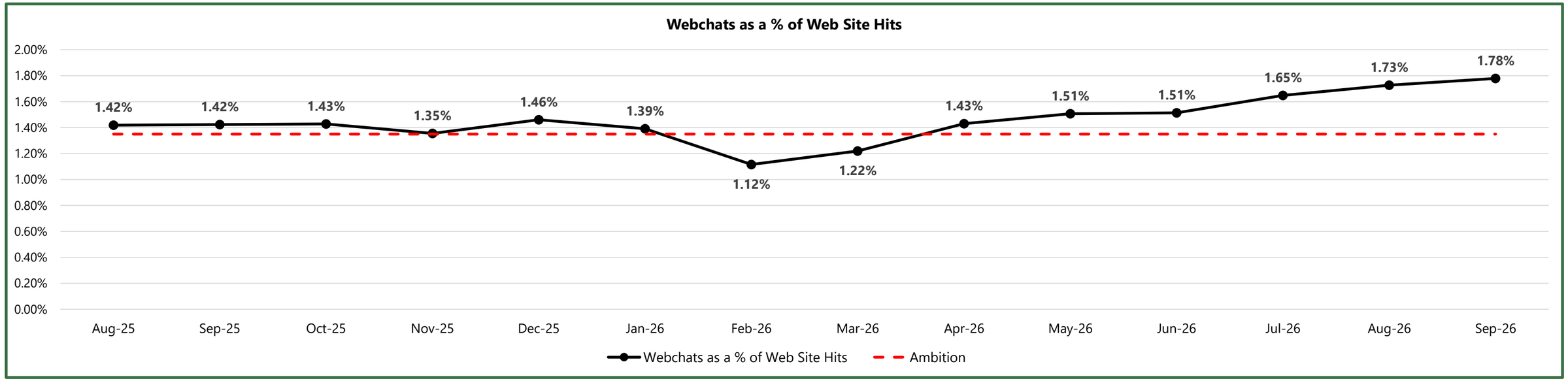


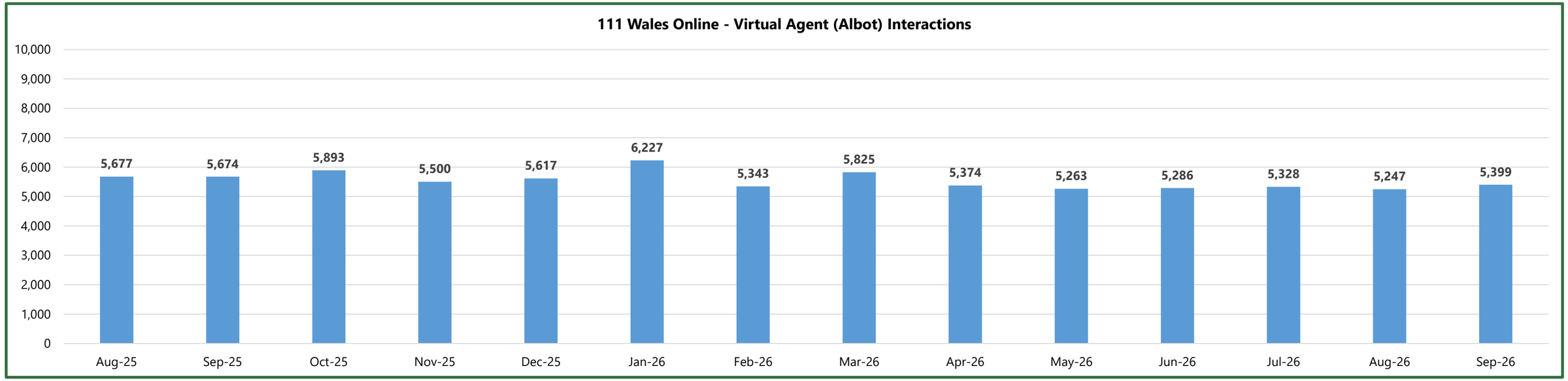
Partnerships / System Contribution

Albot and Web Chats

Strategic Objective 3

Web Chats	Albot
G	MOA



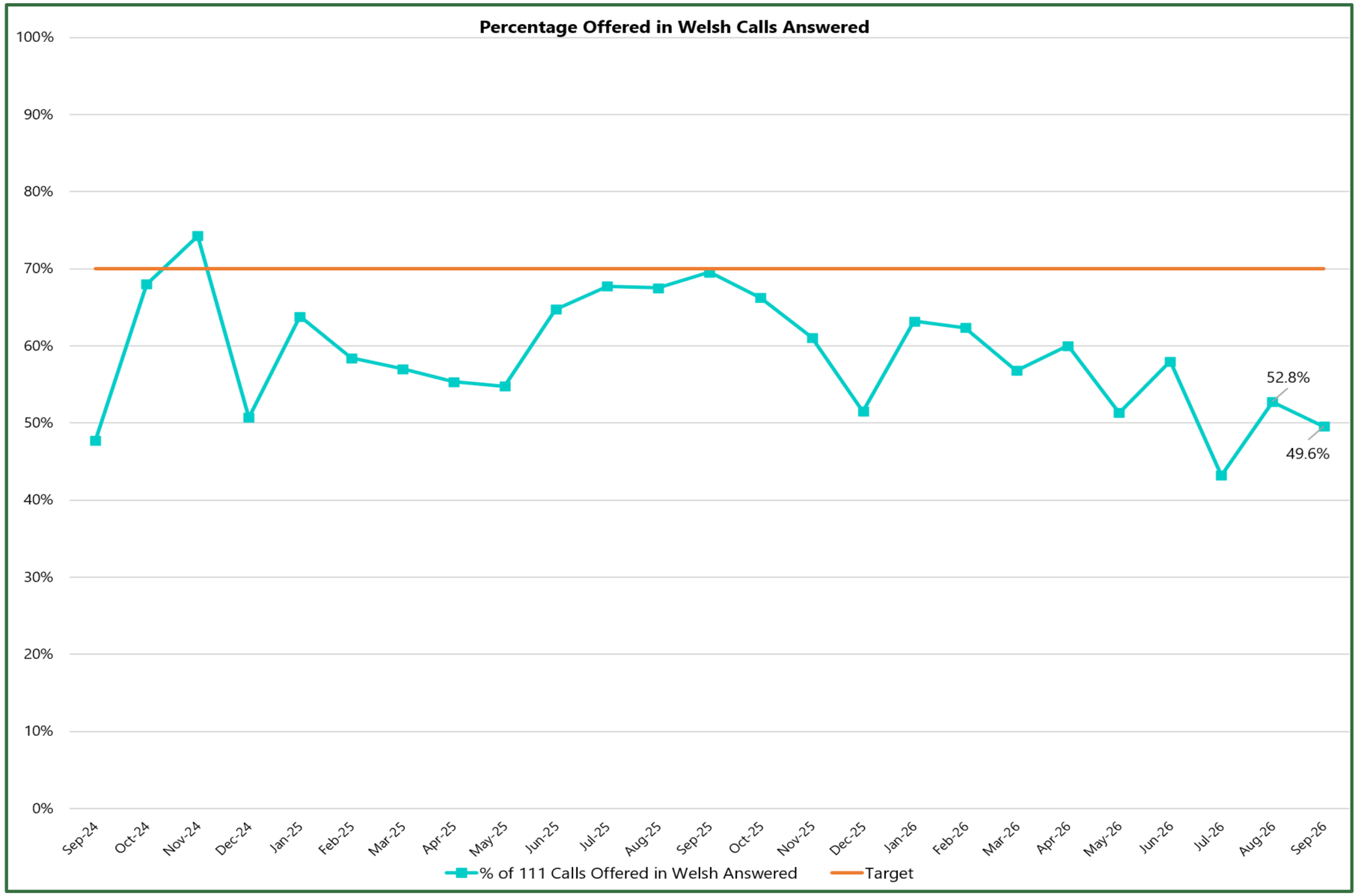


Partnerships / System Contribution

NHS111 Outcomes and Welsh Calls

Strategic Objective 1

R



Analysis

In September 2026, the total number of 111 Welsh calls offered was 1,588 calls, of which 787 were answered, equating to 49.6%. This remains below the 70% ambition and has remained below target since November 2024.

Remedial Plans and Actions

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

Expected Performance Trajectory

The independent modelling was based on 1470 calls to the Welsh line. The figure for September was 1,588, therefore greater than modelling figure, but the key point is that this is a very small part of the overall demand, which was 93,649 calls in September. It would be very inefficient to ring fence Welsh speakers to answer this demand and the independent modellers have not advised that, instead Welsh speaking call handlers are interspersed through the new rosters, when they go live. Being interspersed through the rosters and not ring fenced, means that even if in work, they may be answer an English call at the time a Welsh call comes in. The demand actually needs to be further segmented by regional dialect

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

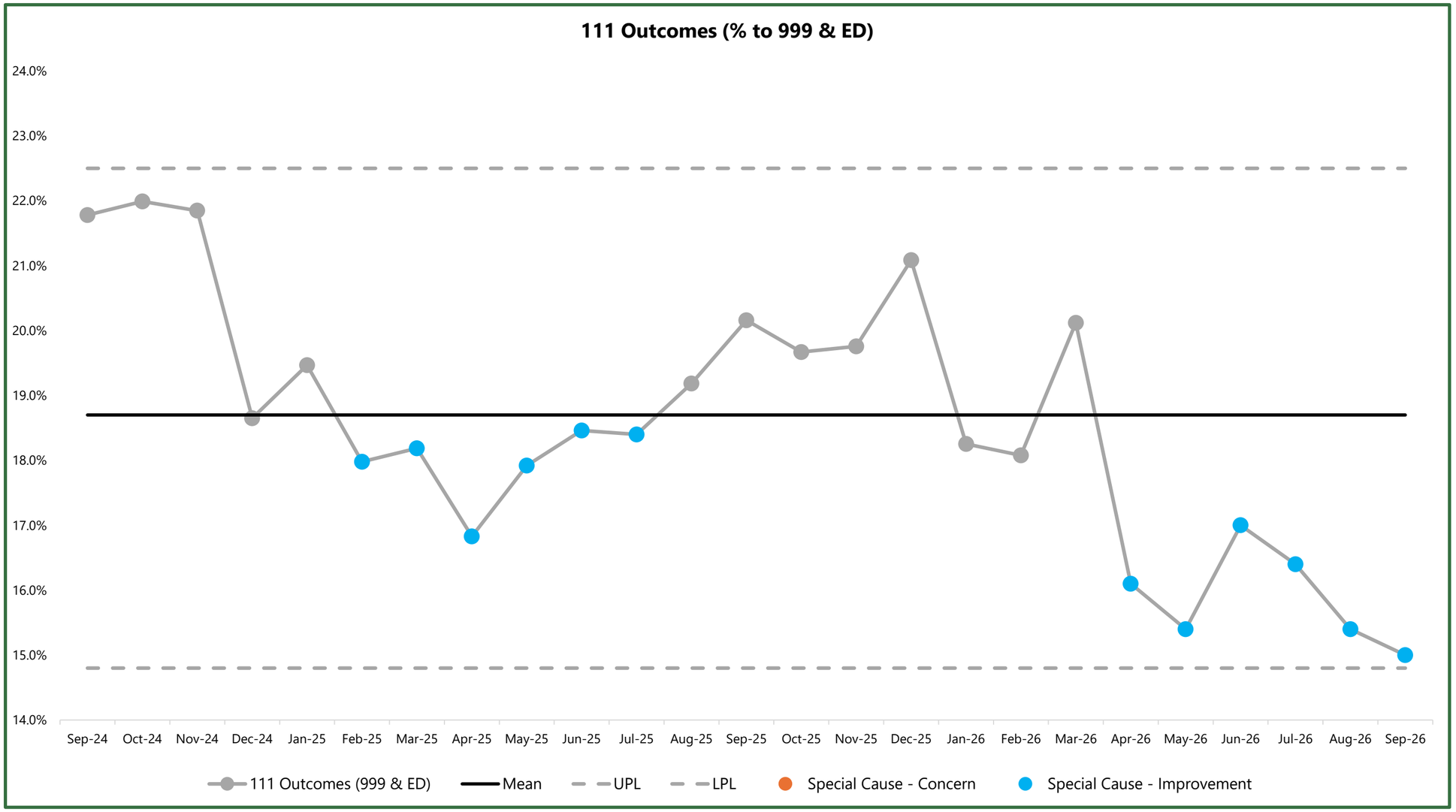
Partnerships / System Contribution

NHS111 Outcomes

Strategic Objective 4

111 Outcomes

MOA



Analysis

There has been a sustained decrease in the number of 111 calls being referred to 999 and ED with six data points below the mean since April 2026. Total 999 and ED referrals have also reduced from 11,170 in September 2025 to 7,649 in September 2026. Whilst this highlights a positive trend and improvement, it comes at a time when overall calls answered in September 2026 is 3,849 below the figure answered in 2025, with a significant increase in the number of abandoned calls.

Therefore, the rationale for the ED and 999 referral decrease could partly be driven by a negative performance measure, as an overall reduction would have impacted on the number of referrals into each pathway, thus reducing 999 and ED referrals. This would almost certainly have adversely caused an increase in the number of 111 patients, either ringing 999 directly, or making their own way to ED, increasing the level of unmet demand.

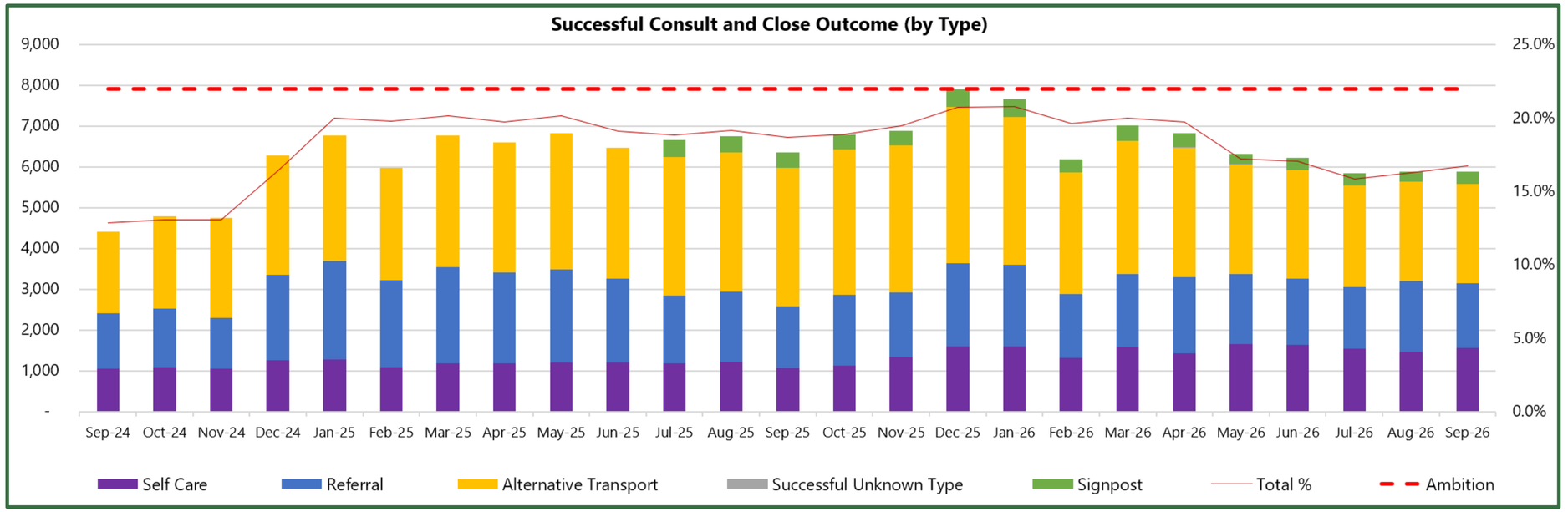
However, from a positive side, the implementation of ICCQ in April 2026 would also have had positive impact on referral numbers into the ED and 999 pathways.

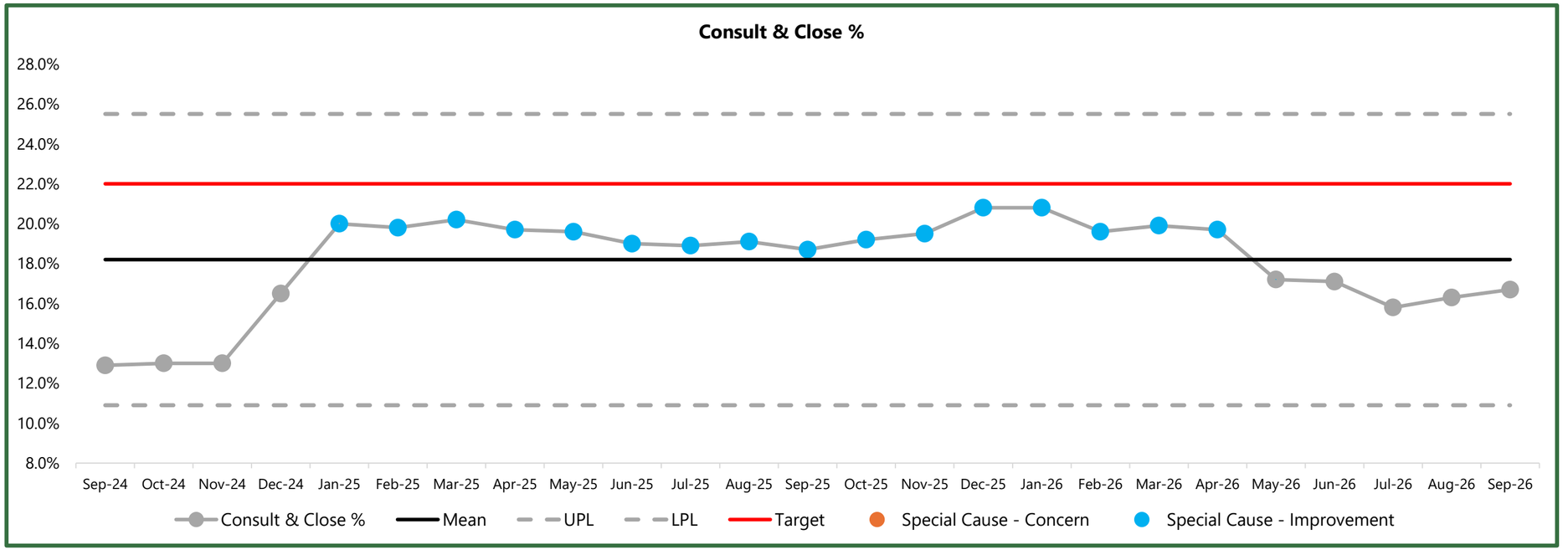
Partnerships / System Contribution

Consult & Close Indicators

Strategic Objective 4

C&C Outcomes: R





Analysis

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

The SPC showed a sustained pattern of system improvement the entirety of 2025 and early 2026 with 16 consecutive data points exceeding the mean. However, since May 2026, performance has dropped below the mean with 16.8% cases having a successful Consult and Close outcome in September 2026 against its 22% ambition.

Remedial Plans and Actions

The likely cause of the fall in the consult & close rate is the move to the RICS single queue and also taxi use recording/taxi use, connected to available budget. The AD Commissioning & Performance is currently undertaking a series of meetings with expert staff, with the aim of resolving these issues in advance of winter. A revised definition has now been approved by CMT Board and is just waiting on JCC approval. This should see an uplift of performance, but only estimated to be one percentage point, so further analysis required to determine what has caused the drop off in performance.

Expected Performance Trajectory

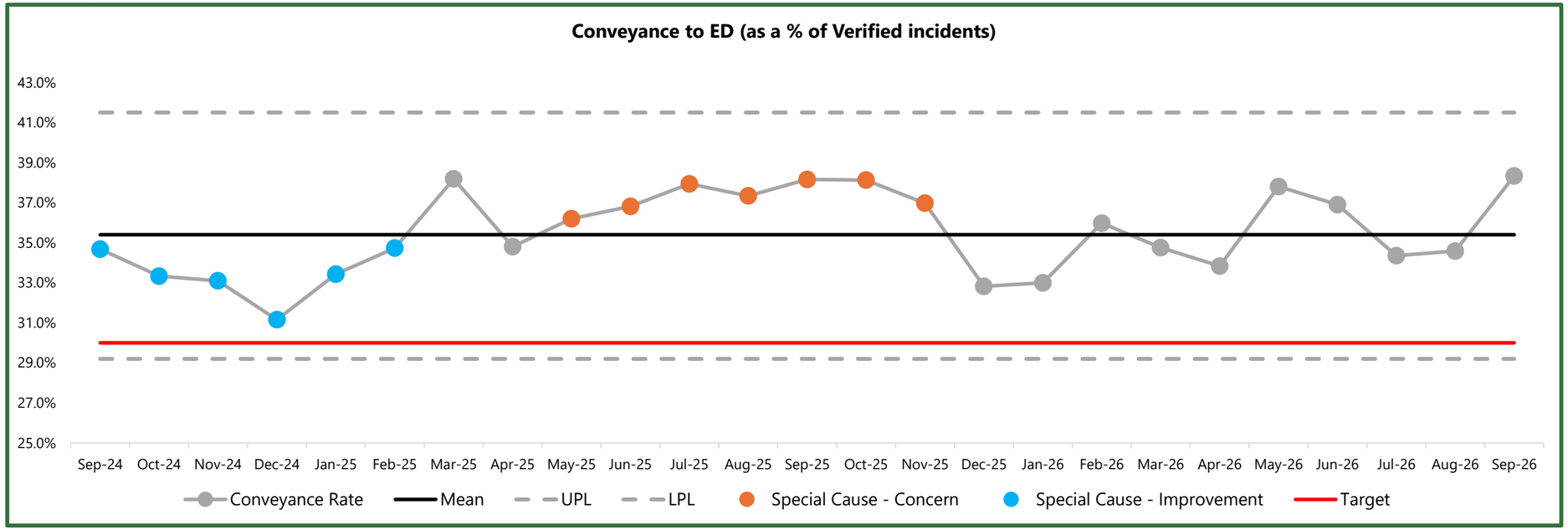
The independently modelled ambition is 22%. A trajectory is now dependent on the work to be undertaken in September as above.

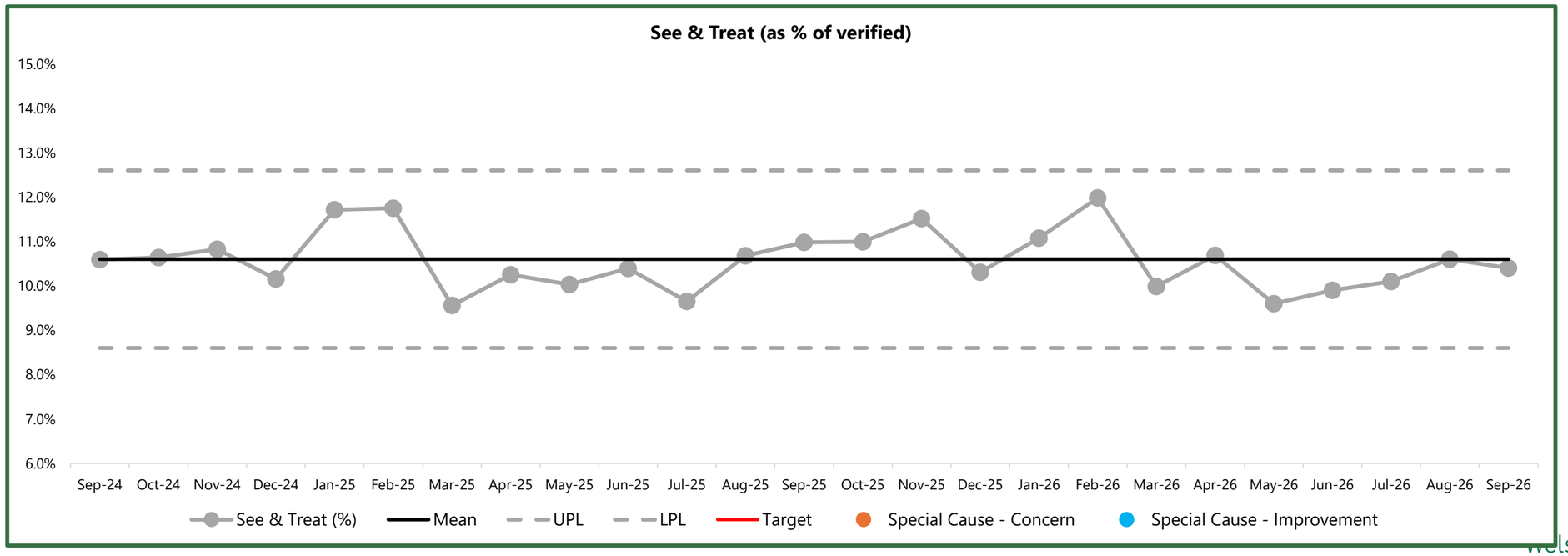
Partnerships / System Contribution

Conveyance to ED/See & Treat Indicators

Strategic Objective 4

Conveyed to ED	% See & Treat
R	R





Analysis

The SPC shows a period of special-cause deterioration in mid-2025, with a sustained run of points above the mean indicating higher conveyance rates.
In recent months, conveyance rates have fluctuated around the mean. However, September 2026 saw the highest number of conveyances to ED recorded in over two years, reaching 38.3%.

It is clear conveyance rates remain above the 30% ambition (an independently modelled benchmark), meaning the system is not currently capable of delivering the ambition.

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

Remedial Plans and Actions

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

Expected Performance Improvement

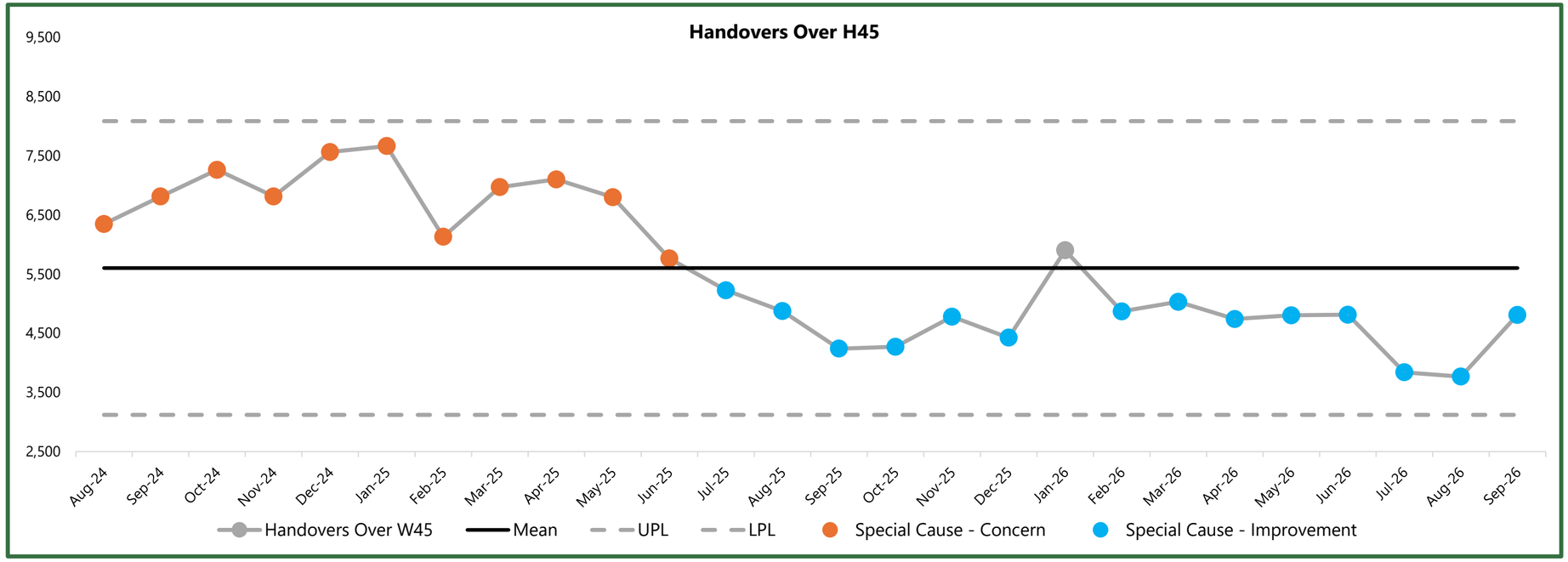
The 2023 Demand & Capacity Review, modelled a position of 30%, if all transformation changes are successfully implemented and W45 delivered.

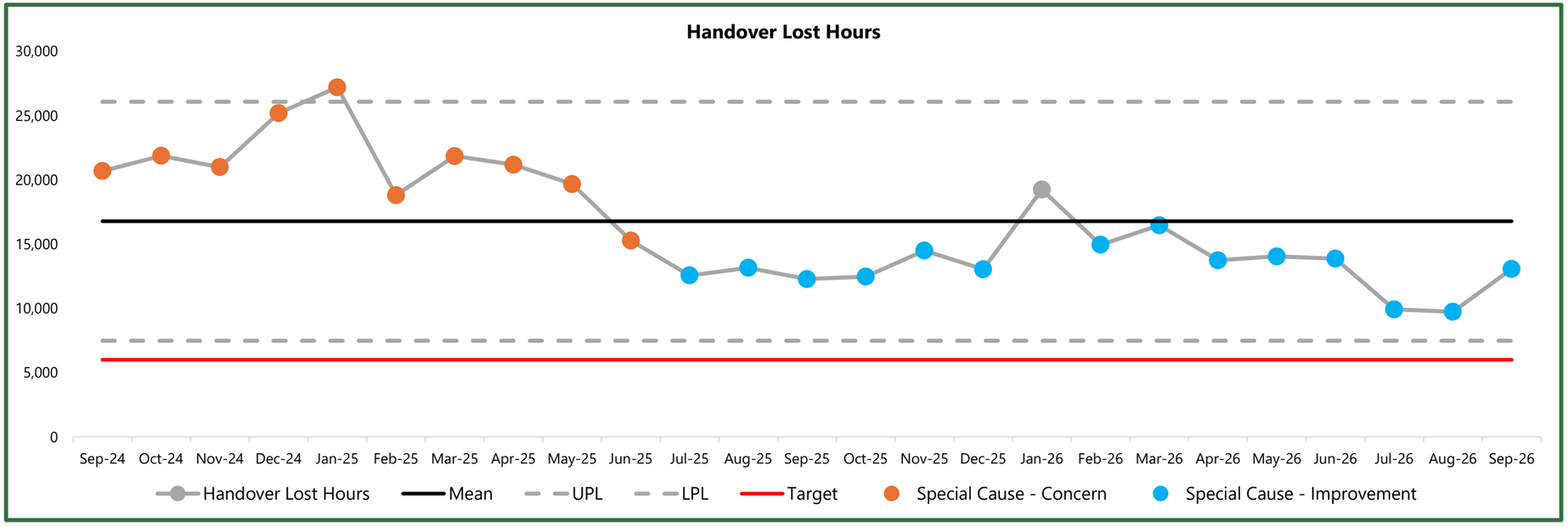
Partnerships / System Contribution

Handover Indicators

Strategic Objective 4

W45	Lost Hours
R	R





Analysis

165,107 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Oct 25-Sept 26), compared to 230,091 hours over the same timeframe last year. There were 13,071 hours lost in September 2026, which is an increase from August where hours lost were at there lowest since June 2021 at 9,737.

In relation to the W45 target, the chart shows there was a sustained improvement in performance between April 2025 and December 2025, with variation remaining positive since June 2025. Following significant improvements in July and August 2026, September saw an increase in handovers over W45, however numbers remain significantly lower than in previous years.

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

In September 2026, the Trust could have responded to approximately 4,217 more patients if handovers were reduced to the target level, which highlights the impact these numbers are still having on the service.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	D&T	Discharge & Transfer	KPI	Key Performance Indicator	ROSC	Return Of Spontaneous Circulation
APP	Advanced Paramedic Practitioner	EA	Emergency Ambulance	LtP	Listening to People (previously PTR)	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
BAU	Business As Usual	ED	Emergency Department	LTS	Long Term Strategy	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	ELT	Executive Leadership Team	NEPTS	Non-Emergency Patient Transport Services	SDEC	Same Day Emergency Care
C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	EMS	Emergency Medical Services	NHS	National Health Service	SLT	Senior Leadership Team
CAD	Computer Aided Dispatch	EMTs	Emergency Medical Technicians	NOF	Neck Of Femur	SPC	Statistical Process Control Chart
CHARU	Cymru High Acuity Response Unit	ePCR	Electronic Patient Care Record	NRI	Nationally Reportable Incident	SPOA	Single Point of Access
CI	Clinical Indicator	FTE	Full Time Equivalent	OH	Occupational Health	STEMI	ST segment Evaluation Myocardial Infarction
CIAG	Clinical Intelligence & Assurance Group	HB	Health Board	P / PHB	Powys / Powys Health Board	T&F	Task and Finish
CMP	Capacity Management Plan	HCP	Health Care Professional	PDAR	Personal Appraisal Development Review	UHP	Unit Hours Production
CMT	Clinical Model Transformation	HD / HDHB	Hywel Dda / Hywel Dda Health Board	PECI	Patient Engagement & community Involvement	WAST	Welsh Ambulance Services University NHS Trust
CSD	Clinical Service Desk	IMTP	Integrated Medium-Term Plan	PTR	Putting Things Right	WG	Welsh Government
CSP	Clinical Safety Plan	JCC	Joint Commissioning Committee	RCS	Rapid Clinical Screening	YTD	Year To Date
CTM / CTMHB	Cwm Taf Morgannwg Health Board	JIF	Joint Investigation Framework	RICS	Remote Integrated Care Service		

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

ACADEMIC PARTNERSHIPS 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 our website.

Trust Board Meeting Date	26 November 2026
Committee Meeting Date	18 September 2026
Chair	Hannah Rowan

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. There were no alerts raised in this meeting.

ADVISE

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

2. An update was received from the Trust's **Research Non-Executive Director, Prof. Hayley Hutchings** for her involvement as the board's research champion.

3. Members **reflected** on the quality of the papers, particularly the sharing of outcomes and impact. Members felt that research and innovation should be highlighted more in the IMTP which would allow for accountability on deliverables of the five year plan.

ASSURE

(Detail here any areas of assurance the Committee has received)

4. The Committee received an update on the ongoing review of the **Health and Care Research Wales (HCRW) Governance Framework self-assessment**. Members noted that feedback from HCRW was ultimately positive, recognising the Trust's research activity and identifying two areas for further development: strengthening the integration of academic input within governance and decision-making structures, and undertaking a targeted benchmarking exercise. Discussion highlighted the challenges of benchmarking research performance across ambulance services due to differences in organisational size, geography, service models and research portfolios. Work is progressing to develop meaningful comparators, including consideration of research recruitment activity and grant capture, whilst avoiding overly simplistic comparisons. The Committee noted that the exercise is expected to

provide useful insight into the Trust's research contribution and further demonstrate that the organisation continues to perform strongly relative to its size and remit.

5. The committee received the **2025/26 Research, Development and Innovation (RD&I) Annual Report** (which is attached at **annex 1**) and welcomed the continued evolution of the report, noting improvements in accessibility, readability and the demonstration of research impact. Members recognised the breadth of research activity being undertaken and the importance of increasing visibility of this work across the organisation, including sharing outcomes with staff, stakeholders and the board to promote engagement and demonstrate the benefits derived from research activity.

   Discussion also focused on the development of the RD&I measurement framework, with recognition that further work is required to strengthen performance monitoring and provide greater assurance regarding progress against strategic objectives, including milestones and deliverables. The committee noted wider organisational discussions regarding future governance arrangements for research and innovation, including how best to maintain strategic oversight, align research activity with organisational priorities and ensure appropriate visibility within the emerging governance and delivery framework.

RISKS

Risks Discussed: There are no formal risks on the corporate risk register for this Committee.

New Risks Identified: No risks raised.

COMMITTEE AGENDA FOR MEETING		
Health Care Research Wales Research Governance Framework Self-Assessment	Research Development and Innovation Annual Report 2025/26	Update from Research NED

COMMITTEE ATTENDANCE		
Name	**18 September 2026**	**9 March 2027**
Hannah Rowan (chair)		
Jayne Beeslee		
Prof Hayley Hutchings		
Jonathan Chippendale		
Ceri Griffiths		
Estelle Hitchon		
Jo Kelso		
Mark Marsden		
Trish Mills		
Prof Nigel Rees		
Keith Rogers		
Liz Rogers		
Jonny Sammut		
Andy Swinburn		

	Attended
	Deputy attended
	Apologies received
	No longer member

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 November 2026
Committee Meeting Date	5 November 2026
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Across the agenda, the committee identified a mixed assurance picture. While there is evidence of stronger grip and improvement activity, the consistent challenge was to demonstrate that interventions are delivering sustained improvements in patient outcomes and experience, and reducing harm, rather than activity or action completion alone.

2. The committee welcomed the positive overall findings of the Healthcare Inspectorate Wales (HIW) review, which recognised significant progress in leadership and governance while reinforcing the Committee's own challenge around demonstrating the impact, effectiveness and sustainability of improvement. Given HIW's regulatory role, the report is attached at annex 1 for this meeting.

ADVISE

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

3. Members revisited **Alison Clarke's experience of repeated disruption to Ambulance Care transport for essential hospital appointments**, which had delayed access to specialist care and caused significant anxiety. The story reinforced the impact of unreliable transport on patients with complex long-term conditions and the importance of translating patient experience into tangible service improvement. The committee noted that Alison's experience had informed a wider NEPTS improvement programme, including better alignment of rosters and capacity with demand, review of eligibility arrangements following engagement with more than 1,200 people, and revision of the Trust's Ambulance Care capacity management plan. Digital changes were therefore being introduced to assess capacity at the point of booking, provide earlier certainty and identify alternative options where transport was unavailable.

4. Members welcomed the progress but challenged whether the changes had yet demonstrated materially improved outcomes for patients, emphasising the need to evidence fewer cancellations, reduced harm and improved experience rather than improvement activity alone. Opportunities to implement changes within the Trust's control more quickly and reduce transport demand through care closer to home were also highlighted. The committee received reassurance from the actions and learning demonstrated but acknowledged the need for further improvement pending implementation of the changes discussed, and the need to demonstrate this through improved patient outcomes and experiences.

5. Members received an **update on Mario Jolazza's patient** experience, which highlighted the continuing impact of transport challenges on rural communities. The committee acknowledged the need to translate learning into tangible improvements in access, response times and patient outcomes, particularly in reference to patients with suspected stroke.

6. Members noted the significant breadth and scale of **operational delivery in Q2** and welcomed the revised focus of the report on the committee's remit.

7. **Two areas referred by the Trust Board** for deeper scrutiny have been deferred to the February meeting:

    - Patient waiting times: Initial analysis identified the need for further work to understand the relationship between extended waits and patient harm. The work has been more substantial than anticipated and affected by capacity pressures. A fuller update will be considered in February.
    - NRI/serious incidents: Further analysis of trends, learning and whether reported levels are within expected parameters remains in progress. The current concerns management improvement sprint is focused on NRIs, providing additional impetus to this work, with a fuller update due in February.

8. **Members reflected** that the meeting had been challenging but constructive, with open and honest discussion of significant issues. The need to maintain transparency, strengthen integrated governance, focus on key priorities and demonstrate measurable impact of the trust's operations was emphasised; while recognising continuing system and commissioning pressures on capacity and patient outcomes. The committee also recognised the need to focus on agenda planning and time management to ensure sufficient space for appropriate scrutiny of the significant and complex issues within its remit.

ASSURE

(Detail here any areas of assurance the Committee has received)

Strategic Delivery (SO5 and outcomes for SO1): IMTP update, strategic quality plan update and mental health report

9. The Committee welcomed its first detailed oversight of **Q2 assurance report on IMTP deliverables within its remit**. Members welcomed the improved visibility of delivery and recognised areas of good performance alongside off-track deliverables and mitigating actions. There were concerns about organisational and leadership capacity to deliver the breadth of commitments, particularly through

winter, and where delivery and impact remain to be demonstrated. The Committee emphasised the need for sharper prioritisation and continued focus on outcomes and deliverability.

10. The Committee welcomed progress made in implementing the **strategic quality plan** and the stronger focus on demonstrating outcomes and impact. Discussion focused on the effectiveness of the governance and learning arrangements internally, including how learning from concerns and incidents is identified, translated into action and its impact subsequently evaluated. Members welcomed the new risk 700 related to this and that work underway through the integrated governance programme and the opportunities that arose from integrating the Clinical and Quality Directorates are intended to strengthen the relationship between delivery, assurance and learning.

11. Notwithstanding the progress made, the Committee noted that evidence of sustained impact remained developing, alongside continuing capacity and digital dependencies, and therefore took partial rather than full assurance on implementation of the strategic quality plan. There was recognition that capacity cannot simply continue to be cited as the constraint: priorities need to be clearer, and resources focused on those areas most likely to make a difference.

12. Members received the 2025/26 mental health annual report, with the **mental health delivery plan** for 2026-29 and welcomed the significant progress made in developing the trust's mental health provision. Members particularly welcomed the development of consistent triage and pathways, dementia-friendly fleet design and improved identification and support for people with learning disabilities; however, recognised that further work with system partners remained necessary to address geographical variation and strengthen access.

Performance and outcomes

13. The Committee welcomed the continuing development of the **Monthly Integrated Quality and Performance Report** (MIQPR), including the broader quality measures, and noted positive ROSC performance. However, concern remained that significant improvement activity was not yet translating consistently into improved outcomes. Key areas of discussion were:

    - Stroke and STEMI: call-to-door performance and regional variation remained concerns, with further evidence needed that interventions are improving outcomes.
    - Cancelled ambulance responses: the continuing volume and impact on patients were challenged, with further scrutiny proposed through Finance and Performance Committee.
    - Red/Emerge: performance continued to be affected by ambulance availability and handover delays, with the planned demand and capacity review expected to provide greater clarity on the resource base.
    - Orange Now: work to safely reduce the cohort could release capacity for the most time-critical patients, although the clinical risks require careful management.
    - Winter: a smaller number of high-impact interventions are being prioritised, including single points of access and greater use of advanced paramedics.
    - Patient experience: the emerging measure was welcomed, although low response volumes currently limit the assurance available.

14. Overall, the Committee received assurance from areas of improvement and the work underway but

remained concerned about continuing patient risk and harm. Greater evidence is required that interventions are delivering sustained improvement in outcomes, rather than demonstrating activity alone

15. The committee considered the reports on concerns management, mortality reviews and learning from deaths together, recognising the close relationship between the areas and the opportunity to strengthen the triangulation of concerns, incidents, Medical Examiner intelligence, inquests, safeguarding and other sources of learning. There was evidence of stronger organisational grip, clearer accountability and more structured recovery arrangements for the **concerns management improvement programme**, including encouraging progress with early resolution of concerns and the resumption of weekly Level 2 mortality review panels.

16. Discussion focused on sustainability and learning with members challenging whether recovery activity was addressing the underlying causes of backlogs, rather than simply reducing numbers, and sought assurance that higher-risk concerns and mortality cases were appropriately prioritised. Particular emphasis was placed on closing the learning loop, demonstrating that learning from concerns, deaths and incidents is translated into changed practice, monitored for effectiveness and ultimately reduces risk and patient harm.

17. The committee also considered the limited assurance **Internal Audit opinion on Medical Examiner and mortality review arrangements**. Members expressed concern about the governance arrangements that had allowed Level 2 review activity to be paused and sought greater understanding of the sequence of events that led to this. Reassurance was provided that Level 1 clinical review had continued, enabling potential harm and significant learning to be identified and escalated, and that a six-month recovery trajectory, strengthened governance and additional support are now in place.

18. The committee recognised that colleagues now had greater grip, shared ownership and clarity of recovery trajectories. Moving beyond partial assurance will depend upon evidence that the recovery trajectories are being achieved, improvements are sustainable and, critically, organisational learning is demonstrably improving outcomes and reducing harm.

People's Experience Team report

19. Members welcomed the report (formerly the patient experience and community involvement report) for the period April to September 2026, and received assurance that mechanisms were in place to capture, understand and respond to people's experiences. Patients continued to value the compassion, communication and care provided by staff, while overall experience was increasingly influenced by the timeliness and reliability of access and wider system flow; the Falls Assistance Service was highlighted as a positive example of learning being embedded and experience improving.

20. Discussion highlighted the significant increase in 111 demand and the value of developing a better understanding of why people contact the service and their expectations. Overall, members were assured by the arrangements for capturing and responding to people's experiences, while recognising the continued need to broaden participation and demonstrate how learning translates into tangible service improvement.

Audit Tracking

21. Members were assured that **clinical audit** activity across Q2 remained responsive to emerging priorities and informed improvements in clinical practice and reporting. Members welcomed the strengthened ROSC methodology, and noted that it aimed to improve accuracy, consistency and national and international comparability, with further data required before any impact on reported performance could be determined.

22. Members were assured that **internal audits** on their final revised date had appropriate mitigations in place and had not unduly increased risk exposure.

RISKS

Risks Discussed:
The committee reviewed the most recent risk report on **risk 223 (**the Trust's inability to reach patients in the community causing patient harm and death) and **risk 224** (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).

Both risk 223 and 224 have remained at a score of 25 (5x5), with the new identifier of 'purple' indicating the highest score of 25. Attention has been given to the risk ratings of each principal risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances and any gaps. The majority of the papers for this meeting went to the issues of quality and patient safety at the heard of risks 223 and 224, with the committee focusing on what WAST can mitigate and the ways in which it can influence those areas that we monitor.

New Risks Identified: Members noted that several new risks are navigating Trust governance within this reporting cycle which will be considered by the Executive Leadership Team on 12 August 2026. These include:
Risk 700 – Listening to People Regulations, score of 16 (4x4)
Risk 706 – Pandemic Response, score of 15 (3x5);
Risk 708 – Access to Property, initial score of 20 (5x4) reduced to 8 (2x4) due to the strength of the interim controls applied; and
Risk 669 – Avoidable patient and staff harm resulting from failure to investigate and learn from safety incidents, score of 15 (3x5) which has been escalated from the directorate risk register.

COMMITTEE AGENDA FOR MEETING		
Patient experience of Alison Clarke and update re Mario Jolazza	Q2 IMTP delivery update	Strategic Quality Plan 2025/28 quarterly update
MIQPR	Risk management and BAF	HIW report
Concerns, patient safety and legal services assurance report	Learning from deaths (mortality reviews) report Medical examiner and mortality reviews internal audit	Patient experience team biannual report

Mental health annual report, delivery plan and deliverables	Monitoring report on clinical audit	Audit tracker Q2
Operations Q2 report		

COMMITTEE ATTENDANCE				
NAME	**07 May 2026**	**06 August 2026**	**05 November 2026[1]**	**04 February 2026**
Bethan Evans (Chair)				
Ceri Jackson				
Dr Umar Ahmad				
Liam Williams	Penny Durrant			
Andy Swinburn		Jonathan Chippendale		
Penny Durrant				
Lee Brooks				
Rachel Marsh				
Trish Mills				
Mark Marsden				
Hugh Parry				
Henry Garrard				

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Phil Berrington (board chair) and Emma Woods (CEO) attended for this meeting

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Welsh Ambulance Services University NHS Trust: Review of progress following HIW reviews

HIW review of the effectiveness and sustainability of improvements arising from reviews published in 2020 and 2021.

Publication date: 7 October 2026



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.



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1. What we did

Healthcare Inspectorate Wales (HIW) undertook an assessment to consider how far the Welsh Ambulance Services University NHS Trust (WAST) has addressed the concerns and recommendations arising from two previous HIW reviews.

The first review published in 2020, considered patient management arrangements within Emergency Medical Service Clinical Contact Centres (EMSCCCs). It also included arrangements for patients waiting in the community, workforce capacity, escalation, training, wellbeing, leadership, and incident reporting.

The second review published in 2021 considered patient safety, privacy, dignity, and experience while patients waited in ambulances outside Emergency Departments during delayed handovers.

Together, those reviews described connected risks across the urgent and emergency care pathway. Delays in hospital handover reduce ambulance availability, which in turn affects patients waiting in the community, the operation of EMSCCCs, workforce pressure, escalation, clinical oversight, and patient experience. We acknowledge that this is not an issue the Trust can resolve alone, and that sustained improvement requires continued action from health boards, commissioners and wider system partners.

This assessment focused on the Trust's 2026 response to our requested five theme updates, which included:

- Patient flow and handover processes
- Escalation processes
- Communication with patients and NEPTS cancellations
- Leadership, governance, workforce, and learning culture
- Data quality and accurate recording.

To support our understanding of the progress made under the above themes, we asked the Trust to complete a self-assessment and submit this to us along with supporting evidence by the end of January 2026. The information was provided to us and was considered alongside other intelligence held by HIW.

We assessed the information submitted within the self-assessment and supporting evidence against the above themes, and considered whether it demonstrated implementation, embedding, effectiveness and sustainability.



2. Summary of assessment

Executive Summary

During early 2026, Healthcare Inspectorate Wales (HIW) assessed the extent to which Welsh Ambulance Services University NHS Trust (WAST) has addressed the findings and recommendations arising from HIW reviews published in 2020 and 2021.

Overall, we found that the Trust has made strong progress since our previous reviews and is in a materially stronger position than that described in 2020 and 2021. The Trust has introduced a wide range of governance, operational, workforce, clinical and digital improvements, many of which now appear embedded within routine operational and governance arrangements. We found evidence of strengthened oversight of delayed handovers, improved clinical decision-making arrangements, more developed escalation processes, increased leadership capacity, enhanced workforce support arrangements and strengthened digital and data governance.

We also identified several areas of noteworthy practice. These include the development of advanced clinical decision-making and alternative care pathway models, strengthened clinical support arrangements within EMSCCCs, improved operational oversight of system pressures, enhanced workforce support and speaking-up arrangements, and investment in training, development and digital governance. These developments suggest that the Trust has responded positively and constructively to many of the concerns identified through our previous reviews.

However, whilst implementation and embedding are generally well evidenced, the evidence submitted was less developed in demonstrating impact. Across several themes, the Trust described strengthened governance arrangements, monitoring processes and improvement programmes, but there was more limited evidence demonstrating sustained improvements in patient outcomes, staff experience, operational performance or wider system effectiveness. Further assurance is required regarding programme evaluation, patient harm reduction, organisational learning, workforce competency in practice and measurable improvements in data quality.

Delayed handovers remain the most significant assurance challenge. Although the Trust provided evidence of improvements in handover performance, alternative pathway development and patient flow initiatives, the risk associated with delayed emergency department handovers continues to be assessed by the Trust at its highest level. This limits the level of assurance that can currently be derived from the improvements described. Assurance is also constrained by the limited evidence available regarding the contribution of health boards and wider system partners to improving patient flow across Wales.

Overall, we conclude that the Trust has made positive progress since our previous reviews and is in a materially stronger position than that described in 2020 and 2021.

However, further evidence is required before a higher level of assurance can be provided regarding the effectiveness, sustainability and whole-system impact of improvements. In particular, further assurance is required regarding the sustained impact of major transformation programmes, reductions in patient harm associated with delayed handovers, shared accountability across the urgent and emergency care system, operational compliance, organisational learning and measurable improvements in data quality.

This report makes eight recommendations requiring a formal Trust response. These recommendations focus on evaluation of major improvement programmes, system-wide accountability, demonstration of reduced patient harm, operational compliance, communication with patients, organisational learning, workforce competency and data quality. The recommendations are set out in the improvement plan.

3. What we found

This report sets out our assessment of Welsh Ambulance Services University NHS Trust's progress in addressing the findings and recommendations from HIW's 2020 and 2021 reviews. It considers the Trust's 2026 response and the evidence submitted to support it. The purpose of the report is to provide a balanced view of how far improvements have been implemented, embedded and sustained, while identifying noteworthy practice, remaining assurance gaps, and recommendations for further improvement.

The 2020 review focused on how patients were managed by Emergency Medical Service Clinical Contact Centres (EMSCCCs) from the point at which a 999-emergency call was received until an ambulance arrived. HIW considered patient management, workforce, and governance arrangements supporting quality and patient safety. The review identified that systems and processes were in place to provide safe and effective care, but that staff were working in a demanding and stressful environment affected by workforce capacity, resource constraints, delayed handovers, training gaps, senior leadership visibility concerns, and inconsistent incident reporting.

The 2021 review focused on patients waiting in ambulances outside Emergency Departments (EDs) during delayed handovers. It found that prolonged handover delays were a regular occurrence across Wales and were affecting patient safety, privacy, dignity, patient experience, and ambulance availability. The review also identified variation in handover processes, uncertainty over accountability for patient care, a need for stronger escalation processes, workforce support, and more effective governance and learning arrangements.

We did not review each recommendation separately. Instead, we used the findings and recommendations from the 2020 and 2021 reviews, alongside current HIW intelligence, to identify common themes and areas of continuing assurance interest. This allowed us to assess progress in a more integrated way.

The Trust's 2026 response set out its position across five requested themes: patient flow and handover processes; escalation processes; communication with patients and Non-Emergency Patient Transport Service (NEPTS) cancellations; leadership; governance; workforce and learning culture; and data quality and accurate recording. We assessed the evidence submitted against these themes and considered whether it demonstrated implementation, embedding, effectiveness and sustainability.

Our assessment distinguishes between evidence that arrangements exist and that those arrangements are making a measurable difference. Governance frameworks, policies, dashboards, training programmes, and escalation protocols are important, but they do not, by themselves, demonstrate effectiveness or sustained improvement.

Throughout this report, we therefore consider both the presence of improvement

activity and the strength of evidence demonstrating its impact.

Theme 1: Patient flow, handover, crew release and pathways

Previous HIW findings

The 2020 review identified delayed hospital handovers as a major factor affecting the Trust's ability to respond to patients waiting in the community. Staff consistently described handover delays as the root cause of limited ambulance availability, call waiting queue backlogs and increased waits for emergency ambulance responses. The review reported that almost 9,000 ambulance hours per month were lost during 2019 because of hospital handover delays, with 13,821 hours lost in December 2019 alone.

The 2021 review confirmed that delayed handovers remained a serious system-wide concern. It found that prolonged handovers were affecting patient safety, privacy, dignity and experience, and reducing the Trust's ability to coordinate timely responses for patients waiting in the community. It also identified inconsistent handover processes, variation between sites, and uncertainty among staff regarding responsibility and accountability for patients during delayed handovers.

The significance of these findings is that handover delays create risk at multiple points in the urgent and emergency care pathway. They affect patients already waiting outside EDs, they reduce ambulance availability, and they increase pressure on EMSCCCs and crews managing patients waiting in the community.

What the Trust has implemented

The Trust's response demonstrates that it has implemented a wide range of initiatives intended to address these issues. The Trust describes a deliberate move away from viewing handover delays solely as a hospital handover issue and towards a broader whole-system patient flow approach. This includes Clinical Model Transformation, Welsh Government Ambulance Performance Framework pilot work, test-of-change initiatives with health boards, IMTP actions and responses to Audit Wales recommendations. Oversight of these pressures is supported through Board Assurance Framework Risks 223 and 224. Risk 223 relates to ambulance response capability and access to patients waiting in the community, whilst Risk 224 relates to delayed handovers at EDs.

The Trust also describes strengthened handover guidance and escalation arrangements. These include Immediate Release Protocols, Regional Escalation Protocols, Resource Escalation Action Plan (REAP), Clinical Safety Plans, daily huddles, national escalation calls, shift reports, command oversight, and Electronic Patient Care Record (ePCR) documentation. These arrangements indicate a stronger governance and operational framework than was evident in either the 2020 or 2021 reviews.

Evidence of progress

The Trust's evidence includes reference to the Integrated Quality and Performance Dashboard for December 2025, and states that November 2025 recorded the lowest handover lost hours in four years, alongside improvements in average handover times in many acute hospitals. The Clinical Model Transformation scorecard also showed increased consult-and-close rates and increased remote clinical decision-making. Supporting evidence submitted by the Trust described increased remote clinical assessment activity and more incidents being resolved without an ED outcome. The Trust also reported that the removal of the previous "No Send/ Can't Send" outcome category was intended to provide greater clinical oversight of these decisions and influence a reduction in ED walk-in activity.

The Trust's investment in Advanced Paramedic Practitioners (APPs) is particularly noteworthy. Its 2025 data showed that APPs conveyed 35.5% of patients to EDs compared with 67% for standard paramedics. Advanced Paramedic Practitioner Navigation (APPNAV) conveyance was reported as 38.1%. This is among the strongest outcome evidence submitted because it demonstrates a measurable difference in conveyance outcomes and supports the case that APP models may reduce unnecessary ED conveyance.

The introduction of Clinical Navigators and Remote Integrated Care also responds directly to concerns from the 2020 review about access to clinical support within EMSCCCs. The Trust reports that Clinical Navigators have streamed 57% of incidents to remote clinical assessment pathways. This demonstrates that the model is being used and that more clinical decision-making is being brought earlier into the pathway.

These developments demonstrate a more sophisticated operational model than was evident in the previous reviews. The Trust has strengthened clinical decision-making, introduced more structured operational oversight and developed alternatives to traditional ambulance dispatch and ED conveyance.

Assurance limitations

Despite this progress, important assurance gaps remain. The Trust has not provided formal evaluation reports demonstrating which interventions have caused the reported improvements or whether those improvements are sustainable. This matters because Clinical Model Transformation, Clinical Navigators, Remote Integrated Care and APP models are central to the Trust's improvement narrative, but their specific impact on delayed handovers, patient flow, ambulance availability, and patient outcomes has not yet been fully evidenced.

Risk 224 remains scored at 25, indicating that delayed handovers remain a significant unresolved system risk. We found that the continued presence of this risk at the highest possible rating limits the assurance that can be derived from the improvements described. Whilst the Trust has strengthened controls and implemented mitigation

measures, the evidence provided does not yet demonstrate that the underlying risk associated with prolonged handovers has reduced sufficiently to indicate sustained system-wide improvement.

There is also a tension between reported operational improvements and the continued maximum risk score. If handover lost hours and average handover times have improved, but the principal handover risk remains at the highest rating, further explanation is required. We expect the Trust to consider whether the risk score reflects ongoing system fragility, variation between sites, risk of deterioration during escalation, or limited confidence that improvements are sustainable.

Further evidence is also required to demonstrate whether patient harm associated with delayed handovers has reduced. The evidence submitted provides assurance that the Trust has implemented controls and monitoring arrangements, but it does not yet provide sufficient outcome evidence showing reduced harm, sustained patient safety improvement, or measurable whole-system impact.

We also found that assurance on the effectiveness and sustainability of handover improvements is restricted by the limited evidence available from health boards. Many of the improvements described by the Trust depend on wider system action, including patient flow, ED capacity, timely handover, immediate release arrangements, alternative pathway availability, and escalation processes. Delayed handovers therefore cannot be assessed as a Trust only improvement issue.

There is also insufficient evidence demonstrating that frontline staff consistently understand and apply handover guidance and SOPs across all sites. The Trust has described policies and frameworks, but the evidence does not sufficiently demonstrate workforce-wide training, competency assessment, compliance audit, or point-of-care evidence showing consistent application during periods of operational pressure.

HIW assessment

Overall, we found that the Trust has made substantial progress in strengthening its approach to patient flow, delayed handovers, alternative pathways and operational oversight. The evidence demonstrates a more mature and integrated approach than was evident during our previous reviews, including strengthened governance arrangements, improved clinical decision-making, increased use of alternative pathways and enhanced oversight of operational pressures.

We found evidence that several improvement initiatives have been implemented and embedded within routine operational and governance arrangements. Positive examples include the development of APP and APPNAV models, the introduction of Clinical Navigators and Remote Integrated Care, strengthened escalation and handover arrangements, and increased organisational focus on whole-system patient flow. The evidence submitted also demonstrates some measurable improvements, including reduced conveyance rates through advanced clinical pathways and reported

reductions in handover lost hours.

However, whilst implementation is generally well evidenced, the Trust has not yet provided sufficient information demonstrating the effectiveness, sustainability and impact of many of these initiatives. In particular, evidence remains limited regarding the specific contribution that major transformation programmes have made to reducing delayed handovers, improving ambulance availability, reducing patient harm and delivering sustained system-wide improvement.

These limitations mean that, while the Trust has demonstrated extensive mitigation activity and some reported operational improvement, the evidence does not yet provide sufficient assurance that the underlying strategic risk associated with delayed handovers has reduced.

Overall, we conclude that the Trust is in a stronger position than at the time of our previous reviews in relation to patient flow, delayed handovers and alternative pathways. However, further assurance is required before higher levels of assurance can be provided regarding the effectiveness, sustainability and whole-system impact of the improvements described.

Theme 2: Escalation processes

Previous HIW findings

The 2020 review identified concerns about the consistency of REAP and Demand Management Plan escalation arrangements. Staff reported that escalation and de-escalation levels were not always applied consistently and that the rationale for escalation decisions was not always clear. The review also found that senior managers did not routinely attend EMSCCCs as directed within escalation processes, particularly out of hours.

These findings were important because escalation processes are central to managing demand, clinical risk, and operational pressure. Inconsistent escalation can affect the timeliness of decision-making, clarity of responsibilities and the ability of staff to respond effectively during periods of high demand.

What the Trust has implemented

The Trust's response indicates that escalation arrangements have been strengthened significantly. The Trust reports that escalation processes are now set out in SOPs and operational policies, with defined escalation triggers, roles and responsibilities, and clinical and operational decision-making routes. Oversight has also been strengthened through a revised EMS Coordination Management model. In addition, the Trust has introduced an Operations Manager role providing national performance and escalation monitoring.

The Trust has also provided escalation documentation, including the EMS Clinical

Incident Response SOP, EMS Coordination Business Continuity Plan, Quality Meeting Highlight Reports, and the Trust's Incident Response Plan. These documents show that escalation arrangements are described and monitored through governance processes.

Evidence of progress

We found positive evidence in relation to Clinical Navigators. The Clinical Navigator Quality Assurance Framework provides structured training, induction, and ongoing audit, including checks on escalation-related decision-making. It includes monthly audits, deviation scoring, and feedback processes. This is a stronger quality assurance model than was evident at the time of the 2020 review and provides a positive example of how the Trust checks whether escalation decisions are being made appropriately within a defined staff group.

The Clinical Navigator model therefore provides a clearer line of sight between training, audit, feedback, and practice for one important staff group. This is positive because it moves beyond policy description and provides some evidence of quality assurance in practice.

Assurance limitations

The evidence is stronger for Clinical Navigators than for other EMSCCC staff groups. We found limited evidence of formal training completion records, competency sign-off or workforce-wide assessment of escalation understanding for call handlers, dispatch staff, and supervisors. The quality assurance reports, complaint investigations, incident reviews and audit activity submitted by the Trust continue to identify issues relating to call prioritisation, coding accuracy, protocol compliance and the consistent application of operational processes. These findings indicate that variation in understanding and application remains and support the need for continued assurance and improvement activity.

The quality assurance model is also weighted towards retrospective review. The Trust describes call reviews, case audits, incident investigations, and Datix reporting, but there is limited evidence of proactive escalation-specific audits that assess whether escalation processes are followed consistently in day-to-day operations. While the Trust has implemented arrangements to address the wider operational incident backlog, the scale of unresolved incidents may limit the timeliness of assurance, investigation and organisational learning.

HIW assessment

Overall, we found that the Trust has made positive progress in strengthening escalation arrangements since our 2020 review. The evidence demonstrates that escalation processes are now supported by clearer governance arrangements, defined operational frameworks, documented procedures and strengthened management oversight. The revised EMS coordination management structure and introduction of enhanced escalation monitoring arrangements provide a more robust framework than

was evident at the time of our previous review.

We also found positive evidence that aspects of the escalation process are subject to quality assurance and oversight, particularly through the Clinical Navigator Quality Assurance Framework.

However, the evidence submitted was stronger for Clinical Navigators than for the wider EMSCCC workforce. Further assurance is required to demonstrate consistent understanding and application of escalation processes across call handlers, dispatch staff and supervisors, and to show that proactive assurance arrangements are routinely testing practice during day-to-day operations.

Overall, we conclude that escalation arrangements have improved significantly and are supported by stronger governance and assurance structures than were evident in 2020. However, further assurance is required to demonstrate consistent workforce-wide understanding, competency in practice, and that learning from escalation issues is effectively shared and embedded.

Theme 3: Patient communication and NEPTS cancellations

Communication with patients during delays

Communication with patients during delays is a key patient experience and dignity issue. Our 2020 review highlighted concerns regarding welfare check calls, including the difficulty staff experienced in maintaining timely welfare checks during periods of high demand and the frustration caused when staff were unable to provide clear expected arrival times. Our 2021 review also found that delayed handovers affected patient experience, including access to basic needs, dignity and communication during prolonged waits.

The Trust's response describes a framework for communicating with patients during delays. This includes expected time of arrival scripts, policy standards, clinical and operational guidance, media statements, operational oversight arrangements and the use of patient experience feedback, complaints, incidents, Duty of Candour processes and staff feedback to inform learning and improvement. This demonstrates that the Trust recognises communication as an important component of quality, safety, dignity and patient experience.

Assurance limitations

At the time of our assessment, we found that the evidence available provided greater assurance regarding the existence of communication processes, governance arrangements and oversight mechanisms than their effectiveness in practice. Whilst the Trust described the arrangements in place, we found limited evidence demonstrating whether communication was consistently improving patient experience during periods of delay and operational pressure.

Since completion of our assessment, the Trust has provided additional evidence through its Improvement Plan, including patient experience survey findings, quality audit activity, governance reporting, compliments analysis and patient feedback. This evidence provides positive indicators relating to dignity, involvement in care and the provision of information to patients and demonstrates that communication arrangements are subject to routine monitoring and review.

Whilst this additional evidence provides further assurance, continued monitoring and evaluation will remain important to demonstrate the consistency and effectiveness of communication arrangements during periods of prolonged delay and significant operational pressure. Given the findings of previous HIW reviews regarding the impact of delays on patient experience, dignity and wellbeing, any future assurance should continue to focus on demonstrating sustained improvements in patient experience and communication outcomes.

Non-Emergency Patient Transport Service cancellations

The evidence relating to NEPTS is stronger. The Trust reported that during 2025, the service completed 552,602 journeys and recorded 169,895 cancellations. The Trust advised that most of these cancellations occurred before the service planning process commenced, most commonly because appointments had changed, been cancelled, or transport was no longer required. Of the 63,368 journeys cancelled within four hours of the planned appointment time, the majority were cancelled by hospitals or patients. A further 29,434 journeys were cancelled under the Trust's Capacity Management Plan where demand exceeded available capacity. The Trust also noted that journey numbers do not directly equate to individual patients as most patients have both inbound and outbound journey bookings. The Trust described daily, weekly, directorate and Board-level monitoring of cancellation performance.

We found that the Trust demonstrated a clear understanding of the capacity challenges affecting NEPTS. The evidence submitted identified pressures associated not only with increasing activity levels but also increasing service complexity. These include longer journeys, higher acuity patients, reduced volunteer driver availability, increased reliance on specialist ambulance provision for renal services and increased mileage associated with oncology and outpatient services.

The Trust also provided evidence of improvements in several timeliness measures, including inward outpatient, oncology and renal performance. In addition, the Trust described several mitigation measures, including text confirmation systems, improved booking and cancellation processes, enhanced patient communications, system integration, roster review, volunteer driver recruitment and journey planning improvements.

However, despite these actions, cancellation levels remain significant and capacity remains insufficient to meet current levels of demand. We found that many of the factors contributing to cancellations extend beyond the direct control of the Trust and

are likely to require commissioner, stakeholder and health board decisions regarding service capacity, eligibility criteria, service standards and investment.

HIW assessment

Overall, we found mixed levels of assurance across this theme. In relation to communication with patients during delays, the Trust has developed governance arrangements, guidance, communication processes and oversight mechanisms. At the time of the review, there was limited evidence demonstrating the effectiveness of these arrangements in practice. However, the additional evidence subsequently provided through the Trust's Improvement Plan, including patient experience survey findings, quality audit activity, governance reporting and patient feedback, provides further assurance regarding patient experience, including positive indicators relating to dignity, involvement and explanation. While this evidence is encouraging, continued monitoring will be important to demonstrate the consistency and effectiveness of communication arrangements during periods of delay and operational pressure.

In relation to NEPTS, the evidence is stronger. The Trust demonstrated a clear understanding of the challenges affecting service delivery and provided evidence of monitoring arrangements, mitigation measures and some measurable improvements in performance. We found that the Trust has taken a proactive approach to managing increasing demand and service complexity, although cancellation levels remain significant and capacity continues to represent an ongoing challenge.

Overall, we found that the Trust has demonstrated progress in its approach to patient communication and management of NEPTS pressures. The additional evidence provided through the Improvement Plan strengthens assurance regarding communication with patients, particularly in relation to patient experience monitoring and governance oversight. However, the Trust continues to face significant capacity challenges within NEPTS and further assurance will be required to demonstrate sustained improvements in patient experience, reductions in avoidable cancellations and the long-term effectiveness of improvement measures.

Theme 4: Leadership, governance, wellbeing and training

Leadership and governance

The 2020 review identified concerns about senior leadership visibility, communication, and engagement with operational staff. It found that 70% of EMSCCC survey respondents felt communication between senior management and operational staff was ineffective, and that staff felt concerns were not always heard, acknowledged, or addressed.

The Trust’s response demonstrates significant structural improvement. The Trust introduced a revised EMS Coordination career structure in November 2024, including

additional management posts. This includes the Band 7 Operations Manager role described earlier, together with Band 8a Locality Managers for each of the three coordination centres, providing strengthened operational leadership, escalation oversight and a clearer line of sight from Band 3 Call Handlers to Head of Service. The introduction of Clinical Navigators also provides improved 24/7 clinical leadership and supervision

These developments are noteworthy because they respond directly to previous HIW concerns regarding leadership presence and governance. The revised structure provides a stronger foundation for operational oversight, staff support and escalation. It also suggests the Trust has recognised that leadership presence must be built into routine operational arrangements rather than being dependent on ad hoc senior intervention.

However, we found that the evidence remains largely descriptive. The Trust has shown that leadership structures have changed but have not provided sufficient evidence demonstrating that these changes have improved staff experience, psychological safety, communication, operational decision-making, or governance risk. Future assurance should therefore assess the impact of these changes, not only their implementation.

Learning and staff feedback

The 2020 review identified that staff wanted more effective mechanisms to submit views and suggestions and receive feedback on the outcome. It also found concerns about incident reporting, including uncertainty about what should be reported, limited time to complete reports, and lack of feedback following Datix submissions.

The Trust now describes multiple mechanisms for staff feedback and organisational learning, including NHS Wales staff survey participation, pulse surveys, local engagement forums, social partnership arrangements, Quality Impact Assessments, and the Clinical Model Transformation programme. These mechanisms are supported by 'SimplyDo', Datix, Duty of Candour, and the Trust's Improvement Network and Quality Management Group oversight.

There are positive examples where the Trust reports that staff survey participation increased to 43.2% in 2025, compared with 35.2% in 2024 and 23.2% in 2023. It also describes how a 2025 cultural survey influenced the Clinical Model Transformation programme by leading to revisions in programme pace, role clarity, change management support and leadership expectations.

However, increased survey participation does not, by itself, demonstrate improved staff experience or psychological safety. It is encouraging because it may indicate greater engagement, but further evidence is required to show whether staff feedback has led to measurable change, whether staff confidence has improved, and whether concerns raised through feedback mechanisms are consistently acted on and closed.

We found that the evidence does not yet demonstrate that feedback loops are consistently closed. The Trust gathers feedback, but evidence is limited in showing what decisions were made as a result, what changed in practice, whether improvements were measured and whether they were sustained. This limits assurance that staff feedback is embedded into decision-making in a demonstrable and systematic way.

Duty of Candour, reporting and speaking up

The Trust has also described how Duty of Candour, Datix and 'Always On' reporting contribute to its wider learning arrangements. However, the evidence provided does not yet show clearly how learning from these routes is brought together, acted on and tracked through to improvement.

The Trust has strengthened speaking-up arrangements since the 2020 review. Staff can now raise concerns through line management, formal incident reporting, the Speaking Up Safely framework, Work in Confidence and other feedback routes. A full-time Lead Guardian was appointed in June 2024, and the Trust reported that 113 concerns were raised between July 2024 and June 2025. We found that this demonstrates staff are aware of, and are making use of, the available reporting mechanisms. The Trust also reported that an NHS Wales Shared Services Partnership audit confirmed strong governance, clear processes and the safe handling of concerns.

However, the number of concerns raised does not, by itself, provide assurance regarding the effectiveness of the speaking-up arrangements. The evidence submitted does not sufficiently demonstrate the nature of concerns raised, actions taken in response, lessons learned, or whether concerns resulted in measurable improvements. Further evidence is therefore required to demonstrate that speaking-up arrangements are contributing to a culture of openness, learning and psychological safety, and that concerns raised by staff lead to tangible and sustained improvement.

Workforce wellbeing

Workforce wellbeing is one of the stronger areas of evidence. The 2020 review identified sickness absence, stress, morale, and workforce capacity as key issues. At that time, EMSCCC sickness levels were around 10%, and staff described significant pressure arising from demand, handover delays, and staffing constraints.

The Trust's response describes a broader well-being framework. This includes occupational health support, resilience programmes, flexible working, psychological safety measures, trauma risk management, suicide risk training and employee assistance programme access. It also includes well-being drop-ins, stress and sleep workshops, People Networks and People and Culture Committee oversight.

The Trust also provided organisational workforce data demonstrating that sickness absence reduced from a peak of 12.5% in December 2021 to 9.26% in December 2025, with a low of 6.81% recorded in May 2025. Whilst these figures relate to the wider Trust

workforce rather than EMSCCC specifically and are therefore not directly comparable with the sickness absence levels reported in the 2020 EMSCCC review, they provide some evidence of improvement in organisational sickness absence over time.

However, the evidence does not clearly demonstrate which specific interventions contributed to the reduction in sickness absence, whether the improvements are sustained across all services and staff groups, or whether staff experience has improved alongside the reduction in absence.

Training and development

The Trust's response demonstrates considerable progress. It describes Board oversight of training, the 'Our Way' leadership framework, International Academies of Emergency Dispatch qualified instruction, Emergency Medical Dispatcher certification, structured induction, and mentorship and call signoffs. It also describes remote integrated care induction, Datix and complaints training, mandatory in-service training, ESR tracking, continuing professional development and regulated qualifications. The Trust also noted that mandatory in-service training achieved reasonable assurance in audit.

This represents a significant maturation of training infrastructure since the 2020 review. However, we found that the evidence demonstrates training availability, attendance, and governance more clearly than competency in practice. Further assurance should show whether staff consistently apply training during prolonged handover care, escalation, risk documentation, and incident reporting.

HIW assessment

Overall, we found substantial evidence of progress across leadership, governance, organisational learning, workforce wellbeing, speaking-up arrangements and training. The Trust has invested in leadership capacity, while also expanding mechanisms for staff engagement, feedback, and speaking up. In addition, the Trust has broadened wellbeing support and developed a more comprehensive training and development infrastructure to support staff across the organisation. Taken together, these developments represent a more mature governance and workforce support framework than was described in our 2020 review.

However, the evidence submitted remains stronger in demonstrating that arrangements exist than in demonstrating their effectiveness and impact. Across several areas, including leadership visibility, organisational learning, speaking-up arrangements, psychological safety and workforce development, the Trust has not yet provided sufficient evidence demonstrating how these initiatives have improved staff experience, organisational culture, competency in practice or learning outcomes.

Overall, we found that the Trust has made significant progress in addressing many of the workforce and governance concerns identified in previous HIW reviews. Future assurance should focus on measurable impact, closed-loop learning, improved staff experience and evidence that workforce development and wellbeing initiatives are

translating into sustained changes in practice and organisational culture.

Theme 5: Data quality and accurate recording

Previous HIW findings and Trust response

Accurate data is essential for assurance ratings, performance monitoring, service planning, patient safety, and Welsh Government reporting. The 2021 review identified concerns regarding accurate recording of handover times through dual-PIN processes. The Trust's response demonstrates a strengthened approach to digital governance and data quality.

The Trust describes a refreshed Digital Plan for 2024–2029 and expansion of the Data Quality Assurance Team from 0.6 to 2.6 whole time equivalent. It also describes a bespoke e-learning module, data quality metrics, and reporting through the Information Governance Steering Group and the Information Asset Management Group. In addition, the Trust describes ePCR and continued use of the dual-PIN process.

These developments provide a stronger foundation for future assurance than was evident in the earlier reviews.

Assurance limitations

We found limited evidence demonstrating measurable improvement. The Trust did not provide sufficient ePCR audit results, trend data, dual-PIN compliance reporting, site-level variation analysis or examples of data quality issues being identified, corrected, and prevented from recurring.

This is important because the quality of data underpins assurance on handover performance, ambulance availability, patient safety, Welsh Government reporting and operational decision-making. The Trust has described the governance arrangements intended to improve data quality, and several assurance mechanisms are already in place. However, the evidence does not clearly demonstrate that these arrangements are consistently producing accurate, complete, and timely data in practice.

HIW assessment

Overall, we found that the Trust has made positive progress in strengthening its approach to data quality and digital governance. The refreshed Digital Plan, expansion of dedicated data quality capacity and oversight through established committee structures demonstrate increased organisational focus on data quality as both a governance and patient safety issue. This represents a more mature approach than was evident during our previous review and provides a stronger foundation for assurance, performance monitoring, service planning and reporting.

However, whilst the Trust has demonstrated that governance arrangements, oversight mechanisms and improvement initiatives are in place, the evidence submitted was less

effective in demonstrating measurable improvements in data quality outcomes. In particular, we found limited evidence relating to ePCR audit findings, trends in data quality performance, dual-PIN compliance, site-level variation and examples showing how data quality issues are identified, addressed and prevented from recurring.

Accurate and reliable data is fundamental to assurance regarding handover performance, ambulance availability, patient safety and wider service performance. Future assurance should therefore focus on demonstrating measurable improvements in data integrity and providing evidence that data quality improvements are supporting operational decision-making, service planning and organisational learning.

4. Conclusion and next steps

Having considered the evidence submitted by the Trust and supporting documentation, we found that it has made substantial progress in responding to the findings and recommendations arising from our 2020 and 2021 reviews. It is therefore in a materially stronger position than that described in those reviews.

The evidence demonstrates that the Trust has introduced a wide range of governance, operational, workforce, clinical and digital improvements. Many of these improvements appear to be embedded within routine organisational structures, governance processes and operational practice. We found evidence that clinical decision-making arrangements had improved, supported by stronger escalation processes and increased operational oversight. Leadership arrangements had also been strengthened, together with broader workforce wellbeing support and enhanced speaking-up arrangements. Improvements were also evident in training and development infrastructure, digital governance, and data quality management.

A particular strength of the Trust's response is that many improvements are not presented as isolated or short-term actions. They appear to form part of wider organisational arrangements for governance, operational oversight and assurance. This suggests that the Trust has responded positively and constructively to many of the concerns raised in HIW's previous reviews.

However, the central limitation in the evidence remains the distinction between implementation and impact. Across several themes, the Trust has provided stronger evidence that arrangements, policies, monitoring processes and improvement programmes are in place, than evidence that these arrangements are consistently improving outcomes for patients, staff and the wider urgent and emergency care system. In particular, further assurance is required regarding the effectiveness and sustainability of major transformation programmes, reductions in patient harm associated with delayed handovers, communication with patients during delays, organisational learning, workforce competency in practice, and measurable improvements in data quality.

Overall, we conclude that the Trust has made significant progress and is in a materially stronger position than at the time of our previous reviews. Whilst we found evidence that many improvements have been implemented and embedded, further assurance is required regarding their effectiveness, sustainability and impact. In particular, delayed handovers remain a significant system challenge and continue to limit the level of assurance that can currently be provided.

Areas of noteworthy practice

During this assessment we identified several areas of noteworthy practice which demonstrate meaningful organisational progress since our previous reviews.

Advanced Paramedic Practitioner and APPNAV models

Evidence submitted by the Trust demonstrated substantially lower rates of ED conveyance for patients managed through APP and APPNAV pathways when compared with standard paramedic practice. This was among the strongest outcome evidence submitted during the assessment and demonstrates the potential value of advanced clinical decision-making and alternative care pathways.

Clinical Navigators

The Clinical Navigator model responds directly to concerns identified during our 2020 review regarding access to clinical support within EMSCCCs. The model supports earlier clinical assessment, improved decision-making and increased use of alternative pathways.

Operational Delivery Unit

The Operational Delivery Unit provides structured operational oversight of delayed handovers, ambulance availability, escalation arrangements and wider system pressures. It is a significant component of the Trust's operational management framework.

Leadership and operational oversight

The revised EMS coordination leadership structure provides improved operational leadership, local accountability and management support, and addresses concerns identified during our previous reviews regarding leadership visibility and engagement.

Workforce wellbeing and speaking-up arrangements

The Trust has expanded wellbeing services and strengthened its speaking-up arrangements through the introduction of a full-time Lead Guardian and multiple reporting mechanisms. These developments demonstrate a clear organisational commitment towards staff wellbeing, openness and psychological safety.

Training and development infrastructure

The Trust has significantly strengthened its training and development framework through structured induction arrangements, leadership development programmes, improved governance oversight and monitored compliance arrangements.

Digital governance and data quality arrangements

Investment in digital governance and expansion of dedicated data quality capacity provides a stronger foundation for future assurance activity and service planning.

Next steps

The recommendations arising from this assessment focus on the next phase of improvement. These are highlighted in appendix A. They are intended to move the Trust beyond demonstrating that arrangements have been implemented, towards

demonstrating measurable impact, sustained improvement and stronger evidence of outcomes.

The Trust is required to provide a formal response to the recommendations set out in the improvement plan. The response should identify the actions to be taken, intended outcomes, responsible leads, implementation timescales, and how completion and impact will be measured and evidenced.

HIW will consider the Trust's response and supporting evidence as part of its ongoing assurance activity and future engagement with the Trust. The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Recommendations

Recommendations:
Recommendation 1: Evaluate major improvement programmes The Trust should formally evaluate major improvement programmes, including Clinical Model Transformation, Clinical Navigators, Remote Integrated Care, APP and APPNAV models, and alternative pathway initiatives.
Recommendation 2: Strengthen whole-system accountability for delayed handovers The Trust should work with health boards, system partners and commissioners to demonstrate shared accountability for delayed handovers, patient flow, and ambulance release across Wales.
Recommendation 3: Demonstrate reduction in patient harm associated with delayed handovers The Trust should provide clearer evidence that mitigation activity is reducing patient harm associated with delayed handovers and prolonged ambulance waits.
Recommendation 4: Assure consistent operational compliance with handover and escalation procedures The Trust should strengthen assurance that handover guidance, local SOPs, immediate Release arrangements, escalation processes and related operational procedures are consistently understood and applied across all relevant staff groups and sites.
Recommendation 5: Improve assurance on communication with patients during delays The Trust should provide stronger assurance that patients receive timely, clear, and consistent communication during delays, including during periods of operational pressure.
Recommendation 6: Strengthen organisational learning and closed feedback loops The Trust should demonstrate how learning from incidents, Duty of Candour cases, speaking-up concerns, staff feedback and ‘Always On’ reporting leads to action, measurable improvement, and sustained change.

Recommendation 7: Demonstrate staff competency and behavioural change from training The Trust should strengthen evidence that training and development programmes are resulting in consistent competencies and behavioural change in practice, particularly in prolonged handover care, escalation, incident reporting, and EMSCCC risk documentation.
Recommendation 8: Demonstrate measurable improvement in data quality The Trust should provide measurable evidence of improvement in data quality, including ePCR completeness, timeliness and accuracy, dual-PIN compliance, site-level variation, and data quality corrective action.

Appendix A – Improvement plan

Service: **Welsh Ambulance Services University NHS Trust**

Date of assessment: **January – June 2026**

The table below sets out the recommendations requiring a formal response from the Trust. The Trust should describe the actions it will take, the intended outcomes, responsible leads, timescales, and **how completion and impact will be measured and evidenced**.

Recommendations requiring Trust Response:		
1.	**Recommendation 1: Evaluate major improvement programmes** The Trust should formally evaluate major improvement programmes, including Clinical Model Transformation, Clinical Navigators, Remote Integrated Care, APP and APPNAV models, and alternative pathway initiatives. **Trust response required:** The response must explain how the Trust will evaluate effectiveness, what outcome measures will be used, and how the Trust will demonstrate impact on delayed handovers, patient flow, ambulance availability, and patient outcomes.	
Trust response:		**Planned completion date & responsible officer:**

The Trust acknowledges the importance of formally evaluating the impact of the CMT Programme and the revised model, which includes developing a structured approach to benefits realisation, ad-hoc model optimisation, and completion of an independent evaluation. The CMT Programme established the Benefits Realisation Steering Group (BRSG) to provide strategic oversight and assurance for benefits realisation across the Clinical Model Transformation Programme and its workstreams. The BRSG is multi-disciplinary and includes clinical, operational, IDS, QI, and transformation colleagues to ensure that benefits are clearly defined, measured, monitored and reported. The BRSG oversees delivery of the CMT Benefits Realisation Plan, which outlines the process by which intended benefits have been realised (sustainably) following implementation. A plan for a series of interim and internal evaluations, which aims to ensure that benefits are tracked beyond implementation and that emerging learning informs ongoing service improvement, is currently in development and will be monitored through CMT Programme Board. A) The minutes of CMT programme board will evidence the creation and approval of the interim evaluation plan. B) The subsequent minutes of CMT programme board across 4 cycles will provide evidence of the delivery against the approved interim evaluation plan	**A) 31 December 2026 – Andy Swinburn, Chief Clinical Officer** **B) 31 December 2027 – Andy Swinburn, Chief Clinical Officer**

As part of the Benefits Realisation Steering Group (BRSG) remit, opportunities for improvement are consistently being identified, and some key focus areas have led to the establishment of a dedicated Call Categorisation Phase 3a Group which aims to take learning from Phases One and Two of the Ambulance Performance Framework implementation and identify opportunities for further refinement. The group focuses on six key areas (Orange Now, Breathing Difficulties & RCS0, On Scene Times, Call to Door, Clinical Navigators, and Dispatch Optimisation) each with its own dedicated lead. Each group sets a dedicated problem statement, and identifies early learning, identifies unintended consequences, reviews performance trends, and recommends and implements refinements or solutions. The early optimisation phase is scheduled for completion by 30th November 2026, to inform Winter Planning, however optimisation work will continue beyond and into 2027.	**30 November 2026** **Andy Swinburn, Chief Clinical Officer**

In parallel with the internal benefits realisation and optimisation activities, the Trust is undertaking an independent Clinical Model Evaluation to provide additional (external) assurance regarding programme effectiveness and impact. The independent evaluation will assess the implementation and outcomes of key programme deliverables, including Clinical Navigators, Remote Integrated Care, APP and APPNAV models, alternative pathway initiatives and other CMT interventions, in particular, the new Ambulance Performance Framework. The evaluation will aim to triangulate available data from multiple sources, including operational, clinical, quality, workforce and experiential data (where available), to provide a robust assessment of impact. The independent evaluation being undertaken by Edge Hill University will, where possible, draw on wider NHS Wales data to assess patient outcomes and the impact on the wider system, alongside relevant operational, clinical, quality, workforce and patient-experience data held by the Trust. The minutes of CMT Evaluation Steering Group will evidence the conclusion of the independent evaluation and associated improvement activity where required. The minutes of Strategic Transformation Board will evidence the escalation and assurance evidence of senior monitoring and oversight.		**30 September 2028** **Andy Swinburn, Chief Clinical Officer**
2.	**Recommendation 2: Strengthen whole-system accountability for delayed handovers** The Trust should work with health boards, system partners and commissioners to demonstrate shared accountability for delayed handovers, patient flow, and ambulance release across Wales. **Trust response required:** The response must explain how it will obtain and present evidence of health board contribution, shared escalation arrangements, and measurable whole-system improvement.	
Trust response:		**Planned completion date & responsible officer:**

The Trust recognises that delayed ambulance handovers are a whole-system challenge requiring shared accountability across WAST, Health Boards, NHS Wales P&I, Commissioners and wider urgent and emergency care partners. Although handovers occur at the interface between organisations, many of the factors affecting ambulance release and patient flow sit outside the Trust's direct control. WAST's role is therefore to provide transparent data, escalate risk, support improvement activity through the relevant national, regional and local arrangements. The Trust contributes to health board handover improvement work through strategic and operational engagement, participation in local action plans and the review of progress and identification of barriers to delivery. The Trust also participates in national and regional system improvement initiatives including Release to Respond, alongside health boards and other system partners. To support situational awareness and real-time escalation, WAST has developed live 'Always On' information dashboards with notification processes that identify when handover delays exceed the 45-minute compliance window. The dashboards were developed in consultation with NHS Wales P&I colleagues and provide evidence of WAST's contribution to shared information and escalation arrangements. Progress and risk are reported through the Quality, Patient Experience and Safety Committee and the Finance and Performance Committee, supported by specific assurance reports and quarterly operational updates. The associated reports and minutes provide evidence that handover performance and risk are routinely monitored and scrutinised within the Trust. These arrangements demonstrate WAST's contribution to information sharing, monitoring and escalation. They do not, in isolation, demonstrate measurable whole-system improvement or establish that changes in wider response performance are attributable to ambulance release. Wait45 compliance and ambulance release performance provide the most direct indicators of change. Existing monitoring and escalation arrangements associated with Release to Respond (Wait45) will form part of the evidence used to assess progress and shared accountability. WAST will review and present the available evidence of progress through its established governance arrangements by 31 March 2027, recognising that delivery of whole-system improvement is dependent on collective action by health boards and other system partners.	**A) By 31 December 2026, the Trust will document the existing monitoring and escalation arrangements supporting Release to Respond (Wait45), including the available evidence of WAST and health board contributions.** **B) This will inform the review and presentation of evidence through the established governance arrangements by 31 March 2027.** **Lee Brooks, Executive Director of Operations**

3.	**Recommendation 3: Demonstrate reduction in patient harm associated with delayed handovers** The Trust should provide clearer evidence that mitigation activity is reducing patient harm associated with delayed handovers and prolonged ambulance waits. **Trust response required:** The response must identify the patient safety outcome measures, harm indicators, audit findings, or review mechanisms the Trust will use to demonstrate reduced harm and sustained improvement.	
	Trust response:	**Planned completion date & responsible officer:**
	The Trust recognises that delayed hospital handovers can result in both direct harm, where a patient experiences delayed access to definitive assessment, treatment or admission whilst awaiting handover; and indirect harm where ambulance resources remain unavailable to respond to patients waiting in the community, creating the risk of delayed clinical intervention and deterioration. The absence of linked patient-level data across NHS Wales limits the extent to which the Trust can determine the full clinical consequences of delayed handovers and delayed responses in the community. The Trust will therefore triangulate the available evidence through a defined set of direct and indirect harm measures. These will include incidents, concerns, Duty of Candour cases and structured case reviews in which delayed handover or response is identified as a contributory factor, together with the severity of any harm identified. This will be considered alongside handover duration, response-time distribution, clinical outcome indicators where available, and relevant patient-experience intelligence. The March 2026 patient harm paper provides the baseline assessment. Subsequent reporting to the QuESt Committee will show trends over time, distinguish between direct and indirect harm, identify any variation or deterioration and record the action taken in response. Evidence of sustained improvement over four reporting cycles, rather than the existence of the reporting process alone, will be used to support closure of this action. Four consecutive reports and the associated QuESt Committee minutes will provide evidence of the triangulated assurance.	**31 March 2027** **Penny Durrant, Interim Director of Nursing**

4.	**Recommendation 4: Assure consistent operational compliance with handover and escalation procedures** The Trust should strengthen assurance that handover guidance, local SOPs, immediate Release arrangements, escalation processes and related operational procedures are consistently understood and applied across all relevant staff groups and sites. **Trust response required**: The response must describe the audit, competency assessment, observation, case review or ePCR evidence the Trust will use to demonstrate compliance in practice.	
Trust response:		**Planned completion date & responsible officer:**
Immediate release protocol compliance is subject to an established quality assurance process including audit of recorded requests to test whether release requests and responses have been managed and documented in accordance with the protocol. The resulting compliance report is provided to the Exec Director of Operations internally for assurance and shared weekly with Health Board Chief Operating Officers, providing visibility of application, non-adherence and variation. Review of example reports provide evidence of this process and support closure.		**Complete.** **Lee Brooks, Executive Director of Operations**
The All-Wales Immediate Release Protocol sets out the principles and processes for managing the release of ambulance resources to minimise patient safety risks associated with reduced ambulance capacity due to delayed handover of care between WAST and emergency departments. We recognise that our role in supporting this process is broader than our role in notification and escalation of release requests, as a result we are reviewing the protocol in collaboration with Chief Operating Officers to create the All-Wales Release Protocol which will include escalation activity for WAST clinicians whilst actively delayed. Publication of the revised protocol will provide evidence that the requirements and escalation arrangements have been updated. Evidence of implementation and compliance will be obtained through the established audit and assurance arrangements.		**31 December 2026** **Lee Brooks, Executive Director of Operations**

The trust is committed to assuring operational compliance with handover and escalation arrangements through real-time oversight and review of exceptions. The Operational Delivery Unit (ODU) monitors handover delays, prolonged waits and escalation triggers, with operational issues considered through daily risk huddles. Health Board escalation arrangements and command structures include relevant NHS P&I stakeholders. Daily risk calls monitor compliance and provide a route for escalating risk to health board colleagues and strategic leaders', supporting shared intelligence and accountability. Daily escalation records provide evidence that delays and exceptions are monitored and escalated through the established arrangements. Where available, records of the actions and responses arising from escalation will provide evidence that identified risks have been acted upon.		**Complete.** **Lee Brooks, Executive Director of Operations**
5.	**Recommendation 5: Improve assurance on communication with patients during delays** The Trust should provide stronger assurance that patients receive timely, clear, and consistent communication during delays, including during periods of operational pressure. **Trust response required:** The response must identify how the Trust will monitor communication standards, patient experience, complaint's themes, incident learning, and improvement actions.	
Trust response:		**Planned completion date & responsible officer:**

The Trust recognises that effective communication is a key component of patient safety, experience and dignity. This is particularly important during delayed responses. Standard operating procedures set out clear expectations for the information that should be communicated to service users during delays, and assurance is provided through a range of intelligence. The use of real-time ETAs as part of 999 call handling ensures that service users are aware of possible delays in response timeframes from the outset of their interaction with the Trust. Operational compliance is monitored through routine audit activity of 999 call records and quality assurance processes to assess adherence to expected communication standards including the use of ETA scripts. Learning arising from audits is incorporated into local governance processes and informs coaching, education and service improvement activity. Thematic insights and script compliance are monitored through the EMS Coordination quality meetings with assurance and escalation of risks and issues communicated to the Senior Operations Team as well as through the Quality Management Group. Routine call-audit findings are reviewed through the EMS Coordination quality meetings, where compliance with expected communication standards, identified themes, variation and resulting actions are considered. The associated Alert, Advise, Assure reports provide evidence of this review and any necessary escalation. The Quality Management Group provides broader oversight by considering this assurance alongside patient experience, concerns and incident intelligence. Its Alert, Advise, Assure reports provide evidence of how the different sources of intelligence have been triangulated and used to inform improvement activity.	**Complete**

The Trust monitors patient experience through a range of mechanisms including patient surveys, compliments, concerns, complaints and incident reports. These sources provide insight into how patients and families experience communication, including during periods of delay. Survey insights are a key measure of experiential intelligence reviewed during both operational quality meetings and quality management group forums. A review of intelligence since November 25, when our operating model changed, demonstrates that quantitative measures for dignity, involvement and explanation are all above 93% and that call taking experiences are positive overall (89%). Compliment intelligence supports this position with consistent praise across all services relating to the kindness, empathy, clinical expertise and dedication displayed by our staff. Patients valued being listened to, treated with dignity and respect and reassured during times of distress. People Experience Survey analysis between November 2025 and August 26 provides evidence of this intelligence. Compliments analysis between January 2025 and January 2026 supports the experiential intelligence analysis. Alert, Advise, Assure highlight reports from Quality Management Group to Clinical Quality Governance group demonstrates the consistent monitoring, evaluation and assurance of this intelligence and how improvement activity is informed as a result of this feedback. The survey and compliments analyses, together with the associated governance reports, provide evidence that patient experience is routinely monitored. They also demonstrate how communication-related feedback is identified and used to inform improvement activity.	**Complete.** **Penny Durrant, Interim Director of Nursing**
However, we recognise that whilst call taking experiences are positive overall (89%) there are still improvements to be made in how we communicate increased touch points of the new model to callers from the outset. To provide more real time communication about touchpoints within the new model we will introduce SMS messaging following clinical review to inform service users of next steps in their journey. Assurance on the effectiveness of this improvement activity will be informed by People Experience survey analysis.	**31 December 2026** **Lee Brooks,** **Executive Director of Operations**

	In addition, we are reliant on service users specifically reaching out to provide us with experiential intelligence, either through accessing our survey or providing narrative feedback via our website. To improve the volume of experiential intelligence available to support our improvement planning we will introduce SMS reach out to our services users providing them with hyperlinks to access our surveys. It is expected that this will increase volumes of feedback provided and give greater assurance on the thematic intelligence derived from them. Survey response volumes and themes will be compared with the position before implementation. Three reporting cycles through the Quality Management Group and Clinical Quality Governance Group will provide evidence of whether the intervention has increased the volume and breadth of patient feedback. This evidence will support closure of the action.	**31 March 2027** **Penny Durrant,** **Interim Director of Nursing**
6.	**Recommendation 6: Strengthen organisational learning and closed feedback loops** The Trust should demonstrate how learning from incidents, Duty of Candour cases, speaking-up concerns, staff feedback and 'Always On' reporting leads to action, measurable improvement, and sustained change. **Trust response required:** The response must provide an approach for evidencing closed-loop learning, including examples showing the issue identified, action taken, outcome measured and learning sustained.	
	Trust response:	**Planned completion date & responsible officer:**
	The Trust has a maturing Quality Management System, supported by the forward improvement plan arising from its Quality Assurance Assessment. This plan is aligned with the IMTP and Strategic Quality Plan and is focused on supporting individual teams to strengthen the effectiveness of their local quality management systems. This includes improving ownership and use of quality intelligence, learning, escalation and assurance. Delivery of the improvement plan will be monitored through the Clinical Quality Governance Group, with oversight through the Quality, Patient Experience and Safety Committee. Progress reporting will provide evidence of the actions completed and the improvements made within individual teams. As the plan progresses, this will increasingly include evidence that learning has resulted in change and that the intended improvement has been achieved and sustained.	**30 September 2027** **Penny Durrant,** **Interim Director of Nursing**

A “Learning from Events” report (LFER) is required to comply with Welsh Risk Pool indemnity arrangements. These are comprehensive documents that contain case findings, detail improvement actions and must contain extensive evidence of completion as well as requiring the Trust to provide assurance as to how the improvements will be monitored and sustained. The review of highlight reports from the Quality Management Group, where LFER are reviewed and endorsed, providing assurance to the Clinical Quality Governance Group, provide evidence of this activity and support the closure of this action.	**Complete.** **Penny Durrant,** **Interim Director of Nursing**
Complaint investigations, Duty of Candour reviews and Nationally Reportable Incident investigations include improvement actions where learning is identified. Responsibility for delivery sits with the relevant service, with progress monitored through local quality and safety arrangements. A sample of completed actions will be used to demonstrate the issue identified, action taken, intended outcome and evidence that the change has been implemented and sustained. The associated governance records will provide evidence of scrutiny and follow-up.	**Complete.** **Penny Durrant,** **Interim Director of Nursing**
The Trust now has a Just and Learning Culture forum, chaired by the Lead Speaking up Safely Guardian which brings together triangulated culture data to enhance lessons learned from our cases; this forum will need to be further strengthened as it starts to develop from its inaugural meeting in July 2026. This will feed into a broader programme of work looking at people and culture metrics as part of the business transformation agenda. Work is underway to identify the appropriate monitoring and delivery group through the integrated governance review. Evidence for closure will include the agreed governance route and reporting across four cycles, demonstrating how triangulated culture intelligence has identified themes, informed action and enabled progress to be reviewed.	**30 September 2027** **Angie Lewis, Director of People & Culture**

A) Staff Survey feedback is used to drive closed-loop learning, with Executives and Trade Union partners agreeing three priority focus areas and Directorate Leads developing local actions from their own survey results; We are also increasing visibility of actions taken in response to views shared, using a "you said, we did" approach ("Voices Heard, Actions Taken"). The review of minutes of People and Culture Committee provides evidence of the continuous learning and improvement approach following staff survey feedback as well as the increasing visibility of actions taken in response to views shared and supports closure of this action B) We are committed to strengthening our learning approach further by increasing shared accountability across the Trust, so delivery is owned collectively rather than seen solely as a People and Culture responsibility. Governance routes for monitoring this activity are currently being reviewed as part of our integrated governance review. The terms of reference for newly formed Delivery Groups will provide evidence of enhanced monitoring forums	**A) Complete** **B) 31 March 2027** **Trish Mills,** **Director of Corporate Governance**
Always On Reporting is currently supported through the publication of Board and Committee papers and reports, the Annual Duty of Quality Report, the Monthly Integrated Quality and Performance Report (MIQPR), and the Trust-wide incident management Power BI dashboard. Always On Reporting is currently reliant on a combination of governance reporting and a limited number of dashboards, with real-time quality reporting and visibility of improvement outcomes not yet consistently available; development of a broader dashboard-based approach is planned through the Trust's Quality Management System programme. Evidence for closure will include delivery against the relevant Quality Management System improvement actions, increased availability of quality intelligence and examples showing how that intelligence has informed action and improvement. Clinical Quality Governance Group reporting will provide evidence of oversight and scrutiny of progress.	**31 March 2028** **Penny Durrant,** **Interim Director of Nursing**

7.	**Recommendation 7: Demonstrate staff competency and behavioural change from training** The Trust should strengthen evidence that training and development programmes are resulting in consistent competencies and behavioural change in practice, particularly in prolonged handover care, escalation, incident reporting, and EMSCCC risk documentation. **Trust response required:** The response must describe how competency will be assessed beyond attendance, and how the Trust will evidence application of learning in practice.	
	Trust response:	**Planned completion date & responsible officer:**

The Trust has an embedded programme of clinical practice learning and assurance for frontline responding clinicians which communicates changes in clinical practice via Joint Royal Colleges Ambulance Liaison Committee guidelines enhanced by internal clinical notices. Clinical practice is assured through real-time observation in practice by senior clinicians as well as through Clinical audit activity. This is further enhanced through a programme of operational quality and support days which target experiential intelligence and focused assurance/improvement activity. The minutes of Quality, Patient Experience and Safety (QuESt) committee provide evidence of operational oversight and reporting of key themes and findings from Quality and Support days.	**Complete**
The EMS Coordination operates a programme of induction training for 999 call handlers which is assured through retrospective audit and recertification every 24 months. Certification as an EMD is provided by the International Academy of Emergency Dispatch, the requirement for recertification includes exam certification as well as evidence of continual professional development. This programme is supported by a programme of coaching and educational products such as bulletins which are informed as a result of themes and trends from retrospective audit, concerns and incident investigation. Audit programmes are designed to contain a mix of random audit and focused review to ensure thematic learning has taken place. The EMS Coordination Quality Framework sets out the process and procedure for EMS Coordination quality assurance activity. Review of Alert, Advise and Assure highlight reports from the EMS Coordination quality meeting provides evidence of this activity and supports the closure of this action.	**Complete**
The Trust is committed to continual learning and improvement and is now developing a programme of dispatch audit within EMS Coordination centres. The development of dispatch audit will help to assure that education and training based on learning from events is embedded as improvement not just for call handling processes but also for those in non-clinical roles responsible for the dispatch of clinical resources in the patient facing environment. The introduction of dispatch audit learning will provide assurance that learning has taken place across a broader cohort of our workforce. Review of Alert, Advise and Assure highlight reports from the EMS Coordination quality meeting across 3 cycles will support the closures of this action.	**30 September 2027** **Lee Brooks** **Executive Director of Operations**

The programme for Mandatory in Service Training (MIST) for frontline operational staff and volunteers is informed by learning from clinical review, learning from events and statutory requirements. During 2025-26 content included a focus on improving risk documentation and reporting quality. Attendees are required to provide self-reflection activities including identification of learning having taken place and feed forward indicating further self-identified learning requirements. MIST pre-learning and session learning activities include knowledge checks. To improve assurance that this learning translates into the operational environment we will develop a WAST competency framework covering statutory, mandatory and Continuing professional development activity moving from a simple compliance model to a competency assured model.		**30 September 2027** **Angie Lewis** **Director of People and Culture.**
8.	**Recommendation 8: Demonstrate measurable improvement in data quality** The Trust should provide measurable evidence of improvement in data quality, including ePCR completeness, timeliness and accuracy, dual-PIN compliance, site-level variation, and data quality corrective action. **Trust response required:** The response must explain how data quality improvements will be evidenced and how improved data will inform operational decision-making, service planning, and assurance reporting.	
Trust response:		**Planned completion date & responsible officer:**

The Trust recognises that data quality is demonstrated not only through governance processes, but through the extent to which information supports clinical decision-making, operational improvement and organisational assurance. The introduction of electronic Patient Clinical Records has increased the quality, granularity and usefulness of the clinical information available to the organisation. Data quality assurance will draw on measures that can be reliably produced through existing ePCR reporting, clinical audits and clinical indicator monitoring. This will include ePCR completeness and accuracy identified through audit, with variation by service or operational area where the available data supports this. Dual-PIN compliance is not used as a standalone measure within WAST. Crew information is held within linked CAD and ePCR data rather than reported through a separate ePCR dashboard measure. Clinical indicator performance and relevant audit findings are considered through the Clinical Indicators Assurance Group, with assurance reported to the Clinical Quality Governance Group. Responsibility for delivering resulting improvement actions sits with the relevant service or operational owner. Where an established baseline and comparable data are available, evidence for closure will include trends over time. Where an initial audit establishes the baseline, the arrangements and timescale for subsequent monitoring will be documented. Governance records will demonstrate how findings have been considered, actions allocated and progress reviewed, supported by examples of how improved data has informed clinical assurance, operational decision-making or service planning where these can be evidenced.	**31 March 2027,** **Andy Swinburn, Chief Clinical Officer**
Clinical audit reports and real-time monitoring dashboards have repeatedly identified opportunities to improve documentation, user interface design and recording compliance within ePCR. Recommendations have subsequently informed system enhancements, staff education and change requests to improve data quality at source. Evidence from clinical data assurance audits demonstrate a clear feedback loop between data quality findings, corrective actions and subsequent improvements in documentation standards. Monthly data-quality reports, clinical audit findings and the associated QuESt Committee minutes across four consecutive reporting cycles will provide evidence of measurable improvement, action taken in response to identified variation and the impact of those actions.	**Complete.**

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): Penny Durrant

Job role: Interim Director of Nursing

Date: 3 September 2026

PEOPLE AND CULTURE 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 November 2026
Committee Meeting Date	10 November 2026
Chair	Ceri Jackson

KEY ESCALATION AND DISCUSSION POINTS

ALERT (Alert the Board to areas of attention)

1. There were no alerts arising from this meeting.

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

2. The committee received **a staff experience story** from Nik Dart, Operations Support Officer/Co-Chair of the Carers Network and Carer, and Mike Hope, Ambulance Care Assistant and Carer. The discussion highlighted that caring responsibilities are often hidden or not recognised by staff themselves and demonstrated the significant value of the network in providing peer support, information and signposting. Members explored the importance of greater manager awareness, flexibility and consistent application of support, recognising potential differences in experience between operational and corporate roles and the additional risk of isolation for colleagues working remotely. The aspiration that good support should not depend on role or location was strongly supported. The discussion also reinforced the importance of triangulating staff experience with wider people and culture intelligence to inform future priorities, particularly around compassionate leadership, psychological safety, inclusion, wellbeing and flexible working. Members expressed sincere thanks to Nik and Mike for sharing their personal and lived experiences so openly.

3. Members noted the previous **staff experience update** from Chayesteh Azadegan (Chay), Professional Practice Educator in the Integrated Care Service, and agreed the importance of following Chay's development journey through to completion of her Masters, demonstrating the impact and "so what" of the support provided.

4. Alex Nestor, Chief People Officer, was warmly welcomed to her first meeting and presented the **Chief People Officer report** highlighting an early focus on strengthening organisational culture and sexual safety and developing more strategic, forward-looking people reporting. Members supported further research into the cultural early warning score (CEWS) to build an evidence base for its effectiveness, with potential for published research. Challenges around psychological safety and protected characteristics, and the need to triangulate these with the wider cultural picture, were discussed.

5. Members noted the significant breadth and scale of **operational delivery in Q2** and welcomed the revised focus of the report on the committee's remit. The importance of maintaining strategic oversight of volunteers within the new people reporting arrangements was highlighted, ensuring volunteering remains visible within the committee's strategic objectives.

6. Members **reflected** positively on the meeting, highlighting the powerful contribution from the carers' lived-experience presentation. The introduction of Integrated Medium Term Plan (IMTP) reporting to the committee was seen as an important step in strengthening its strategic focus and improving the line of sight between delivery, metrics, risk and assurance. Overall, the meeting was considered to demonstrate increasingly effective triangulation between strategic delivery, performance information and lived experience, with the move towards a single, coherent metrics pack expected to strengthen this further.

ASSURE (Detail here any areas of assurance the Committee has received)

Strategic Delivery (SO2 – enabling our people to be the best they can be)

7. The Committee welcomed its first detailed oversight of **Q2 assurance report on IMTP deliverables within its remit**. Members recognised that the reporting would continue to mature, particularly through stronger triangulation of delivery, performance measures and strategic risk. For the board to note:

   - In relation to Our WAST Way, the committee heard that a review of the wider culture, leadership and organisational development portfolio is under way. This is intended to bring existing activity together into a more coherent and prioritised plan for next year, with Our WAST Way at its centre and a clearer framework for demonstrating impact.

   - The committee also considered staff survey participation, noting that participation is currently at lower rates than last year. Members recognised the considerable work under way to encourage engagement, the need to better understand barriers to participation, including perceptions of psychological safety, and the introduction of pulse surveys to provide more frequent insight.

8. Overall, the committee considered the SO2 position positive, whilst emphasising the opportunity for future assurance to demonstrate the impact and outcomes being achieved.

Performance and outcomes

9. The committee considered the **people and culture metrics** and **workforce scorecard** alongside the **Monthly Integrated Quality and Performance Report** (MIQPR) and welcomed the continued development of reporting, including the introduction of statistical process control charts. It emphasised the need to move towards one coherent metrics pack and single source of truth, with the new People and Culture Delivery Group providing greater grip on the measures required for strategic oversight. For the board to note:

    - Sickness absence remains an area of focus. The committee sought greater insight into causes, costs, hotspots and preventative action, rather than reliance on the headline rate. Assurance was provided that key hotspots and contributory factors are understood. The committee also welcomed the opportunity to use the forthcoming demand and capacity review and benchmarking to test whether the longstanding 6% target remains appropriate and achievable.

    - PADR compliance remains below the 85% target, although improvement in August was noted. Early feedback from the revised simplified and streamlined PADR pilot approach is positive, with greater emphasis on meaningful conversations. The committee stressed that improvement must address both the quality of conversations and compliance.

    - Flu vaccination uptake has reduced. The committee heard that the position reflects several factors, including vaccine hesitancy, workforce dispersion and incomplete capture of vaccinations delivered elsewhere. It will continue to seek assurance on improvement and learning from the campaign.

10. The committee considered the **Workforce Equality Standard (WES)** alongside the **Strategic Equality Plan (SEP)** maturity assessment, noting areas of inequity particularly affecting disabled colleagues, unpaid carers and LGBTQ+ colleagues. It welcomed plans to integrate the WES with lived experience, people networks and wider workforce intelligence to identify clearer priorities and targeted interventions. The board will note the RAG rating in the report, which is attached at annex 1, and whilst Welsh Government expressed they were pleased with the progress made, the RAG ratings caused, the committee to seek further assurance on the underlying data, methodology and representativeness of the findings, and their triangulation with existing Trust intelligence, lived experience and the SEP maturity assessment. The findings were therefore noted, but the committee considered that further triangulation was required before it could be fully assured that the proposed priorities and interventions were sufficiently evidence-based. An update will return through the Chief People Officer's report.

11. Members received updates from the August and October meetings of the Welsh Ambulance Services Partnership Team (**WASPT**), the board's local partnership advisory forum. The committee endorsed the WASPT 2025/26 annual report and updated terms of reference for onward submission to the Trust Board, and both are attached at annex 2. The committee welcomed the overall positive picture of partnership working reflected in the annual report, while recognising that the organisation's financial and change agenda may inevitably require some challenging conversations as the

partnership continues to mature.

12. Members were assured that **internal audits** on their final revised date had appropriate mitigations in place and had not unduly increased risk exposure.

13. In **private session** members reviewed the complex case update which included details of suspensions and employment tribunal matters.

RISKS

Risks Discussed: Members noted that risks had been considered and triangulated throughout the meeting as part of the substantive agenda discussions, providing a broader basis for assurance on the principal Risk 680 and Risk 163. No material changes to either risk were reported during the period. Work has continued with the People Services team to develop the strategic risk aligned to strategic objective 2, with progress to be reported through future risk reporting.

New Risks Identified: No new risks identified at this meeting for the register.

COMMITTEE AGENDA FOR MEETING		
Chief People Officer update	Staff experience – carers network Staff experience update from August 26	Q2 IMTP for SO2
People and culture plan metrics MIQPR	Risk management and BAF	WES report and SEP maturity matrix
WASPT AAA	Audit tracker Q2	Operations directorate report Q2
Social partnership report		

COMMITTEE ATTENDANCE				
Name	**5 May 2026**	**11 August 2026**	**10 November 2026[1]**	
Ceri Jackson (Chair)				
Bethan Evans			Jayne Beeslee[2]	
Hayley Hutchings				
Hannah Rowan				
Lee Brooks				
Penny Durrant		Ceri Griffiths		
Tim Cahalane				
Christian Fox				
Estelle Hitchon				
James Houston				
Jo Kelso				
Carl Kneeshaw				
Angela Lewis				
Trish Mills				
Alex Nestor				

[1] Phil Berrington, Trust Board Chair, joined for this meeting
[2] Left just after staff experience

COMMITTEE ATTENDANCE				
Name	**5 May 2026**	**11 August 2026**	**10 November 2026[1]**	
Lizzie O'Shea				
Andy Swinburn		Jonathan Chippendale		
Chris Turley				
Damon Turner				
Liam Williams				
Marcus Viggers				
WASPT Co-Chair	Mark Marsden	Mark Marsden	Mark Marsden	

	Attended
	Deputy attended
	Apologies received
	No longer member

GIG CYMRU NHS WALES

Llywodraeth Cymru
Welsh Government

Adroddiad lefel sefydliad

Organisation-level Report

Safon Cydraddoldeb y Gweithlu (SCG)
Gweithlu cynhwysol sy'n darparu'r gofal gorau

Workforce Equality Standard (WES)
An inclusive workforce provides the best care

1. WAST Organisational-level data snapshot

Priority Indicator	Data identified issue / Area requiring improvement	What Improvement Looks Like
Leadership and Representation	Progression: low appointment likelihood (LR 0.26) and no progression into senior roles	Increased progression into senior roles and improved appointment likelihood
Professional development	Consistent parity across all groups	Sustain high appraisal coverage with progression linkage
Disciplinary and capability	Persistent disproportionality across groups	Stable reduction in disproportionality and consistent decision-making
Workplace behaviours	Very high, system-wide harassment and discrimination	Sustained reduction across all staff groups
Wellbeing, safety and voice	Elevated harm and uneven psychological safety	Improved speaking-up confidence and reduced harm exposure
Workplace conditions sustainability	System-wide burnout and high presenteeism	Reduced burnout and improved workload sustainability

2. Purpose and Scope

This report presents an equity-focused analysis of the Workforce Equality Standard data for WAST. It highlights where staff experience differs by protected characteristic, where intersections deepen disadvantage, and where WAST has the strongest opportunities to act.

The scope covers all protected characteristics captured in WES. It uses the same national indicators and methodology to ensure comparability and the focus is on actionable findings, not exhaustive description.

To better describe organisational culture, the WES Indicators were grouped into six domains, aligned to contributors influencing workplace experience.

- **Leadership and Progression**
- **Professional Development**
- **Disciplinary and Capability**
- **Workplace Behaviours**
- **Wellbeing and Safety**
- **Workplace Conditions**

A thematic analysis allows more strategic insight, moving from a long list of indicators to a coherent organisational story for WAST. Grouping indicators that conceptually belong together allows patterns to emerge and thus help identify systemic challenges rather than seeing indicator silos. It also allows anchoring the intersectional narrative in lived experience domains.

3. Executive Summary

This analysis indicates that WAST's equity profile is characterised by system-wide and sustained organisational strain, with severe inequity across workforce experience domains and persistent structural barriers in leadership progression.

Leadership inequity remains severe. Ethnic minority staff are significantly less likely to be appointed from shortlisting (LR ≈ 0.26), and progression into senior roles does not occur at key transition points. This demonstrates that leadership systems are not converting available talent into outcomes, despite a small but present pipeline.

Workplace behaviours represent a critical cultural risk. Very high levels of harassment, bullying and discrimination are reported across all staff groups, indicating a system-wide behavioural issue with disproportionate impact on vulnerable and minoritised groups.

Workplace conditions are the most acute pressure point. Burnout levels exceed 70% across all groups and rise above 90% in some cohorts, alongside high levels of presenteeism and relatively low flexibility satisfaction. This reflects sustained operational pressure affecting the entire workforce.

Disciplinary processes show moderate to high inequity, with persistent disproportionality affecting ethnic minority and other staff groups, indicating inconsistent application of formal processes.

Wellbeing and safety show moderate to high risk, with elevated exposure to harm and uneven confidence in speaking up, reflecting underlying psychological safety challenges.

Professional development remains a relative strength, with equitable appraisal coverage across all groups, although this does not currently translate into equitable progression outcomes.

Overall, WAST's challenge is systemic and organisation-wide. Effective improvement will require coordinated action across leadership systems, workplace culture, and workload sustainability, rather than isolated interventions within single domains.

Executive Assurance Questions
Are leadership systems converting available talent into senior outcomes?
Are development systems translating into progression?
Are disciplinary processes consistently equitable?
Are cultural behaviours improving across the organisation?
Do staff feel safe to speak up?
Are workloads sustainable for staff?

4. Domain Profiles

WAST's workforce composition differs in several important respects from the national NHS Wales profile:

- **Ethnic minority representation is substantially lower, with Black, Asian and minority ethnic staff comprising around 2% of the workforce compared with over 11% nationally.**
- **The gender profile is notably more balanced than the NHS Wales average, with women and men represented in broadly similar proportions.**
- **Disabled staff are more highly represented than nationally**
- **LGBTQIA+ staff also form a larger proportion of the workforce compared to the NHS Wales profile.**
- **Rates of non-disclosure ('Prefer Not to Say') are higher across several characteristics, including disability and sexual orientation, indicating potential issues of trust or psychological safety.**
- **Age distribution is broadly aligned with the national picture, with a similar spread across early, mid and later career stages.**

Overall, the WAST workforce is smaller and less ethnically diverse than the NHS Wales average, but more balanced by gender and more open in some characteristics, which provides important context for interpreting leadership, progression, and experience outcomes.

The scale of inequity across multiple characteristics, despite a small ethnic minority workforce, confirms that organisational systems and operational pressures are the primary drivers of inequality rather than workforce composition alone.

4.1 Equity scoring

Equity RAG ratings were derived through a triangulated assessment of each domain, combining the scale of inequality (difference from benchmark), the consistency of patterns across protected characteristics, and the robustness of the data. Particular weight was given to signals that were repeated across multiple groups and indicators, while findings based on small numbers or inconsistent patterns were treated cautiously to avoid over-interpretation. The Equity Scorecard and ratings are designed to support data interpretation at a glance and to highlight specific areas of disparity. Priority actions have also been identified.

Rating	Meaning	Response
Minimal or no inequity	Broad parity; no consistent disadvantage pattern	Maintain what works
Mild inequity	Small or inconsistent differences	Monitor for deterioration
Moderate inequity	Consistent disadvantage across multiple indicators	Focused domain improvement action needed
Severe inequity	Persistent, intersectionally reinforced disadvantage	Executive oversight needed

4.2 Organisational Workforce Equity Scorecard

Domain	Overall equity signal	Characteristics most affected	Key intersectional risk signals	Comparison to national pattern	Primary equity signal	Action priority
Leadership and Representation	🔴 Severe	Ethnic minority staff; Gender-diverse staff; Disabled staff; LGBTQ+ staff; Unpaid carers; PNS	Ethnic minority status intersects with gender diversity, disability, LGBTQ+ identity and non-disclosure to produce near-complete exclusion from senior leadership and very low confidence in fair progression	Inequity substantially worse than national across appointment, pipeline, and perception indicators	Structural exclusion at leadership gateways reinforced by cultural trust and disclosure failure	Urgent priority (system-level redesign and executive oversight)
Professional Development	🟢 Minimal	No consistent disadvantage identified	No reinforcing intersectional patterns; minoritised and PNS staff show strong appraisal coverage	Often stronger than national across multiple characteristics	Structurally consistent and inclusive professional development processes	Maintain and monitor
Disciplinary & Capability	🟡 Mild inequity	Residual racial disproportionality (substantially reduced)	Previously elevated racial risk now declining; no consistent intersectional reinforcement	Improving towards national range following prior divergence	Effective procedural correction and governance reducing inequity over time	Reinforce and sustain improvement
Workplace Behaviours	🔴 Severe	Gender-diverse staff; Disabled staff; LGBTQIA+ staff; PNS; Ethnic minority staff	Gender diversity intersects with disability, LGBTQIA+ identity and non-disclosure to produce the highest risk across harassment and discrimination indicators	Substantially worse than national across nearly all characteristics	Cultural and behavioural risk, with unequal protection and low psychological safety	Urgent priority (leadership-led cultural and behavioural intervention)
Wellbeing & Safety	🔴 Severe	Gender-diverse staff; Disabled staff; Ethnic minority staff; PNS	Higher experience of physical violence combined with lower speaking-up confidence among gender-diverse, disabled and PNS staff; reporting occurs but does not mitigate harm	Aligned with national direction, with locally heightened exposure and safety gaps	Structural exposure to harm reinforced by cultural and psychological safety deficits	Priority (system-wide safety and psychological safety intervention)
Workplace Conditions	🔴 Severe	Gender-diverse staff; Disabled staff; LGBTQIA+ staff; Ethnic	High burnout and presenteeism persist despite adjustments, particularly for gender-diverse, disabled and non-disclosing staff	Substantially worse than national for flexibility satisfaction and burnout	Unsustainable workload and uneven application of supportive practices	Urgent priority (workload, flexibility, recovery)

Domain	Overall equity signal	Characteristics most affected	Key intersectional risk signals	Comparison to national pattern	Primary equity signal	Action priority
		minority staff; PNS				

4.3 Leadership and Progression Domain

Equity rating	Headline finding
Severe	This classification is driven by structurally reinforced disadvantage at leadership entry points and pipelines, large and consistent gaps in perceived fairness of progression for multiple minoritised groups, very low senior representation, and amplified intersectional effects, with no mitigating parity at executive level.

Overview

The Leadership and Progression domain shows severe inequity, shaped by a combination of a structurally constrained leadership pipeline and inequitable progression and appointment mechanisms.

WAST has a much smaller ethnic minority workforce than NHS Wales (around 2% compared with over 11%), which limits immediate leadership supply. However, this does not account for the near-complete absence of ethnic minority representation at senior and executive pipeline levels, nor for the substantially worse appointment outcomes from shortlisting compared with the national picture.

In addition, multiple other groups that are well represented in the workforce overall, including disabled and LGBTQIA+ staff, report markedly lower confidence in fair career progression.

Taken together, the data indicate that leadership inequity is not explained by workforce composition alone, but reflects systemic failure to convert, support, and progress available talent equitably. Leadership systems are structurally restrictive and are not converting available talent into senior outcomes.

Intersectional signals

Intersectional analysis indicates cumulative and reinforcing disadvantage within leadership systems. Ethnic minority staff experience the strongest structural exclusion at leadership entry points, and this disadvantage intensifies where ethnic minority status intersects with gender diversity, disability, LGBTQIA+ identity, unpaid caring, and non-disclosure.

Notably, disabled and LGBTQIA+ staff—who are proportionately more represented in this workforce than nationally—also report low confidence in fair progression, confirming that inequity is not solely a supply issue. Elevated 'Prefer Not to Say' responses compound this picture, suggesting that psychological safety, visibility, and trust intersect with structural barriers, particularly at senior levels.

Organisational interpretation

Leadership inequity in WAST is driven primarily by structural barriers within recruitment and progression systems that reproduce under-representation, even from a small available pipeline.

While workforce composition limits the size of the leadership pool for some characteristics, the severity of appointment disadvantages, lack of senior representation, and consistently low perceptions of fairness across multiple protected characteristics indicate that current systems are not neutral converters of talent.

Cultural factors—particularly low trust in progression processes and reduced confidence in safe disclosure—further suppress engagement and aspiration, while behavioural elements linked to discretionary judgement likely reinforce these effects.

Overall, executive-level equity cannot be expected to improve organically without targeted, system-level intervention to address how leadership potential is identified, supported, and progressed.

4.4 Professional Development Domain

Equity rating	Headline finding
Minimal	High appraisal completion across all characteristics, relative likelihood ratios close to or above parity, absence of intersectional reinforcement, performance that is often stronger than the national picture

Overview

The Professional Development domain shows low inequity and broadly equitable functioning, with high appraisal coverage across all protected characteristics.

Appraisal completion rates for minoritised groups in WAST are consistently higher than national benchmarks, including for ethnic minority, disabled, LGBTQIA+, and Prefer Not to Say (PNS) staff.

Relative likelihood ratios are close to or exceed parity across most characteristics, indicating that professional development processes are being accessed comparatively consistently, even within a workforce that is less ethnically diverse than the NHS Wales average.

Overall, the data suggest that professional development systems are functioning reliably and inclusively.

Intersectional signals

Intersectional signals in this domain are weak and non-reinforcing. Groups that experience disadvantage in other domains — including ethnic minority, disabled, LGBTQIA+, and PNS staff — do not show reduced engagement with appraisal or development processes.

Notably, despite WAST's very small ethnic minority workforce, appraisal completion among BME staff is high and exceeds national levels, indicating that pipeline size does not translate into exclusion from development opportunities.

PNS and Unknown groups also show strong appraisal coverage, suggesting that non-disclosure does not function as a barrier in this domain.

Organisational interpretation

Professional development systems are consistently equitable, with likelihood ratios at or near parity across all characteristics. Unlike leadership progression, professional development outcomes do not appear to be constrained by workforce composition or by cultural barriers to engagement.

Line-manager behaviours in relation to appraisal appear comparatively standardised, and appraisal is functioning as a universal process rather than one dependent on visibility, sponsorship, or discretionary judgement. While continued monitoring is appropriate, there is no evidence that professional development processes are contributing materially to cumulative inequity within WAST.

4.5 Disciplinary and Capability Domain

Equity rating	Headline finding
Mild inequity	significant year-on-year reduction in racial disproportionality, low absolute rates of disciplinary and capability entry, absence of reinforcing intersectional patterns, evidence of effective corrective action already in place

Overview

The Disciplinary and Capability domain shows a clear and meaningful improvement trajectory, particularly in relation to racial disproportionality.

The relative likelihood of ethnic minority staff entering the formal disciplinary process has reduced substantially over time, falling from 4.81 in 2024 to 2.17 in 2025 and now to 1.79, indicating sustained progress toward greater procedural equity.

While disproportionality has not yet fully resolved, event rates remain low overall and the direction of travel is positive.

Capability process entries are rare, and although some variability remains, there is no evidence of consistent or escalating inequality across protected characteristics.

Intersectional signals

Intersectional signals in this domain are limited and weakening over time. Earlier racial disproportionality is no longer reinforced consistently across capability and disciplinary indicators, and disadvantage does not compound systematically with gender, disability, or other characteristics.

While some isolated ratios remain above parity, these occur alongside very small absolute numbers and are not repeated across multiple indicators or years. Importantly, the reduction in racial disproportionality over successive years indicates that intersectional risk is being actively reduced rather than reproduced, suggesting effective mitigations are in place.

Organisational interpretation

The observed pattern suggests that formal disciplinary and capability processes are becoming more equitable and consistently applied. The sustained reduction in racial disproportionality points to effective organisational learning, governance, and scrutiny, particularly in relation to decision-making thresholds and process oversight.

Remaining variation is likely influenced by small numbers and case mix rather than embedded structural or cultural bias. The priority for WAST is therefore to maintain, reinforce, and institutionalise the practices that have driven improvement, ensuring progress is resilient to organisational change and operational pressure.

4.6 Workplace Behaviours Domain

Equity rating	Headline finding
Severe	Directionally consistent disadvantage across all three behaviour indicators, strong intersectional reinforcement, very high prevalence relative to national benchmarks, clear behavioural and cultural drivers

Overview

The Workplace Behaviours domain shows severe inequity, with markedly higher rates of harassment, bullying and abuse reported across all three indicators: from patients/public, from colleagues, and personal discrimination.

Prevalence is substantially higher than the NHS Wales benchmark for almost every protected characteristic, including White staff, indicating that this is not a marginal or isolated issue.

Risk is particularly elevated for gender-diverse staff, disabled staff, LGBTQIA+ staff, and those selecting Prefer Not to Say, with consistently extreme values across indicators.

While WAST has a small ethnic minority workforce, the scale and breadth of reported behaviours indicate a system-wide cultural and behavioural risk, not one driven by workforce composition alone

Intersectional signals

Intersectional inequity in this domain is strong, cumulative, and reinforcing.

Gender-diverse staff show among the highest exposure to harassment and discrimination across all three indicators, particularly in staff-to-staff behaviour and discrimination.

Disabled staff, LGBTQIA+ staff, and PNS groups also experience sharply elevated risk across public-facing abuse, colleague harassment, and discrimination, indicating that visibility, vulnerability, and non-disclosure intersect to intensify harm.

Although ethnic minority staff form a small proportion of the workforce, their reported exposure is high relative to White staff, meaning intersectional disadvantage persists even in a constrained pipeline.

The consistency of these patterns confirms that inequity is not episodic or demographic-driven but embedded in everyday working interactions.

Organisational interpretation

The evidence indicates that inequity in workplace behaviours is driven primarily by cultural and behavioural factors, rather than formal structures or processes.

Elevated abuse from patients and the public reflects operational exposure, but the very high levels of staff-to-staff harassment and discrimination point to deeper cultural tolerance of unacceptable behaviour and inconsistent challenge when it occurs.

The fact that White staff also report substantially higher levels than the national average suggests a broader behavioural environment issue, while the much higher rates among gender-diverse, disabled, LGBTQIA+ and PNS staff demonstrate unequal impact and protection.

Low psychological safety is likely amplifying these risks, particularly for those with multiple minoritised identities.

4.7 Workplace Safety Domain

Equity rating	Headline finding
Severe	Directionally consistent disadvantage across violence exposure and speaking-up indicators, strong intersectional reinforcement (gender diversity, disability, LGBTQIA+, PNS), evidence that harm and reduced voice co-occur, limited explanatory power of workforce composition

Overview

The Wellbeing and Safety domain shows severe inequity, with elevated exposure to physical violence and uneven psychological safety across multiple protected characteristics.

While overall experience of violence is broadly comparable to the NHS Wales range for some groups, this masks markedly higher exposure for others, including men, gender-diverse staff, disabled staff, LGBTQIA+ staff, and those selecting Prefer Not to Say (PNS).

Confidence in speaking up is consistently lower for the same groups, with particularly pronounced gaps for gender-diverse and PNS staff.

Given that disabled and LGBTQIA+ staff are relatively well represented in WAST, these patterns cannot be explained by workforce composition alone and point to systemic safety and voice issues.

Intersectional signals

Intersectional analysis indicates reinforced and compounding disadvantage where exposure to harm intersects with reduced confidence to speak up.

Gender-diverse staff experience higher exposure to physical violence alongside the lowest speaking-up confidence, creating a high-risk profile combining harm and silence.

Disabled staff and PNS groups show a similar pattern, with above-average violence exposure but weaker safety perception and trust in raising concerns.

Although ethnic minority staff form a very small proportion of the workforce, their confidence in speaking up is also lower than the White comparator, indicating that intersectional vulnerability is present even within a constrained pipeline.

These consistent patterns confirm cumulative inequity rather than isolated variation.

Organisational interpretation

The domain reflects elevated exposure to harm combined with uneven psychological safety. While risks are not extreme across all groups, consistent gaps in confidence to speak up indicate underlying cultural and trust issues.

The evidence suggests that inequity in wellbeing and safety is driven by a combination of structural exposure and cultural safety deficits. Operational risk explains some exposure to physical violence, but it does not

explain why specific groups are disproportionately affected, nor why confidence in speaking up is lower for those same groups.

The data indicate uneven psychological safety, with inconsistent reassurance that raising concerns will lead to protection and support rather than detriment. Behavioural factors, including local response, follow-up, and visible action after incidents, are likely reinforcing these risks.

Overall, the domain reflects high exposure combined with unequal protection and voice, requiring system-level intervention rather than reliance on reporting mechanisms alone.

4.8 Workplace Conditions Domain

Equity rating	Headline finding
Severe	Strong directional disadvantage across multiple workplace condition indicators, clear intersectional reinforcement (gender diversity, disability, PNS), extremely high burnout and presenteeism among minoritised groups, limited explanatory power of workforce composition

Overview

The Workplace Conditions domain shows severe inequity, with consistently poorer experiences reported across access to flexible working, presenteeism, and burnout, particularly for ethnic minority staff, gender-diverse staff, disabled staff, LGBTQIA+ staff, unpaid carers, and those selecting Prefer Not to Say (PNS).

While reported availability of workplace adjustments is comparatively strong for some groups, this is outweighed by substantially lower satisfaction with flexibility, high pressure to attend work when unwell, and very high burnout levels, especially among PNS and minoritised groups.

Given that disabled and LGBTQIA+ staff are proportionately well represented in this workforce, these disparities cannot be attributed to workforce composition alone and indicate systemic strain in day-to-day working conditions.

The consistency across characteristics confirms system-wide operational strain rather than group-specific experience.

Intersectional signals

Intersectional analysis indicates compounding disadvantage where minority status intersects with health, gender diversity, or non-disclosure.

Gender-diverse staff report very high presenteeism and burnout combined with low flexibility satisfaction, indicating unsustainable working conditions.

Disabled staff show persistently high burnout despite reasonable access to adjustments, suggesting that adjustments alone are insufficient to mitigate workload pressure.

PNS groups consistently report the highest levels of presenteeism and burnout, alongside lower flexibility satisfaction, reinforcing the interpretation that psychological safety and trust intersect with working conditions to intensify harm.

The repeated appearance of the same groups across multiple indicators confirms cumulative rather than isolated inequity.

Organisational interpretation

The data suggests that inequity in workplace conditions is driven by structural workload pressures amplified by cultural and behavioural norms. While policies on adjustments and flexibility appear to exist and are used, their impact is uneven, particularly for staff whose needs are less visible or safely disclosed.

High levels of presenteeism and burnout indicate that expectations around attendance, resilience, and capacity are not consistently aligned with staff wellbeing. Behavioural factors at local management level, including how flexibility is negotiated and how absence is perceived, are likely reinforcing these pressures.

Overall, the domain reflects a system that accommodates difference in principle but not consistently in practice, particularly under pressure.

5. Preserving What Works

Alongside significant inequities, the data identifies important areas of strength that should be protected:

- **Clear continuing improvement in disciplinary disproportionality, particularly for racial equity, demonstrates that focused action and governance can deliver change.**
- **Professional Development systems function equitably, with high appraisal coverage across all groups, including PNS and minoritised staff.**
- **Access to workplace adjustments is comparatively strong, especially for disabled staff, indicating positive organisational intent.**
- **Reporting of violence is broadly comparable across groups, providing a foundation for strengthening prevention and support rather than starting from scratch.**

Preserving these strengths will be critical to sustaining trust while addressing more acute risk areas.

6. Data-Informed Opportunities for Action

Drawing across all six domains, the data points to three critical system-level intervention areas, alongside targeted domain-specific interventions.

1. Repair leadership and progression conversion mechanisms

- **Redesign early leadership gateways (appointment from shortlisting, senior progression) to ensure that a small but present pipeline is not systematically filtered out.**
- **Introduce clearer, safer progression signals to rebuild confidence among disabled, LGBTQIA+, and PNS staff.**

2. Tackle culture, behaviour, and safety together

- **Address Workplace Behaviours and Wellbeing & Safety as a linked system, not separate issues.**
- **Strengthen visible challenge, follow-up, and consequence management for harassment and abuse.**
- **Improve psychological safety so reporting leads to protection, not further harm.**

3. Reduce burnout and presenteeism at their source

- **Prioritise workload design, recovery, and flexibility consistency rather than relying solely on individual adjustments.**
- **Use burnout and pressure-to-attend metrics as early warning indicators, especially for minoritised groups.**

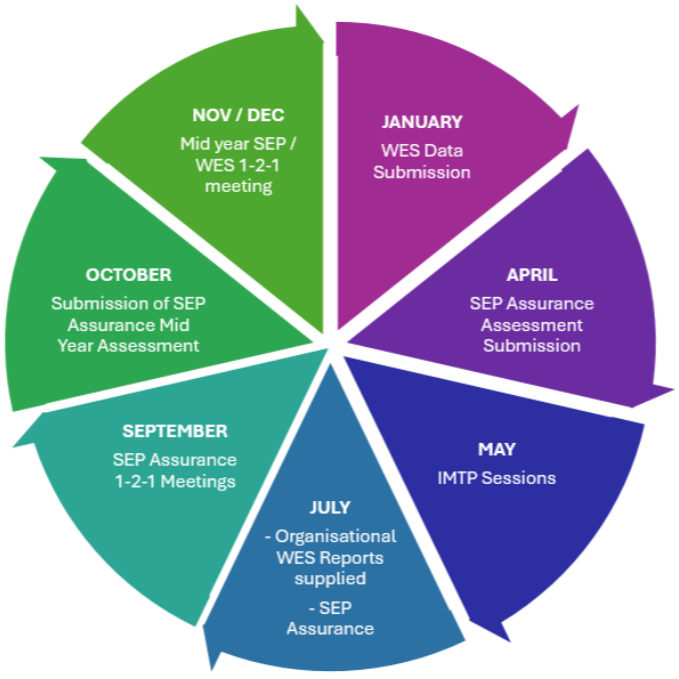
7. What Success Would Look Like

Success would be evidenced by sustained directional improvement rather than parity across all metrics:

1. **Leadership confidence improves: Narrowing gaps in perceived fairness of career progression for disabled, LGBTQIA+, ethnic minority and PNS staff.**
2. **Safer workplace behaviours: Year-on-year reduction in harassment, bullying and discrimination for the highest-risk groups.**
3. **Improved safety and voice: Increased confidence in speaking up among gender-diverse, disabled and PNS staff.**
4. **Reduced burnout and presenteeism: Declining pressure to attend work when unwell and lower burnout rates, particularly for PNS and minoritised groups.**
5. **Greater trust and disclosure: Gradual reduction in PNS and Unknown responses across characteristics, interpreted as improved psychological safety.**

8. What Next

The WES organisational report sits at the midpoint of the NHS Wales planning and assurance cycle. This report should be used as a structured equity diagnosis, to informs IMTP planning and refinement of organisational priorities. These strategic equality priorities will translate into delivery plans and tested through SEP assurance assessment meetings and mid-year be reported (October). Findings will governance through the Welsh process to Boards and scrutiny of both Government, enabling As the cycle progress and impact. creates a repeats annually, this loop—linking data, continuous feedback assurance— planning, delivery, and governmental ensuring sustained accountability, and oversight, improvement in progressive outcomes. workforce equity



WELSH AMBULANCE SERVICES PARTNERSHIP TEAM (WASPT) ADVISORY GROUP ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's standing orders and committee terms of reference require that board committees and advisory groups evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of board committees and advisory groups ensure governance remains fit for purpose.

3. The advisory group met on 20 August 2026 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This annual report reflects on the effectiveness of the committee in 2025/26 and any changes to terms of reference.

4. The Trust Board has commissioned an external effectiveness review which will be undertaken in early 2026 by the Good Governance Institute (GGI). The GGI reviewed the board committee framework in quarter four 2025/26 and quarter one of 2026/27, and the outcome report was received by the Trust Board in July 2026. There are no recommendations which directly impact the role or operations of this group.

PURPOSE OF THE ADVISORY GROUP

5. 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.

6. WASPT will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The Trade Union Congress (TUC) principles of partnership will apply.

7. Members work in partnership, including:
   (a) showing joint commitment to the success of the organisation with a positive and constructive approach
   (b) recognising the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
   (c) demonstrating commitment to employment security for workers and flexible ways of working
   (d) sharing success – rewards must be felt to be fair
   (e) practising open and transparent communication – sharing information widely with openness, honesty, and transparency
   (f) bringing effective representation of the views and interests of the workforce
   (g) demonstrating a commitment to work with and learn from each other
   (h) take account of social partnership duties in the Social Partnership and Procurement (Wales) Act 2023

MEMBERSHIP AND ATTENDANCE

8. WASPT met six times as scheduled in 2025/26 and was quorate on each occasion.

9. WASPT membership consists of eight management members, the chair of the corporate local partnership forum, and twelve trade union partner members. Meetings are chaired on rotation between the management and trade union partner chairs.

10. Trade union membership includes three seats for each of the four recognised trade unions (GMB, Royal College of Nursing, UNISON and UNITE). The chart below illustrates attendance of members as listed in the terms of reference for 2025/26.

ATTENDANCE						
Name	**30 May 2025**	**24 July 2025**	**22 Sept 2025**	**20 Nov 2025**	**22 Jan 2026**	**18 Mar 2026**
Jason Killens	**Chair**					
Emma Wood						
Mark Marsden (UNISON)				**Chair**		
Carl Kneeshaw						
Lee Brooks				Sonia Thompson	Deputy chair	
Rachel Marsh		Interim CEO	Interim CEO **Chair**			
Chris Turley			Ed Roberts	Ed Roberts	Ed Roberts	Ed Roberts
Andy Swinburn						
Estelle Hitchon						
Trish Mills						
Chair Corporate LPF	Liz Rogers		Liz Rogers	Sara Williams	Liz Rogers	
Unite representative	Christian Fox	Christian Fox **Chair**	Christian Fox	Kevin Gamblin	Christian Fox	
Unite representative	Kevin Gamlin	Hugh Parry	Hugh Parry	Hugh Parry	Hugh Parry	Hugh Parry
Unite representative	Alison Williams	Alison Williams	Alison Williams	Alison Williams	Alison Williams	Alison Williams
GMB representative	Marcus Viggers	Marcus Viggers	Marcus Viggers		Marcus Viggers	Marcus Viggers
GMB representative	Jane Wellington-Rees	Mal Jones	Charlie Phillips	Sharon Thorpe	Mal Jones	Richie Bullen
GMB representative					Jane Wellington-Rees	Jane Wellington-Rees
UNISON representative	Mark Marsden		Chris Ferris	Carol Roberts	Carol Roberts	Carol Roberts
UNISON representative	Henry Garrard	Henry Garrard	Henry Garrard	Henry Garrad	Henry Garrard	Henry Garrard
UNISON representative		Carol Roberts	Damon Turner	Damon Turner		Damon Turner
RCN representative		Vicky Rees	Vicky Rees	Vicky Rees	Vicky Rees	Vicky Rees
RCN representative						
RCN representative						

	Attended
	Deputy attended
	Apologies received/Not attended
	No longer member/Not member

11. Attendance is steady and the group recognises the importance of consistent membership across the trade unions wherever possible to aid in the flow of information but also acknowledges that this can be difficult to achieve with shifts etc., and that there is a need for some flexibility. It has been challenging to get staff representation from RCN at meetings; therefore, it was agreed that the RCN full time officer, Vicky Rees, would attend in her capacity as RCN member at meetings where possible. Further work is ongoing by RCN to field membership at meetings.

12. No changes to membership are proposed.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

13. WASPT's effectiveness was reviewed through consideration of its terms of reference and a member questionnaire, which sought views on what works well and where improvements could be made. Twenty-three surveys were circulated with 12 returned which is a 52% response rate compared to 39% in 2024/25. Five responses were received from management members and seven were from Trade Union Partners (TUPs).

14. Overall, respondents recognised WASPT as an effective forum for open, respectful and, at times, robust discussion, with papers provided in good time and space for meaningful dialogue. The partnership was consistently described as constructive and transparent.

15. Most respondents did not identify a need to change the terms of reference or membership, although comments were made about strengthening joint working on workforce issues, including recruitment, retention and terms and conditions, and about increasing representation from the RCN and corporate functions.

16. In considering areas for improvement, respondents highlighted a desire for more strategic focus, clarity on where issues should be discussed, and assurance that concerns raised are clearly minuted and progressed through the appropriate delegated forums. WASPT's terms of reference confirm it as the formal mechanism for consultation and negotiation on strategic workforce matters, and established processes exist for both management and trade union partners to propose agenda items.

17. At the meeting in August 2026 the results were discussed. The review identified a strong and consistent theme of respectful and constructive partnership working, with members highlighting openness, healthy challenge, good engagement and positive relationships as key strengths of the forum. Areas for further development included increasing the strategic focus of discussions, improving agenda prioritisation, providing earlier visibility of discussion topics, and ensuring the forum continues to evolve its ways of working in response to organisational and financial pressures.

18. Discussion focused in particular on the potential for more flexible meeting arrangements, including the use of virtual meetings where appropriate to reduce costs, whilst retaining face-to-face meetings for workshop-style discussions where engagement and relationship building are most beneficial. The group agreed that the review provided a fair reflection of the effectiveness of WASPT and supported continued consideration of opportunities to strengthen strategic focus, member engagement and meeting effectiveness.

Management of the committee's work programme

19. The nature of matters coming to WASPT means it can be difficult to develop a predictable cycle of business. Having said that, the agenda is set with the co-chairs and the Corporate Governance directorate in advance with reference to the action log, forward plan, escalations and reporting from the local partnership forum structures, and any issues that would benefit from a partnership discussion.

20. Trade union partners convene a pre-meeting before the main group meeting. Since 2024/25, substantive issues from this session are directly added to the agenda rather than being placed under 'any other business.' This change ensures these items receive equal prominence during the main meeting.

21. The following informal workshops were held following the formal meeting in 2025/26, all of which were well received and well attended:

    - Financial savings requirements for 2025/26
    - Risk management
    - Social partnership self-assessment
    - Social partnership conference and emerging themes
    - Changing political landscape

22. The People and Culture Committee is kept informed of the committee's oversight of a range of issues by way of an 'Alert', 'Assure' and 'Advise' (AAA) report to the board after each meeting. Any issues of concern are escalated in the 'Alert' section, and this is presented at the People and Culture Committee meeting.

23. The substantial detail of the work of the committee in 2025/26 was included in the AAA reports to the People and Culture Committee.

24. The AAA report is approved by the co-chairs and then circulated to members to share with their respective trade union members as the key communication took for WASPT.

SUB-STRUCTURES

25. WASPT is serviced by the operational and corporate sub-structures established in 2023. Those groups are meeting regularly and reporting to WASPT by way of a AAA report, escalating issues where they are unable to resolve them at a local level.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

26. Minor changes to the terms of reference have been proposed for 2026/27, which reflect the change in titles for management members of the group and clarifying the focus on the role of group in regard to the focus of discussions being of a strategic nature.

WELSH AMBULANCE SERVICES PARTNERSHIP TEAM (ADVISORY GROUP)

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2026-27

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 on organisational strategic matters. The TUC principles of partnership will apply.

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,

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

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.

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~~Chief People Officer
- ~~Executive Director of Operations~~Chief Operating Officer
- ~~Executive Director of Strategy, Planning and Performance~~Deputy Chief Executive
- Executive Director of Finance and Corporate Resources
- ~~Executive Director of Paramedicine~~ Chief Clinical Officer
- 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. The union membership allocation does not include the partner co-chair.

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.

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 trade union partners. ~~staff side.~~

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.

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 SBARN is not possible due to operational pressures, a shortened template will be developed.

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

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

	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	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. • 7.3 – codifies the position with respect to minute taking and	WASPT	19 February 2024

	aligns to the timetable for Board and Committee drafts.		
3.0	As above	Trust Board – Approval	30 May 2024
4.0	TBC changes as agreed at WASPT on 28/3/25 • 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 action	WASPT agreement	28 March 2025
4.0	Changes as above	Trust Board – Approval	31 July 2025
5.0	Amendment for clarity on strategic nature of committee in para 2.2~~.~~	Trust Board (for approval), in November 2026~~Trust Board – Approval~~	
5.1	Changes to membership (job title updates; clarification on the trade union partner co-chair being in addition to the respective union allocation; minor formatting changes; and inclusion of amendment cited against change 5 (row above).	Trust Board (for approval), in November 2026	

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	26 November 2026
committee Meeting Date	17 November 2026
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No alerts for the board's attention arose from this meeting.

ADVISE

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

2. The **membership of the committee was extended** to Ross Whitehead, Programme Director, Finance and Sustainability and Andy Swinburn, Chief Clinical Officer is also now a member of the committee.

3. The Committee noted a more positive position on the **Manchester Arena Inquiry** (MAI), with the Joint Commissioning Committee (JCC) recognising that the majority of the Trust's proposed preparedness and capability enhancements were reasonable and proportionate. However, the proposed frontline asset uplift remained unresolved, including additional 24/7 emergency ambulance crews, workforce and fleet to support recall-to-duty arrangements. A clearer route forward was emerging through the JCC-supported demand and capacity review to be commissioned by WAST, which will incorporate the resilience assumptions arising from our work in relation to the Inquiry, alongside JCC participation in the steering group. Assurance was also received that the risk should not be held by WAST alone, with the JCC committed to developing its own MAI risk, supported by the Trust's risk framing. While further tangible progress remained dependent on investment, the Committee welcomed the stronger alignment through commissioning, risk and future IMTP planning.

Financial Sustainability Programme

4. The Committee noted that the Financial Sustainability Programme, first established in 2022 in response to a challenging financial environment, had been refreshed and reshaped on a number of occasions, most recently to broaden its focus beyond savings and cost reduction towards longer-term organisational sustainability. Recognising that a programme of this scale required dedicated senior

leadership capacity, a Programme Director had now been appointed to provide greater pace, drive and programme discipline.

5. This evolving programme was described as having four principal objectives: delivering targeted cost reduction; improving productivity and efficiency; increasing income through commercial opportunities; and developing a longer-term approach to financial planning and organisational sustainability. The respective workstreams have distinct scope but interrelated ambitions with some being more developed and mature in terms of delivery. These are being taken forward through four corresponding workstreams: targeted cost reduction, productivity, commercial delivery and future financial planning. Importantly, the programme is not, in itself, the Trust's financial plan or the sole means by which financial balance is achieved. Wider financial governance, budgetary management, controls and grip continue to underpin the Trust's overall financial position. Committee expressed wide support for the programme and expressly encouraged the maintenance of the current momentum to leverage flexibility for future organisational sustainability.

6. Commercial development was recognised as an important component of the programme, with the ambition to generate sustainable additional income and maximise opportunities from the Trust's assets and capabilities. The committee reviewed the commercial development plan in more detail in the private session given commercial sensitivities.

7. **Members reflected** positively on the quality of discussion and constructive challenge, particularly around balancing finance, performance and quality. The value of strengthening links across committees was recognised, alongside the significant improvement in the clarity and presentation of committee papers, with the IMTP assurance report highlighted as a particularly strong example.

ASSURE

(Detail here assurance items the committee receives)

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

Financial Position

8. Financial performance months 6 and 7 2026/27 was reviewed and that detail will be in the board meeting on 26 November. Of note from the committee:
   - In considering the risk relating to failure to deliver the Trust's statutory financial duties (Risk 139), the committee noted that the financial position required continued active management to deliver the forecast year end position. Increased fuel costs had effectively absorbed available contingency, while the approximately £2.5m Welsh Risk Pool exposure technically remained a risk until the year-end position was confirmed; notwithstanding assurances from Welsh Government that it would be covered in-year. Committee members recognised the strong financial management demonstrated across the Trust and the importance of maintaining this discipline to secure the year-end balanced position.
   - Members considered whether savings attributed to vacancy management could genuinely be regarded as recurrent. Reassurance was given that budgets had been reduced on a recurrent basis and that some vacancy savings represented permanent establishment reductions, while

recognising that normal recruitment gaps created some variation in delivery of savings on a a recurring basis . There was confidence that the underlying recurrent budget reduction would carry forward in terms of savings delivery into 2027/28.

- Members recognised that securing further recurrent savings would require increasingly difficult choices. The need to balance the Trust's financial duties with its duty of quality was strongly emphasised. Quality impact assessments should therefore be integral to the development of savings proposals from the outset, with the board given early sight of potentially challenging or unpalatable choices so that the financial and quality implications could be considered together.

Integrated Medium Term Plan (IMTP)

9. Discussion in relation to strategic objectives 1, 3 and 6 highlighted organisational capacity and prioritisation as a recurring concern, with dependency mapping and further prioritisation being undertaken as part of the development of the 2027/28 IMTP to ensure that planned commitments are realistic and deliverable.

10. Particular attention was given to NEPTS, where the committee explored the relationship between productivity, quality and financial benefits. The improvement work, including revised rostering, is expected to create capacity for around 300 additional journeys per week, helping to address unmet need and reduce cancellations. The committee noted that this sits alongside financial savings from NEPTS and reflected a deliberate approach whereby productivity gains support improved service quality while separate savings measures contribute to financial balance, with quality impact assessment used to ensure the two are considered together.

11. The committee also considered the low-confidence rating for the all-Wales data-sharing deliverable, noting that progress is largely dependent on arrangements outside the Trust's direct control. Work is therefore underway to reshape the deliverable for the next IMTP and develop a more locally controlled alternative, including targeted data linkage with health boards to better understand patient journeys and outcomes.

Monthly Integrated Quality and Performance Review (MIQPR) August/September 2026)

12. The committee noted that, despite progress against a number of improvement actions, several key measures remained below the desired level and sought greater clarity on when improvement should realistically be expected and whether existing targets remained appropriate. It was noted that modelling for a number of EMS measures is being retuned using a full year of data from the new clinical model, with updated modelling expected in January 2027. This should enable clearer trajectories to be established and demonstrate the anticipated impact of individual improvement actions on performance.

13. Particular concern was raised regarding the NHS 111 service, where demand had increased significantly, including by around 20–25% in recent months compared with the previous year, with consequent deterioration in call abandonment and significant unmet demand. The committee heard that the current establishment would not enable achievement of the 10–15% abandonment target at prevailing demand levels, even with further efficiency measures. The changing pattern of demand, including increased in-hours use and potential deflection from primary care, was considered indicative of a wider question about the future role, specification and resourcing of 111. The committee

supported continued engagement with commissioners and wider NHS Wales strategic forums, alongside consideration of whether current targets and assumptions should be recalibrated as the evidence and modelling develop.

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

14. The committee received an update on the **digital portfolio**, and noted the following:
    - The Digital Oversight Group was embedding well, with processes refined following feedback from its initial meetings. Directorate-wide scoring had been introduced to strengthen organisational input into the prioritisation of digital requests.
    - Digital workforce capacity had strengthened, with key appointments to the digital front-end team expected to enable greater pace of delivery.
    - Members welcomed progress on AI governance, noting that the Trust's developing approach was being aligned with the emerging national framework. This was considered important given the growing use of AI and its potential contribution to productivity and financial sustainability.
    - Members highlighted the importance of digital resilience and business continuity, particularly following the recent Microsoft outage and a short power interruption at Vantage Point House. Existing contingency arrangements had responded effectively, but it was acknowledged that increasing reliance on digital services, AI and automated workflows would require robust and regularly tested fallback arrangements.

15. Additionally, members received **feedback on the use of ALBOT,** which was mixed but constructive; with around half of surveyed users reporting a positive experience. Further work was required to understand benefits realisation, including whether ALBOT was meeting users' needs and its impact on telephone 111 demand, with strengthened capacity within the digital front-end team expected to support continued development and improvement of the service. The feedback is available in the public papers from this meeting.

16. The committee received an update on the **information governance** position, controls and improvement activity. It was noted that there is continued pressure in relation to Subject Access Request (SAR) and Freedom of Information (FOI) compliance, including the timeliness and ageing of outstanding requests and associated workforce pressures. Members noted that ELT had agreed a short-term improvement programme across SARs and FOIs to address underlying process and resilience issues, with continued oversight through the Information Governance Steering Group.

17. The **shift overruns internal audit report** (reasonable assurance) was received by way of information, noting that the People and Culture Committee will oversee the actions.

18. The **audit tracker** Q2 report was received with one audit action on a final date. This related to the Audit Wales Urgent and Emergency Care report and in particular the 111 website. Members were assured that the extension of time to complete the action did not materially increase the risk.

19. In **private session** members discussed the submission to Welsh Government of the vehicle procurement business justification case and endorsed this for board approval. Due to sensitivities, the emergency preparedness, response and resilience annual report 2025/26 and the incident response plan were also taken in private session, along with the report and risk on cyber management.

RISKS

Risk Management: The committee reviewed the principal risks for its remit and noted that the risks within its remit had been substantively considered through the preceding agenda discussions and welcomed the introduction of a new Information Governance risk domain within the risk assessment framework, strengthening consideration of information governance impacts when assessing organisational risk. There are no escalations for the board. The risks within the remit of the committee are as follows: -

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 at a score of 20 (4x5).

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).

Risk 671 *Unauthorised or Inappropriate use of AI technologies* remains at a score of 16 (4x4) during this review period remains at a score of 16 (4x4).

Risk 690 *SAR and Disclosure of Records Compliance* remains at a score of 16 (4x4), despite a potential reduction in score being discussed by the ELT remains at a score of 16 (4x4).

Risk 594 *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* remains at a score of 15 (3x5) following exhaustion of internal mitigations.

Risk 139 *Failure to Deliver our Statutory Financial Duties* remains at a score of 12 (3x4) in line with the financial position for 2026/27.

Risk 100 *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience*. Members were asked to note that the ELT considered proposals to reframe this risk to focus on the commissioning and contractual framework, including clear expectations, accountability and funding arrangements, and the associated impact on the delivery of safe and effective services.

COMMITTEE AGENDA FOR MEETING		
Financial performance months 6 and 7	Financial sustainability report	IMTP
Manchester Arena Inquiry update	MIQPR	Digital reporting
Risk management and BAF	IG report	Audit tracker Q2
Q2 Operations report	Shift overruns internal audit	

COMMITTEE ATTENDANCE						
Name	**19 May 2026**	**21 Jul 2026**	**15 Sep 2026[1]**	**17 Nov 2026[2]**	**19 Jan 2027**	**16 Mar 2027**
Jayne Beeslee (Chair)						

[1] Emma Wood was in attendance for this meeting
[2] Phil Berrington, Trust Board Chair, joined for this meeting

COMMITTEE ATTENDANCE						
Bethan Evans			[3]			
Peter Curran		Until item 8[4]				
Chris Turley		[5]				
Rachel Marsh		James Houston				
Lee Brooks		Mark Harris				
Liam Williams						
Director of People		Liz Rogers	Bev Flood			
Jonny Sammut		Leanne Smith		Leanne Smith		
Trish Mills	Julie Boalch					
Hugh Parry	Until 12:40					
Damon Turner						
Matt Dugdale						
Penny Durrant						
Ross Whitehead						
Andy Swinburyn						

	Attended
	Deputy attended
	Apologies received
	No longer member

[3] Not in the meeting for items 9 to 12
[4] Colin Dennis and Emma Wood were in attendance for this meeting also
[5] Jason Collins was in attendance for this meeting

Agenda Item No.	13

REPORT TITLE

Governance report: November 2026

MEETING

Name of meeting	Trust Board
Date of meeting	26 November 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	AnnaMaria Williams, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This report sets out where applicable the Chair's Actions taken since the last board meeting, use of the **Trust Seal, decisions made in private session and any other governance matters**. There have been no decisions made by Chair's Action which require reporting to the public.

Trust Seal approval requests

2. There are no requests for the Trust Board to approve the application of the Trust Seal.

Decisions made in private session

3. The board made a number of decisions in private session on **24 September 2026** including:

3.1 The approval of the submission of ESN Phase 2 FBC to Welsh Government and the approval to commence the Air to Ground design document work ahead of FBC submission, with the request for funding submitted to Welsh Government.

3.2 The approval of the following discretionary capital business cases:

- The Swansea Ambulance Station MRD business case
- The Pembroke Dock Ambulance Station refurbishment works business case
- The contract award for the Pembroke Dock Ambulance Station refurbishment works
- The business case for the creation of a National Operations Co-ordination Centre (NOCC) at Vantage Point House

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Trust Board is requested to:

1. Note the decisions made in private session as outlined above.

ADDITIONAL PAPER(S)

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

n/a

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

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

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
APF	Ambulance Performance Framework
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
CMT	Clinical Model Transformation
CRM	Clinical response Model
CRR	Corporate Risk Register
CQGG	Clinical Quality Governance Group
CSD	Clinical Support Desk

ACRONYMS BUSTER

ABBREVIATION	TERM
CTP	Clinical Transformation Programme
DAP	Decarbonisation Action Plan
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

ACRONYMS BUSTER

ABBREVIATION	TERM
MACA	Military Aid to Civil Authorities
MAI	Manchester Arena Inquiry
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

ACRONYMS BUSTER

ABBREVIATION	TERM
SCIF	Significant Clinical Incident Forum
SDECs	Same Day Emergency Care Centres
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