Bundle Trust Board (Open Session) 29 January 2026

Agenda attachments
Item 00 Agenda
0 09:45 - OPENING ITMES
1 Chair's Welcome, Apologies and Quorum
2 Declarations of Interest
Item 02 Board Member Register of Interests
3 Minutes of the Previous Meeting: 27 November 2025
Item 03 2025-11-27 unconfirmed Trust Board OPEN Minutes
4 Action Log & Matters Arising (no open actions)
Item 04 Action Log
5 09:50 - Chair and Vice Chair's Report
Item 05 Chair's and Vice-Chair's Report to Board - January 2026
6 10:00 - Chief Executive’s Report
Item 06 CEO Trust Boad Report
7 10:20 - Questions from members of the public
7.1 FOR APPROVAL, ASSURANCE AND DISCUSSION
8 10:30 - Patient Experience: Judith Parfitt (video)
8.1 11:00 - Previous story follow up: Staff Experience, Rusna Begum (November 2025) [VERBAL]
9 11:05 - Actions to Mitigate Avoidable Patient Harm
Item 09 Patient Harm Mitigations
Item 09 Annex 1 Patient Harm November December 2025
10 11:25 - Risk Management and Board Assurance Framework
Annex 4 Board Assurance Framework can be viewed in the Reading Room
Item 10 Risk Management Report
10.1 11:35 - COMFORT BREAK
11 11:50 - Monthly Integrated Quality and Performance Report (MIQPR)
Item 11 MIQPR TB November December 2025
Item 11 Annex 1 MIQPR November December 2025
12 12:05 - Integrated Medium Term Plan (IMTP) 2025/26 Quarter 3 Assurance Report
Item 12 IMTP 2025_26 Q3 Assurance
13 12:15 - Finance Update Month 9, 2025/26
Annex 1 WAST Month 9 2025-26 Day 9 is available to view in the Reading Room
Item 13 Finance Report Month 9 25-26
Item 13 Annex 2 Month 09 2025-26 - Monitoring Return
14 12:30 - Structured Assessment 2025, Audit Wales Annual Audit Summary 2025
Item 14 Structured Assessment 2025
Item 14 WAST Annual Audit Summary 2025
15 12:40 - 2025/26 Quality Governance Reviews
Item 15 2025-26 Quality Governance Reviews
Item 15 Annex 1 Spread of board delegated committee remits for 26-27
Item 15 Annex 2 QuEST Terms of Reference 2026-27
Item 15 Annex 3 PCC Terms of Reference 2026-27
Item 15 Annex 4 FPC Terms of Reference 2026-27
Item 15 Annex 5 RemCom Terms of Reference 2026-27
Item 15 Annex 6 APC Terms of Reference 2026-27
16 12:50 - Governance Report, to include 26/27 board and committee calendar
Item 16 Governance Report January 2026
Item 16.1 Annex 1 Board and Committee Calendar 2026-27-28
17 13:00 - Board Committee Reports:
17.1 02 December 2025: Audit, Risk and Assurance Committee
Item 17.1 ARAC AAA Report 2 December 2025
17.2 04 December 2025: Remuneration Committee

Item 17.2 Remuneration Committee AAA Report 4 December 2025

17.3 20 January 2026: Finance and Performance Committee

Item 17.3 Finance and Performance Committee Highlight Report January 2026

17.4 Academic Partnership Committee AAA from Chair's Action: 5 Year Research Plan annexed (for approval)

Item 17.4 Academic Partnership Committee Report, Chairs actions January 2026

Item 17.4 Annex 1 APC Chairs action AAA, Responsible (RDI) 5 Year Plan 2025-30

17.4 CONSENT ITEMS

18 Minutes of Board Committees:
02 September 2025 Audit, Risk and Assurance Committee
10 October 2025 - Quality, Patient Safety and Experience Committee
18 November 2025 - Finance and Performance Committee

Item 18 2025-09-02 ARAC OPEN Minutes

Item 18 2025-10-10 QUEST OPEN Minutes extraordinary

Item 18 2025-11-18 F&P OPEN Minutes

18.1 13:15 - CLOSING ITEMS

19 Reflections and Summary of Decisions/Actions

20 Any Other Business

21 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).

22 Date & Time of the Next Meeting: 26 March 2026

23 Acronyms

Length of Meeting: 03:35		Agenda Status:	OPEN TRUST BOARD-29 January 2026				Deadline for papers: 20 January 2026				Last good practice Exec Review: 14 January 2026
Time	**Mins allotted**	**Agendum**	**Title**	**Item for**	**Item requested by**	**Format**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**	**Scheduled at ELT**	**Further approval route (if app.)**
			OPENING ITEMS								
09:45	00:05	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		
		3	Minutes of the Previous Meeting: 27 November 2025	Approval	Standing	Paper	n/a	Chair	n/a		
		4	Action Log & Matters Arising (no open actions)	Discussion	Standing	Paper	n/a	Chair	Steve Owen		
09:50	00:10	5	Chair and Vice Chair's Report	Information	Standing	Paper	CorGov	Chair, Vice Chair	Alex Payne		
10:00	00:20	6	Chief Executive's Report	Information	Standing	Paper	CEO Office	Emma Wood	Keith Ellingham		
10:20	00:10	7	Questions from members of the public	Information	Standing	Verbal	Partnerships	Estelle Hitchon	n/a		
			FOR APPROVAL, ASSURANCE AND DISCUSSION								
10:30	00:30	8	Patient Experience: Judith Parfitt (video)	Discussion	Standing	Verbal	QPSE	Liam Williams,	Alison Kelly, Leanne Hawker		
11:00	00:05	8.1	Previous story follow up: Staff Experience, Rusna Begum (November 2025)	Discussion	Standing	Verbal	People	Angela Lewis	Sarah Parry		
11:05	00:20	9	Actions to Mitigate Avoidable Patient Harm **(revised narrative regarding modelling approach)**	Assurance	Standing	Paper	SPP	Liam Williams	Rachel Marsh, Hugh Bennett		
11:25	00:10	10	Risk Management and Board Assurance Framework	Assurance	Standing	Paper	CorGov	Trish Mills	Julie Boalch		
11:35	00:15		COMFORT BREAK								
11:50	00:15	11	Monthly Integrated Quality and Performance Report (MIQPR)	Assurance	Standing	Paper	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Georgia Tizzard, Melanie O'Connor		
12:05	00:10	12	Integrated Medium Term Plan (IMTP) 2025/26 Quarter 3 Assurance Report	Assurance	CoB	Paper	SPP	Rachel Marsh	James Houston		
12:15	00:15	13	Finance Update Month 9, 2025/26	Assurance	Standing	Paper	FinCor	Ed Roberts	Ed Roberts, Jason Collins		
12:30	00:10	14	Structured Assessment 2025, Audit Wales Annual Audit Summary 2025	Assurance	Standing	Paper	Audit Wales	Fflur Jones	Fflur Jones		
12:40	00:10	15	2025/26 Quality Governance Reviews	Approval	CoB	Paper	CorGov	Trish Mills	Julie Boalch, Alex Payne		
12:50	00:10	16	Governance Report, to include 26/27 board and committee calendar	Approval	CoB	Paper	CorGov	Trish Mills	Alex Payne		
13:00	00:15	17	Board Committee Reports:	Assurance	Standing	Paper	CorGov	Various	Alex Payne		
		17.1	02 December 2025: Audit, Risk and Assurance Committee	Assurance	Standing	Paper	CorGov	Peter Curran	Sarah Harland		
		17.2	04 December 2025: Remuneration Committee	Assurance	Standing	Paper	CorGov	Colin Dennis	Alex Payne		
		17.3	20 January 2026: Finance and Performance Committee	Assurance	Standing	Paper	CorGov	Jayne Beeslee	Alex Payne		
		17.4	Academic Partnership Committee AAA from Chair's Action: 5 Year Research Plan annexed (for approval)	Approval	Standing	Paper	CorGov	Hannah Rowan	Alex Payne		
			CONSENT ITEMS The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.								
13:15	00:00	18	Minutes of Board Committees: 02 September 2025 Audit, Risk and Assurance Committee 10 October 2025 - Quality, Patient Safety and Experience Committee 18 November 2025 - Finance and Performance Committee	Information	Standing	Paper	CorGov	Chair	CorGov		
			CLOSING ITEMS								
13:15	00:05	19	Reflections and Summary of Decisions/Actions	Discussion	Standing	Verbal	n/a	Chair	n/a		
		20	Any Other Business	Discussion	Standing	Verbal	n/a	Chair	n/a		
		21	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		
		22	Date & Time of the Next Meeting: 26 March 2026	Information	Standing	Verbal	n/a	Chair	n/a		
		23	Acronyms	Information	Standing	Paper	n/a	Chair	n/a		
13:20	**03:35**		**CLOSE**								

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Non-Executive Director, Chair of Finance and Performance Committee
Colin Dennis	Chair of the Trust Board
Emma Wood	Chief Executive
Peter Curran	Non-Executive Director, Chair of the Audit, Risk and Assurance Committee
Estelle Hitchon	Director of Partnerships and Engagement
Fflur Jones	Audit Wales
Angela Lewis	Director of Culture Change
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Ed Roberts	Acting Director of Finance and Corporate resources
Liam Williams	Executive Director of Quality and Nursing

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022	17 July 2025	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024	30 September 2025	
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015	January 2025	
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021	January 2025	
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		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*		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
EVANS, Bethan **[continued]**	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
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	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995	31 May 2025	
		Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025		
		Consultancy (temporary cover for the Director of Operations - Clinical Trials Unit) at Wolverhampton University	Financial Interest	10 October 2025	31 December 2025	
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROBERTS, Edward	**Interim Finance Director (from 09 September 2025)**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017	31 March 2025	
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 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**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		
WOOD, Emma	**Chief Executive (from 01 October 2025)**	Chartered Fellow of CIPD (Chartered Institute of Personnel and Development)	Non-Financial Professional	2000		
		External Moderator for HR Masters modules for University West of England	Financial Interest	September 2024		
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025		
		Sub-Yoga Teacher - Burnham Swim and Leisure Centre	Financial Interest	July 2025		

MINUTES OF THE OPEN MEETING OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST, TRUST BOARD ON THURSDAY 27 NOVEMBER 2025 HELD IN THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

Meeting started at 09:30

PRESENT:

Colin Dennis	Chair of the Trust Board
Emma Wood	Chief Executive Officer
Rhiannon Beaumont-Wood	Non-Executive Director
Jayne Beeslee	Non-Executive Director
Peter Curran	Non-Executive Director
Bethan Evans	Non-Executive Director (Virtual)
Estelle Hitchon	Director of Partnerships and Engagement
Professor Hayley Hutchings	Non-Executive Director
Angela Lewis	Director of Culture Change
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Ed Roberts	Acting Director of Finance and Corporate Resources
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine
Hugh Parry	Trade Union Partner
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

ATTENDEES:

Meshack Ezeadim	Aspiring Board Member
Sarah Harland	Corporate Governance Officer
Angela Mutlow	Director of Operations, Llais (Virtual)

APOLOGIES:

Lee Brooks	Executive Director of Operations
Ceri Jackson	Vice Chair and Non-Executive Director
Carl Kneeshaw	Director of People
Hannah Rowan	Non-Executive Director
Chris Turley	Executive Director of Finance and Corporate Resources

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1. CHAIR'S WELCOME, APOLOGIES AND CONFIRMATION OF QUORUM

1.1 The Chair welcomed everyone to the meeting. Apologies were received as above. It was confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

2.1 No declarations of interest were made in addition to those already recorded on the Trust's Register of Interests.

3. MINUTES OF THE LAST MEETING 25 SEPTEMBER 2025

3.1 The Minutes of the meeting held on 25 September and 23 October 2025 were received and approved.

4. ACTION LOG AND MATTERS ARISING

4.1 Members noted that all four actions have now been completed.

5. CHAIR AND VICE CHAIR'S REPORT

5.1 The Chair presented the report which is uploaded to Ibabs and to the Trust's website. The contents are therefore not repeated here.

5.2 The Chair expressed deep sadness at the recent passing of three valued colleagues: Paul Hollard, former Non-Executive Director; Richard Durkan from the Urgent and Emergency Care Service; and Natasha Harper, a dedicated Community First Responder.

5.3 The Chair and Angela Lewis recognised Paul Hollard's eight years of service as a Non-Executive Director, his lifelong commitment to the Welsh NHS, and his unwavering support for colleagues, particularly new members. Paul's passion for people, culture, and staff wellbeing was evident in his continued engagement and determination to make the organisation the best possible place for both patients and staff. The Board observed a moment of silence in memory of Paul and the other colleagues who have sadly passed away.

5.4 The Chair also acknowledged the retirement of Steve Owen, Corporate Governance Officer, thanking him for his exemplary service and wishing him a long and happy retirement.

6. CHIEF EXECUTIVE'S REPORT

6.1 The Chief Executive's report is uploaded to Ibabs and to the Trust's website. The contents are therefore not repeated here.

6.2 Emma Wood thanked board members, stakeholders and colleagues for their support during her first seven weeks. Emma discussed ongoing work with Commissioners on the Integrated Medium-Term Plan (IMTP) and Strategic Priorities, including a draft submission to the Joint Commissioning Committee (JCC) and the potential for the new Monthly Integrated Quality and Performance Report (MIQPR) data set to streamline performance management. Emma also noted capital projects, specifically the need to

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review flood defences at Monmouth station following recent floods, expressing her gratitude to staff involved in the emergency response.

7. QUESTIONS FROM MEMBERS OF THE PUBLIC

7.1 One question was received that was operational in nature and has been responded to. Otherwise, no public questions were received for this meeting.

8. STAFF EXPERIENCE – RUSNA BEGHUM, GRADUATE MANAGEMENT TRAINEE

8.1 Rusna Begum, Graduate Management Trainee, shared her journey from working as a dental nurse in London to joining the NHS graduate programme in Wales at age 47. Rusna described the challenges of transitioning from an operational to a strategic environment, especially adapting to WAST acronyms and the scale of the organisation. Rusna emphasised the importance of combining practical experience with her MSc in Applied Health Leadership, particularly in developing compassionate leadership and change management skills.

8.2 Rusna highlighted the value of staff networks such as Black Asian and Minority Ethic (BEAM), which provide a sense of belonging and help address the lack of diversity within the ambulance service. Rusna's multiple voluntary roles, including Magistrate and board member, have broadened her perspective and strengthened her work. Passionate about equality, inclusion, and empowering women from diverse backgrounds, Rusna illustrated the importance of cultural understanding in decision making.

8.3 Board members described Rusna's presentation as both inspirational and insightful, commending her research into diversity within the ambulance sector and her active role in the BEAM network. Rusna praised the welcoming culture for trainees but emphasised the ongoing need for greater diversity and outreach to under-represented communities. Discussions highlighted the challenges of improving diversity in emergency services; the benefits of sharing good practice across sectors; and the importance of engaging communities in service design and digital inclusion. Rusna added that BEAM network members want to feel valued and included, and that leadership support for network events has boosted morale and belonging.

8.4 The Board committed to support the BEAM network by involving it in co-creating policy responses, ensuring senior leadership engagement at events, providing resources to boost morale and belonging, and integrating its perspectives into broader engagement and diversity initiatives to shape organisational change. The Chair and Board members thanked Rusna for her openness and contribution, emphasising the value of listening to staff experiences to inform improvement.

8.1 PATIENT EXPERIENCE FOLLOW UP

8.1.1 Following Taylor's story received at the September 2025 meeting, Liam Williams advised that the driver diagram for improvements is done and ongoing work continues.

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

9.1 Rachel Marsh presented this report which is uploaded to Ibabs and to the Trust's website. The contents are therefore not repeated here.

9.2 Members noted that while improvements such as fewer patient cancellations, increased safe remote call closures, and better conveyance for high-risk cases have been achieved through the new Clinical Model Transformation (CMT), significant risks remain due to persistent handover delays. Additional winter measures are in place.

9.3 Bethan Evans questioned the organisation's preparedness for Phase Two of the CMT. Emma Wood confirmed readiness and ongoing checkpoints, and Liam Williams highlighted post-launch incident monitoring. Damon Turner sought assurance on staff training and support, Rachel Marsh confirmed is in place, as well as leadership presence during and after go-live.

9.4 Board members acknowledged positive trends but stressed that harm levels remain unacceptable, urging transparency, public communication in readiness for Phase Two of the Ambulance Performance Framework.

The Board noted:

1. **That the Trust’s Clinical Model Transformation is beginning to take effect;**
2. **There has been a material reduction in hospital handover lost hours, but levels are rising in November and are much higher than a pan-Wales application of the Wait 45 initiative;**
3. **That whilst these are positives, the continued level of avoidable patient harm in the 999-emergency care pathway it too high;**
4. **The strategic imperative remains for health boards to further reduce hospital handover lost hours and for the Trust to support Health Boards by evolving its clinical model; and**
5. **The Trust has strong tactical planning arrangements in place for Winter.**

10. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK AND RISK APPETITE STATEMENTS

10.1 Trish Mills presented this report which is uploaded to Ibabs and to the Trust's website. The contents are therefore not repeated here.

10.2 Peter Curran queried progress on distinguishing controllable factors for key risks 223 and 224, with Trish confirming work continues for this and whilst risk scores may decrease there is still an intention to delineate between what WAST can manage and what we must monitor, the latter related to external factors. Rhiannon suggested the risk appetite statement for SO2 should include stronger wording on culture and anti-racism. Emma Wood welcomed risk appetite statements, stressing their use in major decisions and proposing more frequent reviews.

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10.3 Damon Turner sought timelines for mitigating Risk 558 [*Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures*]; Angie Lewis clarified each action has its own timeframe and will share details with Damon. Jonny Sammut highlighted balancing upfront costs for innovation with long term efficiencies, and Ed Roberts agreed, noting a more open appetite for commercial innovation to enable risk taking while maintaining financial balance.

The Board:

1. **Approved the suite of seven Risk Appetite Statements;**
2. **Noted that the Audit Risk and Assurance Committee will oversee the next steps for implementation and monitoring of the Risk Appetite Statements, as part of the 2026/27 work programme;**
3. **Took assurance from the review and attention to the principal risks, and their review at the Executive Leadership Team and at relevant Committees;**
4. **Agreed that the reframed Reputational Risks 201a and 201b are overseen by the Board rather than the People & Culture Committee in future; and**
5. **Noted the ratings, mitigating actions and scoring trends for each principal risk.**

11. MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT (MIQPR)

11.1 This report is uploaded to Ibabs and to the Trust's website. The contents are therefore not repeated here.

11.2 Rachel Marsh presented the Monthly Integrated Quality and Performance Report (MIQPR), noting that most Emergency Medical Services (EMS) issues, including avoidable harm and performance, had already been addressed in previous agenda items. Rachel focused her report on other service areas, particularly the 111 service, and explained that the longstanding target of keeping abandoned calls below 5% is now unachievable with the current number of commissioned call handlers. This operational constraint means the service cannot consistently meet the target, and as a result, people who do not get through may seek help elsewhere, increasing pressure on other parts of the system. Rachel emphasised the importance of explicitly reporting harm and performance metrics in future MIQPRs, even if a separate harm report is not produced, to maintain transparency and support effective oversight.

11.3 Board members agreed on the need for clear communication about service pressures, comprehensive data, and a commitment to ongoing improvement and accountability across all service areas

The Board: Considered the September/October 2025 MIQPR and actions being taken.

12. INTEGRATED MEDIUM TERM PLAN (IMTP) DELIVERY/ASSURANCE

12.1 This report is uploaded to Ibabs and to the Trust's website. The contents are therefore not repeated here. Rachel Marsh provided an update on IMTP progress, emphasising that the coming year will be a no investment year due to commissioner guidance, with

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initial board priorities submitted at the end of November and a need for internal prioritisation amid possible budget reductions. Jayne Beeslee confirmed that the IMTP process and updates had been reviewed by the Finance and Performance Committee, and members were assured by the plans and readiness for Phase Two of the Ambulance Performance Framework.

12.2 The Chair enquired about the future direction of IMTPs nationally, given new NHS Wales leadership, and expressed concern about the length and relevance of the planning process. Emma Wood advised that the future of IMTPs is uncertain, especially with the new CEO's background in annual planning. Emma stressed the need for the Trust to focus on consolidation, align services with available funding, and present realistic options, as no new money is expected. Rachel added that planning should primarily clarify internal priorities and resource allocation, advocating for a longer term (three to five years) approach. Rhiannon noted England's shift to five-year planning, welcomed for its long-term focus, with members observing ongoing challenges with integrated financial and strategic planning. Emma concluded that the lack of integration is a barrier, and the Trust will need to moderate commitments, as innovations may not be funded next year.

The Board noted

1. **Progress for the Quarter 2 IMTP deliverables (CMT & Directorate level reported deliverables); and**
2. **The IMTP development approach described in the draft IMTP Planning Guidance (subject to further refinement and approval).**

13. FINANCIAL PERFORMANCE MONTH SEVEN 2025/26

13.1 Ed Roberts presented this report which is uploaded to Ibabs and to the Trust's website. The contents are therefore not repeated here. The Board reviewed the current financial performance, noting ongoing pressures and the challenging context for the remainder of the year. Discussions flagged the need for continued close monitoring of expenditure, with an emphasis on maintaining statutory financial duties despite the absence of new investment and the possibility of budget reductions.

13.2 The Board acknowledged the importance of aligning financial management with strategic priorities and recognised that future planning would require careful moderation of commitments and realistic expectations, given the constrained funding environment. The AAA from the Finance and Performance Committee which reviewed month six and month seven was noted.

The Board:

1. **Took assurance in relation to the Month 7 revenue financial position and performance of the Trust as at 31 October 2025;**
2. **Noted the delivery of the 2025/26 savings plan, and the context of this within the overall financial position of the Trust;**
3. **Noted the capital programme for 2025/26; and**

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4. **Noted the Month 7 Welsh Government monitoring returns submission.**

14. PARTNERSHIPS AND STAKEHOLDER ENGAGEMENT: POSITION STATEMENT, PROPOSITION ON FUTURE APPROACH AND NEXT STEPS

14.1 This report is uploaded to Ibabs and to the Trust's website. The contents are therefore not repeated here.

14.2 Estelle Hitchon addressed the Trust's current position on partnerships and stakeholder engagement, outlining the proposed future approach and next steps. Discussions emphasised the need to focus engagement efforts on areas that will deliver the greatest impact, improve community involvement and ensure diverse voices are heard.

14.3 The Board supported a more targeted and strategic approach to engagement, aiming to strengthen relationships with key stakeholders and communities, and agreed to further develop and implement these plans as part of ongoing organisational priorities.

The Board:

1. **Approved the proposal to focus engagement activity on a small number of core 2026-29 IMTP/corporate priorities;**
2. **Approved the proposal to report that activity through normal IMTP reporting process and/or the MIQPR; and**
3. **Approved the proposal to receive a report at Board on broader influencing and stakeholder relationships on a six-monthly basis from May 2026.**

15. BOARD COMMITTEE REPORTS

15.1 Academic Partnership Committee (APC) – 7 October 2025

15.1.1 Hayley Hutchings reported that the Academic Partnership Committee agreed to disband and redistribute its responsibilities, ensuring research and collaboration remain visible and scheduled. Hayley highlighted the importance of embedding research in the IMTP and noted the committee's receipt of the Strategic Action Plan, progress in Research and Innovation, and the appointment of a new research lead. The committee was assured by the development of a five-year Strategic Plan and progress against the NHS Research and Development framework. Trish Mills clarified that the decision to stand down the APC is deferred pending an external review, so the committee will continue to meet twice next year to maintain research visibility during the transition

15.2 Quality Patient Experience and Safety Committee (QuEST) 4 November 2025

15.2.1 Bethan Evans reported that the QuEST Committee welcomed an observer from the Joint Commission Committee. The committee resolved a PTR data reporting error to ensure future accuracy and discussed a patient story which addressed last minute non-emergency transport cancellations, which highlighted issues with demand and communication. Updates were provided on previous patient stories, including progress on easy-read resources and engagement with learning

disability groups. The committee approved the Prevent Policy; discussed revisions to the Clinical Plan; and noted ongoing work on Quality Governance.

15.3 People and Culture Committee – 13 November 2025

15.3.1 Hayley Hutchings reported that the People and Culture Committee endorsed extending the People and Culture plan to 2027. The Committee received a presentation on personalised learning packages and future training initiatives to widen participation and inclusion. Updates were provided on staff survey response rates; diversity and volunteer events; apprenticeship programmes; and operational training investments. Challenges with training abstraction was discussed, as well as ongoing reviews of rosters and care roles, and efforts to reduce overruns. The committee received assurance of staff readiness for Phase Two clinical model go-live with additional support. The Committee noted improvement in people metrics but raised concerns about falling PADR completion rates and violence/aggression figures.

15.3(a) Workforce Race Equality Standard (WRES) Report 2025

15.3a Angie Lewis emphasised that while the Welsh Government recognised the Trust's commitment to Workforce Race Equality, there is no complacency and more progress is needed. Angie highlighted the importance of the BEAM network and praised Meshack Ezeadim's and Rusna Begum's contributions. Angie also shared positive results from a digital recruitment campaign that increased recruitment from Black and minority backgrounds and called for continued focus on diversity and inclusion. Angie reported a strong staff survey response rate and assured the committee of the Trust's ongoing commitment to improvement.

15.4 Finance and Performance Committee – 18 November 2025

15.4.1 Jayne Beeslee's Finance and Performance Committee report highlighted the Trust's ongoing financial pressures and the need for continued focus on financial sustainability. The committee reviewed key performance metrics, discussed areas requiring improvement and examined the impact of current pressures on service delivery. The committee also considered the management of finance and performance risks and discussed ongoing efforts to address resource challenges and support operational effectiveness.

The Board: Noted the Committee Reports.

16. GOVERNANCE REPORT

16.1 The Governance Report was noted.

17. MINUTES OF BOARD AND OTHER COMMITTEES

17.1 The Board noted the following minutes which have been approved by the respective Committees and were for the Boards's attention / formal receipt:

05 August 2025 - Quality, Patient Safety and Experience Committee
12 August 2025 - People and Culture Committee

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18. REFLECTIONS AND SUMMARY OF DECISIONS AND ACTIONS

18.1 The Chair noted the meeting was comprehensive and highlighted the staff experience as particularly interesting and well aligned with key people initiatives.

19. ANY OTHER BUSINESS

19.1 None

20. EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC – 27 NOVEMBER 2025

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

21. DATE OF THE NEXT MEETING

21.1 Meeting of the Trust Board is scheduled for the 29 January 2026 at 09:30 at Cardiff MRD.

Meeting closed at: 12:55

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ACTION LOG

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST BOARD

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
			NO OPEN ACTIONS				

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

Agenda Item No.	05

REPORT TITLE

Chair and Vice-Chair's Report – January 2026

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Colin Dennis, Chair of the Trust Board Ceri Jackson, Vice Chair of the Trust Board
Author(s) of report	Alex Payne, Corporate Governance Manager

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

CHAIR'S REPORT

1. I am delighted to report to the Trust Board that the Cabinet Secretary for Health and Social Care has confirmed the extension of my tenure as Chair of the Welsh Ambulance Service for a further four years, taking my term to September 2030. Since taking up the role in October 2022, I have had the privilege of working alongside the Board and our colleagues as we continue to modernise the service and adapt to increasing demand, ensuring patients across Wales receive the highest standard of care. I remain fully committed to leading the organisation through the challenges ahead, and I am confident that through innovation and the continued hard work of our teams, we will build on the progress already made for the people of Wales.

2. I offer my sincere congratulations to Rhiannon Beaumont-Wood on her appointment as Vice Chair of Powys Teaching Health Board with effect from 09 February 2026. I wish to record, with thanks, her resignation, and note that today is Rhiannon's final meeting of the Board. Since joining in 2024, she has provided valued support, scrutiny and challenge, including through her membership of the Quality, Patient Experience and Safety Committee, and Audit, Risk and Assurance Committee; as well as through active engagement with our people and patients. On behalf of the Board, I extend sincere thanks for her contribution to the Trust and wish her continued success for the future. I have been actively engaging with Welsh Government on the delivery of the recruitment campaign for the vacancy and will provide an update at the next scheduled meeting of the Trust Board in March 2026.

3. The Board met for its bi-monthly Board Development activity on the 17 December 2025. During this development session the board received a presentation from colleagues in the Welsh NHS Confederation regarding the wider political landscape and focused on the continuing development of the Trust's IMTP for 2026-29. There was also a discussion regarding the Trust's metrics presented in the Monthly Integrated Quality and Performance Report.

4. Since our last meeting I have been busy, with the following activity: -
    - Regular meetings and briefings Emma Wood, Chief Executive, and other executives;
    - Routine meetings with the Cabinet Secretary for Health and Social Care;
    - Chaired a meeting of the Remuneration Committee on the 04 December:
    - Attended training delivered by Audit Wales regarding the role of Audit Wales and the foundations of effective scrutiny, on the 09 December;
    - Attended the Boad Development Day on the 17 December;
    - Attended a meeting of the NHS Wales body Chairs Peer Group on the 23 December;

- Panel membership of the WAST Live meeting on the 23 December;
- Attended a meeting of the Association of Ambulance Chief Executive's on the 07 January;
- Attended a meeting of the Welsh NHS Confederation Chair's Group on the 12 January;
- Met with the Good Governance Institute in regard to the upcoming external effectiveness review;
- Attended a meeting of the Finance and Performance Committee on the 20 January;
- Regular communication with Ceri Jackson, Vice-Chair;
- Routine meetings with Trade Union Partners;
- Routine meetings with Internal Audit;
- Routine meetings with Audit Wales;
- Routine monthly meetings with Non-Executive Director colleagues.

VICE-CHAIR'S REPORT

5. Since our last meeting I have been busy with the following activity: -
   - Attended the Audit, Risk and Assurance Committee on the 02 December;
   - Attended the Remuneration Committee on the 04 December;
   - Attended training delivered by Audit Wales regarding the role of Audit Wales and the foundations of effective scrutiny, on the 09 December 2025;
   - Attended the Vice-Chairs Peer Group meeting on the 10 December and the 14 January;
   - Attended the Boad Development Day on the 17 December;
   - Attended the Charity Committee on 13 January;
   - Visited the Cardiff Make Ready Depot on the 20 January;
   - Held routine meetings with the Chair of the Trust Board;
   - Held routine meetings with members of the Executive Leadership Team;
   - Held routine meetings with people and culture colleagues and Trust executives;
   - Held routine meetings with the Trust's Mental Health Lead;
   - Routine meetings with Trade Union Partners;
   - 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
29 January 2026	Trust Board

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

Agenda Item No.	06

REPORT TITLE

CHIEF EXECUTIVE REPORT: JANUARY 2026

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 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]

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 the 27th of November 2025. It is intended that this report will provide a strategic 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
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
The report references updates which relate to the following risks. 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 558 - Deterioration of staff health and well-being in the face of continued system pressures as a consequence of workplace experiences. Risk 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 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
29 January 2026	Trust Board

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 27 November 2025.

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.

ASSESSMENT

Chief Executive Activity Update

3. Since the last Board meeting, I continue to prioritise visible leadership and engagement across Wales. I visited St Asaph to meet and speak with colleagues, gaining further insight into local operational pressures and opportunities for improvement. I also attended Caernarfon Ambulance Station to celebrate the retirement of Trefor Jones, marking an extraordinary milestone of over 50 years of dedicated service to the NHS.

4. During this period, I was pleased to represent the Trust at both the North Wales Emergency Services Carol Service in Bangor and the Christmas Carol Service at Llandaff Cathedral, where I expressed my thanks to staff and volunteers for their exceptional commitment throughout the winter period.

5. The Trust hosted a visit from Jacqueline Totterdell, Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive, providing an opportunity to discuss shared priorities and system challenges. In addition, I attended the AACE Emergency Capabilities Unit meeting to learn from recent critical incidents managed by the English Ambulance Trusts.

6. I visited Betsi Cadwaladr University Health Board and Swansea Bay University Health Board to strengthen our system partnerships. At both sites, I undertook walk-throughs of Emergency Departments, observing patient flow from ambulance arrival to handover and speaking with our crews and ED colleagues during offload. I also visited Matrix to review progress on the planned move of the 111 service, covering readiness of infrastructure, workforce arrangements and spent time at Swansea Ambulance Station to meet staff, listen to feedback and thank teams for their continued professionalism.

Strategic Update

Ambulance Performance Framework – Phase 2 Highlights

7. The implementation of Phase 2 of the Ambulance Performance Framework (APF) progressed as planned on 2 December 2025 supported by a comprehensive programme of communications to explain the changes to staff, stakeholders and the public. Contact centre teams showed strong adaptation to the new processes, with minimal requirement for additional support.

8. As live operations unfolded, two key decisions were taken to ensure clarity and safety. Firstly, changes were made to the Clinical Services Plan and secondly, a Trust-wide position on blue-light use was published to address uncertainty among EMS crews. For Purple Arrest, Red Emergency, and Orange Now, confirmation was provided that emergency vehicles will respond to the call under emergency conditions, using lights and sirens. For Yellow Soon and Green Planned, emergency vehicles will proceed at normal road speeds without lights and sirens, although clinical judgement may be used on Yellow Soon calls.

9. While seasonal pressures and hospital handover delays continued to influence overall performance, early reviews and those to date confirm no patient safety incidents directly attributable to the APF changes. Command structures remained active for a few days following implementation to support staff and maintain situational awareness.

10. It is too early to offer any view on impacts, noting that the evaluation of change is following. We continue to monitor the impact of phase two on our performance and will update the Board as this embeds.

Level 1 Escalation Status

11. We received a letter from Jacqueline Totterdell, Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive, confirming the Trust's escalation status remains at Level 1 and outlining findings from the latest assessment. The correspondence recognises strengthened governance, improved collaborative working, reduced sickness rates, and our contributions to national programmes such as the new ambulance performance framework and the Handover-45 Taskforce. It also identifies areas requiring continued focus, including development of the Board Assurance Framework, performance within

111, capacity management pressures, complaint handling performance, and staff wellbeing concerns highlighted in the NHS Wales Staff Survey.

Healthcare Inspectorate Wales

12. Healthcare Inspectorate Wales (HIW) has confirmed it will undertake a desk-top review of the Trust during January and February 2026, with key themes to be published in the spring. The review will focus on patient flow and handover processes, escalation arrangements, communication with patients regarding delays, leadership presence and governance, workforce wellbeing and development, and the quality and accuracy of our data recording. The Trust has been asked to provide a detailed self-assessment, supported by evidence, across these thematic areas, with all submissions due via Objective Connect by 28 January 2026. Work is already underway to coordinate the required narrative and data to ensure we provide a comprehensive and transparent response that reflects both our progress and areas for improvement.

Annual Audit Summary 2025

13. The Audit Wales 2025 Structured Assessment and Annual Audit Summary are on today's agenda. These reports once again highlight the Board's strong financial stewardship and the robustness of the Trust's governance, planning and financial arrangements.

Winter Sprint Insights

14. The NHS Performance and Improvement sprint fortnight ran in early December (8–22 December). The intention was to improve flow and the discharge and transfer process. In terms of NEPTS delivery there was a notable increase in advance bookings and earlier discharges, though engagement varied across Health Boards. December saw record activity: the busiest day (354 journeys), the busiest December (6,057 journeys), and nearly the busiest month ever. Discharge & Transfer activity was up 5% compared to the same period in 2024. A second sprint is currently underway for the latter part of January.

15. As part of the Winter Sprints Health Boards were asked to improve upon handover delays, following a decline in compliance with the ambition to meet a 45-minute target. The improvements noted in the month of October were not sustained and some Health Boards' positions worsened. It was agreed at an NHS Leadership Board that hospitals would seek to deliver the October improvement in the month of December aiming at delivering the release to respond protocol by end of January 2026. Despite best endeavours the handover delay position declined in December, and we lost 13,044 hours.

People and Culture

16. As winter pressures intensify, we are taking forward a coordinated range of initiatives designed to strengthen leadership, support wellbeing, and build organisational capability during a critical period for the Trust.

17. Building on our aim to amplify colleague voice and ensure decisions are informed by colleague experience, the NHS WAST Staff Survey has closed with a 43.1% response rate, demonstrating an upward trend in engagement.

Digital

18. December has been a significant month for the Digital Directorate. Most prominently, it saw the inaugural operational deployment of the HART Drone. In parallel, our advanced virtual assistant, Albot, has progressed to the finals of the coveted Excellence in Healthcare Awards.

Royal College Status on the College of Paramedics

19. The College of Paramedics has been granted Royal College status, a prestigious recognition that elevates its standing within the healthcare sector. This milestone reflects the profession's growth, maturity, and contribution to patient care across the UK.

Finance and Planning

20. Reported year-to-date financial position to Month 9 of the current financial year 25/26 is a surplus of £180k. This is an improvement from a small deficit reported at Month 8 of £66k mainly due to notification that the in-year cost pressure for Welsh Risk Pool contribution will be covered centrally. Finance teams continue to

support the forecast year-end position which remains reported as that of break even, balanced position.

21. Continued focus remains on the delivery of the 26/27 financial plan to support the IMTP. Albeit WAST is a commissioned service, the Welsh Government publication of the Health Boards allocation letter for 26/27 (WHC 2025 55) released in December 25 provides some indication of the outlook for 26/27. Headline points include a potential 1.11% revenue increase to support unavoidable inflationary increases and demand growth that will be expected to flow via commissioning arrangements and a Welsh Government funded baseline discretionary capital allocation of £7.018m.

22. We continue to engage with the Senior Leadership Community to build our IMTP and have asked all Directorates to build a savings plan of 5% to enable the Trust to manage 26-27 financial pressures and consider investment opportunities. A number of meetings with the JCC are due to be held to clarify our priorities and the financial settlement.

RECOMMENDATION

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

Agenda Item No.	09

REPORT TITLE

Actions to mitigate avoidable patient harm in the context of extreme and sustained pressure across the urgent and emergency care system

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 2026
Public or Private	Public
If private - rationale	N/A

REPORT SPONSOR

Executive sponsor	Liam Williams – Executive Director of Quality & Nursing
Author(s) of report	Liam Williams – Executive Director of Quality & Nursing

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. At its November 2025 meeting Trust Board received and discussed a report relating to avoidable patient harm that has evolved over time to reflect the changes in organisational and national approaches to patient safety and quality reporting. At the Board Development Day in December 2025, it was agreed that the report should evolve to reflect the changes the clinical model and national regulatory / commissioning governance.

2. This report should be considered in conjunction with the Trust Monthly Integrated Quality and Performance Report (MIQPR). The Trust continues to take many actions to mitigate patient harm resulting from handover delays, at a strategic, tactical and operational level, which are reported through to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report, MIQPR, QuEST committee papers.

3. The Trust went live, as planned, on phase one of the new Ambulance Performance Framework on 1 July 2025 and, Phase Two on 2 December 2025.

4. The Trust is a core participant to the Welsh Government National Handover 45 Taskforce Board, represented by the Executive Directors of Quality and Nursing, Paramedicine and Operations. This Taskforce Board is directed to secure improvements in NHS handover of emergency and urgent care performance at the emergency department and associated other hospital entry points.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Trust Board is asked to:

1. **DISCUSS** the factors negatively impacting the experience of patients seeking care from the Trust because of delays in responding
2. **NOTE** that the Trust's clinical model transformation is taking effect and that this report will evolve alongside the MIQPR to demonstrate the impact on patient experience and specifically in this report, mitigations to harm
3. **NOTE** there has been a reduction in lost hours to hospital handover, however, the level remains substantially above the rostered levels that would enable us to better respond to community need.

ADDITIONAL PAPER(S)

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

Annex 1 Patient Harm Mitigations Indications 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 558 - Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences.

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
22 January 2026	Rachel Marsh – Executive Director Strategy, Planning & Performance
29 January 2026	Trust Board

SITUATION

1. Trust Board has received consistent reporting that sustained pressures across the Welsh NHS urgent and emergency care system negatively impacts on patient flow, leading to avoidable patient harm and increased mortality. This harm and mortality present through both Trust and population level data demonstrating deterioration or death while awaiting a response from WAST, deterioration and deconditioning while awaiting handover from WAST to the appropriate health board and, deconditioning extending care requirements across the acute and community pathway following admission to hospital.

BACKGROUND

2. The July 2022 Trust Board received the first iteration of a report and actions to mitigate real time avoidable patient harm which has then been updated for every Board meeting.

3. At its September 2024 meeting Trust Board received a closure report for the patient mitigations action plan and agreed to receive a patient harm scorecard going forward.

4. At its December 2025 Trust Board Development Day, the Board agreed to evolve the report to reflect improvements in clinical understanding and data sources being gained through changes in the clinical model and national changes to regulatory / commissioning governance.

5. The Trust continues to take many actions to mitigate patient harm, at a strategic, tactical and operational level, which are reported through to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report, Monthly Integrated Quality & Performance Report, QuEST committee agendas.

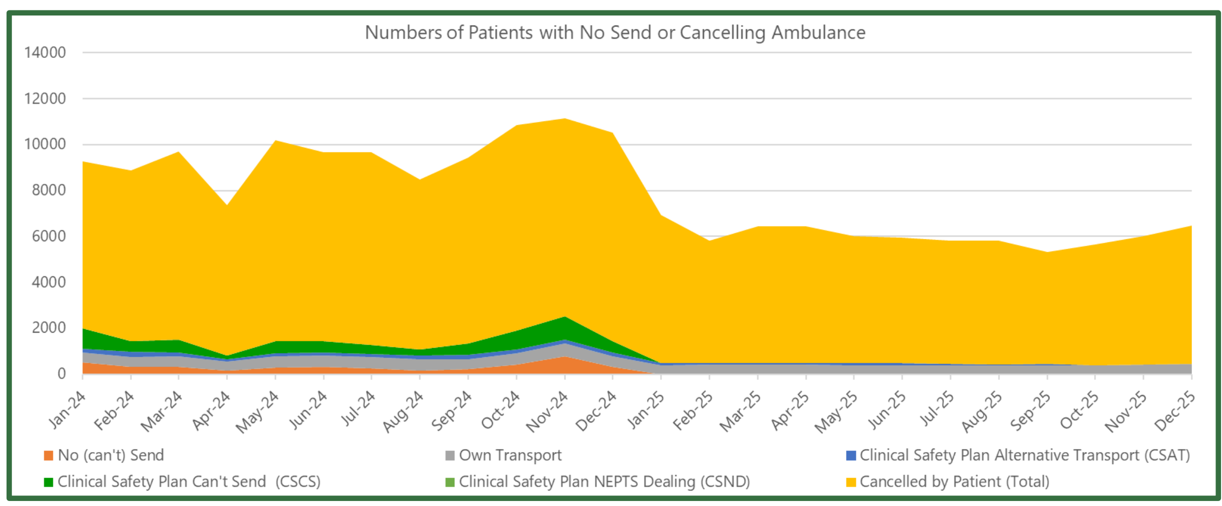
6. The Trust went live, as planned, on Phase One of the new Ambulance Performance Framework on 1 July 2025, and Phase Two on 2 December 2025.

7. The Trust is a core member and contributor to the Welsh Government Handover-45 Taskforce Board.

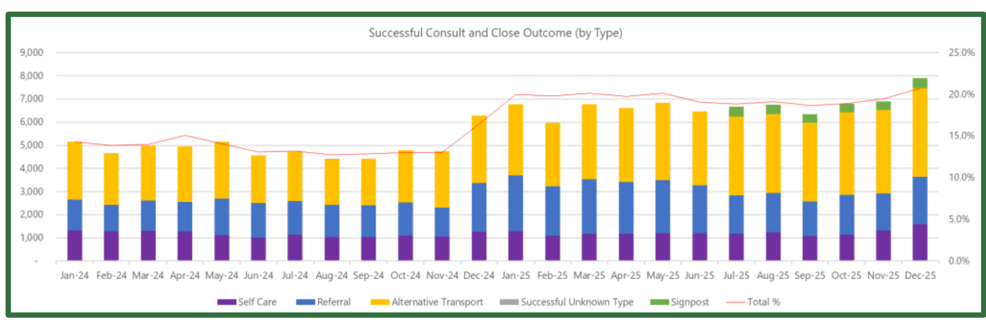
ASSESSMENT

8. Key to reducing delay related harm that occurs in the Trust is the need to reduce the time taken to transfer care from an emergency ambulance crew to the appropriate hospital team. The Trust has worked with Welsh Government, NHS Wales Performance and Improvement and wider NHS partners to secure improvements that are highlighted through this report. Specifically, the Trust has supported Accelerated Design Events that have taken place in across the country, the results of which are being considered by QuESt at their February meeting. The Trust has also supported two periods of national inpatient pathway flow improvement weeks, Sprints, that are designed to support more timely care and discharges from hospital that facilitate capacity at the front door. NHS Performance and Improvement have taken steps to secure improvements in performance to Handover 45 across the country, with the latest correspondence setting out expectations issued on the 22 January 2025.

9. While the Trust has not initiated any 'clinical 'no' or 'can't-send' ambulance instructions since January 2025, there continues to be a significant number of calls which are cancelled directly by patients. This number increased over November and December 2025, correlating with an increase in the volume of calls requiring a response, and the number of handovers of care delays being experienced at hospitals.



10. The increased clinical oversight of 999 calls and changes in call flow resulting from changes in the Ambulance Performance Framework, have secured higher levels of patient flow into Integrated Care (remote clinical assessments and consultations). The graph below demonstrates that this has, in turn, increased the levels of successful remote consult and close episodes for the Trust.



11. In light of the increased call volumes and delays in handover times, it is noted that some of the improvement in remote consult and close will be due to use of alternative transport for hospital journeys, such as taxi's commissioned by the Trust where clinically appropriate, and patients being informed to make their own way to hospital. The Trust is working with partners to secure improvements in patient flow that increases emergency ambulance availability for those that need this level of care, increase the range of available alternative services that remote clinicians can access to avoid referral to the emergency department or hospital, and develop data sharing agreements to understand whole pathway patient outcomes / service utilisation.

12. From October a range of new clinical indicators for the EMERG category went live with a further indicator, the clinical National Early Warning Score 2, due to go live in quarter four. It is expected that future iterations of this report will include reporting when changes have been completed, data has been validated and reporting is insightful.

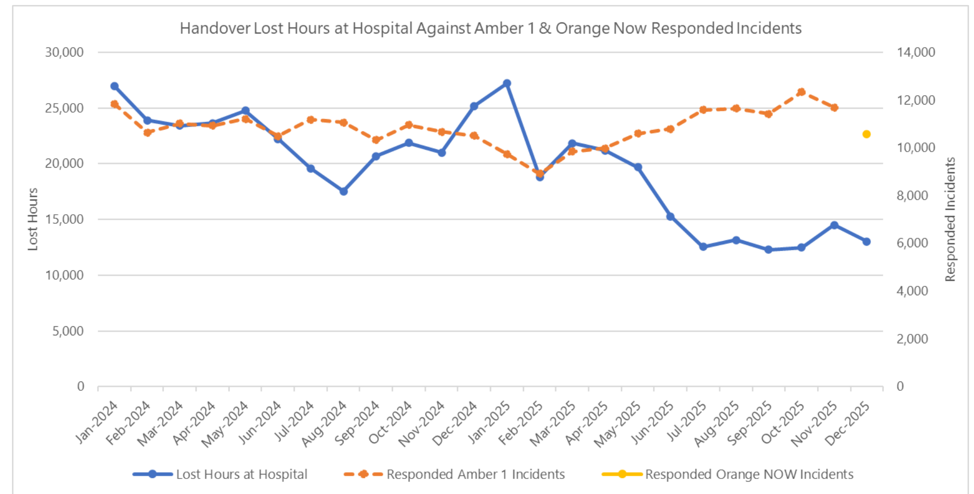
13. Phase Two of the Ambulance Performance Framework introduced three new categories:

- **'Orange: Now'**– for conditions needing a fast response and care from ambulance clinicians before transport to hospital for specialist care, such as a stroke;
- **'Yellow: Soon'**– for conditions which require further clinical assessment to determine the best pathway of care, such as a person suffering from abdominal pain who may be suitable to stay at home or may need further investigations; and
- '**Green: Planned'**– for conditions such as a blocked catheter which may require community care or planned transport to urgent care services.

14. Future iterations of this report will include analyses of the changes made in Phase Two of the Ambulance Performance Framework across the ORANGE, YELLOW and GREEN categories to inform impact on patient safety and harm reduction. Of note, the Trust does have a monitoring and assurance plan for Phase Two that has been

implemented and is reporting through to the Clinical Model Transformation Board, who ensure active monitoring and executive oversight of impact. Furthermore, the construction of a 'Benefits Realisation Group' as a workstream within the CMT programme will have the specific focus in driving improvements from the changes that have been implemented within this fiscal year.

15. Through the MIQPR, Trust Board have highlighted that the Handover Lost at Hospital against Amber 1 responded incidents is an important demonstration of the impact delays have in responding to calls such as stroke, chest pain and falls with a suspected injury. The graph below has been updated to reflect the change in Ambulance Performance Framework Phase 2 with the key comparative measure being ORANGE: Time Sensitive. [1]



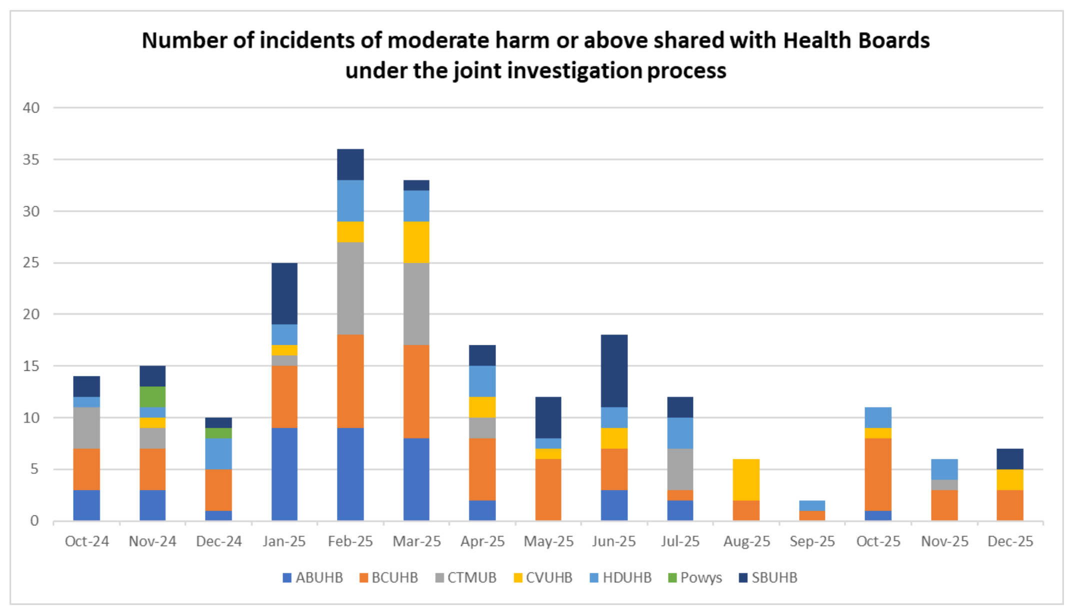
16. During December 2025 the Trust lost 13,044 hours to handover delays which is a significant and welcome improvement on the previous year's performance (25,195). However, this remains more than double the rostered hours for handover delays (6,000) and represents significant loss in capacity. As well as the impact on our ability to respond to patients in the community, this resulted in 3,698 patients waiting over an hour outside of a hospital for their care to be transferred, and 1,175 patients who waited over twelve hours.

17. The MIQPR demonstrates the timeliness and quality of care received by patients assessed as 'ORANGE Now' through 'call to door time' for time sensitive conditions, such as Cardiovascular Accident (stroke) and ST Elevated Myocardial Infarct (specified type of heart attack) and care bundle analyses. Where the Trust is not achieving responses that would ensure effective care, this will be identified through this report. Work continues to more accurately identify and stream

[1] Amber December value reflects the activity undertaken before the Trust moved onto the new performance measures on 2nd December.

patients with time sensitive presentations through the call flow process and, ensure they remain a priority for ambulance response.

18. Further indicators for patient experience and harm reported to the Trust come from Incidents and Complaints. During November and December, the number of National Reported Incidents (NRIs) was eleven and, the number of Joint Investigations opened with Health Boards was thirteen[2]. During this period, the Trust triggered the Duty of Candour on twelve occasions. NRIs and Joint Investigations are reported primarily where there has been significant or catastrophic harm caused to a patient; while NRIs often pertain to call classification and deployment of resources by the Trust, Joint Investigations are most often initiated due to a lack of resource available to respond in the community due to handover delays. Learning from all incidents is collated and thematically reported for consideration by members of the QuESt Committee.



19. Complaints are often received following completion of an episode of care and often means that there is a delay in receipt. Learning from complaints is used to respond inform the Trust, and NHS partners, of overall harm or poor experience that has occurred. This information is regularly considered at the Quality, Safety and Patient Experience Committee through thematic reporting.

RECOMMENDATION(s)

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

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[2] When comparing monthly activity, there can be a lag in formal reporting while incidents are processed, and initial assessments undertaken.

Patient Harm Mitigation Indicators Dashboard

Top Monthly Indicators	Target 2025/26	Oct-25	Nov-25	Dec-25	2 Year Average	RAG
Our Patients						
Volume of Amber 1 Responded Incidents	↑	12,339	11,689	482	10,411	A
Volume of NOW Responded Incidents	·			10,570		
Our People						
Total EMS Resource (all types) UHP	95%	95%	98%	97%	96.51%	G
Value						
% of Conveying Production Lost Due to Handover Lost Hours	7.81%	12.6%	15.2%	13.2%	20.3%	R
% of 111 Demand Referred to ED	↓	16.85%	17.12%	16.38%	15.28%	R
% of EMS Demand Conveyed to ED	↓	38.13%	36.97%	N/A	35.81%	R

Top Monthly Indicators	Target 2025/26	Oct-25	Nov-25	Dec-25	2 Year Average	RAG
Partnerships / System Contribution						
% of EMS Verified Demand Accessing SDECs	4.0%	0.6%	0.5%	0.6%	0.52%	G
Number of Patient Handovers > 45 mins	0	4,270	4,779	4,425	6,428	R
Number of Patient Handovers > 1 hour	0	3,604	4,059	3,698	5,402	R
Immediate Released (Arrest) Declined	0	0	0	0		G
Immediate Released (EMERG) Declined	0	0	4	2		G
Immediate Released (Amber 1) Declined	0	255	254	14	306	R
Immediate Released (Now) Declined	0			182		
Joint Investigation Framework Incidents Referred to Health Boards		11	6	N/A	13	

In-Month RAG Indicates = TBD: Status cannot be calculated (To Be Determined)
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)
Increasing/Decreasing Trend is over the last 3-month period

Agenda Item No.	10

REPORT TITLE

Risk Management & Board Assurance Framework Report

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Governance / Board Secretary
Author(s) of report	Julie Boalch, Assistant Director of Corporate Governance & Risk

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The Board is asked to note the updates against the management of the Trust's principal risks and take assurance that each of these have been reviewed in line with the agreed schedule detailed at Annex 3. The Executive Leadership Team (ELT) approved the principal risk activity on 28 December 2025 undertaken by Risk Owners.

2. Risk 223 *The Trust's inability to reach patients in the community causing patient harm and death* has reduced in score from 25 (5x5) to 20 (4x5) reflecting the impact of handover lost hours by Health Boards over the preceding six months. This is important in the context of 45 minute release (45MR) and the Trust's internal control environment, underpinned by real-time clinical and operational oversight through the Operational Delivery Unit (ODU), the Clinical Safety Plan (CSP), and system-level escalation mechanisms such as REAP and national risk huddles. Phase one and two of the Trust's Clinical Transformation Model - specifically the new

3. performance framework - have gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction.

4. Risk 623 *Failure to comply with Data Protection Legislation*, has achieved target score of 10 (2x5) reducing from 15 (3x5) and will be removed from the Board Assurance Framework (BAF) for ongoing management at a Directorate level.

5. Work continues in relation to the Trust's reputation Risk 201 which has been disaggregated into two separate risks following a reframing exercise. These are Risks 201a *Relationships with Stakeholders* and 201b *Poor Patient Experience Affecting Reputation* both scoring 16 (4x4) with targets of 12 (3x4). The full detail of both these risks will be included in future Trust Board Risk Reports. In the meantime, the BAF entry for Risk 201 has been removed from this report.

6. The report outlines the broader discussions across the senior leadership teams and the Committees on the higher rated risks and signposts the Board accordingly. The Risk Owners have an opportunity to further add to the narrative within the report and detail of any assurances or escalations during the meeting and Committee Chairs will also contribute to this as appropriate, drawing from the Alert, Advise, Assure reports (AAA).

7. The BAF is presented in the standard format and included in the reading room. However, the team, in collaboration with our auditors, is exploring a revised approach that aligns the BAF more closely with the emerging work on the Avoidable Harm paper and which will be expanded to include detail of the position and treatments of Risks 223 and 224. It is not intended that the full BAF will be presented at every meeting of the Board, and the Audit, Risk and Assurance Committee (ARAC) will agree the reporting frequency at its meeting in March 2026.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Trust Board is requested to:

1. Consider and discuss the contents of the report.
2. Note the reduction in scores for Risk 223 from 25 (5x5) to 20 (4x5) and Risk 623 from 15 (3x5) to 10 (2x5).
3. Receive assurance on the review and attention to the principal risks and their review at the Executive Leadership Team and at relevant Committees.
4. Note the ratings, mitigating actions and scoring trends for each principal risk.

ADDITIONAL PAPER(S)

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

1. The Trust Board is requested to receive the following:
   a. Annex 1 - Summary table describing the Trust's Principal Risks.
   b. Annex 2 – Scoring Matrix
   c. Annex 3 – Frequency of Risk Review
   d. Annex 4 – Board Assurance Framework (Ibabs Reading Room)
   e. Annex 5 – Principal Risk Trending Data

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
See Annex 1

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
28 December 2025	Executive Leadership Team
20 January 2026	Finance & Performance Committee
29 January 2026	Trust Board
03 February 2026	Quality, Patient Experience & Safety Committee
10 February 2026	People & Culture Committee

SITUATION

1. The purpose of the report is to provide a progress update on the management of the Trust's principal risks.

BACKGROUND

2. The Trust's principal risks, as outlined in this paper, are allocated to Directors who lead reviews and mitigating actions. In addition to directorate reviews, formal risk review discussions are held by the Executive Leadership Team (ELT) concerning risk escalation, changes in ratings, and new risks for inclusion on the Corporate Risk Register (CRR).

3. This report demonstrates the sustained focus on risk management, not only through risk discussions in various forums but also through broader attention to planned mitigations across the system.

4. The Risk Management programme, overseen by the Audit, Risk & Assurance Committee (ARAC) and monitored through the Corporate Governance Directorate Plan, has included the development of a suite of Risk Appetite Statements (RAs) during 2025/26. The outcome of this work was presented at the Board meeting in November 2025, recognising that the Board should annually agree and set the risk appetite against each of its strategic objectives. An update will be brought to the June 2026 meeting of Trust Board.

ASSESSMENT

Principal Risks

5. The ELT approved the principal risk activity on 28 December 2025 having considered the review of each risk undertaken throughout the period by Risk Owners.

6. A summary table of these risks is set out in Annex 1 with a detailed description of each contained within the Board Assurance Framework (BAF) at Annex 4. All updates are highlighted in blue on the BAF.

7. The more detailed description contained within the BAF provides the Board with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the scoring matrix in Annex 2.

8. The BAF is presented in the standard format and included in the reading room. However, the team, in collaboration with our auditors, is exploring a revised approach that aligns the BAF more closely with the emerging work on the Avoidable Harm paper and which will be expanded to include detail of the position and treatments of Risks 223 and 224. It is not intended that the full BAF will be presented at every meeting of the Board, and the Audit, Risk and Assurance Committee (ARAC) will agree the reporting frequency at its meeting in March 2026.

9. Each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each 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.

10. The Trust's highest rated **Risks 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*, have been reviewed in the context of the Trust's strengthening internal control environment. These controls are underpinned by real-time clinical and operational oversight through the Operational Delivery Unit (ODU), the Clinical Safety Plan (CSP), and system-level escalation mechanisms such as REAP and national risk huddles.

11. Phase one and two of the Trust's Clinical Transformation Model have now gone live, with the new performance framework representing a significant milestone in delivering an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the 45 minute release (45MR) standard by some Health Boards represents a positive development, supporting more timely transfers of care and reducing avoidable harm.

12. Because of this progress, the Board is asked to note a reduction in the score for Risk 223 from 25 (5x5) to 20 (4x5).

13. The ELT agreed that the score for **Risk 224** will remain at 25 (5x5) for this round. Data will be kept under review for the next quarter with a view to reduce the score once an analysis has been completed to determine whether the recent changes have delivered sustained or system-wide risk reduction. Internal controls cannot fully mitigate external system constraints, including Emergency Department capacity, patient flow and inconsistent delivery of national handover standards.

14. While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides an opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and delivery of improvement plans has limited the extent of risk mitigation achievable through internal controls alone. However, increasing national scrutiny and a shift toward system-based accountability present an opportunity to deliver greater consistency and collective impact across organisational boundaries.

15. Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes. The Audit Wales report (June 2025) into the effectiveness of unscheduled care arrangements across NHS Wales provides external insight into whole-system performance and identifies further levers to drive national consistency and accountability.

16. The introduction of 45MR from 1 October 2025 was a partially accepted MAG recommendation. NHS Wales Performance and Improvement (P&I) remains committed to this becoming the national standard, with Health Boards being required to adopt this by the end of January 2026. The progress already made by most Health Boards in the preceding months, represents a positive step toward reducing avoidable patient harm. A clinically led Handover-45 taskforce has been established, and workshops continue to support local improvement plans.

17. The risk data is presented by theme and category, supporting the identification of gaps and required escalations. A detailed operational action plan underpinning these risks is held at an operational level.

18. The risks continue to be reported to the Trust Board, with emphasis on actions within the Trust's control. These are reflected in the avoidable harm dashboard presented at each Board meeting. Further mitigations and transformational actions are also described in the Integrated Medium Term Plan (IMTP) and other regular reports, including the IMTP Assurance Report and the Monthly Integrated Quality & Performance Report to address these risks.

19. Most actions within the avoidable harm dashboard have been completed and several efficiencies and improvements have contributed to stabilised performance. However, the Trust cannot fully mitigate the scale of handover lost hours due to the wider system environment.

20. The Quality, Patient Experience and Safety Committee (QuEST) reviewed both risks in November 2025 with the Agenda items reflecting the controls and mitigations discussed. These risks continue to be escalated to the Board via the meeting's Alert, Assure and Advise (AAA) report.

21. Members are asked to note that work continues on **Risk 201** *A loss of stakeholder confidence that damages the Trust's reputation*, which has been reframed and disaggregated into two separate risks which were reported at the last meeting. The full detail of these risks including controls, assurances, gaps and mitigating actions will be included in future reports and overseen by the Trust Board rather than the People & Culture Committee given the scope of these risks extends beyond staff engagement.

22. **Risk 260** *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems* remains static at a score of 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks. The risk is reviewed in closed sessions of committees and Trust Board given that the specific detail and planned mitigations of this risk are of a sensitive and security based nature. The high level detail of the risk and its rating is included in open session; however, the full detail is not included in Annex 4. The risk will be discussed in closed session of Trust Board today and by the closed meeting of the Finance & Performance Committee (FPC) on 20 January 2026.

23. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in open session of the Board in full transparency. However, members will note that the actions to address individual recommendations are not included in detail in the BAF extract. This is for reasons of sensitivity and security.

24. **Risk 160** *High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service*, remains static at a score of 16 (4x4) during this review period, reflecting that the rolling annual figures for sickness since March 2022 are reducing year on year and therefore a reduction in the score is appropriate. This will be closely monitored by the People & Culture team and Executive Leadership Team.

25. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4). Work is underway to reposition the risk utilising the new approach to separate controls, assurances and gaps into internal and external themes and categories; those that the Trust manages and those that it monitors. Each of the assurances against the controls will be described over three lines of assurance for a future Finance & Performance Committee meeting.

26. **Risk 671** *Unauthorised or Inappropriate use of AI technologies* remains static at a score of 16 (4x4) with a target of 8 (2x4). An AI Steering Group (AISG) has been established, reporting into Information Governance Steering Group, meeting for the first time in October 2025, to ensure the approach of "responsible AI" across the Trust.

27. **Risk 558** *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures,* currently remains unchanged at a score of 15 (3x5); however, work is underway to consider the current actions and mitigations against this risk and to articulate the work that will support this risk to target.

28. **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* remain unchanged this period and static at a score of 15 (3x5).

29. **Risk 623** *Failure to comply with Data Protection Legislation*, has achieved target score of 10 (2x5) reducing from 15 (3x5) and will be removed from the BAF. The risk is unlikely to ever be completely resolved as the landscape around the Trust constantly shifts and will be managed at a directorate level and by the Integrated Governance Steering Group.

30. **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* remains static at a score of 12 (3x4) during this period; however, this risk will be considered more closely to determine whether it can be factored into the new relationships with stakeholders reputation risk in the next round.

31. **Risk 163** *Maintaining Effective & Strong Trade Union Partnerships* remains unchanged at a score of 12 (3x4) in this review period.

32. **Risk 139** *Failure to Deliver our Statutory Financial Duties* remains unchanged at a score of 8 (2x4) during this period; however, this risk will be considered in close detail in the next round in line with the financial position for 2026/27.

Risk Trending Data

33. A dashboard describing principal risk score trends from March 2023 and their movement over time has been produced and is attached at Annex 5. A heat map of these risks will be developed once work commences to map these risks to the overarching strategic risks in development; those that will prevent the Trust from achieving its strategic objectives.

34. The trend data demonstrates where a risk has achieved target score, been fully mitigated or closed and which has then either been removed from the corporate risk register and de-escalated to a directorate risk register for ongoing monitoring or closed from all registers.

35. The use of risk appetite going forward will support a more prescribed interrogation of the risk data as it informs risk scoring, target setting, escalation and assurance mapping of each of the risks.

RECOMMENDATION

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

NEXT STEPS

37. A detailed review of each principal risk is underway with the outcome due to be reported to the ELT on 28 January 2026 for discussion and approval of the activity.

38. The Audit, Risk and Assurance Committee (ARAC) will oversee the next steps for implementation and monitoring of the Risk Appetite Statements, as part of the 2026/27 work programme.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death.	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Executive Director of Operations	**20 (4x5)** ↓ **25 (5x5)**
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service.	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	**25 (5x5)** →
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation.	**IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures **THEN** there will be a loss of stakeholder confidence in the Trust **RESULTING IN** a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny	Director of Partnerships & Engagement	**20 (4x5)** →

260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**20 (4x5)** ➡
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	**IF** the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared **THEN** there is a RISK that the Trust's Incident Response will be suboptimal **RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	**20 (4x5)** ➡

671 FPC	Unauthorised or Inappropriate use of AI technologies	**IF** staff use Gen-AI tools such as ChatGPT, Co-Pilot or other AI enable platforms outside of approved organisational channels or without appropriate governance **THEN** information passed into, accessed by, or returned by the AI tools may breach information security and data protection controls, and use of the output may breach transparency, medical device, equality, Welsh Language and ethical requirements **RESULTING IN** potential breach of confidentiality and data protection law, data, damage to Trust, and non-compliance with other legislation, regulation and standards.	Director of Digital	**16 (4x4)**
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service.	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of People & Culture	**16 (4x4)** ➡
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage	Executive Director of Finance & Corporate Resources	**16 (4x4)** ➡

558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of People & Culture	**15 (3x5)** ➡
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)** ➡

623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.	Director of Digital Services	**10 (2x5)** ↓ **15 (3x5)**
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	**IF** WAST fails to persuade JCC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Executive Director of Strategy Planning & Performance	**12 (3x4)** →

163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of People & Culture	**12 (3x4)** →
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Executive Director of Finance & Corporate Resources	**8 (2x4)** →

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		**Consequence:**				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Highly Unlikely: Will probably never happen/recur	**Not for years**	**1**	**2**	**3**	**4**	**5**
2 Unlikely: Do not expect it to happen/recur but it is possible	**At least annually**	**2**	**4**	**6**	**8**	**10**
3 Likely: It might happen/recur occasionally	**At least monthly**	**3**	**6**	**9**	**12**	**15**
4 Highly Likely: Will probably happen/recur, but not a persisting issue	**At least weekly**	**4**	**8**	**12**	**16**	**20**
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	**At least daily**	**5**	**10**	**15**	**20**	**25**

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Agenda Item No. 11

REPORT TITLE

Monthly Integrated Quality Performance Report –November/December 2025

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 2026
Public or Private	Public
If private - rationale	N/A

REPORT SPONSOR

Executive sponsor	Rachel Marsh– Executive Director of Strategy, Planning & Performance
Author(s) of report	Hugh Bennett – Assistant Director Commissioning & Performance Mark Thomas - Commissioning & Performance Manager Melanie O'Connor - Senior Performance Analyst

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

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

2. The report aims to provide an integrated view of quality and performance, so is made available to all three committees to give that overview, with more specific and detailed reports supplementing it.

3. The general data quality in the report is good (and the amount of data comprehensive), but a number of specific data quality issues have previously been identified. Some have been resolved, and others are being worked through with a clear Executive focus on Phase 2 of the Ambulance Performance Framework, which went live at the beginning of December. Additional capacity is being sought for the Insight & Data Services (IDS) function with a number of appointments into new posts being made, but onboarding and then a lead in time for these new staff to come up to speed is required. In the interim, IDS capacity is being actively managed by senior IDS managers and also through a CMT Metrics workplan.

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

5. The Trust saw 13,044 hours lost to hospital handover during December 2025, compared to 25,195 lost hours in December 2024. This follows on from significant month-on-month reductions seen since June 2025 pan-Wales. Whilst this reduction is very welcome, it is by no means universal, and the ambition is for all health boards to reduce handover to levels which improve patient experience and outcomes, and which are sustainable.

6. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in December 2025 and is not expected to within the current resource envelope.

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

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

RECOMMENDATIONS(S)

See writing and presentation guidance here to inform this section
The Trust Board is requested to: 1. **Consider the November/ December 2025** Integrated Quality and Performance Report and actions being taken and determine whether: a. The report provides sufficient assurance. b. Whether further information, scrutiny or assurance are required, or c. Further remedial actions are to be undertaken through Executives.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
Annex 1 Monthly Integrated Quality and Performance Dashboard

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
223 - The Trust's inability to reach patients in the community causing patient harm and death 224 - 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 & 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
21 January 2026	Hugh Bennett – Assistant Director Commissioning & Performance
21 January 2026	Rachel Marsh – Executive Director Strategy, Planning & Performance
28 January 2026	Executive Leadership Team
29 January 2026	Trust Board

SITUATION

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

BACKGROUND

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

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

Our Patients – Quality, Safety and Patient Experience

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

4. **999** call answering times during December 2025 saw the 95th percentile increasing to 36 seconds, compared to 15 seconds in November 2025. However, the 65th percentile and median performance times remained consistently good. December's data is under review. Work is currently being undertaken on demand and capacity analysis of 999 call demand.

5. **111 call answering performance has minimally decreased over recent weeks,** with the call abandonment rate for December 2025 being 21.8%, and therefore not achieving the 5% target. 111 demand in December 2025 did see an 6.02% increase compared to December 2024. In addition, the external rostering review suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to reach performance without an increase in its workforce (including efficiencies). The current position with commissioners is to focus on efficiencies (roster practices) and the 111 digital front ends as a way of managing demand rather than investment in call handlers.

6. **111 Clinical response:** clinical ring back times for patients with the highest priority dropped below target at 89.1%. Response times for lower priority calls also showed a decrease , reducing to 25.7% and 26% for P2CT and P3CT respectively.

7. **Ambulance Response** (safety / patient experience): on 1 July 2025, the Trust's new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. In December 2025, there were 957 purple calls to the ambulance service, around 2.51% of all calls, and 5,469 (Emerg) red calls, around 14.36% of all calls. The main measure for Purple Arrest calls is the Return to Spontaneous Circulation (ROSC) rate which was 21.9% in December 2025 compared to 19.5% in November 2025. The median response times for purple and red calls were 7 minutes 34 seconds and 9 minutes 19 seconds respectively, with the required range being 6- 8 minutes.

8. On 2nd December, Amber was replaced by the Orange (Now) and Yellow (Soon). The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand.
   The median response time in December 2025 for Orange Now incidents was 1 hour and 19 minutes.
   The Clinical Safety Plan will protect Arrest and Emergency demand, but Orange Now is where the impact of handover lost hours is most felt i.e. there is a strong correlation. These response times still remain too high and have a known impact on avoidable patient harm.

9. Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good and increased to 92% in December, and handover lost hours have significantly improved; with this improvement particularly feeding through into the Amber/Now category's performance. Health Boards are implementing new actions in order to further reduce handover lost hours. The Trust's main focus is to continue to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme. Areas of focus for 2025/26 include: -

   - Further investment into remote clinical capacity;
   - Further investment in APPs;
   - Development of the remote integrated care service (111 clinicians and CSD clinicians);

- Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: use of volunteers, mental health response pilot, Falls response etc.; and
- The transformation of the various clinical model categories as per the previous paragraph.

10. As above, the level of lost hours to **handover outside Emergency Departments** remains a critical component of long waiting times and patient safety incidents. 13,044 hours were lost during December 2025; a 48.2% reduction compared to December 2024 and is the fifth lowest monthly figure since December 2021. This follows on from significant month-on-month reductions seen since June pan-Wales. Whilst this reduction is very welcome, there is variation across Wales, with Betsi Cadwaladr health board remaining high, with 5,568 hours being lost within the health board during December 2025. The ambition is for all health boards to reduce handover to levels which improve patient experience and outcomes, and which are sustainable. WG has re-iterated to health boards the critical importance of improvements in this area and the reduction of all over 45-minute waits was a recommendation from the recent Ministerial Advisory Group on Performance and Productivity. The W45 initiative would see handover lost hours reduce to approximately what the EMS rosters are designed to cope with.

11. **Ambulance Care (Patient Experience)**: Oncology performance in December 2025 was 79.9%, achieving the 70% target. Renal performance reduced minimally but remains above the 70% target achieving 74%. Advanced discharge and transfer journey performance decreased to 72% (95% target), with this primarily being an issue with capacity. Same day discharge and transfer journey performance achieved 95.8% hitting the 95% target. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive health transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is currently re-rostering NEPTS transport which will better align available capacity with changing demand patterns (on target). This is proving complex and difficult but will be delivered.

12. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported five NRIs to NHS Wales Performance & Improvement in December 2025, decreasing from the previous month, and seven serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In December 2025 complaint response times increased slightly to 44%, compared to the 43% recorded in November 2025, and not achieving the 75% target. Data accuracy issues have been identified and addressed. However, a PTR recovery plan remains in place, recognising that cases continue to be complex.

13. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 92.1% in December 2025, increasing from the previous month (88.3%), and remains below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system, and this improvement is clearly being seen in most of the clinical indicators.

14. For December 2025, the Trust saw call to hospital door times of two hours and 25 minutes for stroke patients and two hours and fifty-five minutes for STEMI. Clearly these times remain too long and are representative of the longer response times, because of the pressures and issues outlined earlier within this report, notwithstanding recent improvements in hours lost to handover.

15. In December 2025, 6,020 patients **cancelled** their ambulance (this figure excludes patients who refused treatment), which is a significant reduction on previous levels but a slight increase from November 2025 (5,603). This reduction is likely to be the impact of switching on RCS although caution is required at this stage, as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its Clinical Safety Plan in December, removing the "can't send" application, with the option remaining at the strategic commander's discretion in the new plan.

Our People (workforce resourcing, experience, and safety)

16. **Hours Produced**: The Trust produced 122,863 Ambulance Response unit hours during December 2025 and delivered an emergency ambulance unit hours production (UHP) of 92%, remaining below the 95% target (This will be a product of abstractions being above benchmark and the current vacancy factor).

17. **Response Abstractions:** EMS abstraction levels increased minimally to 33.08% during December 2025 and are close the 30% benchmark figure. Response sickness abstractions stood at 8.83% (benchmark 5.99%).

18. **Trust sickness absence:** the Trust's overall sickness percentage was 9.23% in December 2025, minimally up on the 8.35% recorded in November 2025, which is in line with seasonal factors. Actions within the IMTP concentrate on staff well-being with an aim to reduce this level to the IMTP ambition of 6%.

19. **Staff training and PADRs:** PADR rates did not achieve the 85% target in December2025 however decreased slightly to 76.48%. Compliance for Statutory and Mandatory training increased slightly to 88% achieving the 85% target.

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

<u>Finance & Value</u>

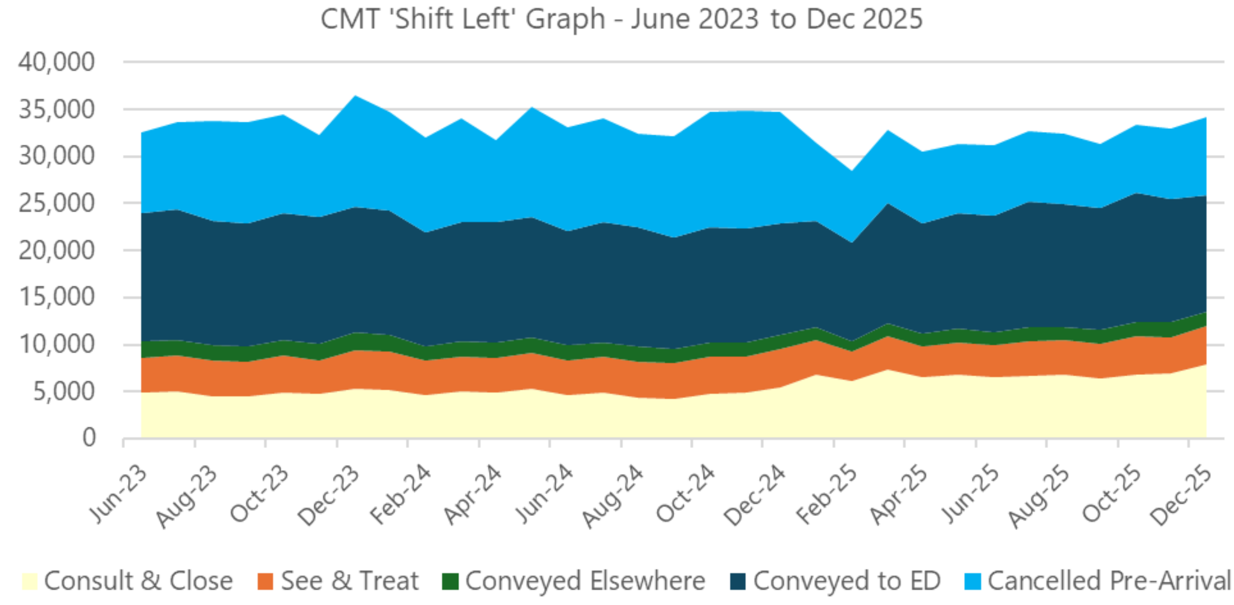
21. **Financial Balance**: the reported outturn performance at Month 8 is a deficit of £0.66m with a forecast to the year-end of breakeven. The Trust is forecasting the achievement of both its External Financing Limit and its Capital Expenditure Limit.

<u>Partnerships & System Contribution</u>

22. The consult & close rate was 20.8% in December 2025, a slight increase from the previous month but not achieving the IMTP ambition (and Welsh Government target) of 22%.

23. Same Day Emergency Care (SDEC) centres continue to see only a low level of ambulance activity.

24.



RECOMMENDATION

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

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

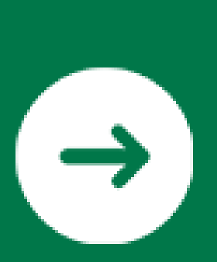
November/December 2025

Annex 1 – Top Indicator Dashboard

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators	Target 2025/26	Sep-25	Oct-25	Nov-25	Dec-25	2 Year Average	RAG
Our Patients							
Timeliness Indicators							
NHS111 Call Handling Abandonment Rates	< 5%	10.5%	12.0%	14.6%	21.8%	10.9%	R
111 Clinical Triage Call Back Time (P1)	90%	99.1%	97.9%	94.6%	89.1%	97.0%	A
999 Call Answer Times 95th Percentile	00:06	00:18	00:10	00:15	00:36	00:22	R
Arrest (Purple) Median	6-8 Minutes	07:15	07:29	07:05	07:34	N/A	G
Emerg. (Red) Median	6-8 Minutes	08:36	08:49	08:27	09:19	N/A	R
Now (Orange) Median		N/A	N/A	N/A	01:19	N/A	
999 Amber 1 Median		01:21	01:27	01:38	N/A	01:38	
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	77.8%	81.1%	78.4%	79.9%	75.9%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	80.6%	82.1%	82.7%	72.0%	79.8%	R
Clinical Outcomes / Quality Indicators							
Return of Spontaneous Circulation (ROSC)	25%	23.7%	20.4%	19.5%	21.9%	20.4%	R
Stroke Patients with Appropriate Care	95%	88.5%	86.7%	88.3%	92.1%	86.7%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:09	02:21	02:22	02:25	02:24	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	67.5%	75.9%	74.7%	74.0%	64.3%	R
National Reportable Incidents reports (NRI)		3	3	6	5	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	5,314	5,651	6,021	6,479	7,849	R
Concerns Response within 30 Days	75%	56%	62%	43%	44%	58%	R
Enactment of the Duty of Candour Total		4	5	7	5	5	
Capacity							
Hours Produced for Emergency Ambulances	95-100%	89%	91%	93%	92%	93%	A

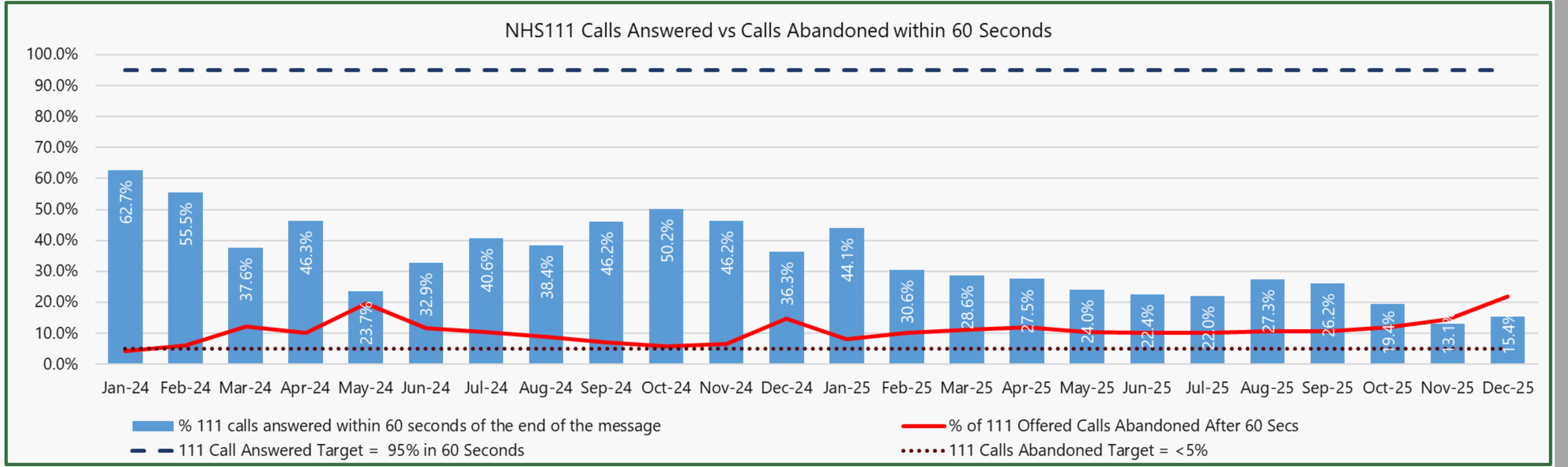
Top Monthly Indicators	Target 2025/26	Sep-25	Oct-25	Nov-25	Dec-25	2 Year Average	RAG
Sickness Absence *(all staff)*	6.0%	7.81%	7.87%	8.35%	9.23%	7.92%	R
Mental Health Absence Rates	Reduction Trend	2.96%	2.81%	2.78%	3.02%	2.51%	R
Staff Turnover Rate	Reduction Trend	8.02%	7.99%	8.12%	7.98%	8.32%	A
Statutory & Mandatory Training	>85%	84.61%	85.56%	87.21%	88.00%	84.95%	G
PADR/Medical Appraisal	>85%	75.35%	76.32%	76.53%	76.48%	74.61%	R
Number of Shift Overruns	Reduction Trend	3,292	3,583	3,538	3,537	3,780	G
Inclusion & Engagement / Culture							
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.50%	1.40%	1.40%	1.60%	1.9%	A
Value							
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	N/A	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	26.4%	27.3%	28.5%	31.4%	28%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.39	2.88	2.85	2.86	2.46	A
NEPTS on the Day Cancellations	Reduction Trend	14.3%	15.2%	14.8%	13.1%	13%	G
Partnerships / System Contribution							
Inverting the Triangle							
Successful Consult & Close Outcome	22% benchmark	18.7%	18.9%	19.5%	20.8%	16.7%	A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	10.20%	10.30%	10.70%	10.25%	10.9%	G
Number of Handover Lost Hours	7,500	12,284	12,477	14,501	13,044	19,701	R
NHS111							
NHS111 Dental Calls	Increasing Trend	8,852	9,016	8,577	8,932	8,315	R
Consult & Close Volumes by NHS111	Increasing Trend	1,940	2,035	1,883	2,414	1,588	A

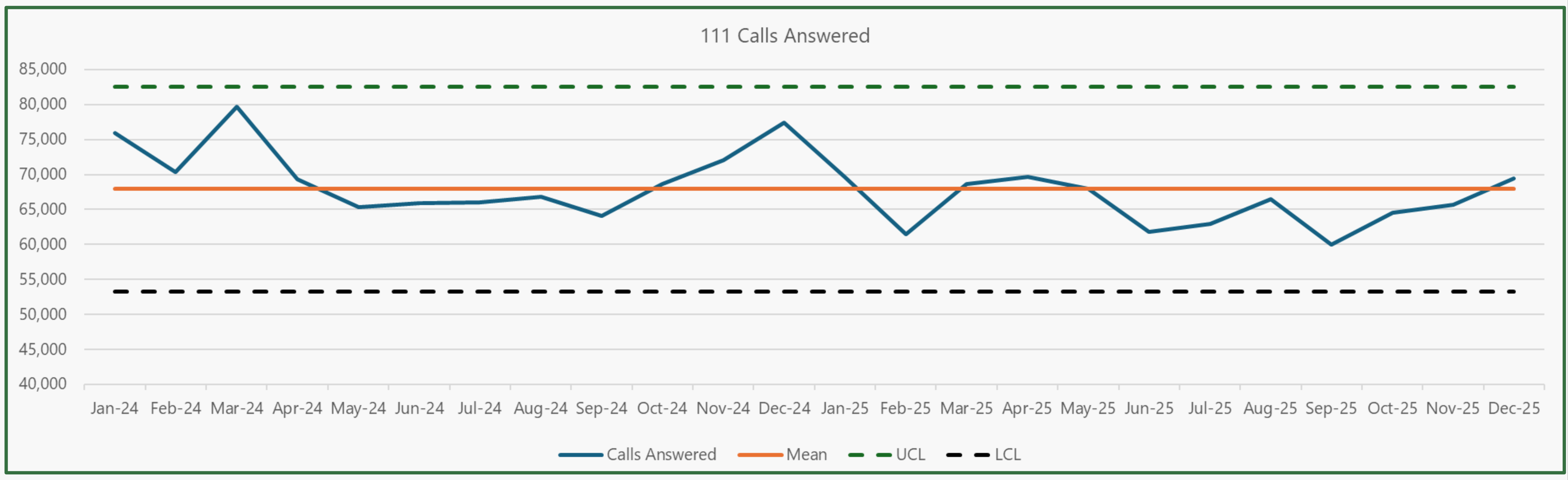
In-Month RAG Indicates = TBD: Status cannot be calculated (To Be Determined)
Green: Performance is at or has exceeded the target *(Indicates no action is required)*
Amber: Performance is at or within 10% of target *(Indicates some issues/risks to performance (monitoring is required))*
Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)
Increasing/Reducing Trend is over the last 3-month period

Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators
Influencing Factors – Demand and Call Handling Hours Produced

(Responsible Officer: Lee Brooks)

FPC





Analysis

The 111-call abandonment rate increased to 21.8% in December 2025 from 14.6% in November 2025. The percentage of 111 calls answered within 60 seconds increased from 13.1% in November 2025 to 15.4% in December 2025 but continues to remain significantly below the 95% target and the levels seen during 2024.

111 call demand reached 107,920, the second highest since November 2022 when call levels reached 144,198 this follows historical patterns whereby a high levels of demand negatively impacts performance.

This call answer rate of 15.4% in December 2025 is the second lowest seen in the past two years and is significantly below the 46.1% recorded in December 2023. This is at a time when UHP capacity for call handlers has increased slightly and is higher than the levels produced in September 2024.

However, the external rostering preview suggests there is a demand and capacity gap i.e. the current funded establishment is not sufficient to meet patient demand, and the Trust is therefore unlikely to achieve the performance targets without an increased workforce.

Remedial Plans and Actions

Key actions include:

Actions were taken to improve the call handling resourcing position through the summer; this included an active recruitment plan.

A 111-re-roster review, is underway, that takes account of the increased demand the Trust is seeing; what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this. The review has identified a demand & capacity gap.

The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.

Actions are underway to increase the utilisation of virtual queuing and review the way patients who are re-accessing for the same care episode could be managed differently.

Expected Performance Trajectory

We would expect to see performance levels decline during the Winter as the demand and capacity gap will widen at this time of year, despite planned over production by the service.

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

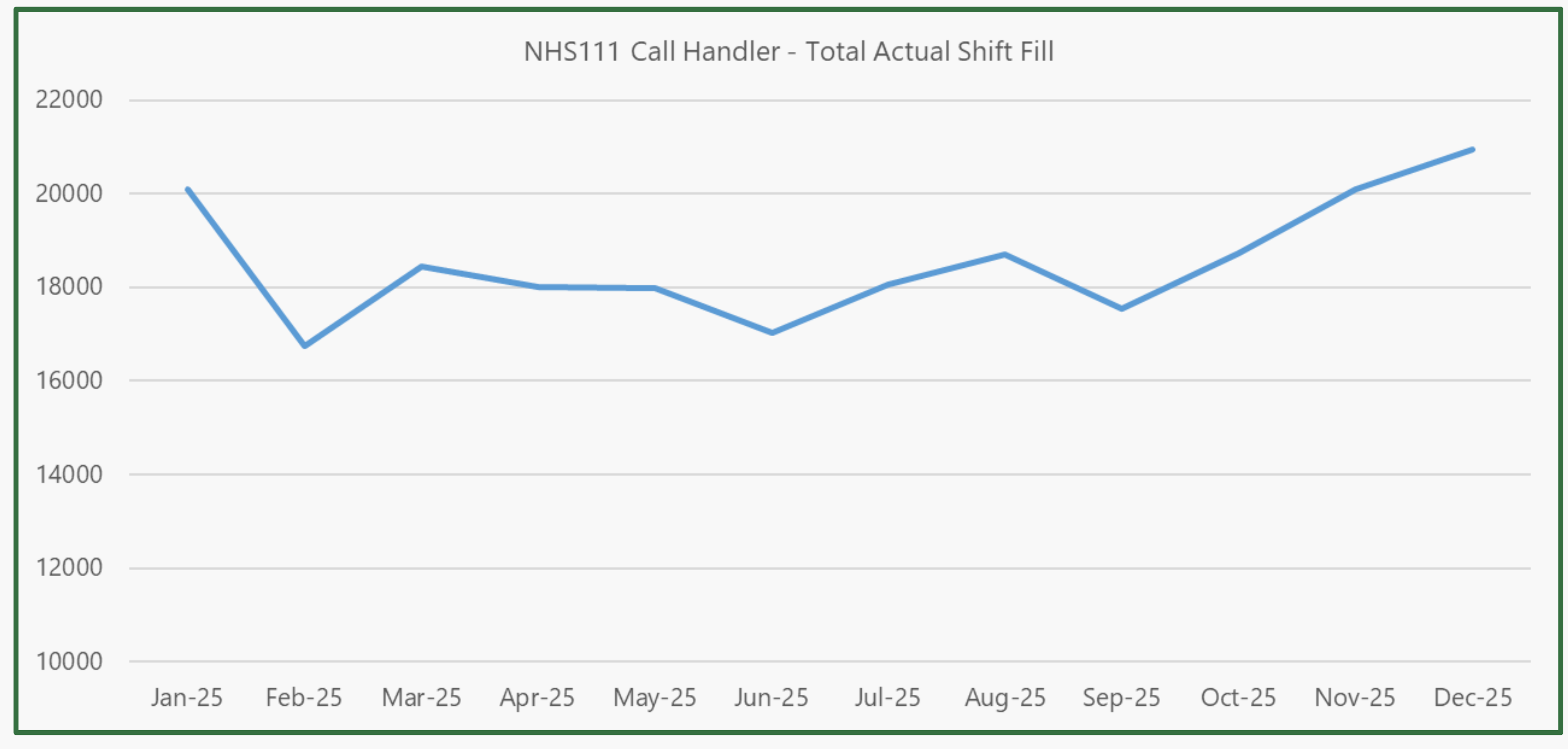
(Responsible Officer: Lee Brooks)

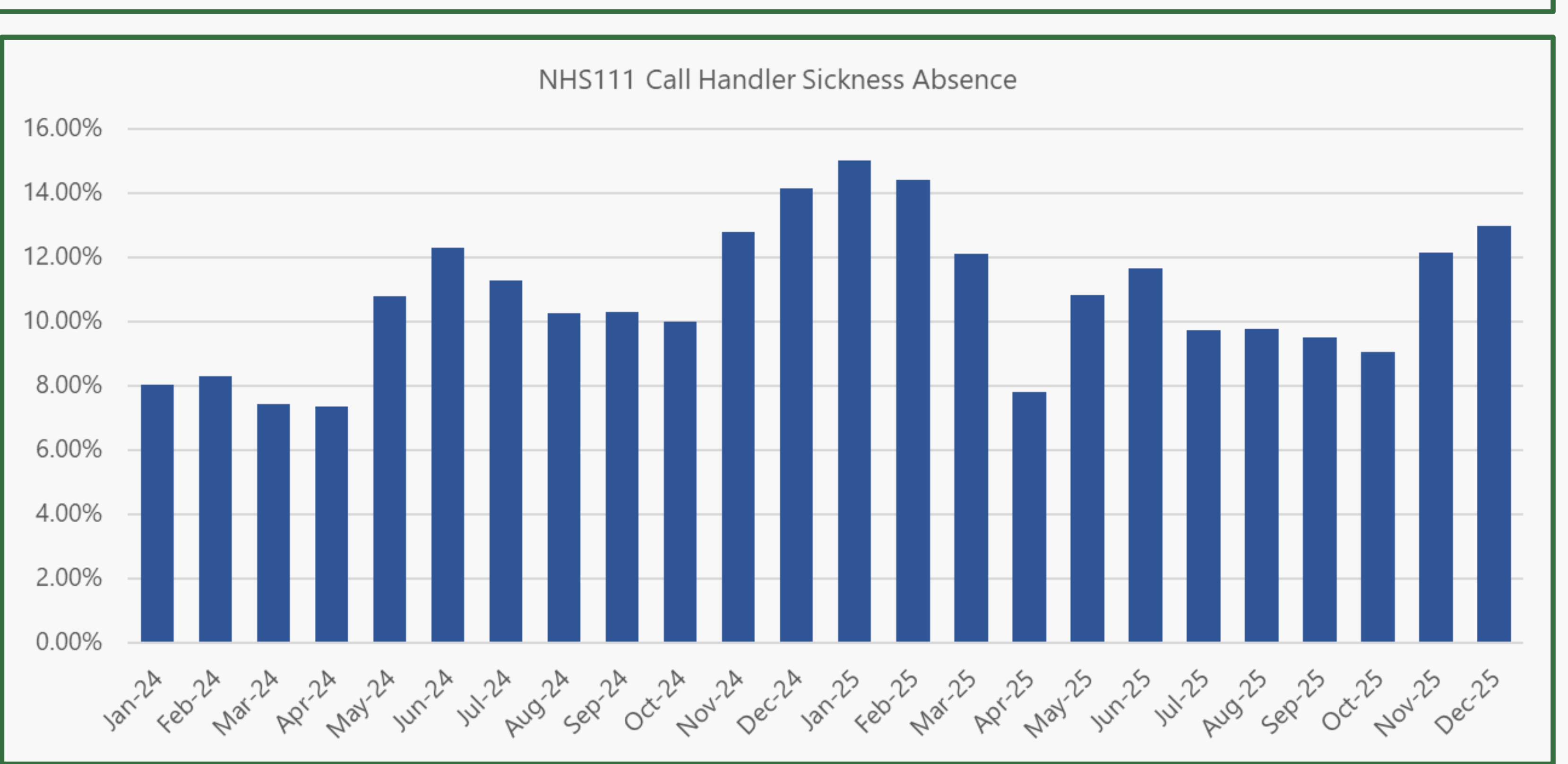
Influencing Factors – Demand and Call Handling Hours Produced

Total NHS111 Calls Expected to be Answered

120,000
100,000
80,000
60,000
40,000
20,000
0

Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25





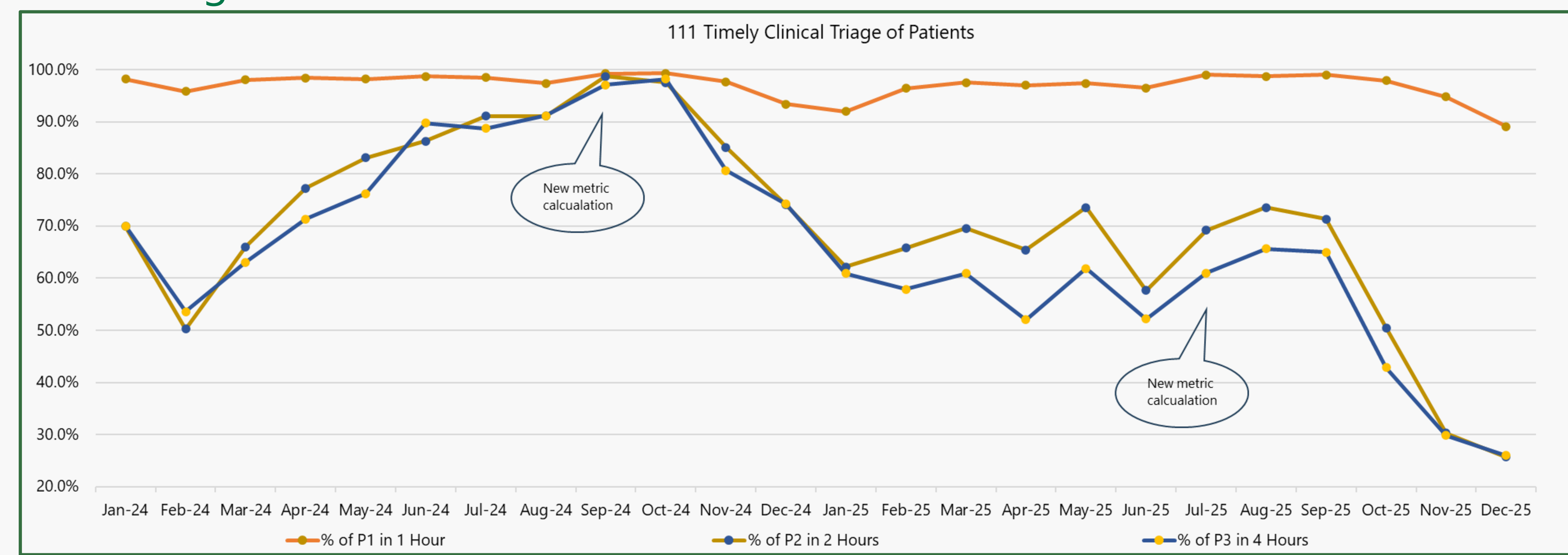
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

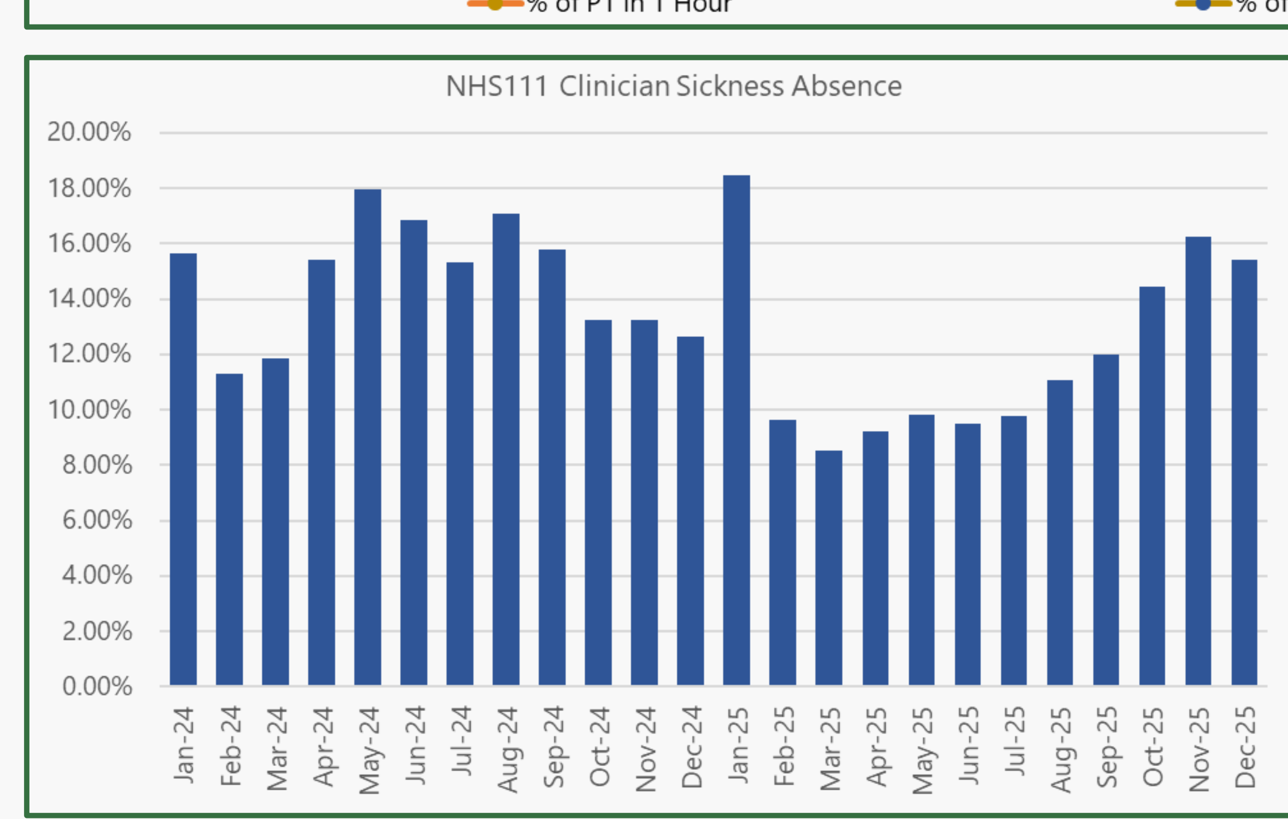
(Responsible Officer: Lee Brooks)

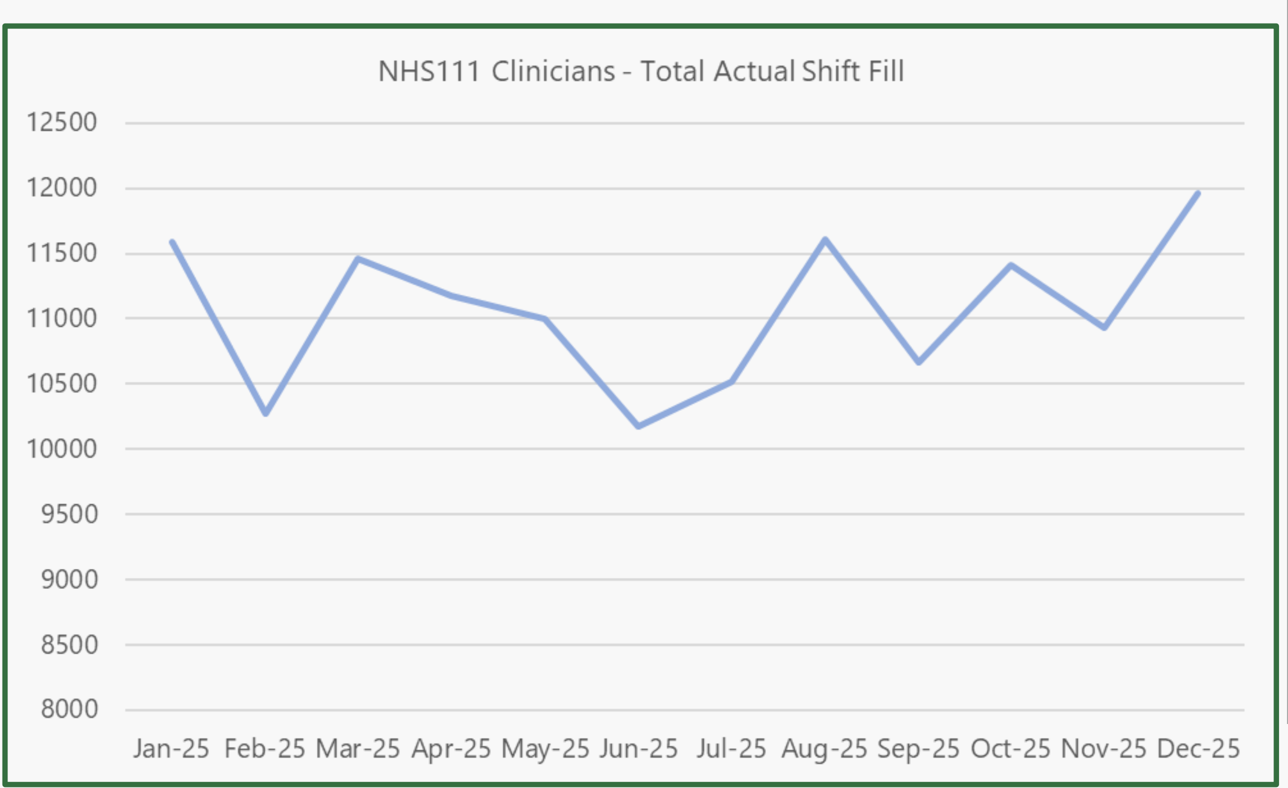
P1CT
A

FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

The highest priority calls, P1CT, dropped just below the 90% target, recording 89.1% in December 2025.

Ring back times for lower category calls decreased during December 2025, with P2CT calls at 25.7% and P3CT at 26%. A factor affecting this would be increased demand.

Number of clinician hours produced increased during December 2025, rising from 10,926 hours in November 2025 to 11,962 hours in December 2025. This is against one more day in the month and they remain consistent with the figure produced for December 2024 (12,052).

Remedial Plans and Actions

The key actions include:

A focus on delivering the benefits of the new 111CAS.
A review to determine appropriate levels of capacity to meet increasing demand, including rostering practice (review now live).

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

The P1-P3 metric calculation has changed. Previously it was when the Trust called back, now it is when the patient answers.

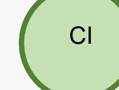
Expected Performance Trajectory

It is likely we will see performance levels decrease during the Winter month due to historically higher levels of demands and abstractions. The external rostering review also suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to reach performance without an increased workforce.

Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

(Responsible Officer: Lee Brooks)

R



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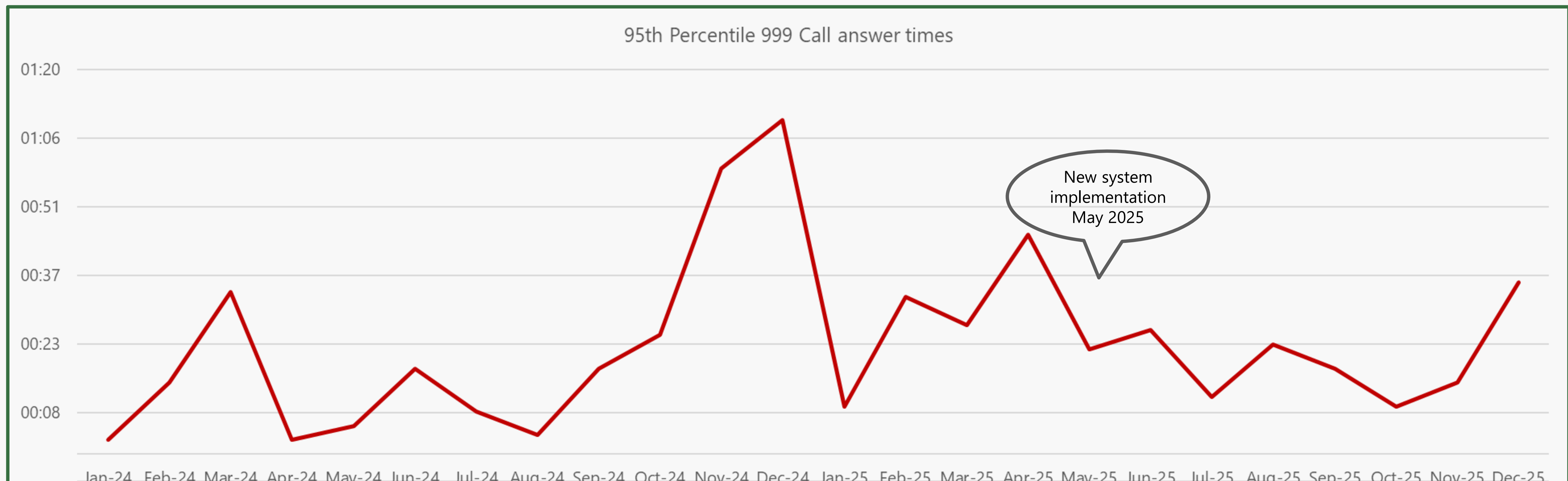
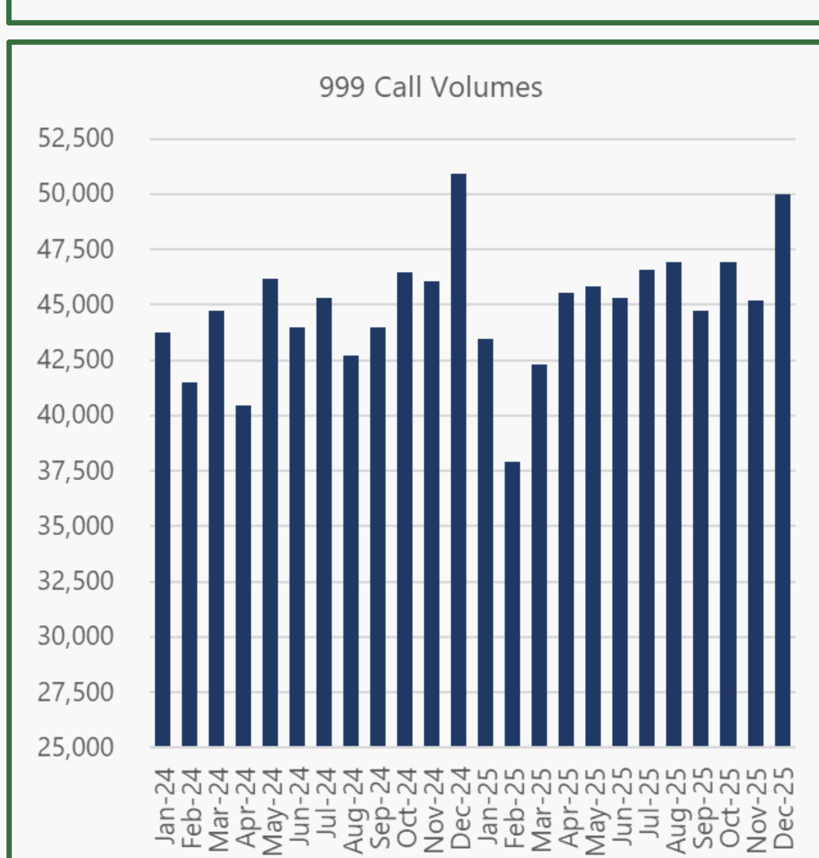
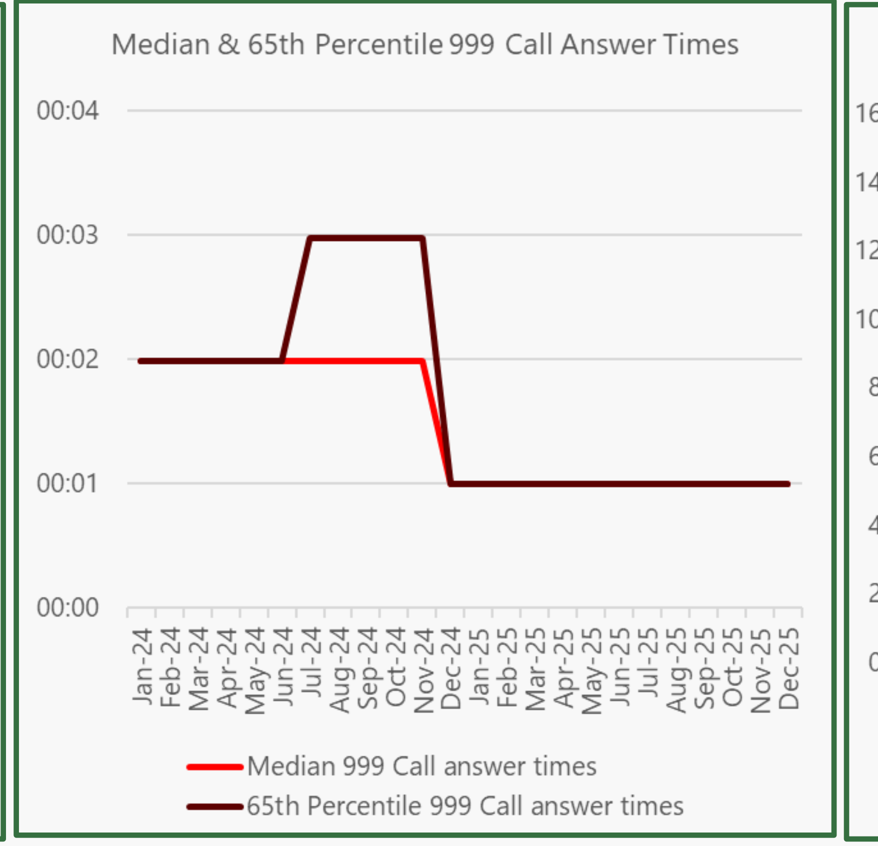
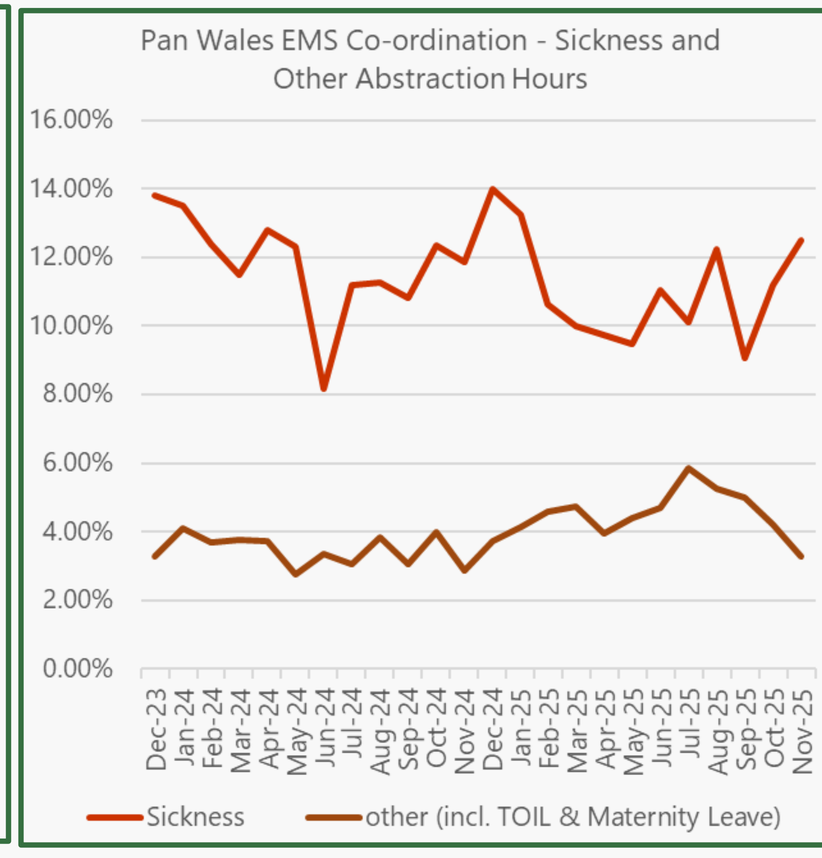
Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance decreased to 36 seconds in December 2025 and remained above the 6 second target; however, the median call answer time for the 999-service has appeared consistently good at 1 second. This data is currently being reviewed.

There was an increase in demand during December 2025 to 49,985 calls from 45,200 in November 2025.

Call taker UHP for the month of November was at 95% and all EMSC sickness level saw an increase, from 11.20% in October 2025 to 12.49% in December 2025.

Remedial Plans and Actions

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

- There is feedback from EMS that the new dispatch boundaries are adversely affecting performance, particularly within the South-East and South-Central regions. Analysis has been undertaken, and a meeting is scheduled in the next two weeks to discuss how we go forward.
- The Executive Director of Operations has asked for some additional modelling on EMD capacity.
- There is a need to keep under review the consequences on allocators of changing/increasing resources e.g. APPs, Falls Resource etc.

Expected Performance Trajectory

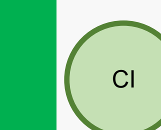
The median and 65th percentile are performing very well and are stable.

Our Patients: Quality, Safety & Patient Experience
Arrest Purple Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

G



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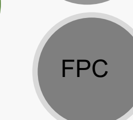
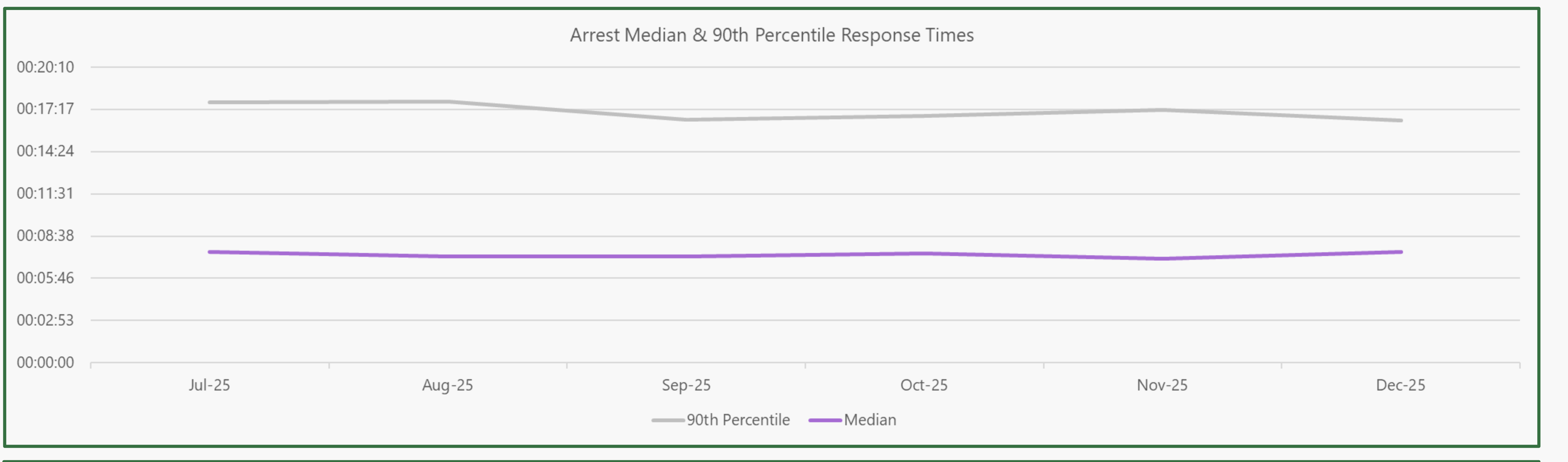
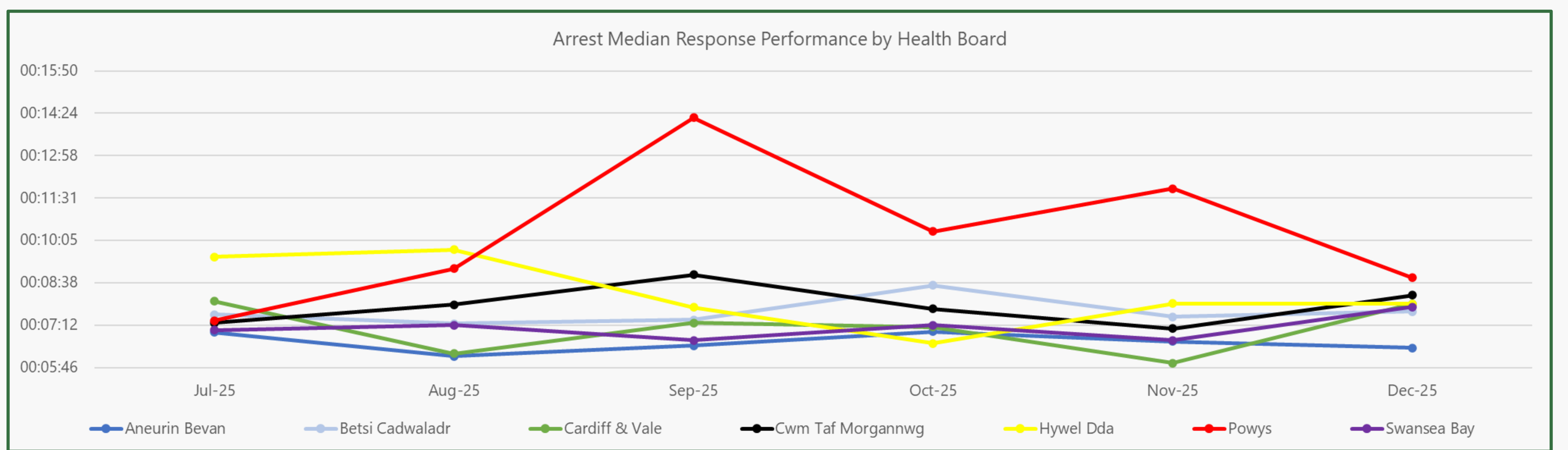
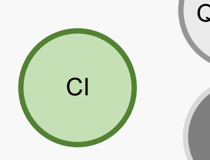


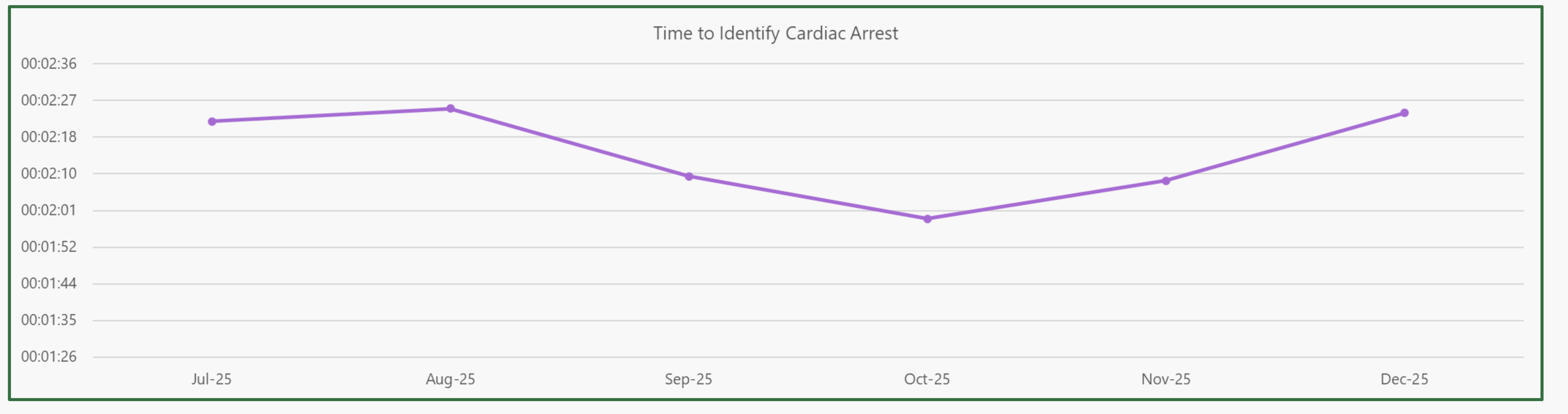


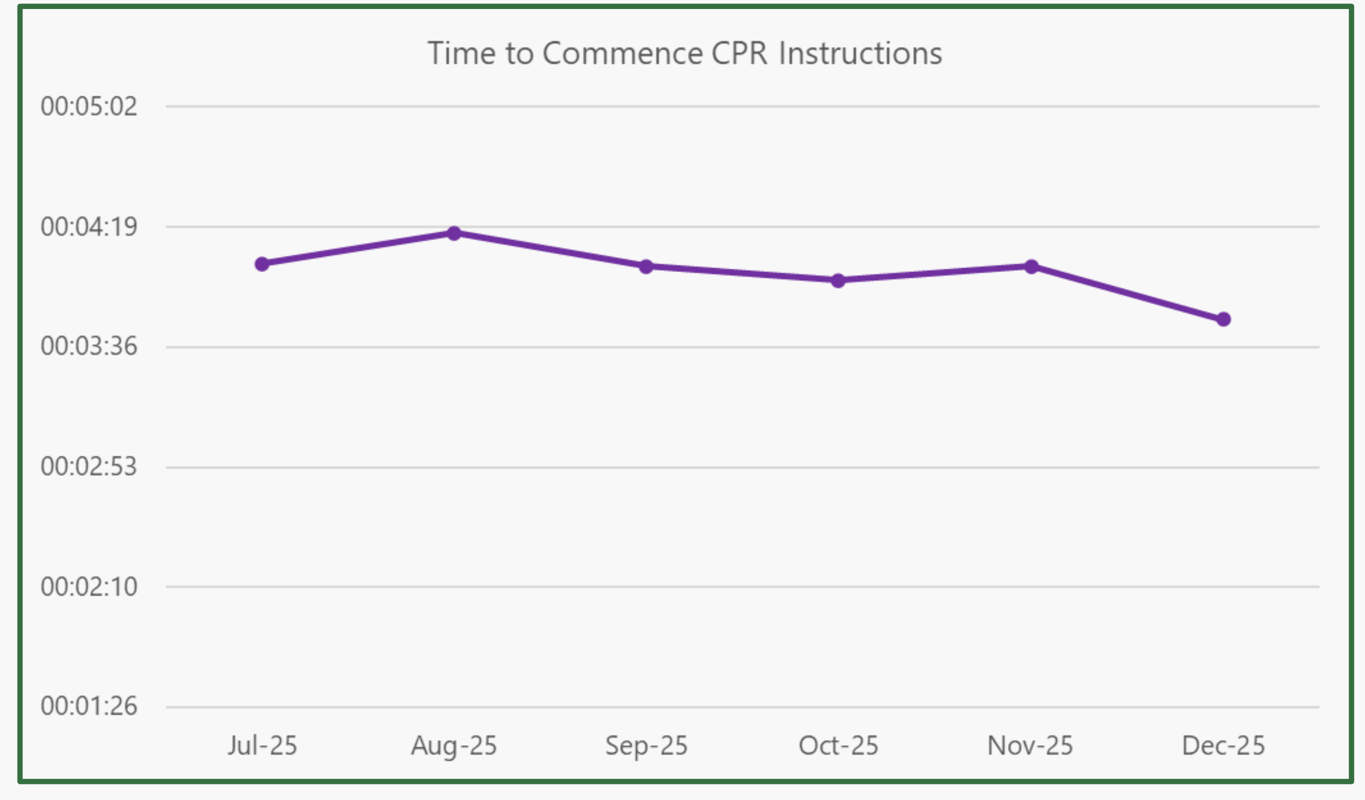


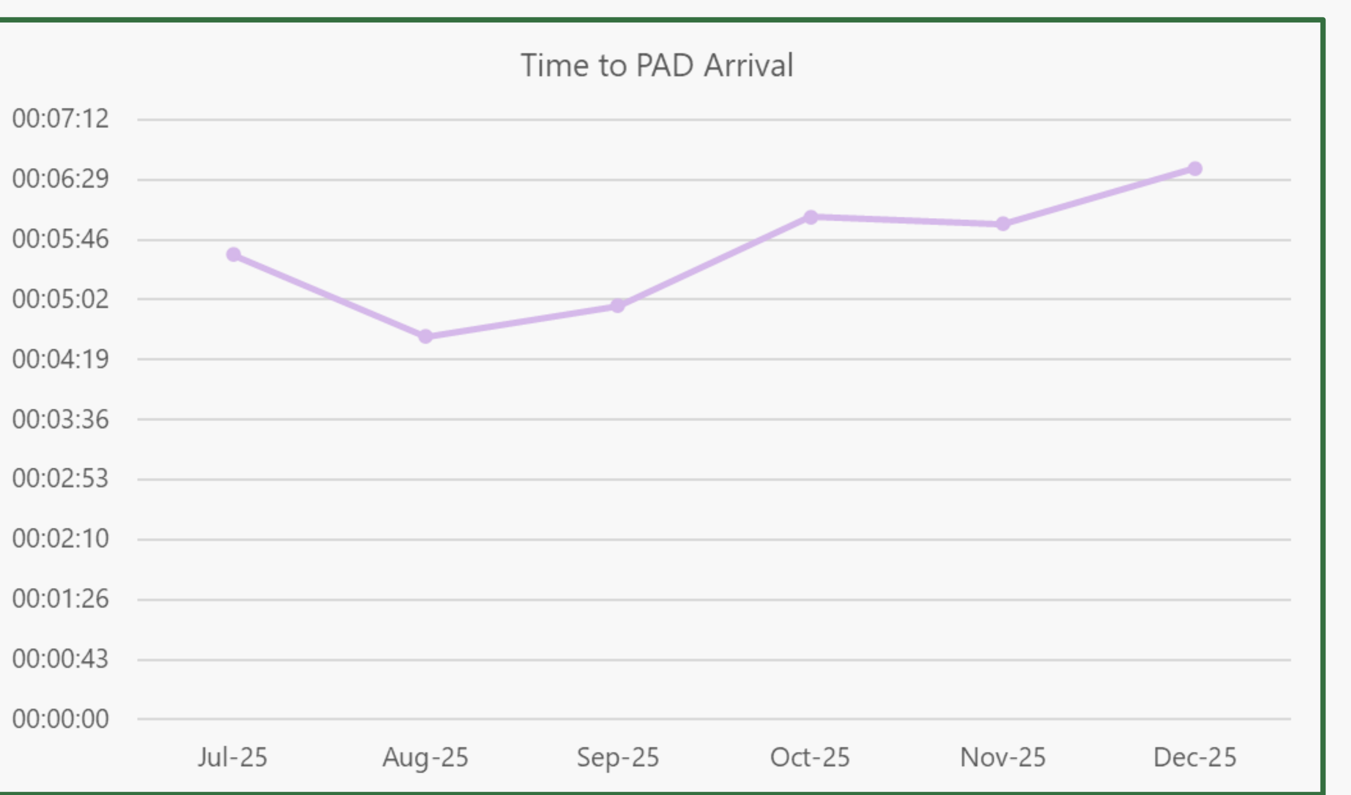
Our Patients: Quality, Safety & Patient Experience
Arrest Purple Performance Indicators

(Responsible Officer: Lee Brooks)









Our Patients: Quality, Safety & Patient Experience
RED EMERG Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

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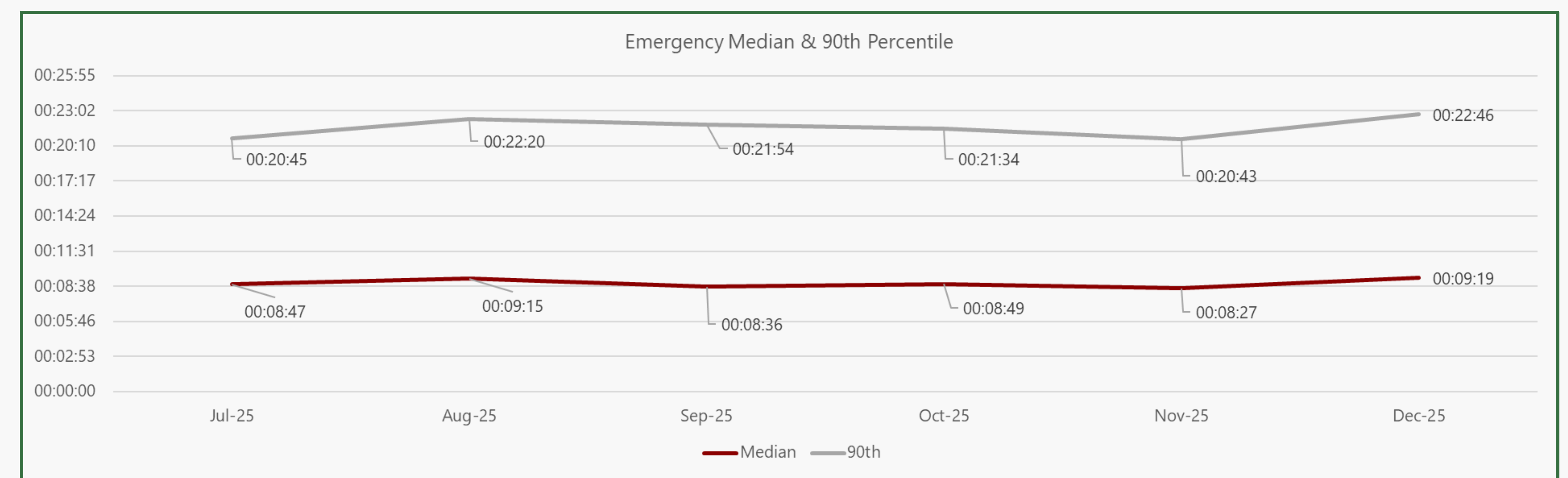

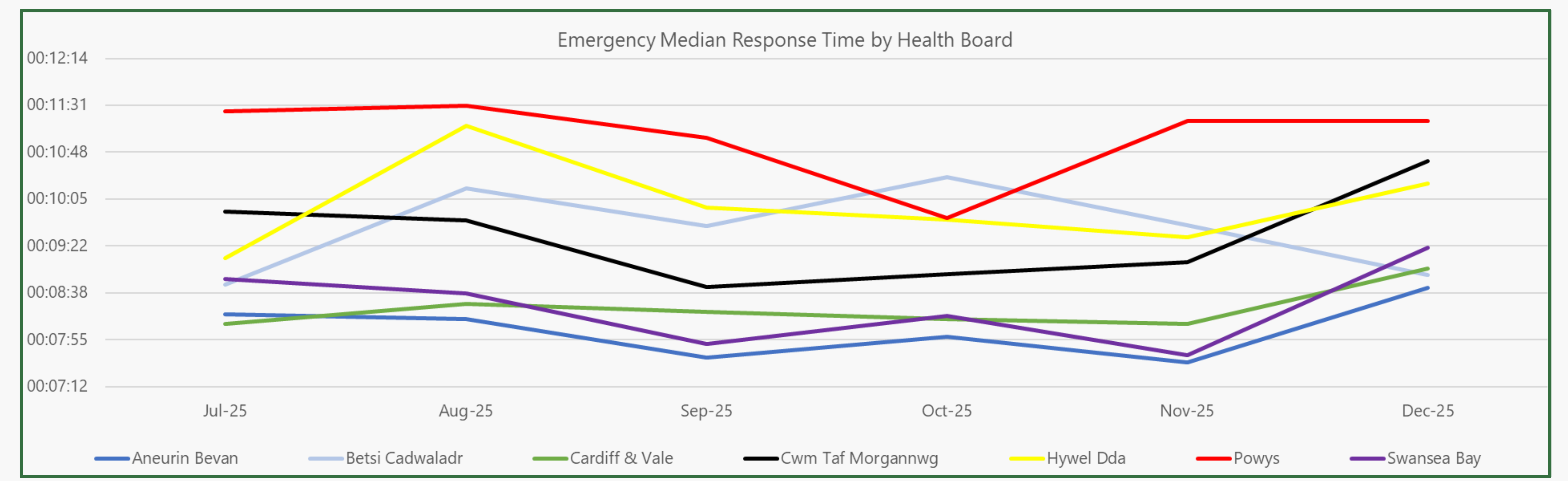

Analysis

In December 2025 there were 5,469 Emerg (Red) calls, around 14.36% of all calls.

The median response time in December 2025 for Emerg incidents was 9 minutes 19 seconds. Aneurin Bevan health board had the lowest median time of 8 minutes and 43 seconds, and Powys had the highest at 11 minutes and 17 seconds.

For Emerg calls, the 90th percentile response time was 22 minutes 46 seconds. Cardiff and Vale had the lowest time of 19 minutes and 43 seconds, and Powys had the highest at 32 minutes and 28 seconds.

For both Arrest and Emerg calls the median and 90th percentile response time targets are 6-8 minutes and 20 minutes, respectively.

Remedial Plans & Actions

Arrest is performing better than the Trust modelled, but Emergency performance is worse than the Trust modelled. Although analysis was carried out on this discrepancy along with several workshops no definitive reason was established. There is a view that the difference in volumes between Arrest and Emerg adversely affected the Emerg response times.

Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators
Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

CI

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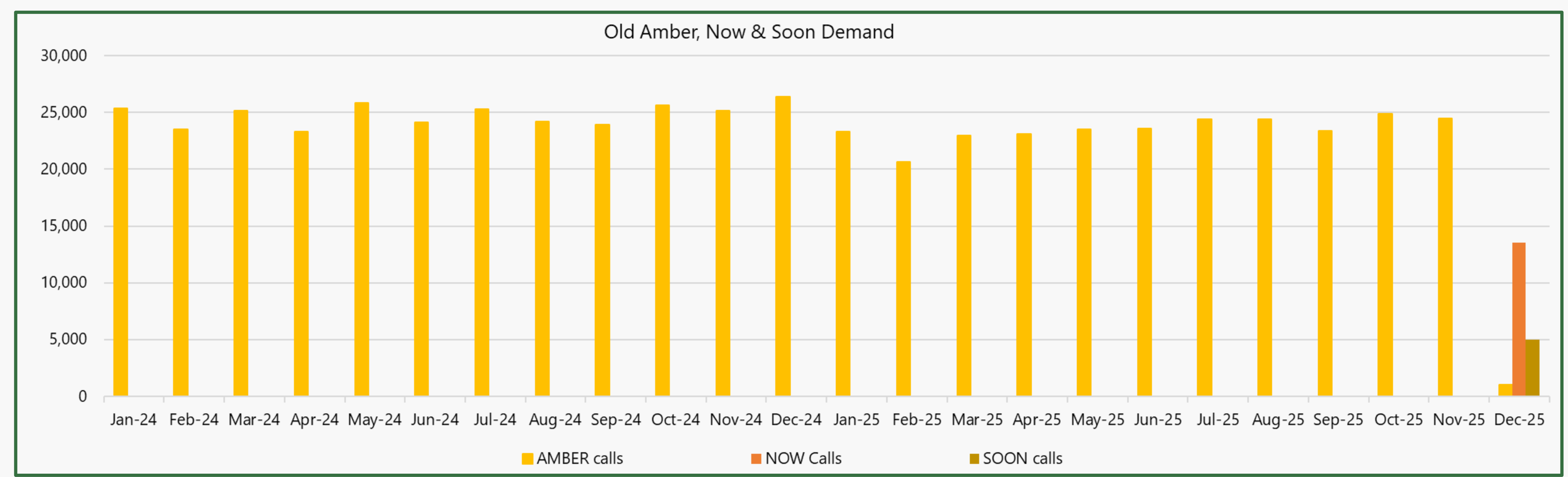
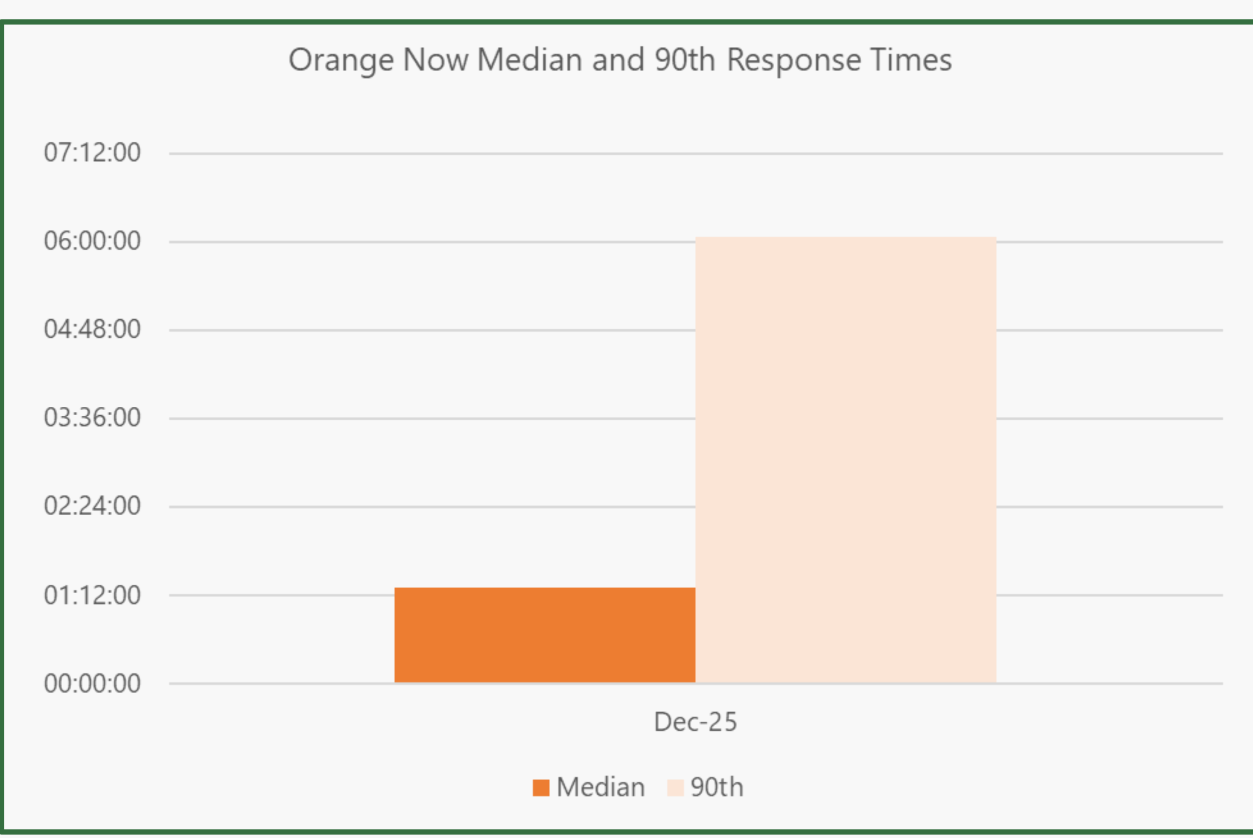
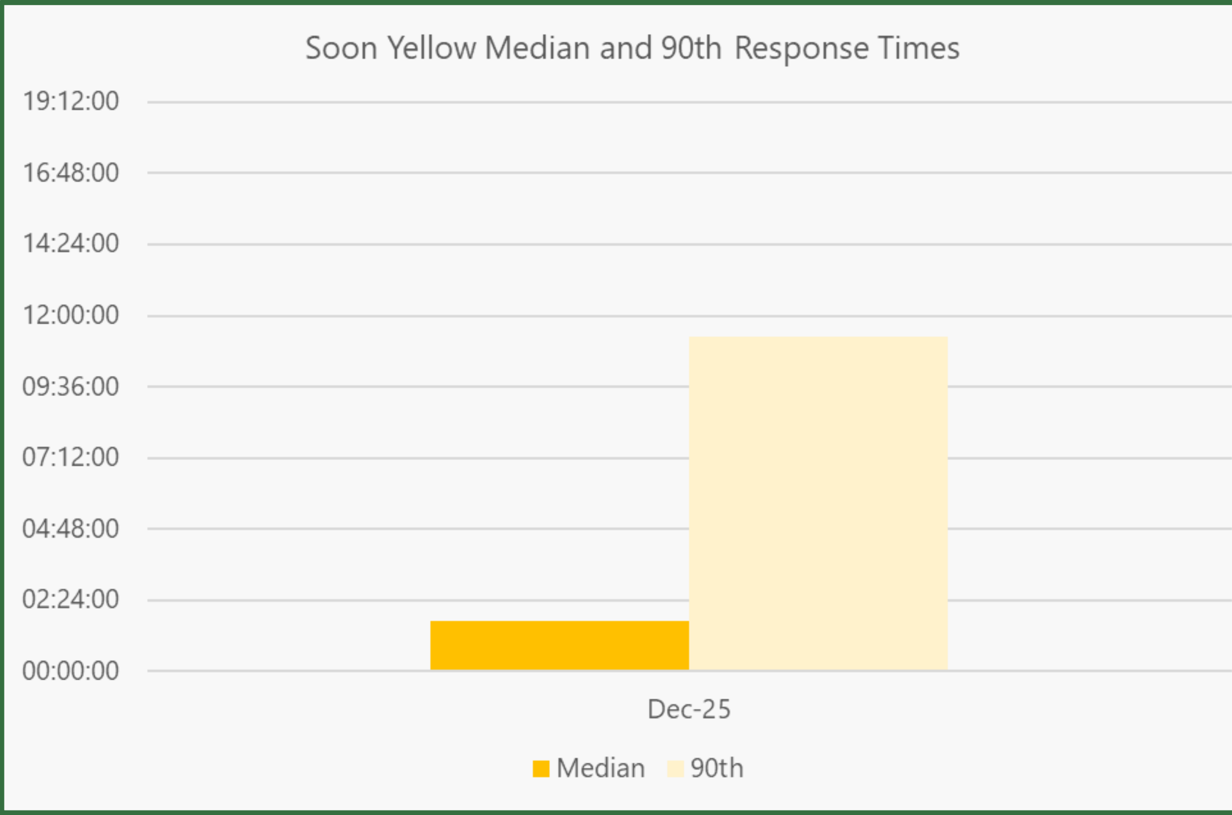






Analysis

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

The median response time in December 2025 for Orange Now incidents was 1 hour and 19 minutes. Betsi Cadwaladr health board had the lowest median time of 38 minutes and 1 second, and Aneurin Bevan had the highest at 2 hours,18 minutes and 34 seconds.
For Orange Now calls, the 90th percentile response time was 6 hours and 4 minutes. Betsi Cadwaladr had the lowest time of 3 hours and 8 minutes, and Aneurin Bevan had the highest at 7 hours and 38 minutes.

The median response time in December 2025 for Yellow Soon incidents was 1 hour and 43 minutes. Betsi Cadwaladr health board had the lowest median time of 1 hour and 46 seconds, and Aneurin Bevan had the highest at 2 hours 53 minutes and 49 seconds.
For Yellow Soon, the 90th percentile response time was 11 hours and 18 minutes. Betsi Cadwaladr had the lowest time of 5 hours and 32 minutes, and Cwm Taf Morgannwg had the highest at 15 hours and 25 minutes.

Remedial Plans and Actions

Welsh Government announced further changes to the Ambulance Performance Framework. Monitoring of phase 2 will continue via Now and Soon categories.

Expected Performance Trajectory

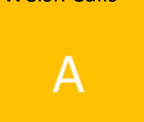
The Trust's commissioned level of production (its rosters) is designed to cope with 6,000 hours of handover lost hours. The application of W45 would see the level of hospital lost hours to be close to this level, estimated to be just under 7,000 hours.

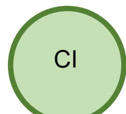
Our Patients: Quality, Safety & Patient Experience

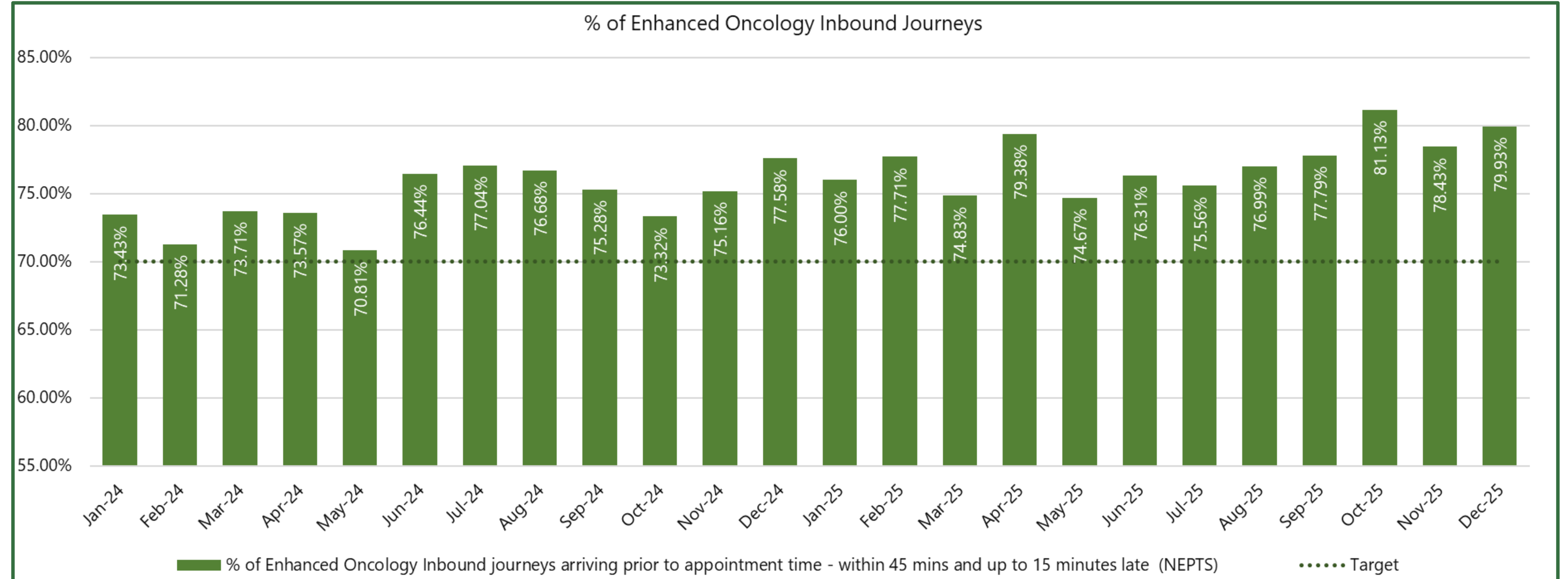
Patient Experience – Influencing Ambulance Care Indicators

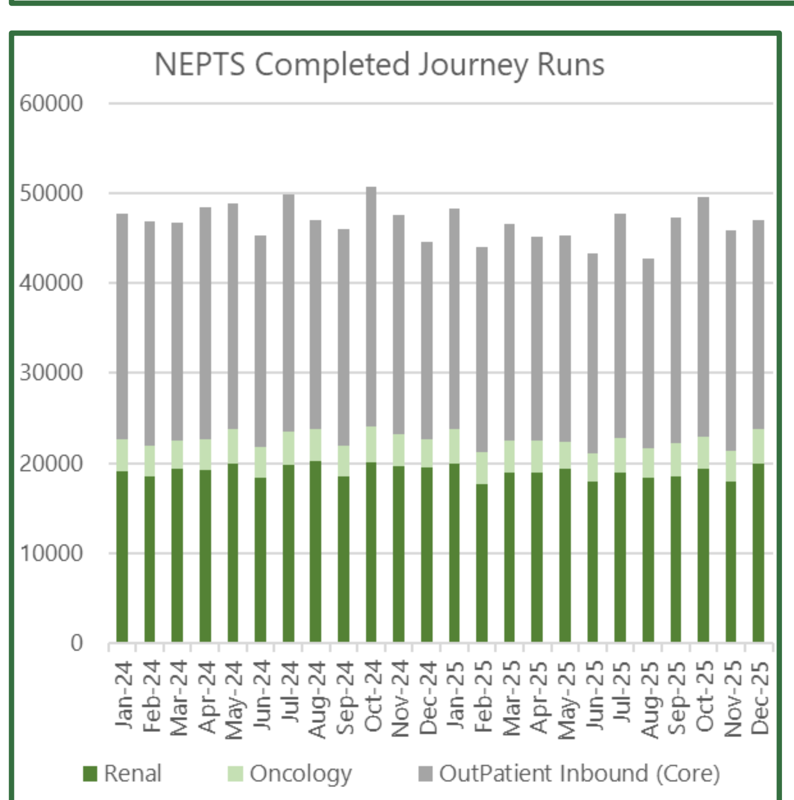
(Responsible Officer: Lee Brooks)

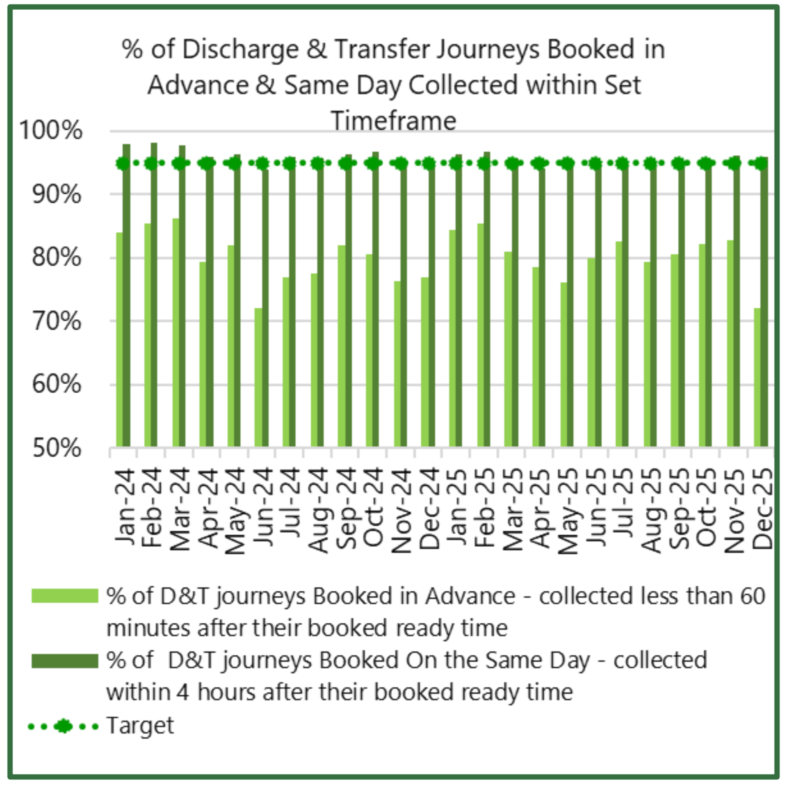
D&T	Oncology	Welsh Calls
R	G	A

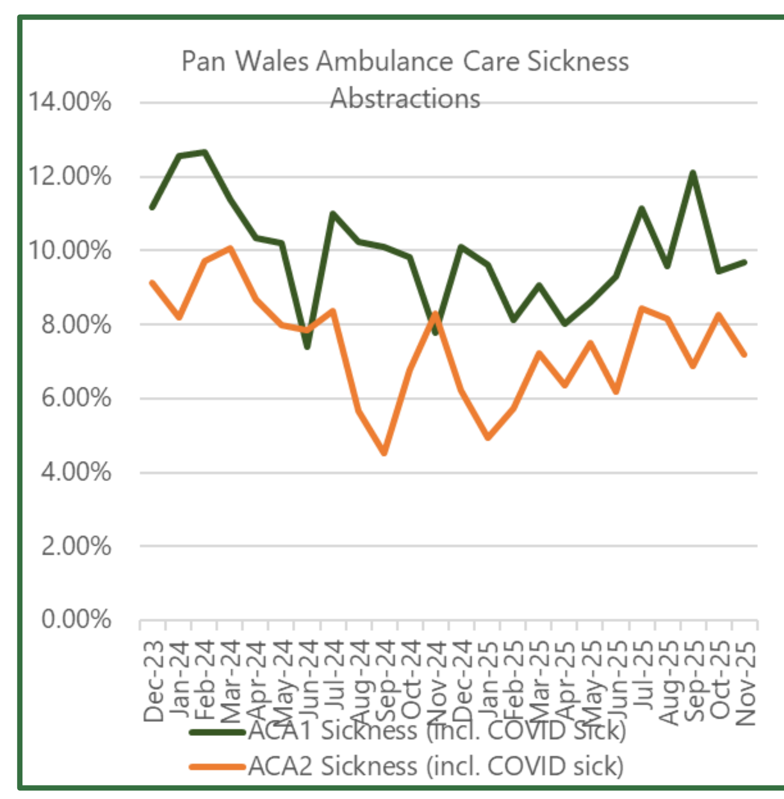












Analysis

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment decreased in December 2025 to 72% and remain below the 95% target. Discharge and Transfer journeys booked on the same day achieved 96% in December 2025, achieving the target (95%).

Renal journeys arriving within 30 minutes prior to their appointment time marginally decreased from 74.47% in November 2025 to 74.06% in December 2025 but still achieved the agreed performance standard of 70%.

Call volumes answered decreased to 16,479 calls during December 2025, from 18,536 in November 2025; but the average speed of call answering deteriorated from 41 seconds to 1 minute and 9 seconds.

In November, ACA1 sickness remained above the 5.99% target, at 9.67% and ACA2 sickness also remains above the 5.99% target at 7.20%.

Remedial Plans and Actions

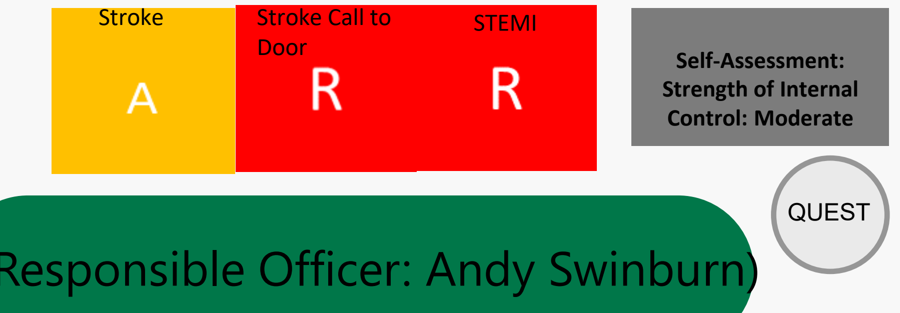
Performance on advanced discharges and transfers has been challenging throughout the last quarter. Measures to address this have been put in place by the team with the aim to improve performance. It is important to note that this measure was always deemed aspirational and requires a shift in booking practice by Health Boards for this to be achieved.

Sickness levels have seen an increase trend during the quarter, with short term sickness proving most challenging. Actions have been put in place across the service areas to increase focus on this area.

Expected Performance Trajectory
An improvement to sickness absence levels and advanced discharge and transfer is anticipated within the next quarter.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

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



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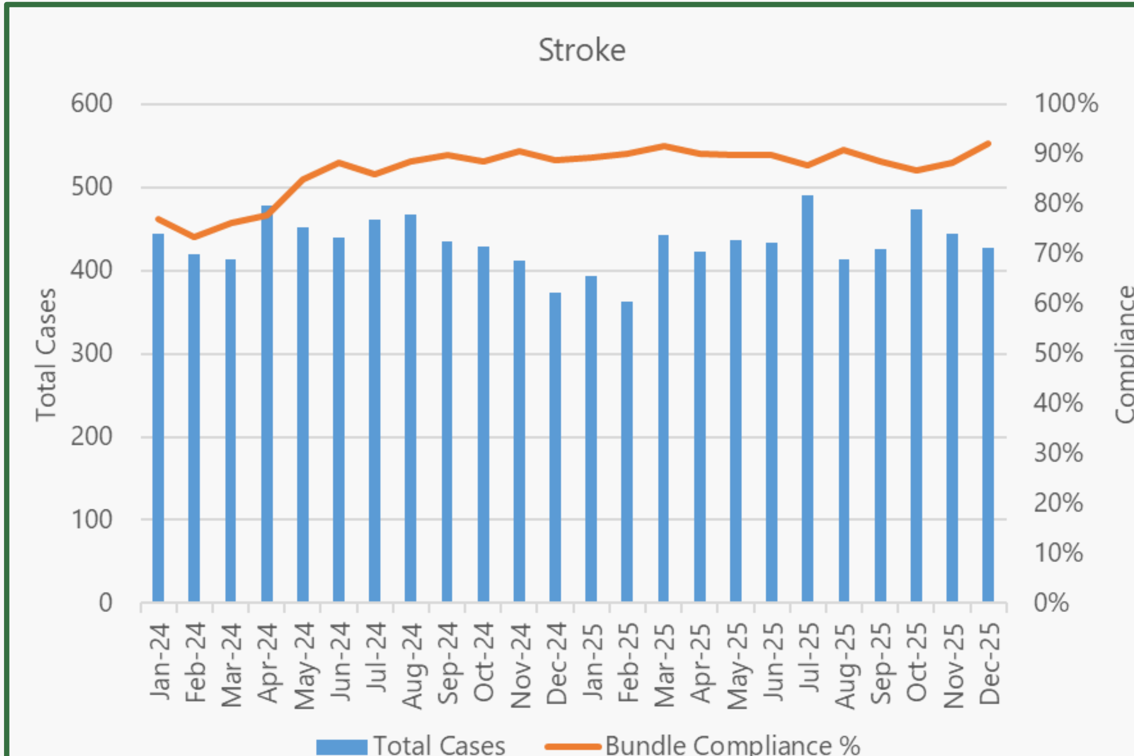
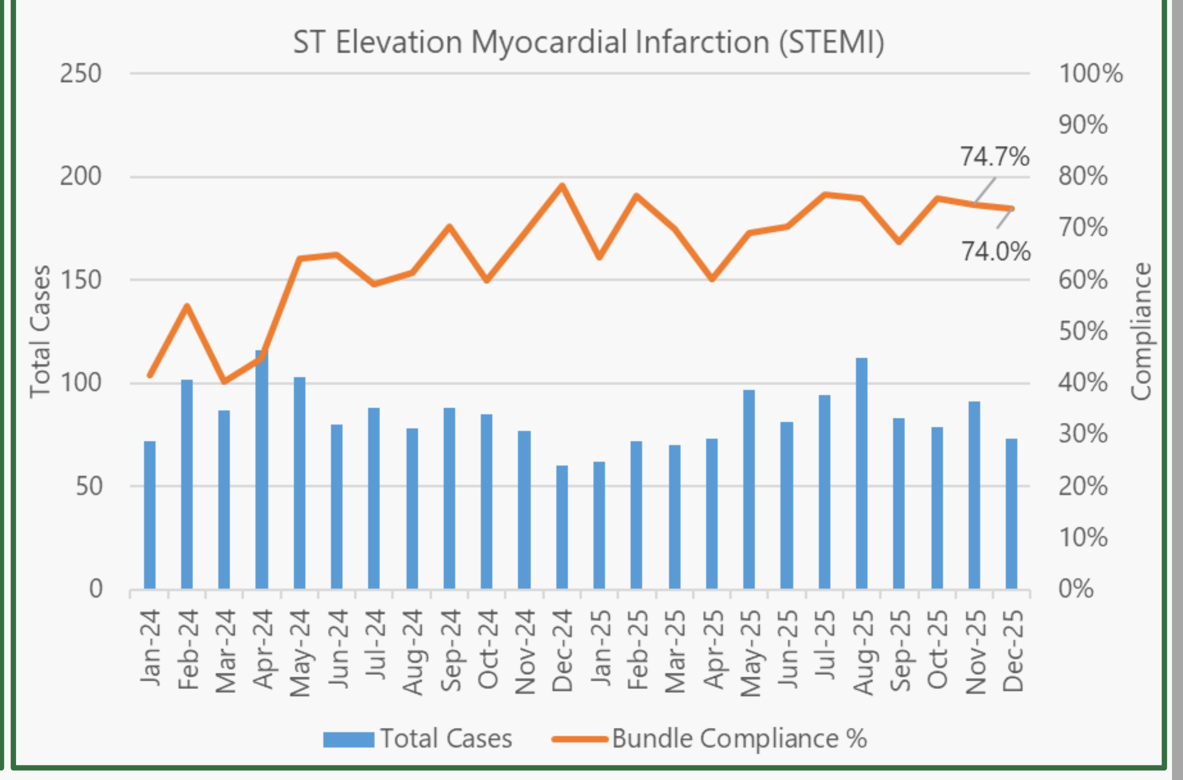
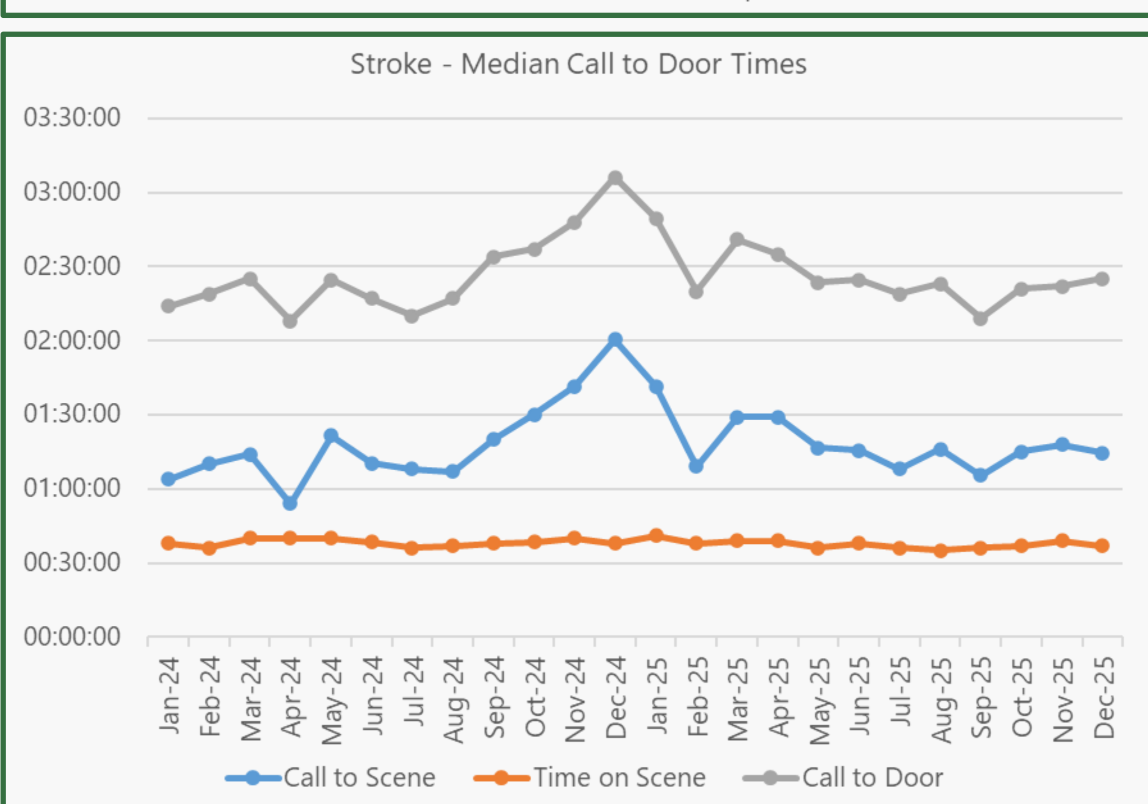
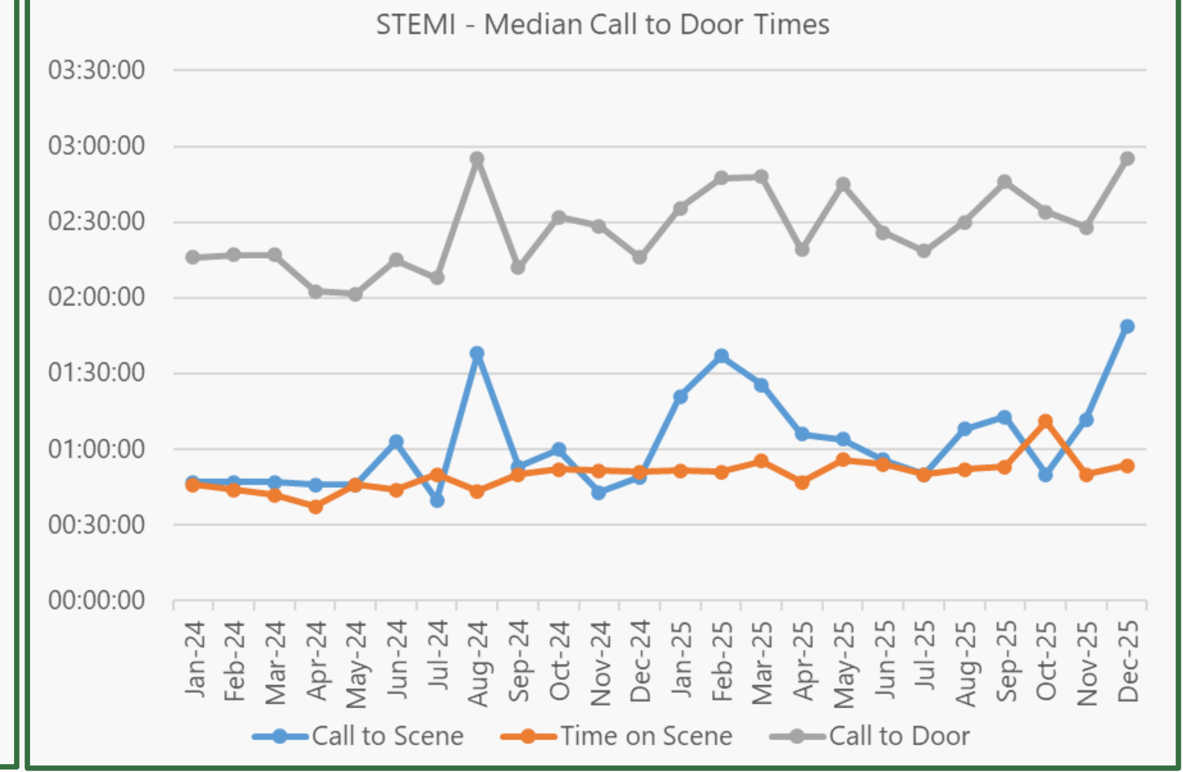
(Responsible Officer: Andy Swinburn)









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

Stroke – 92.06% - performance has consistently remained at or above 85% since May 2024. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance. Pre Alert is not counted towards CI compliance.

STEMI (heart attack) – 75.97%, a slight reduction from Nov2025. There has been good compliance across most of the care bundle elements. The number of cases remained low (73) therefore, increasing the volatility of the compliance data so this could be natural variance. A recent clinical update has removed GTN as part of the treatment of ACS. This will be removed from Jan 2025 to prevent guideline-driven practice reducing the reported bundle score.

Call to door times for Stroke – call to door times increased marginally for stroke in December. All three elements of the bundle have seen consistency on time.
Call to door times for STEMI – Call to door time has increased since last month. This could in part be driven by calls being sent for RCS prior to dispatch.

Remedial Plans and Actions:
A recovery plan implemented from April – September 2024 and remains BAU monitored through CIAG to maintain the improvements:

- Continued focus on communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Provided weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Promoted Clinical Indicators, care bundles and electronic Patient Clinical Record completion at Health Board area focussed workshops.
- Review of the ePCR interface led by the Digital Directorate.
- Ongoing development of the Tennant Structure within ePCR to facilitate clinical feedback to clinicians.

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

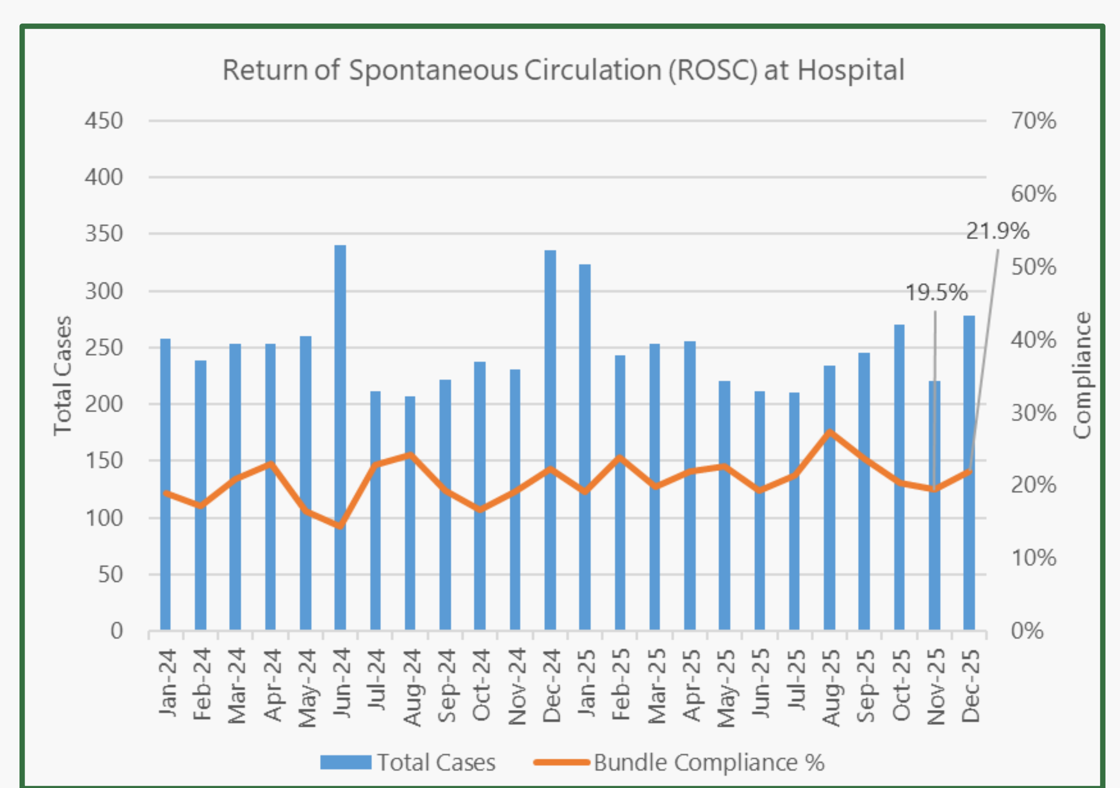
Our Patients: Quality, Safety & Patient Experience Clinical Indicators

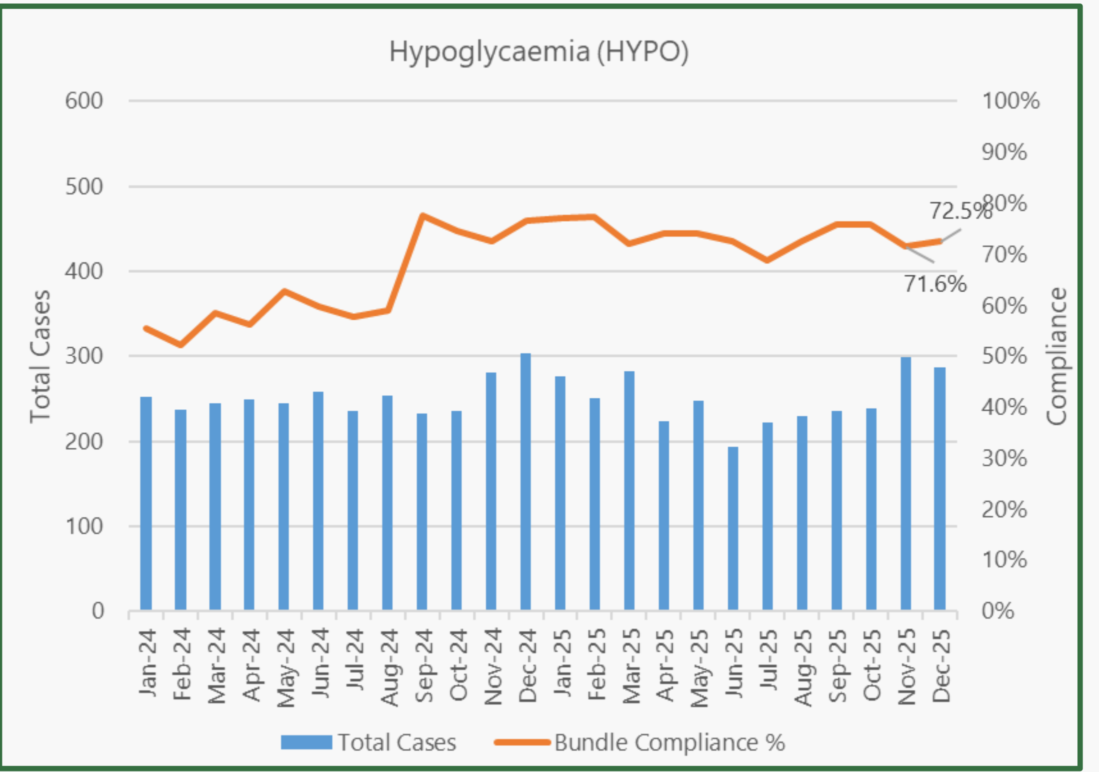
Return of Spontaneous Circulation, Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (#NOF)

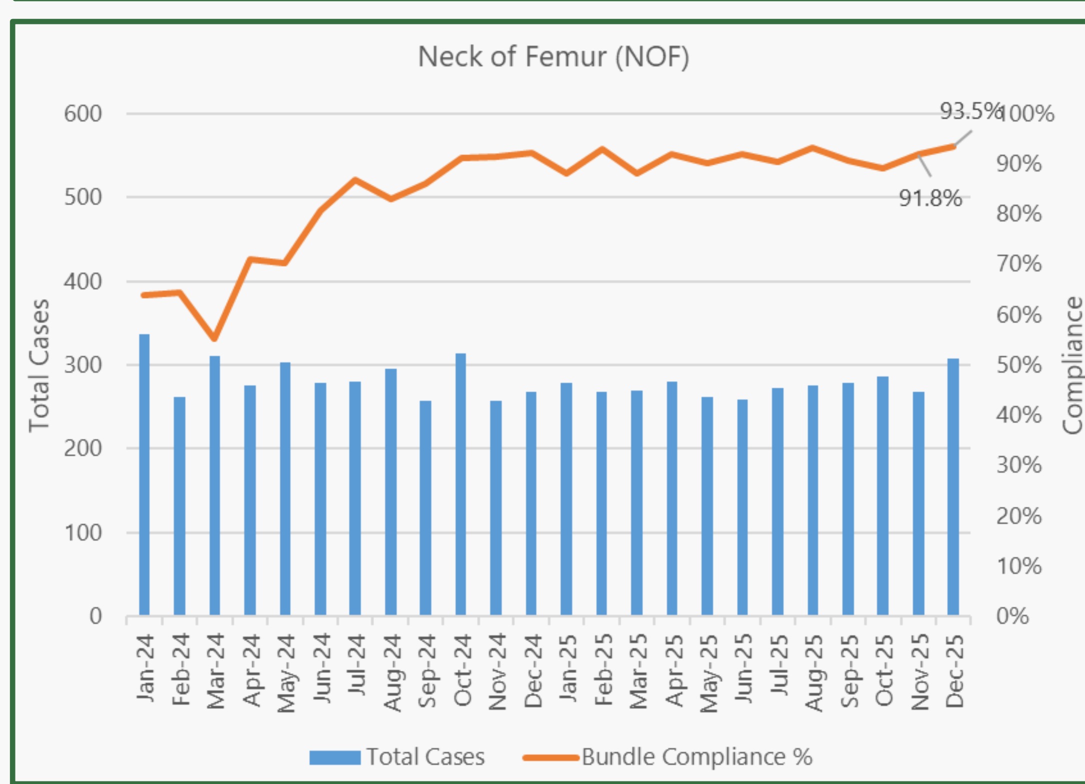
(Responsible Officer: Andy Swinburn)

ROSC
R

Self-Assessment: Strength of Internal Control: Moderate







#NOF Call 2 Door in development

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

Hypoglycaemia (diabetic patients with low blood glucose) – 72.47%, a slight increase since last month. Compliance has remained consistently around 73% compliance across the bundle.

Fractured Neck of Femur (hip fracture) – 93.49%, an increase in performance from November (91.79%). A slight increase in compliance which is evident across the care bundle.

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 21.94%, an increase from 19.46% in November. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024. Low case numbers means a volatile percentage dataset.

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

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

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

Further electronic Patient Clinical Record User Interface changes are planned for the next update, scheduled for Spring 2026

Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Duty of Candour

Responses Indicators

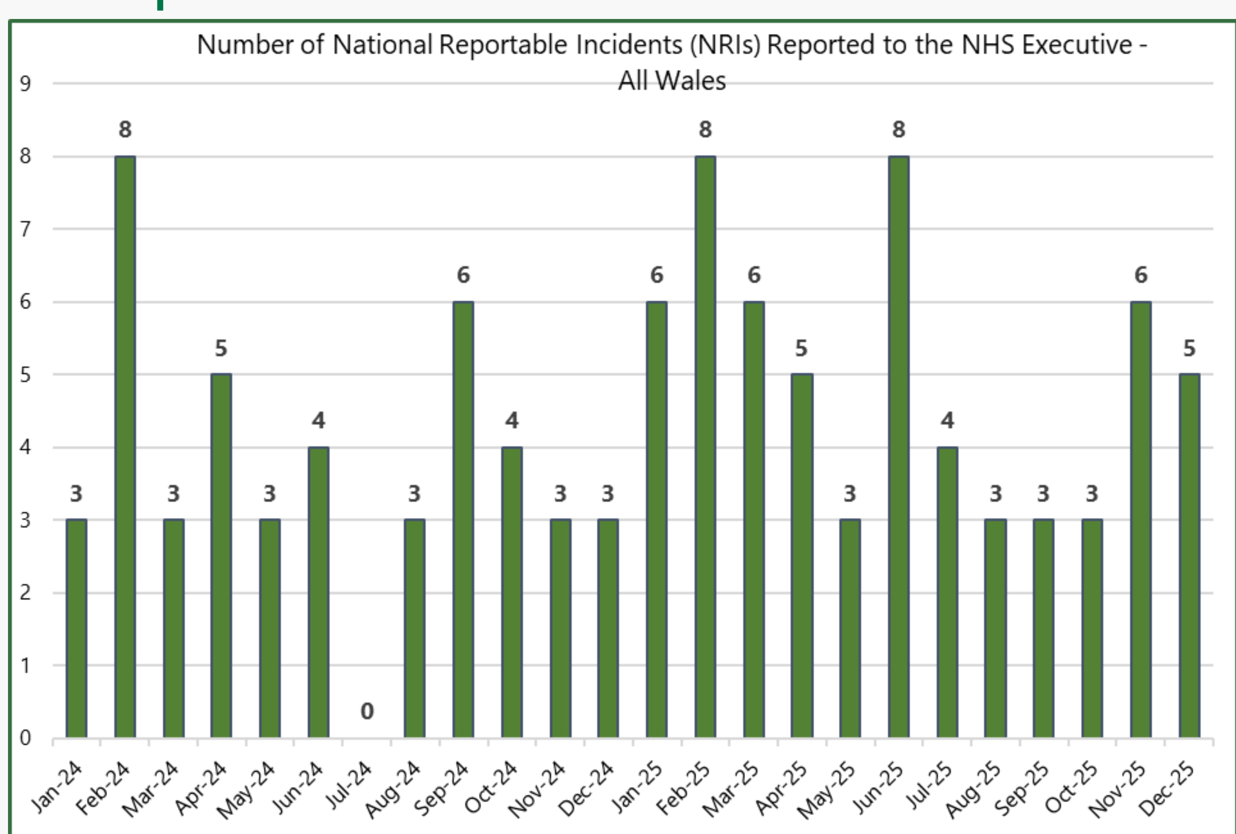
(Responsible Officer: Liam Williams)

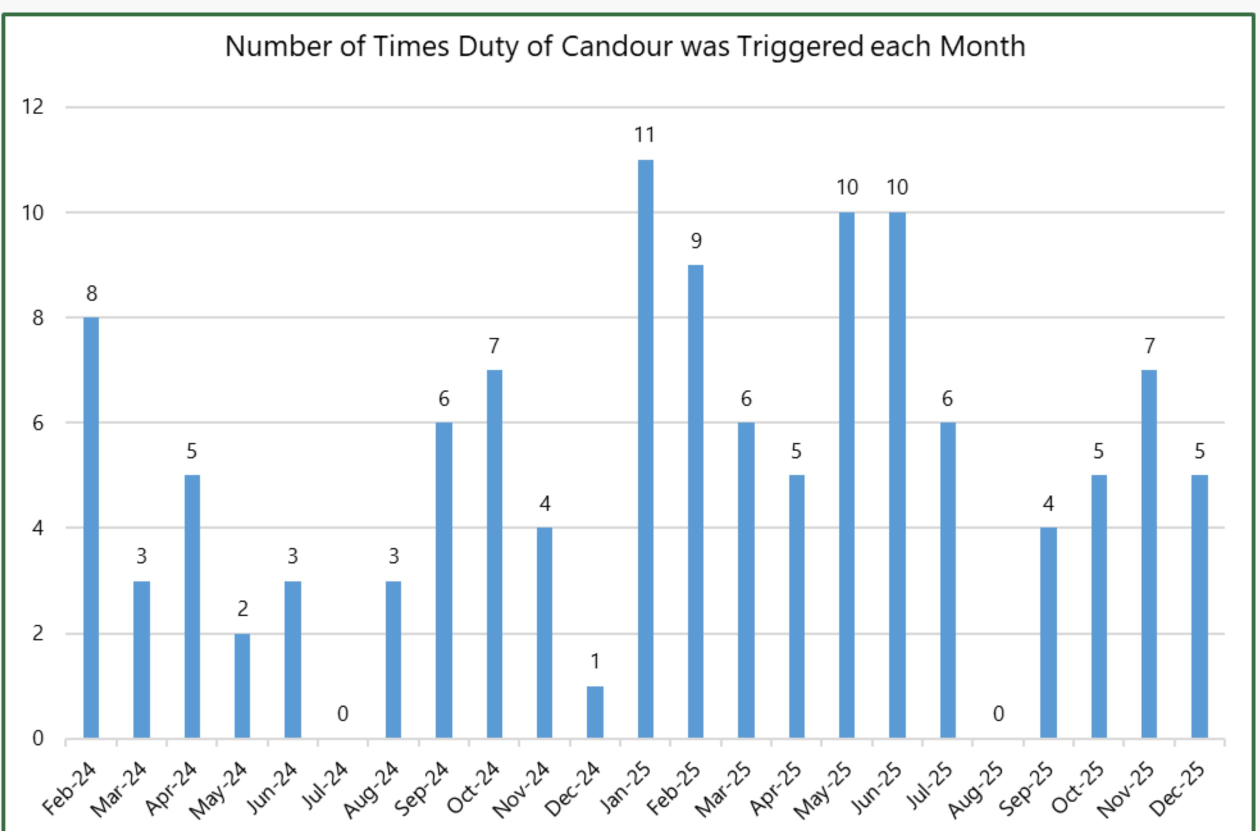
Concerns.

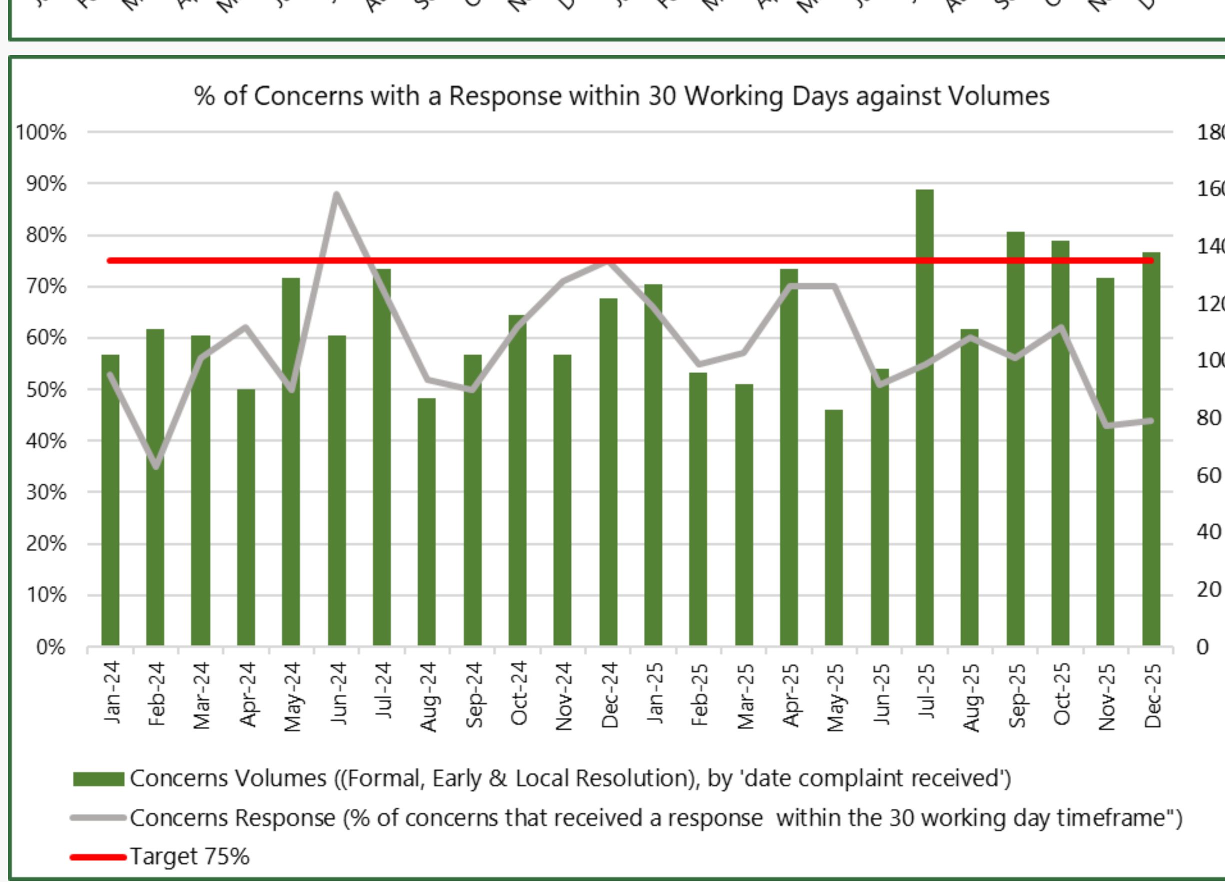
R

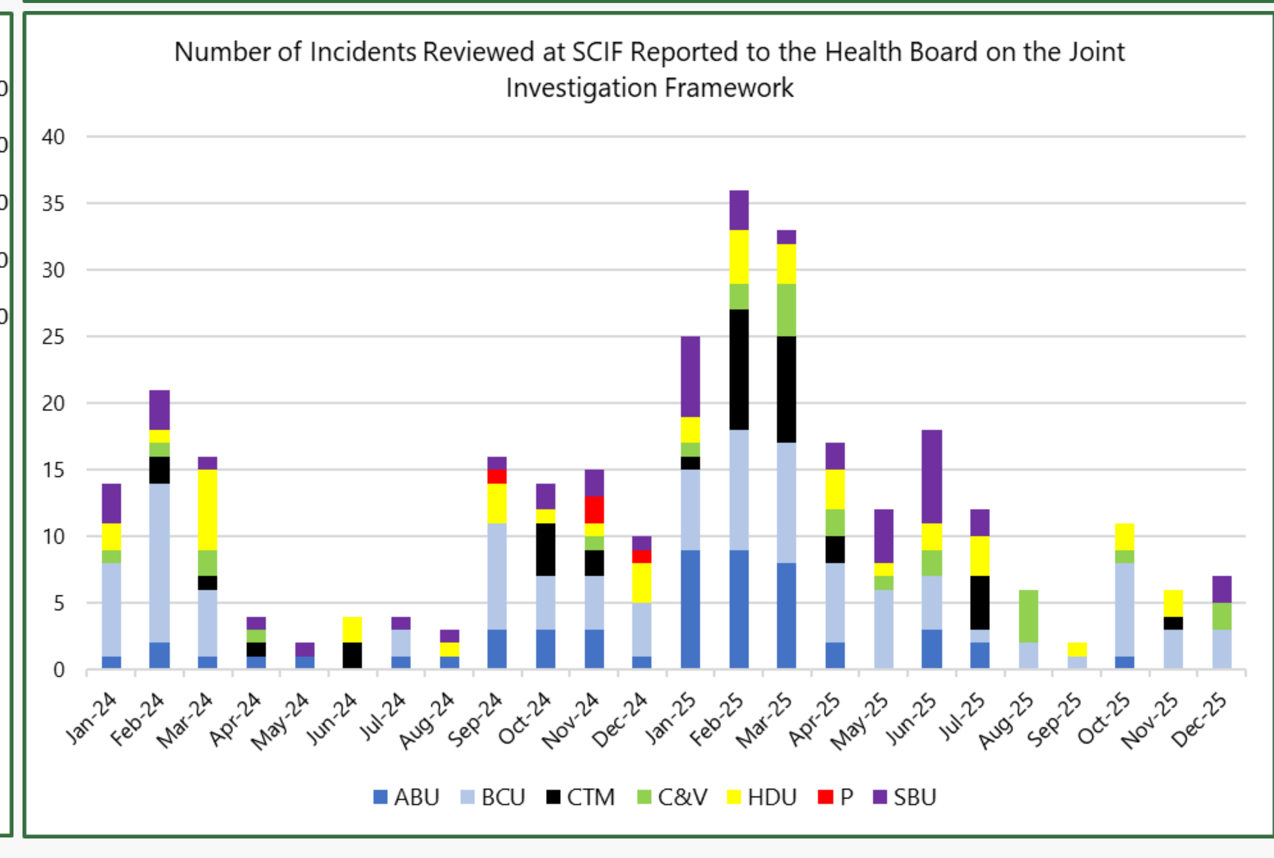
Self-Assessment: Strength of Internal Control: Moderate

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

Complaint response times remain significantly longer than the Welsh Government target. There are early signs of improvement from the PTR Recovery Plan, but this will take some time to be demonstrated in the response time target due to the lagging nature of this metric. Whilst larger numbers of complaints have been closed in the last quarter, a much-improved position in reducing open overdue complaints will be required to provide acceptable performance against this key performance indicator.

The number of complaints received by the Trust continues at high levels. As commented on in last month's report, this is being driven by an increased volume of complaints about Ambulance Care Services.

The Serious Case Incident Forum agreed for 5 incidents to be reported as NRIs.

Remedial Plans and Actions

A Putting Things Right and Legal Services Recovery Plan has been developed to address the number of overdue concerns (complaints and incidents). Governance and oversight of the improvement plan has been strengthened through the implementation of a dedicated Programme Board until end of March 2025. Additional non-recurrent investment is expected to deliver the required improved at increased pace, building on structural workforce changes and a shift to proportionate approaches that have already begun to demonstrate benefit.

This lays the foundations for the long-term objective of quality and safety data sources being available in the Trust data warehouse and a suite of business intelligence products to meet user need and enable effective triangulation of all Trust information.

Expected Performance Trajectory

As service areas focus on reducing the number of open overdue complaints, it is expected that the 30-working day performance will decrease. This is predicted to last until the number of open in-date complaints makes up the majority of open cases and, depending on the success of Recovery Plan actions, may take many months before it picks up again. Support from QPSE to Ambulance Care colleagues in terms of experiential emotional mapping, data visibility and the need to focus on 'on-the-spot' resolution is underway but does not yet appear to have impacted complaint volumes.

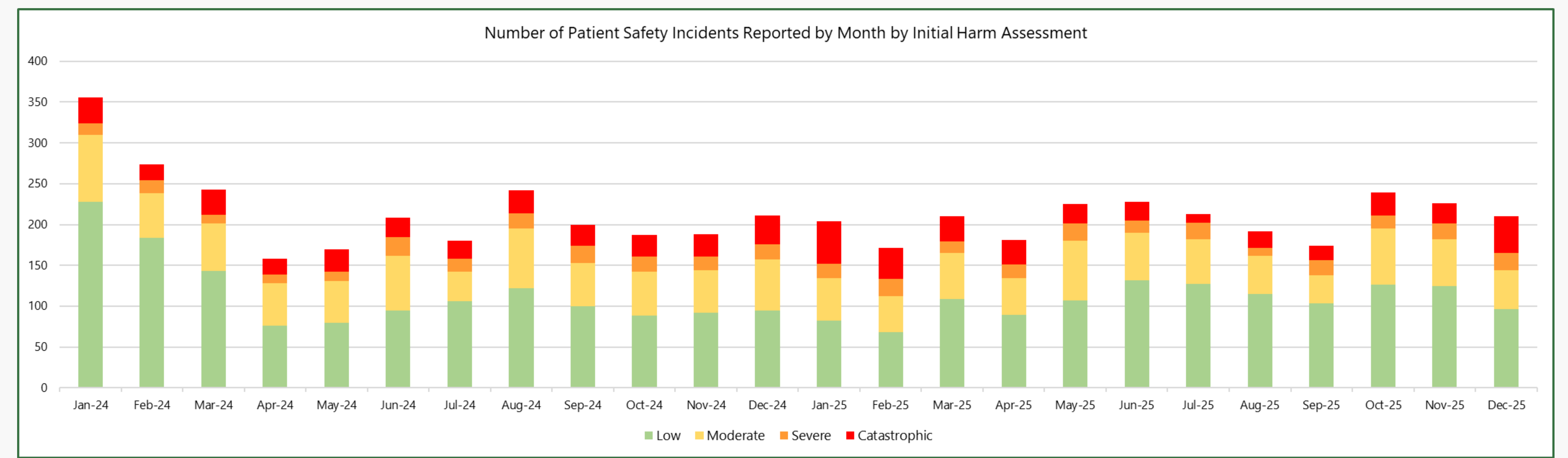
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change **NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated*

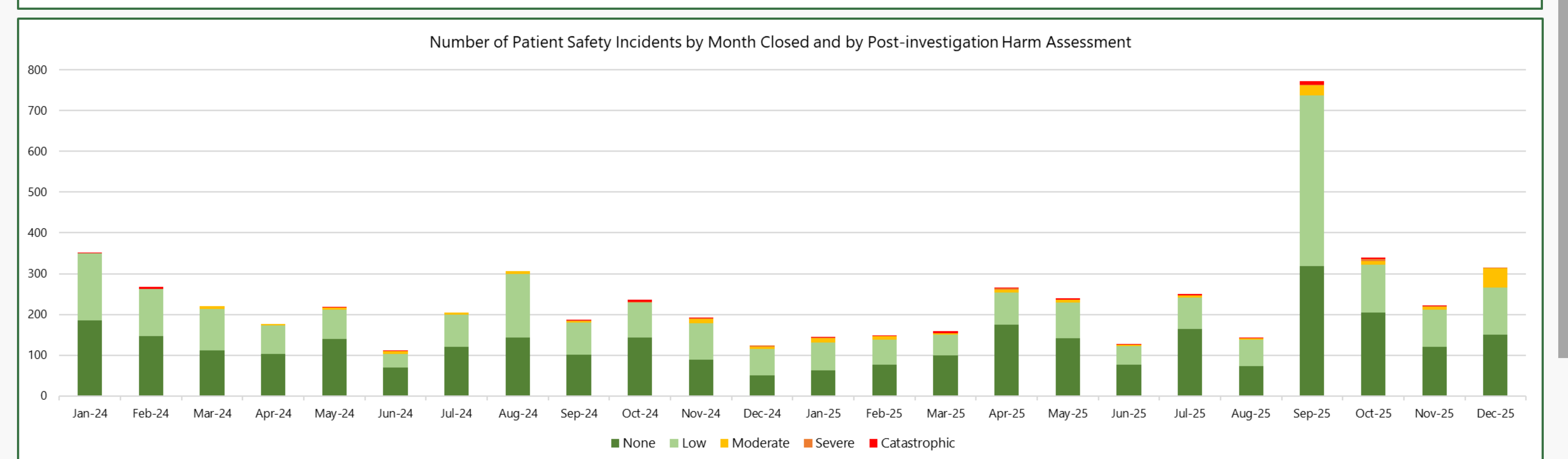
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

Health & Care Standard
Health – Safe Care





Analysis
The number of investigations needing to be shared with other NHS Wales organisations has reduced again since last month and is lower this winter than the previous year, with handover delays being experienced across fewer Health Boards and concentrated in others. This is being monitored closely through the 'Release 45' initiative and will remain an area of focus as to whether initial improvements are sustained during Winter. Incident reporting volumes have increased back to baseline levels however the number of investigations being completed and closed has reduced. Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low.

Remedial Plans and Actions
Incident closures are being monitored through Quality Management Group.

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

Data source: Datix

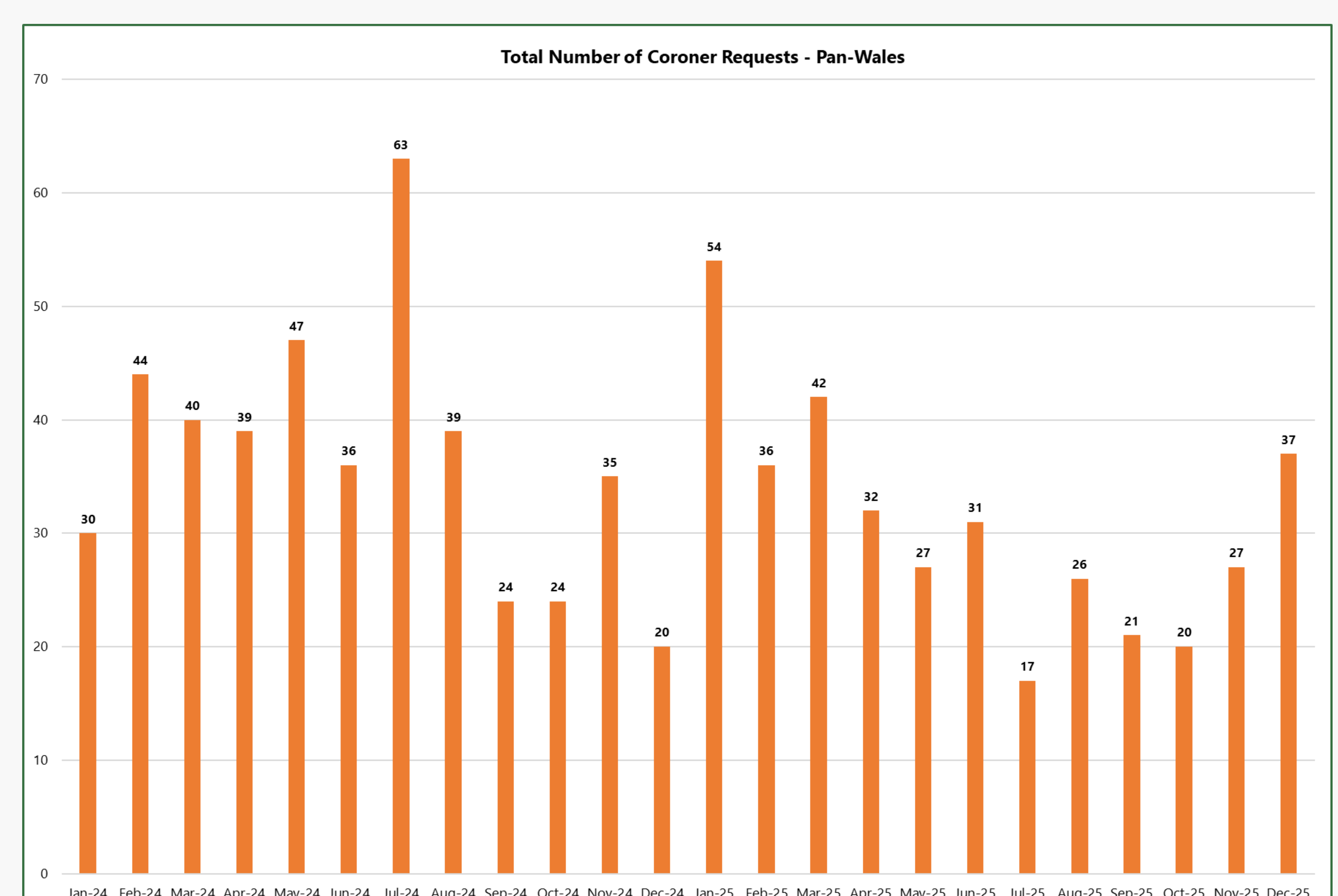
Our Patients: Quality, Safety & Patient Experience
Coroners, Mortality and Ombudsmen Indicators

(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

Health & Care Standard
Health – Safe Care



Analysis

There is a gradually improving picture in the organisational management of medical examiner reviews and coronial workloads. Inquest cases remain at stable levels but present with increased complexity and large numbers of statements and witnesses being called. These factors combined makes this an area of continued pressure across Trust services and for the individual staff involved in representing the organisation.

Level 1 triage of Medical Examiner referrals proceeds at fortnightly intervals with all Q1 and Q2 cases triaged. Progress is being made in reducing delays in reviewing cases at Level 2 Learning Panel with the majority of the backlog now eliminated. Internal review of referrals at Medical Examiner Learning Panel continues to identify learning relating to delays in attending in the community, alongside improvement opportunities for Advanced Care Planning and enhanced end of life care in the community to guide family expectations, avoid admission where not indicated and provide dignified and personalised care.

Remedial Plans and Actions

A Putting Things Right and Legal Services Recovery Plan has been developed to address the number of overdue concerns. This is being monitored through our internal governance structure and reported on in QuESt Committee. Additional non-recurrent investment is expected to deliver the required improved at increased pace, building on structural workforce changes and a shift to proportionate approaches that have already begun to demonstrate benefit.

Expected Performance Trajectory

- Coroner activity will continue to be monitored and delays in statement gathering escalated and prioritised internally as appropriate. Cross directorate teams continue to work together to ensure cases are prioritised, and the coroner is provided with estimated times of completion.
- The ability to provide senior review of Medical Examiner feedback cases will depend on availability of the appropriate professional attendance at Learning Panel.

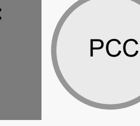
Mortality Reviews Data source: Internal Web Application

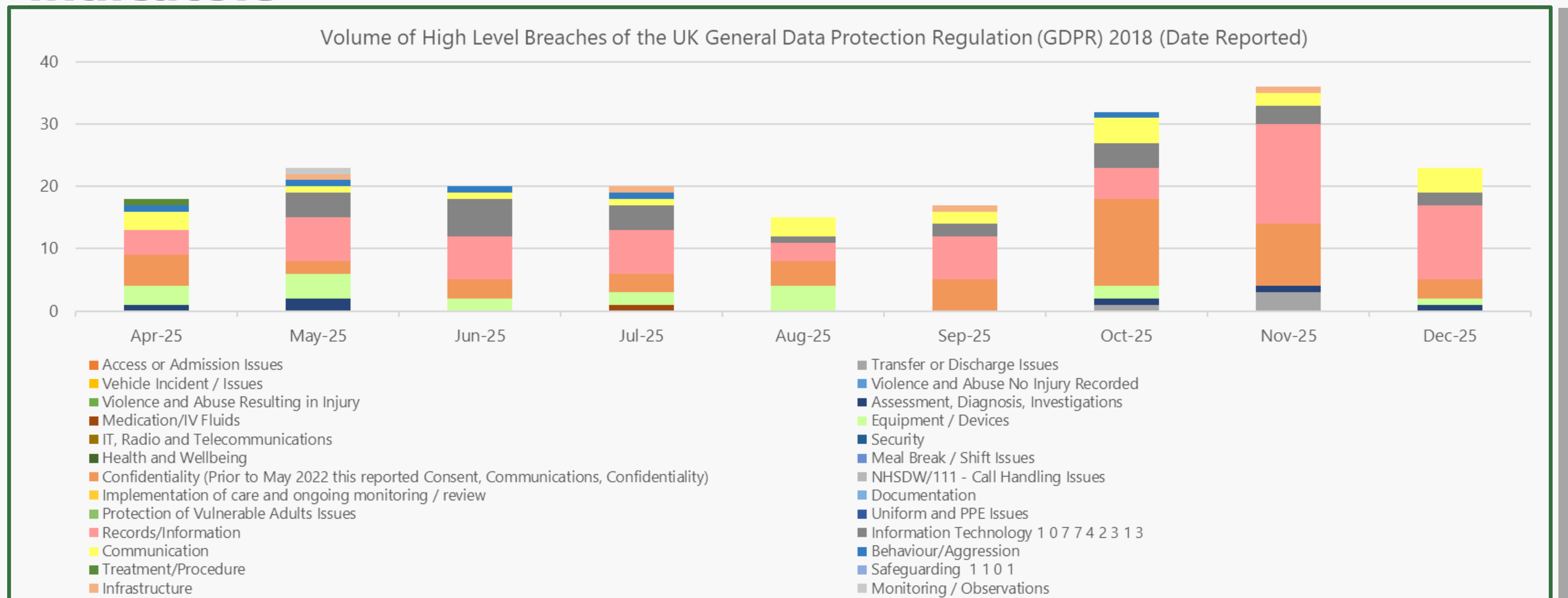
Our Patients: Quality, Safety & Patient Experience Safeguarding, Data Governance & Public Engagement Indicators

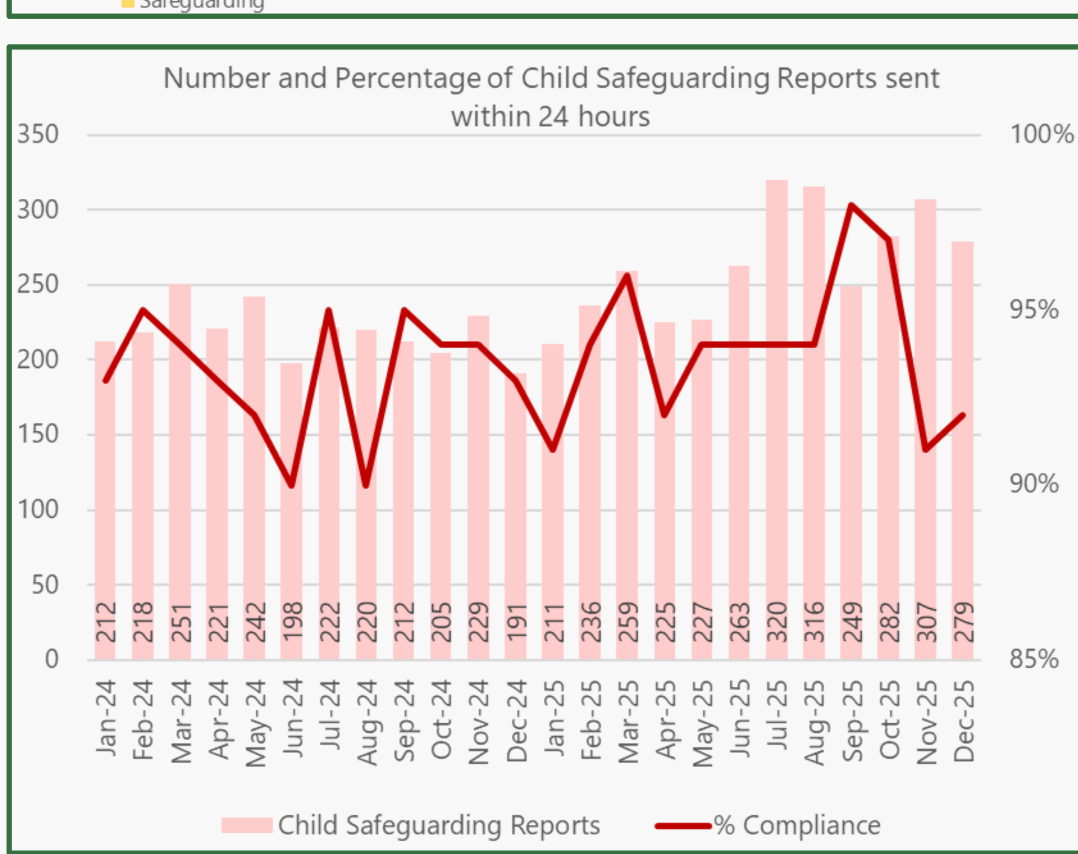
(Responsible Officers: Jonny Sammut & Liam Williams)

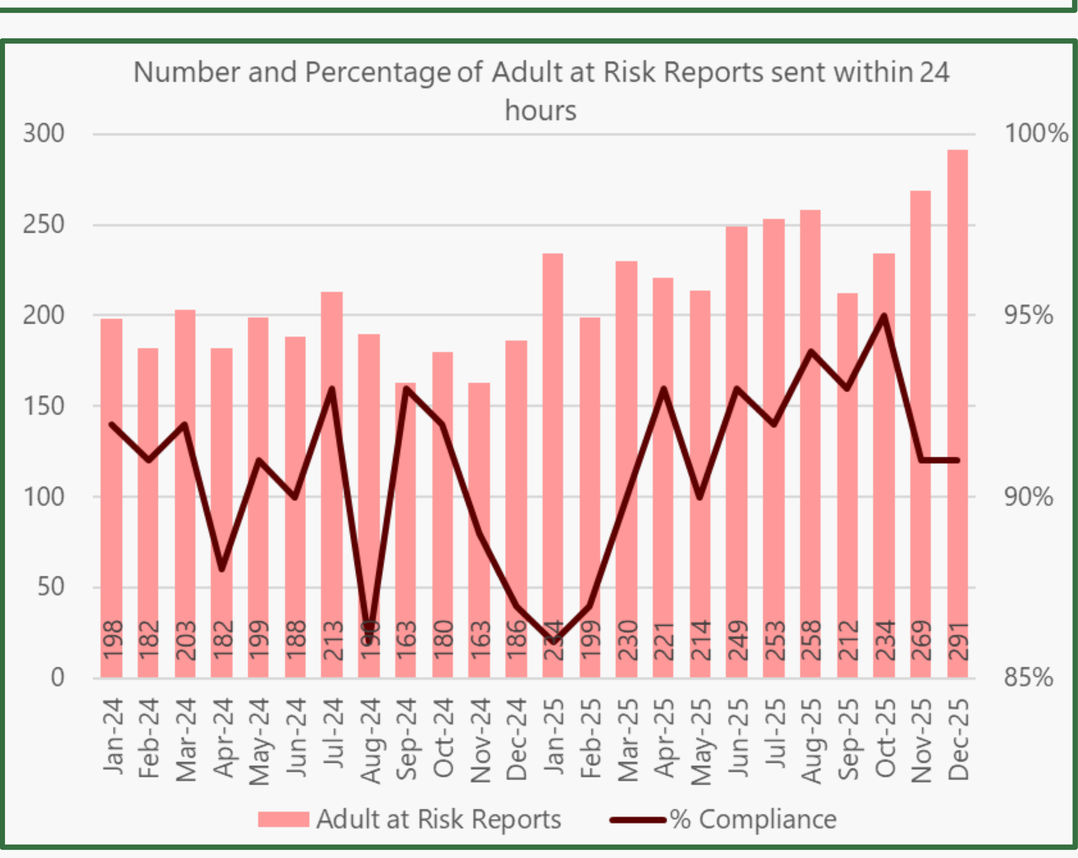
Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong









Analysis

Safeguarding: In December 2025 WAST colleagues submitted a total of 291 Adult at Risk Reports, 91% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 965 reports were shared with local authorities across Wales during this reporting period. There have been 279 Child Safeguarding Reports submitted in December 2025, 92% of these were processed within 24 hours.

Data Governance: In December, there were 23 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 23 breaches, 12 related to Records/Information, 4 Communication, 3 IG/Confidentiality, 2 Information Technology, 1 Equipment/Devices, and 1 Assessment/Treatment/Diagnosis.

Remedial Plans and Actions

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

Data Governance: During the reporting period, of the 23-information governance related incidents reported on Datix, 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO). The IG Team continues to monitor, and review reported incidents where applicable.

Expected Performance Trajectory

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

Data Governance: The next iteration of the IG Toolkit has now opened for FY25/26 submissions. Submission is 91% completed, with the remaining 9% relating mostly to the Video Surveillance category.

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

Safeguarding Data source: Doc Works

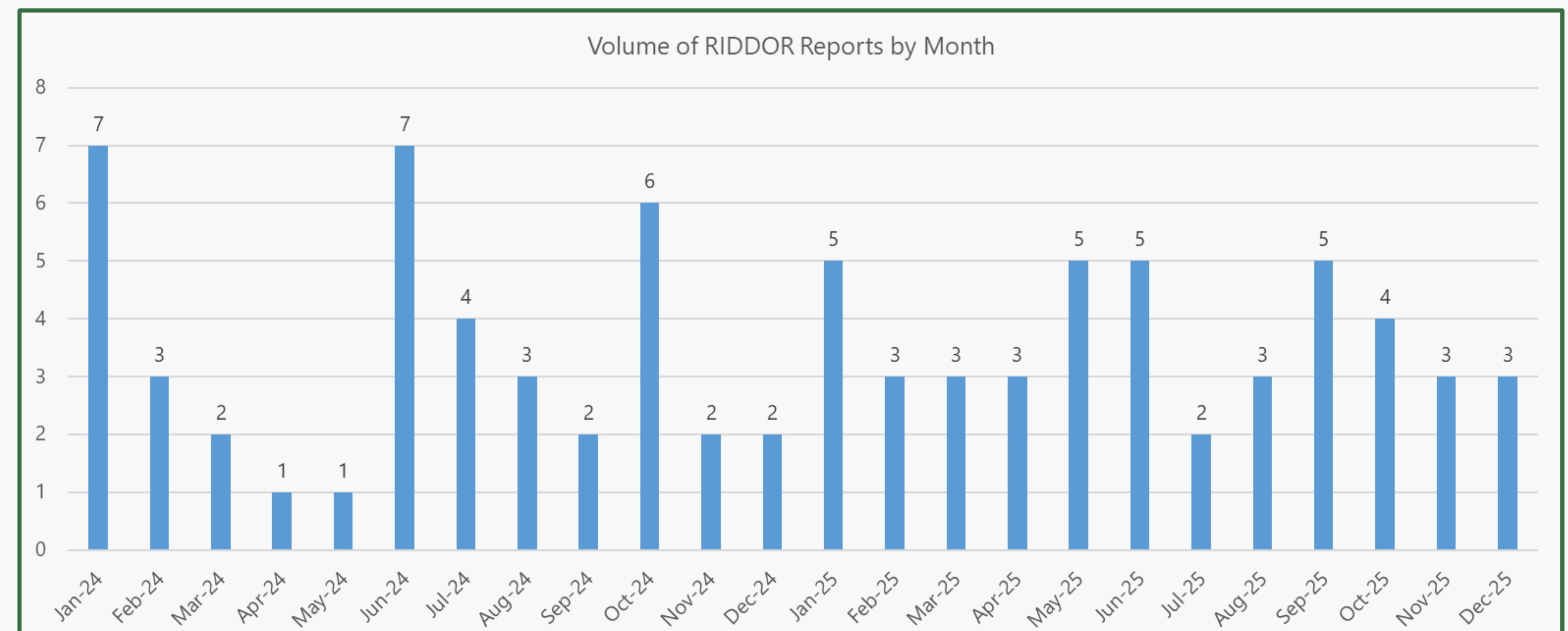
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

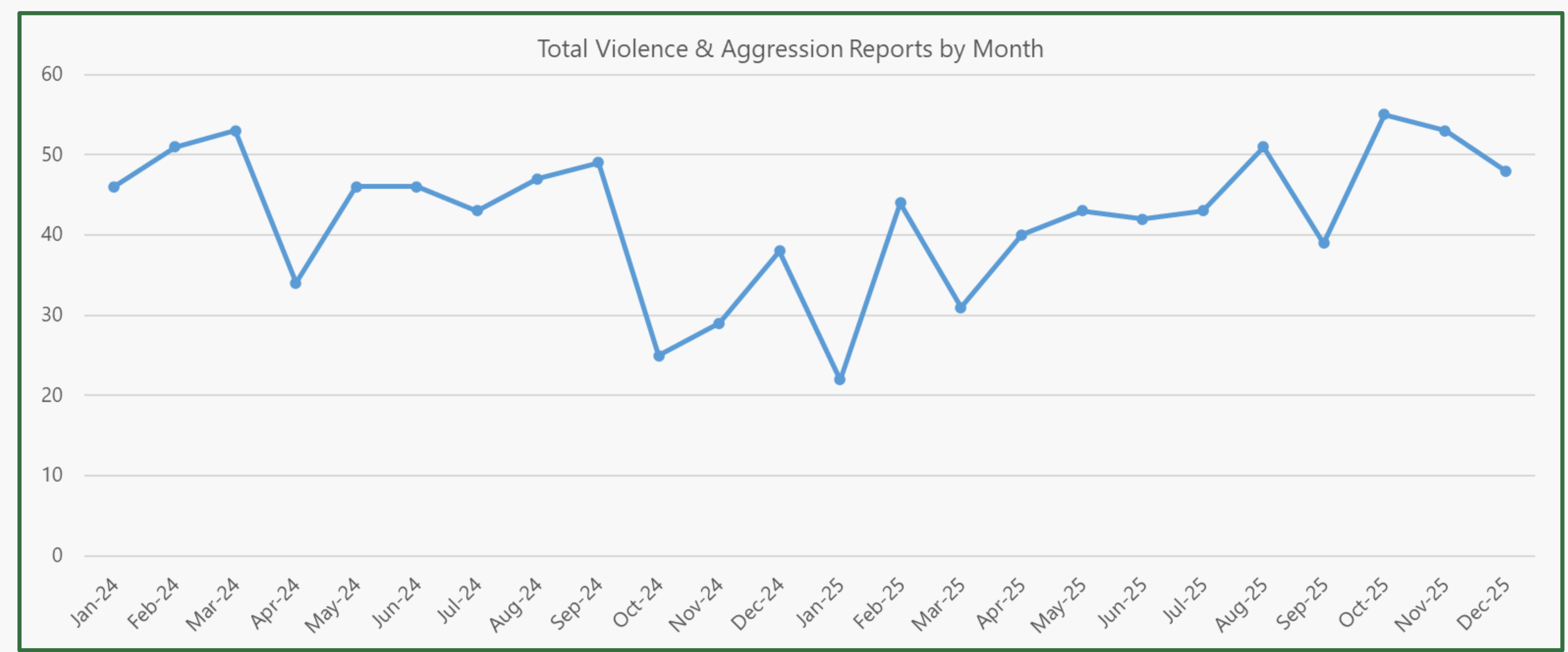
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Analysis

RIDDOR: There were 3 incidents requiring reporting under RIDDOR during December 2025 all were for an injuries requiring over 7 days of work.

- 100% of the RIDDOR's were submitted within the HSE reporting timelines, which is a big improvement from previous months.
- 1 RIDDOR reported during the month were as a result of a manual handling incident, 1 was for a slip, trip, fall and another as a result of being struck against an object.

Violence and Aggression:

- A total of 48 incidents have been reported of V&A in December.
- The number of Aggressive/Threatening behaviour reports decreased slightly this month with 4 less than the previous month.
- 6 Physical Assault on staff were reported during the month with 5 incidents of verbal assault that were for swearing.
- 1 incident were reported as Severe harm, 10 incidents were reported as Moderate in harm and 22 noted as low harm with 13 cases being noted as causing no harm.

Remedial Plans and Actions

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

Violence and Aggression: The use of appropriate Hashtags to flag incidents of verbal aggression within the Trust call centres is being progressed to provide a greater understanding of the verbal abuse experienced by staff.

Expected Performance Trajectory

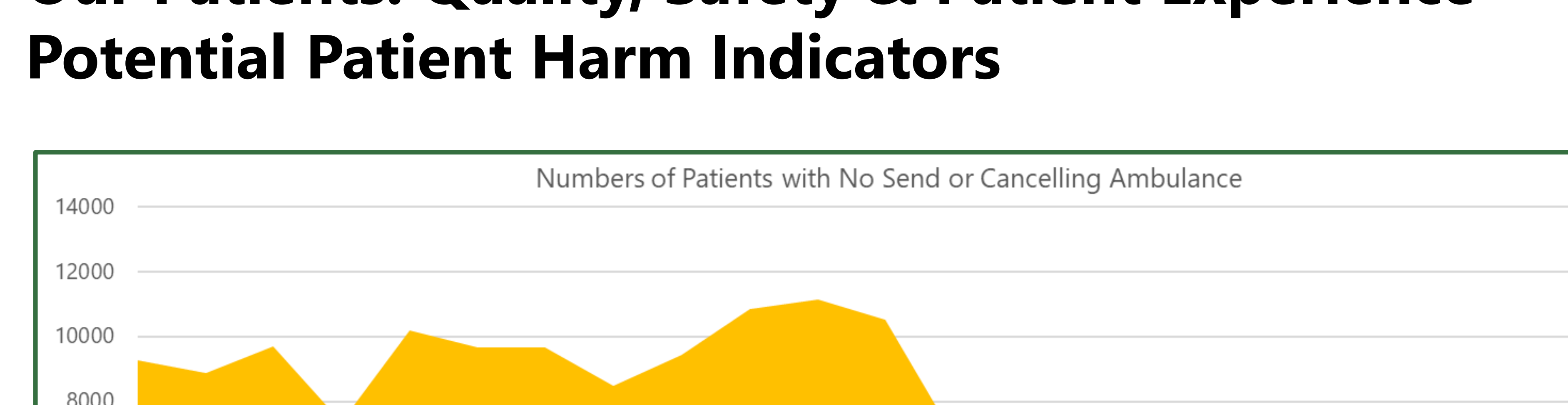
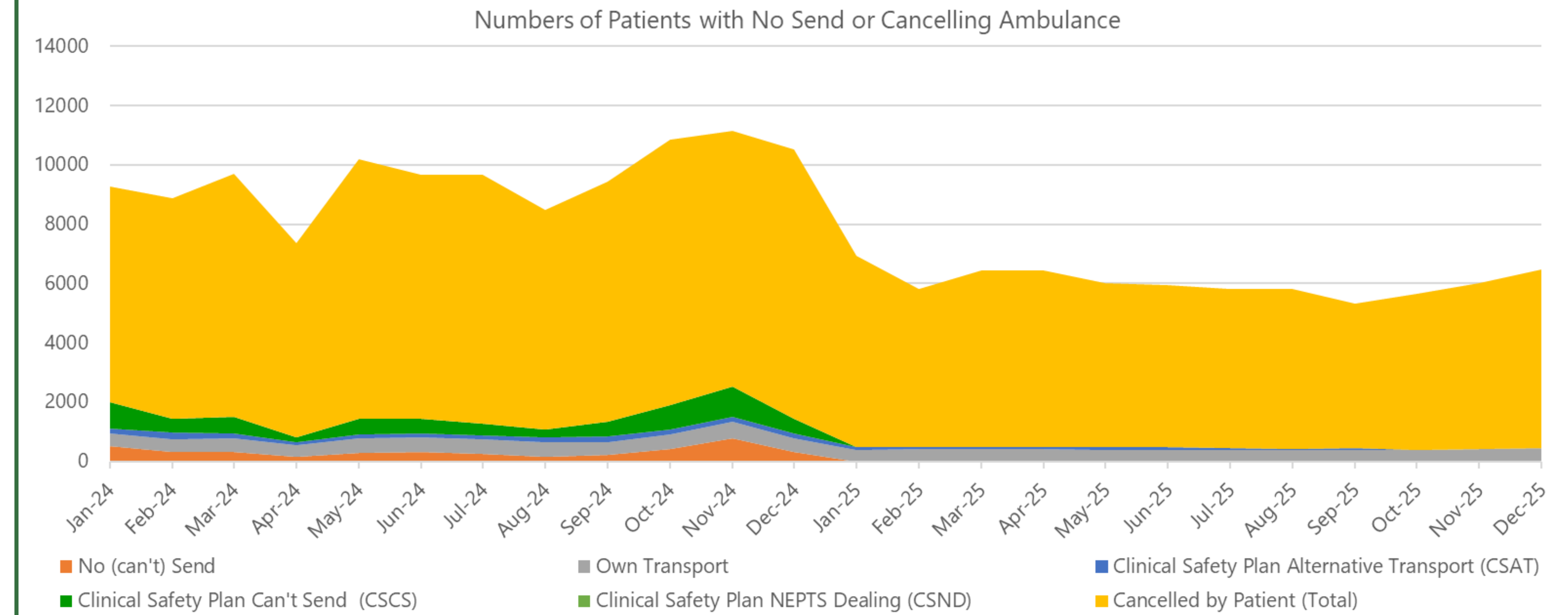
RIDDOR: The actions arising out of the recent deep dive into manual handling incidents aim to address the issues identified in the manual handling incidents this month.

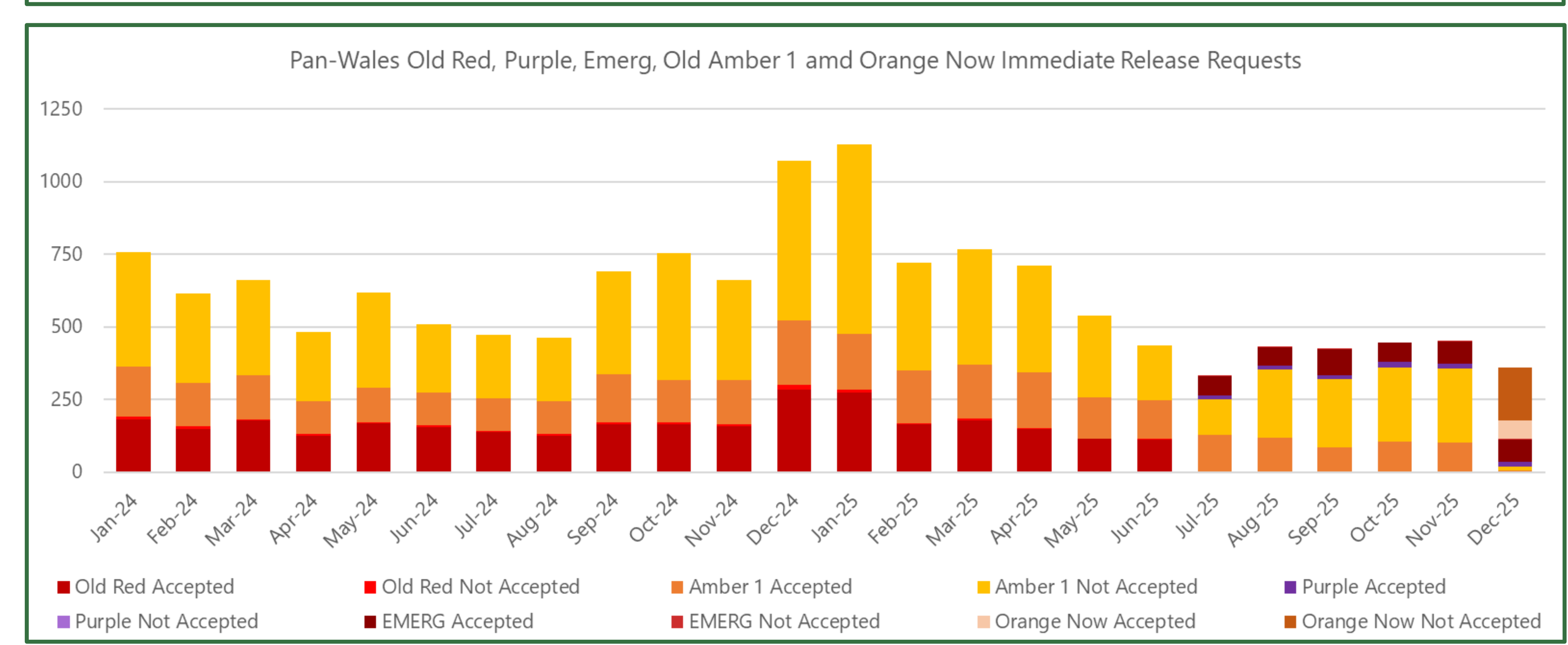
Violence and Aggression: It is expected that the number of verbal V&A incidents will increase over the next few months as a result of increased awareness of reporting mechanisms within the call centre teams.

Data source: Datix

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

(Responsible Officer: Andy Swinburn) R QUEST



Analysis

In December 2025, zero ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 6,020 ambulances were cancelled by patients an increase from the 5,603 in November 2025. There has been a downward trend in patient cancellations since December 2024 which the Trust believes is connected to the implementation of Rapid Clinical Screening during the winter.

There were 360 requests made to Health Board EDs for immediate release of Arrest, Emergency, Amber 1 and Orange Now calls in December 2025. Of these 18 were accepted and released in the Arrest category, with none not being accepted, 75 were accepted in the Emerg category, with 2 not accepted, 5 ambulances were released to respond to Amber 1 calls, but 14 were not and 69 were released for Orange now but 196 were not.

In December 2025 CSP levels for the Trust were:

Remedial Plans and Actions

Immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Arrest and Emerg Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings had been paused as the Trust moves into the new commissioning arrangements with new arrangements expected later this year. The WG target for 2025/26 has a target of no handovers of more than 45 minutes.

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trust's ability to respond to demand.

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

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

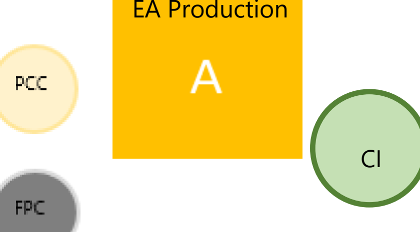
December 2025		
NEPTS (211 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	83
Were you happy with the transport you received?	85	95
999 (4 responses)	Benchmark	Score
The 999-call taker who answered your call listened carefully and explained what was going to happen next.	85	42
The length of time I waited for an ambulance to arrive was acceptable.	85	25
111 (20 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	36
Did you follow the advice given to you by NHS 111 Wales?	85	69
Would you consider using NHS 111 Wales again?	85	46
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	90.30% Good	7.27% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	23.08% Good	76.92% Poor
o NHS 111 Wales Online	43.75% Good	43.75% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

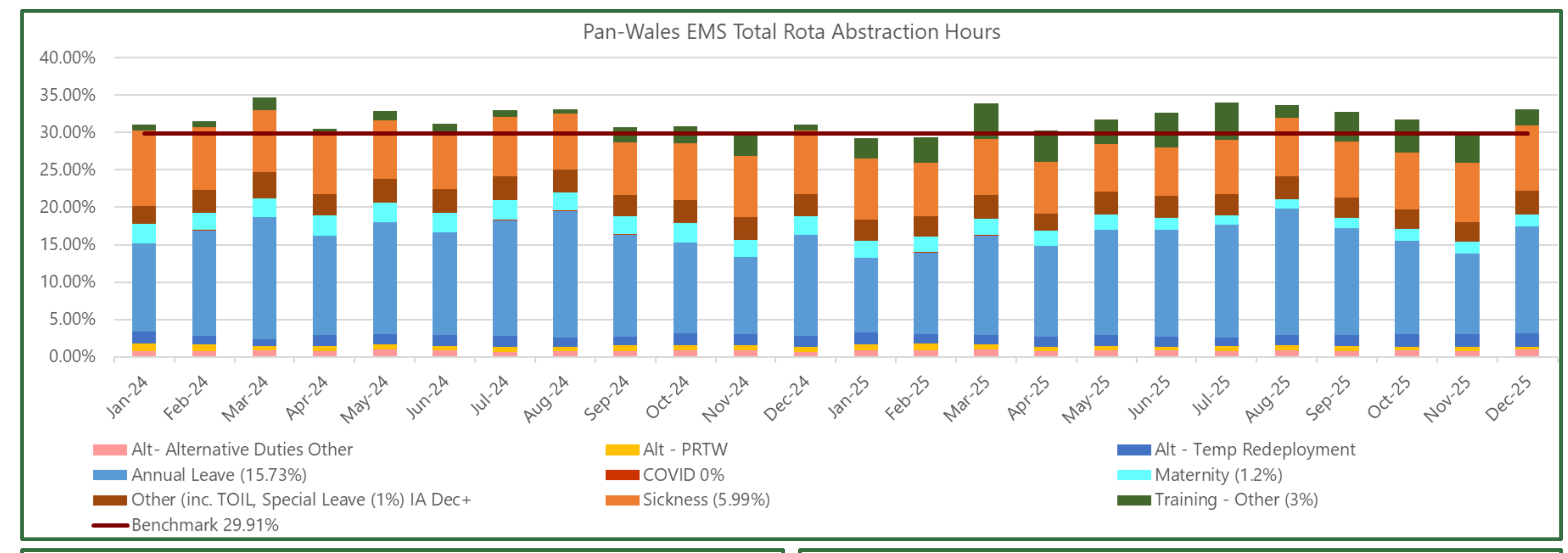
Analysis
The OCP for the PECI Team is expected to commence in quarter 4, with the team to be realigned to support the Trust's strategic objectives and the People's Experience Framework. The framework promotes an always-on approach to capturing experiences through both active and passive methods, ensuring people can share feedback at their convenience.
Meanwhile, the team continues to capture, report and respond to experiences, stories and compliments, and to work with quality teams on improvement actions. Due to ongoing capacity constraints—linked to vacancies awaiting the OCP and work on improving experience-capture systems—no engagement events were attended in December 2025.

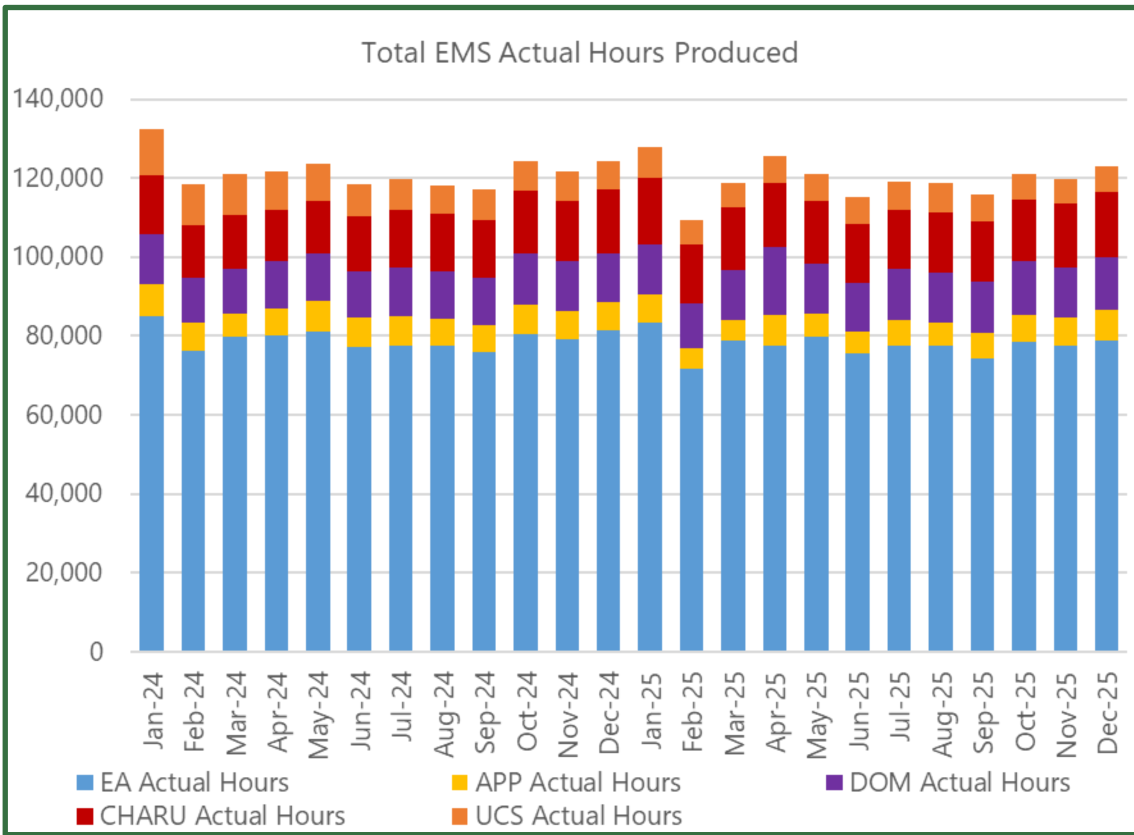
Remedial Plans and Actions
The PECI Team is awaiting the progression of the OCP, which will restructure and realign the team to support the Trust's strategic objectives. While ongoing public engagement remains part of the team's remit, future responsibilities and processes will need to be worked through. The team is also carrying several vacancies, including three Band 5 Engagement Coordinator posts, which cannot be filled until the OCP concludes. As a result, community engagement capacity is significantly reduced, and activity levels will be lower than in previous periods. The team is not scheduling future engagement events and is considering all requests on a case-by-case basis.

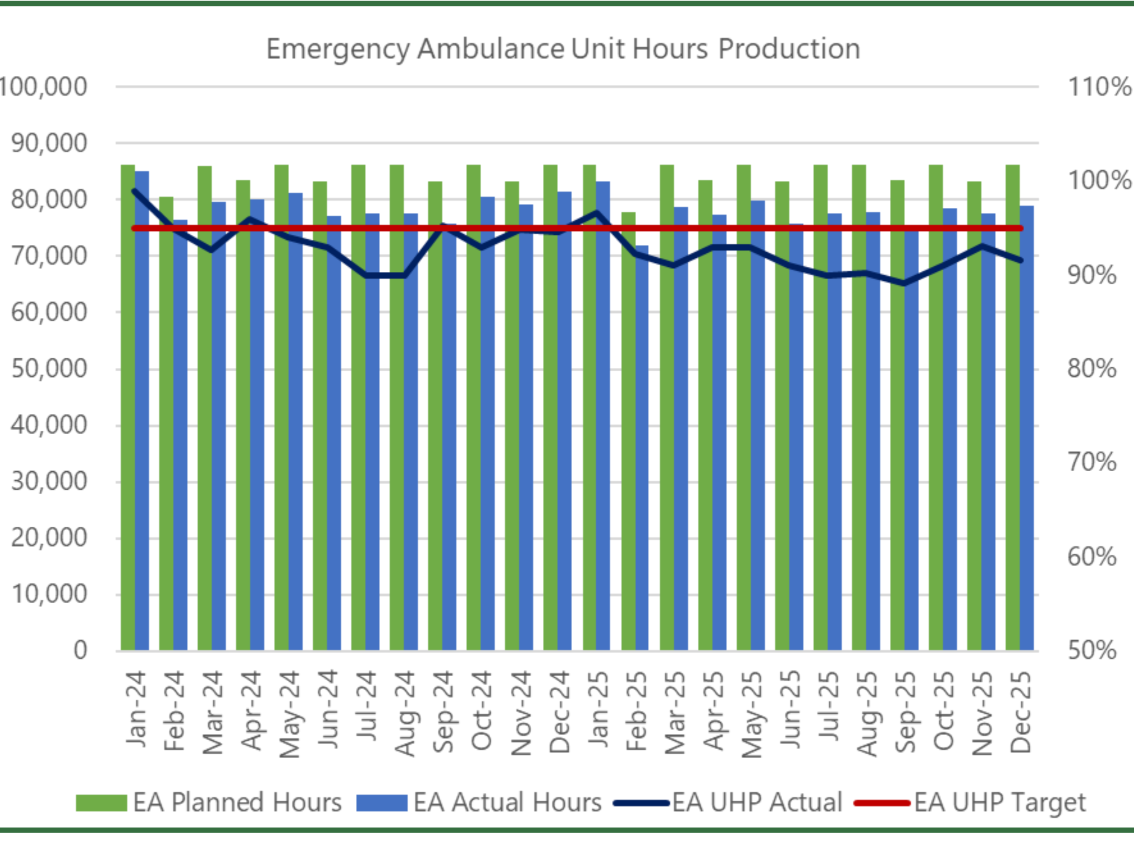
Expected Performance Trajectory
The Team is carrying several vacancies which cannot be backfilled due to the impending OCP. This will impact on our ability to support community engagement opportunities, and the Team is re-focusing its day-to-day efforts onto our core function of patient experience.

Our People
Capacity - Ambulance Abstractions and Production Indicators









Analysis

Monthly abstractions from the rosters are key to managing the number of hours the Trust produces, as are the total number of staff in post. December 2025, saw total EMS abstractions (excluding Induction Training) of 33.08%. This was a minimal increase on the 30.09% recorded in November 2025 and remains above the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 14.30% followed by sickness at 8.83%.

The total EMS hours produced is a key metric for patient safety. The Trust produced 122,863 hours during December 2025; a slight decrease compared to the 124,279 hours produced during December 2024. The Trust is still delivering good levels of production.

Emergency Ambulance Unit Hours Production (UHP) achieved 92% in December 2025 which equated to 78,994 Actual Hours.

In December 2025 CHARU UHP was 92% against the full roll out requirement.

Remedial Plans and Actions

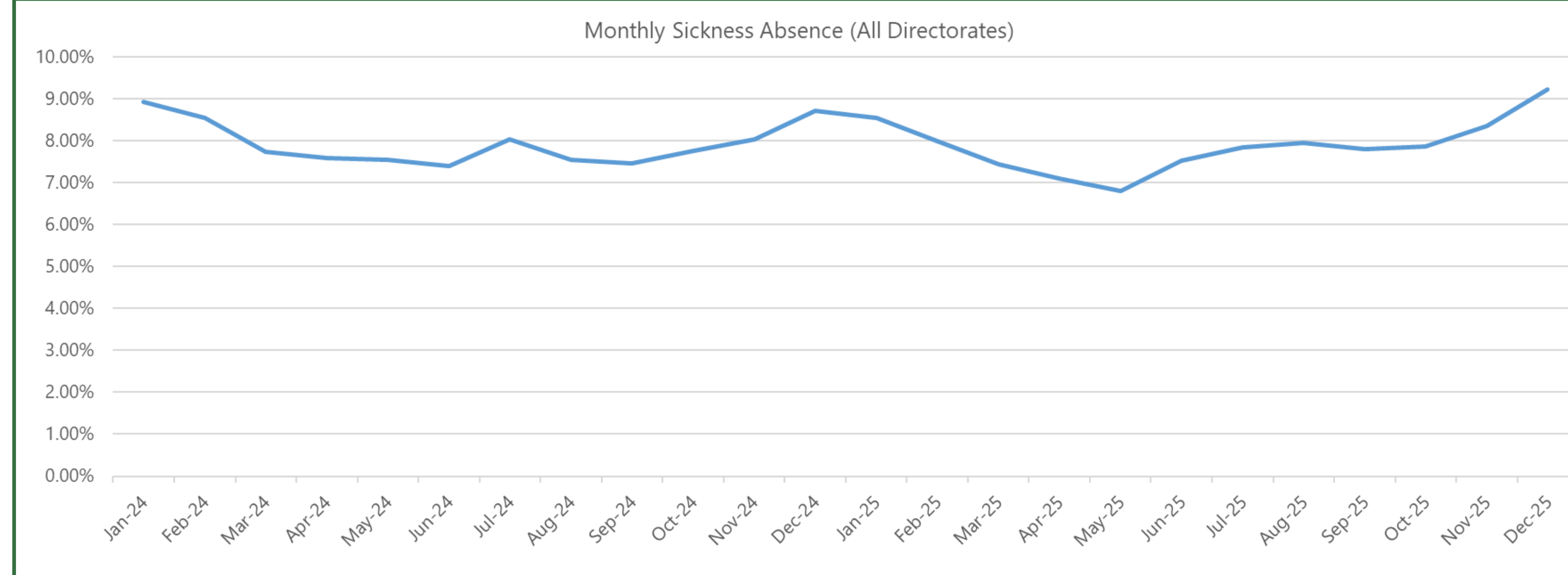
- Continued focus on managing attendance across the Trust and managing abstractions from rosters.
- Full roll out of CHARUs.
- Continued focus on staff in post to establishment, aiming for 95% benchmark.
- Smoothing of staff between urban and rural areas.
- Focus on recruitment to reduce identified vacancy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

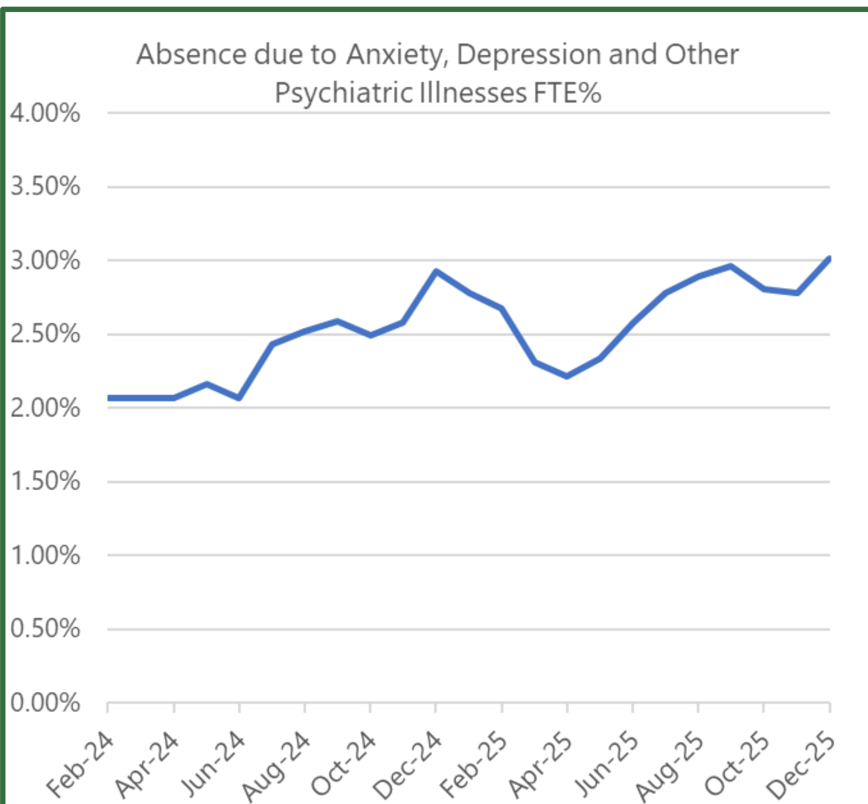
Expected Performance Trajectory

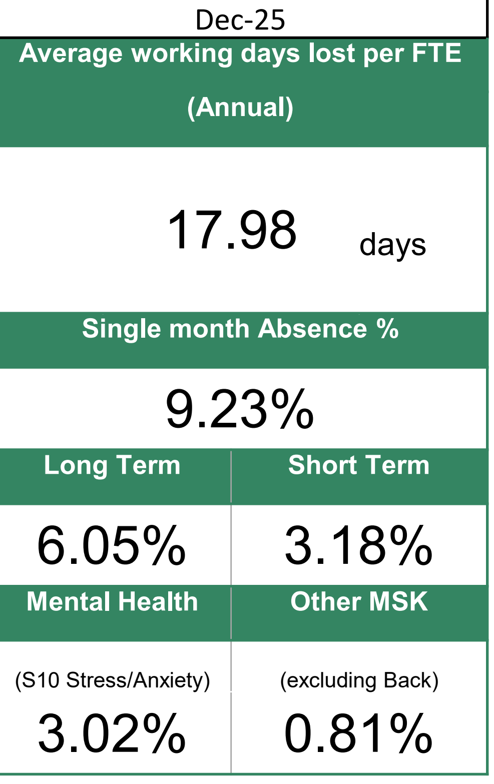
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is just below target. The Trust maintains an ambition to reduce sickness to 6% and maintain abstractions to 30%. This has not yet been achieved for sickness, but the direction of travel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

Our People
Capacity - Sickness Absence Indicators

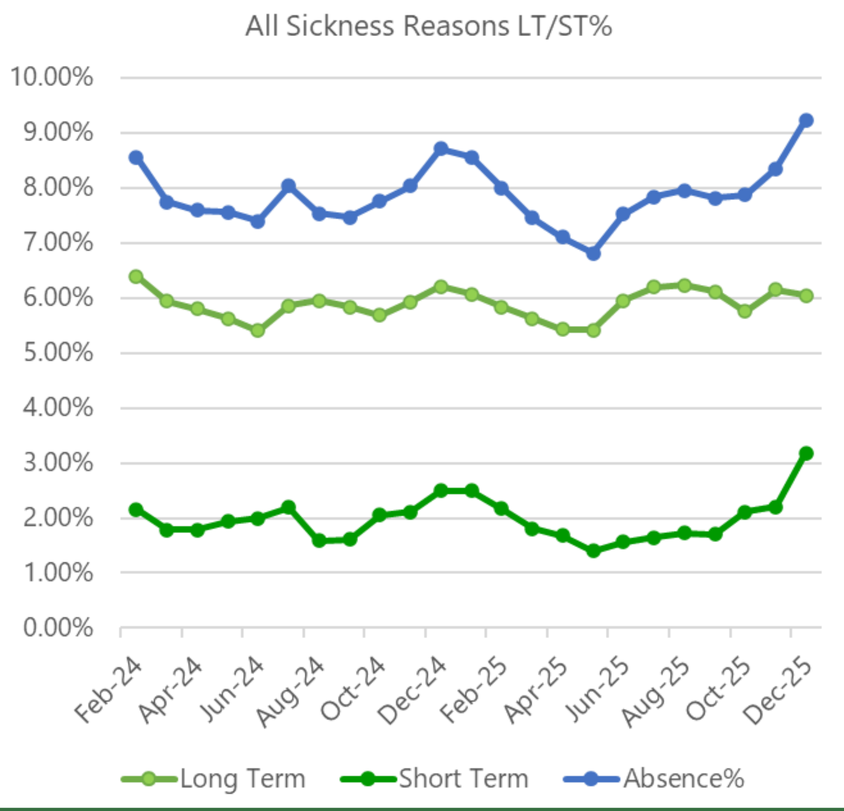
(Responsible Officer: Carl Kneeshaw)







Dec-25	
Average working days lost per FTE (Annual)	
17.98 days	
Single month Absence %	
9.23%	
Long Term	**Short Term**
6.05%	3.18%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
3.02%	0.81%



December 2025

Analysis

There was an increase in overall sickness absence rates between November 2025 and December 2025, increasing from 8.35% to 9.23%. Long term absence minimally decreased from 6.15% in November 2025 to 6.05 % in December 2025, however short-term absence increased slightly to 3.18% (November 2025 - 2.20%). The highest reasons for absence in December 2025 were Anxiety/ Stress/ Depression, gastrointestinal problems, Col, cough, flu – Influenzas and other musculoskeletal problems.

The WAST annual flu campaign kicked off on 6th October 2025, with weekly drop-in clinics held by Occupational Health, alongside multiple clinics held in stations pan Wales by over 40 signed off peer vaccinators.

Remedial Plans and Actions

- The Health and Wellbeing Plan for 2025-29 has been developed and implemented. The focus of the plan is on deliverables to improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits and drop-in clinics. We regularly give presentations to newly recruited staff to highlight and promote the Occupational Health & Wellbeing service.
- The team continue to collect feedback and review services provided by our external partner organisations to help improve those services.
- Additional peer vaccinators have been approved, and they will assist OH with a adjusted delivery programme due to different vaccinations being approved to the one requested.

Expected Performance Trajectory

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

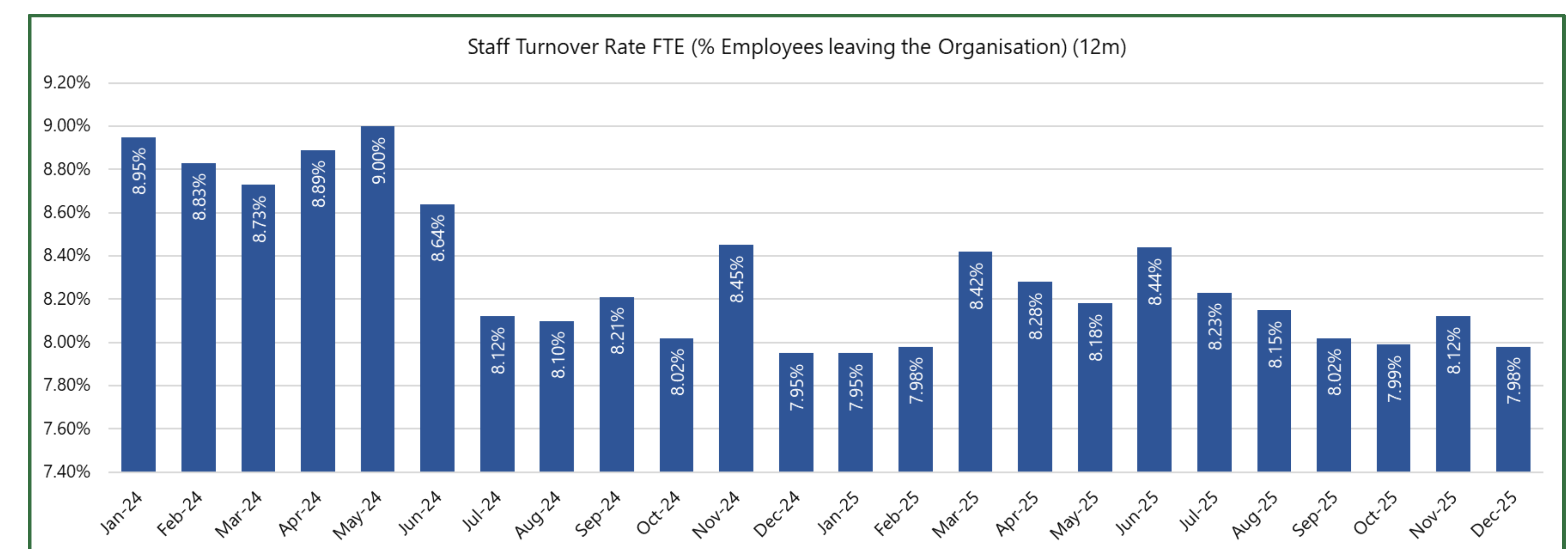
**NB:* Sickness data will always be reported one month in arrears

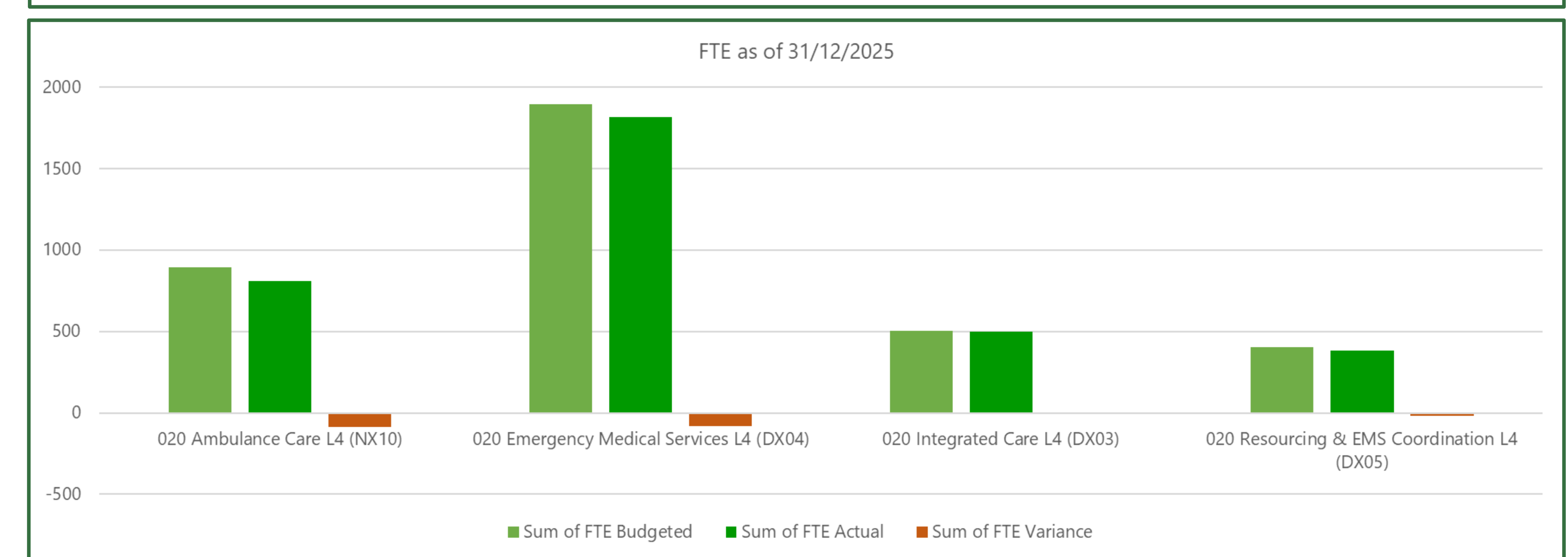
Our People
Capacity – Staff Turnover

(Responsible Officer: Carl Kneeshaw)

A

PCC





Analysis

The staff turnover rate in December 2025 was 7.98%, minimally decreasing from 8.12% in November 2025. December saw 28 leavers (24.48 FTE). Of those leaving, the greatest number were Operational and included;

- Staff Nurse (9 people)
- Call Operators (4 people)
- Emergency Call Handlers (4 people)
- Technician (3 people)
- Paramedics (3 people)

Current trends are being monitored via the leaver's questionnaires; however, these are not mandatory.

In December, the Trust had 6 joiners (6 FTE). A headcount of 2 people into Operational roles and 4 people into Corporate roles:

- Ambulance Care Assistant or Patient Transport Service Driver (1 person)
- Paramedic (1 person)
- Analysts (2 people)
- Officer (1 person)
- Senior Manager (1 person)

Remedial Plans and Actions

- Discussions around the future skill mix of our EMS workforce are ongoing, this could have considerable impact on the EMS workforce going forward. However, sufficient training capacity has been planned during 2025-26 to enable the trust to recruit any staff into the organisation, regardless of what grade that may be.

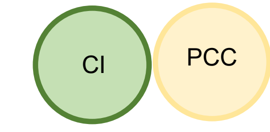
Expected Performance Trajectory

Turnover and FTE trends and themes are being monitored with plans adjusted accordingly.

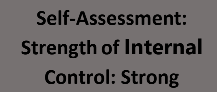
Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

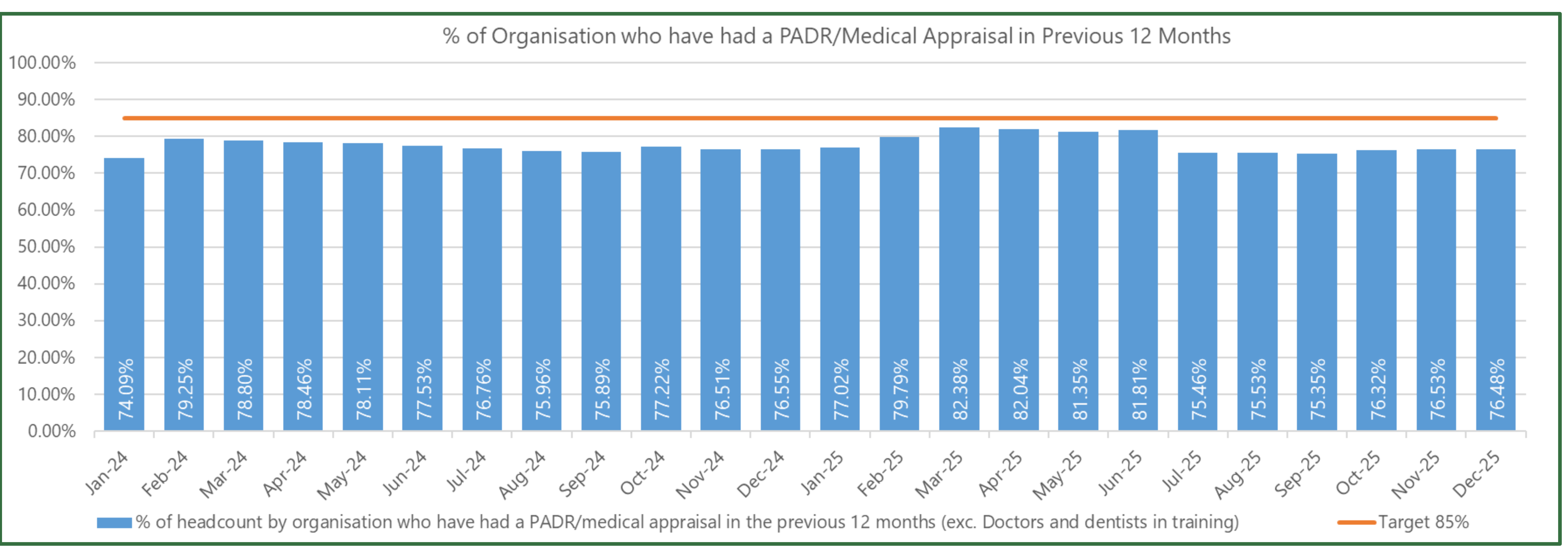
PADR R | Stat & Mand G



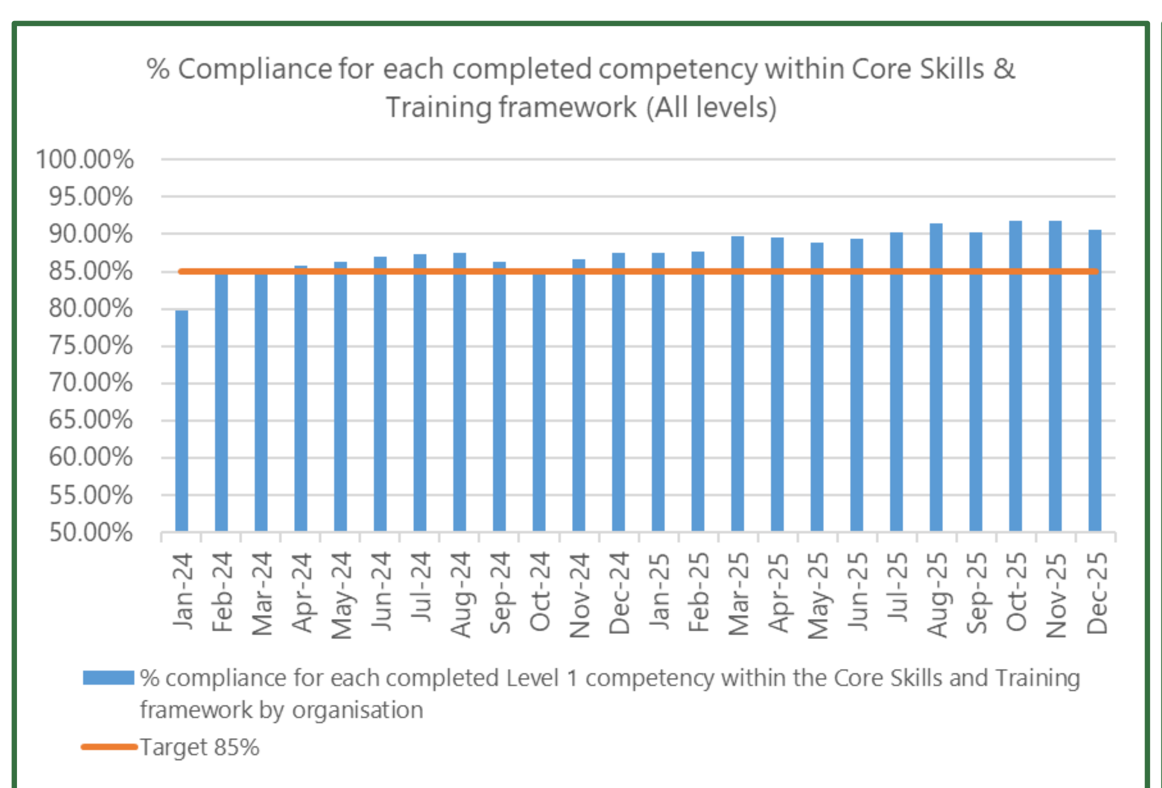
Health & Care Standard Health – Staff & Resources

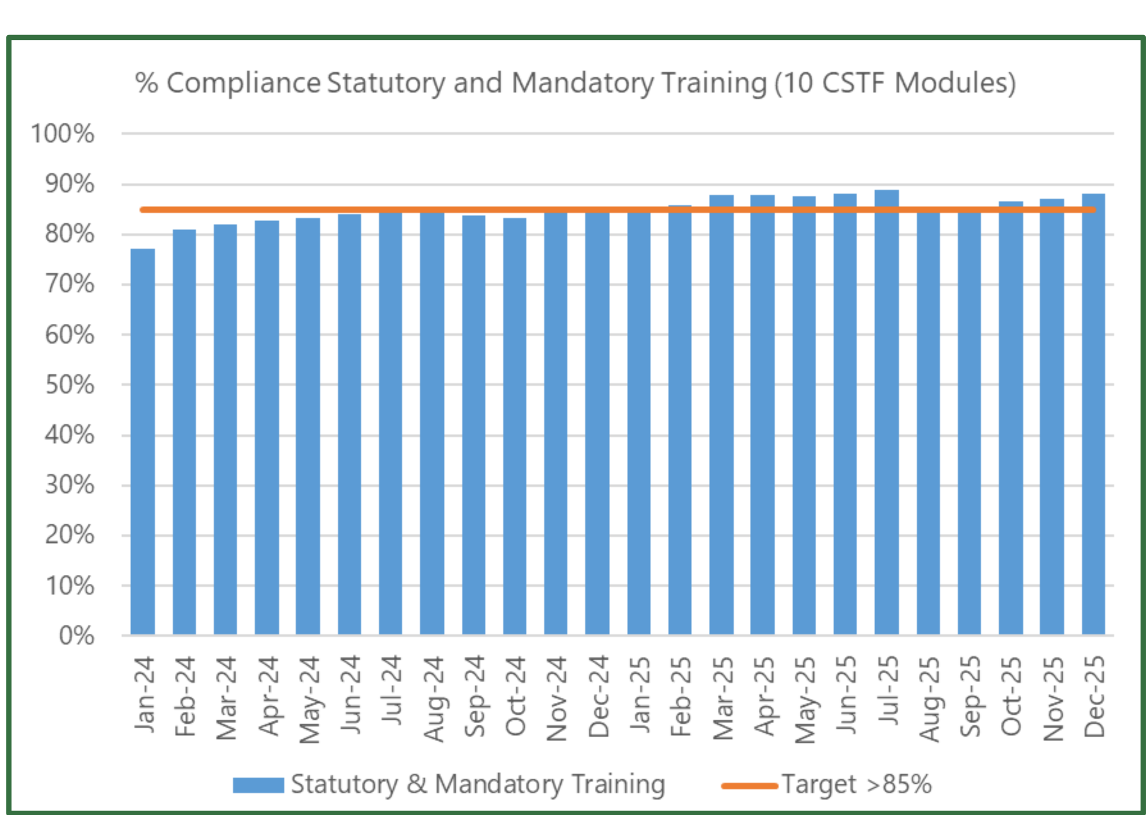


Self-Assessment: Strength of Internal Control: Strong



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





Analysis

PADR rates (excluding pay progression meetings) minimally decreased from 76.53% in November 2025 to 76.48% in December 2025 and remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

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.

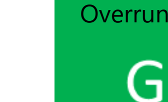
Expected Performance Trajectory

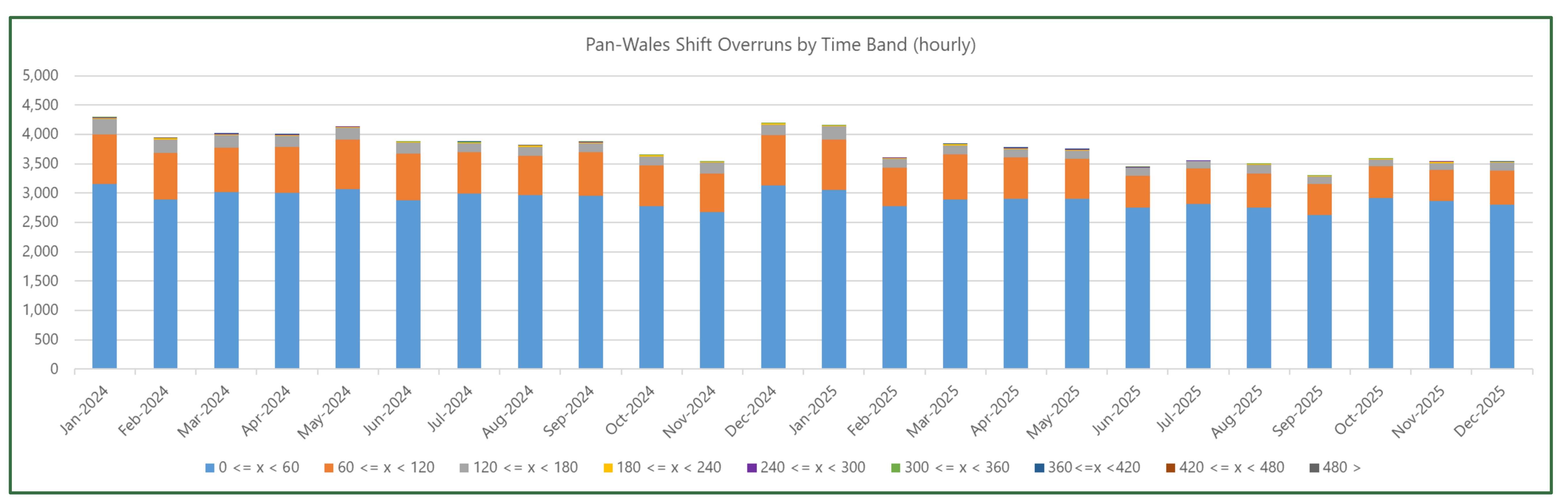
Performance is improving as compliance has risen.

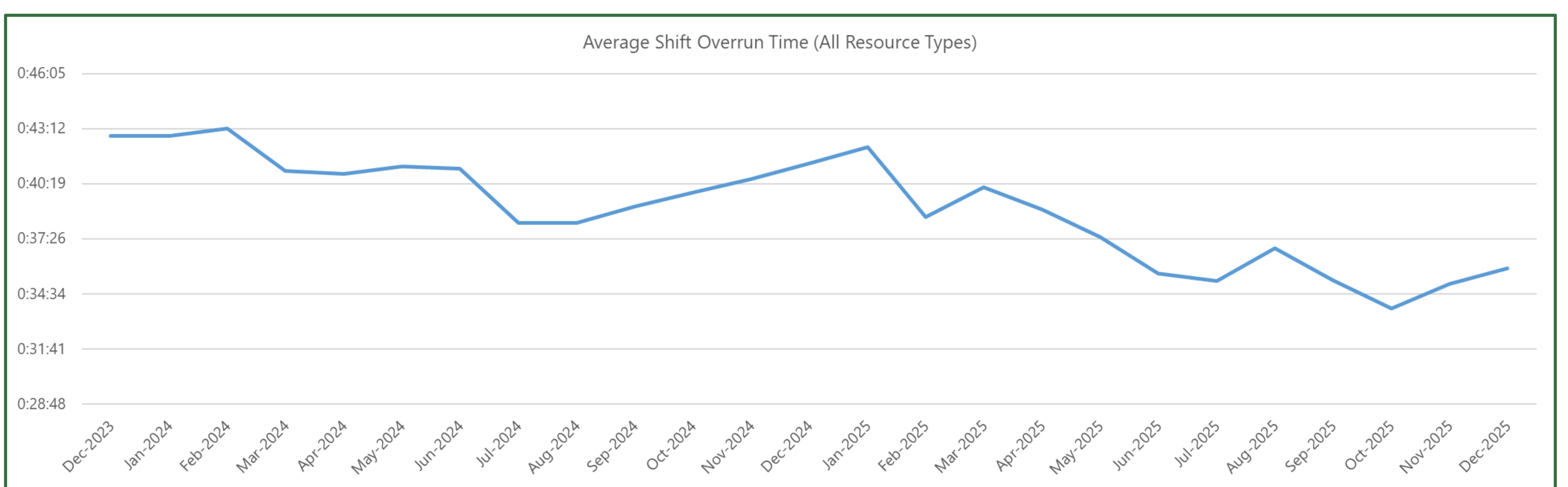
Data source: ESR

Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)





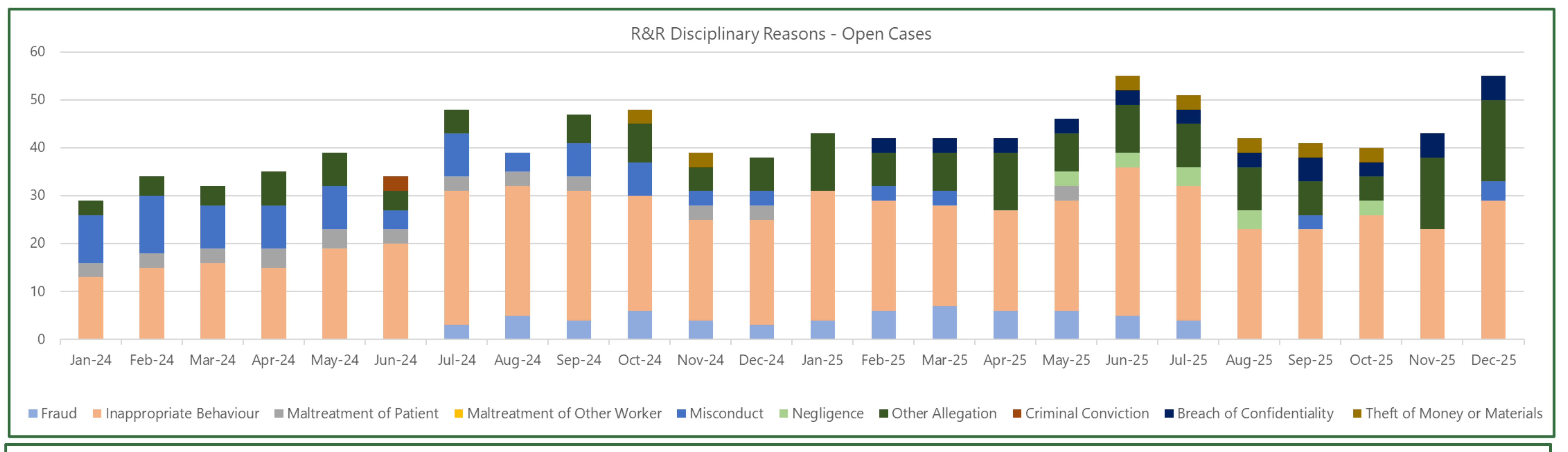


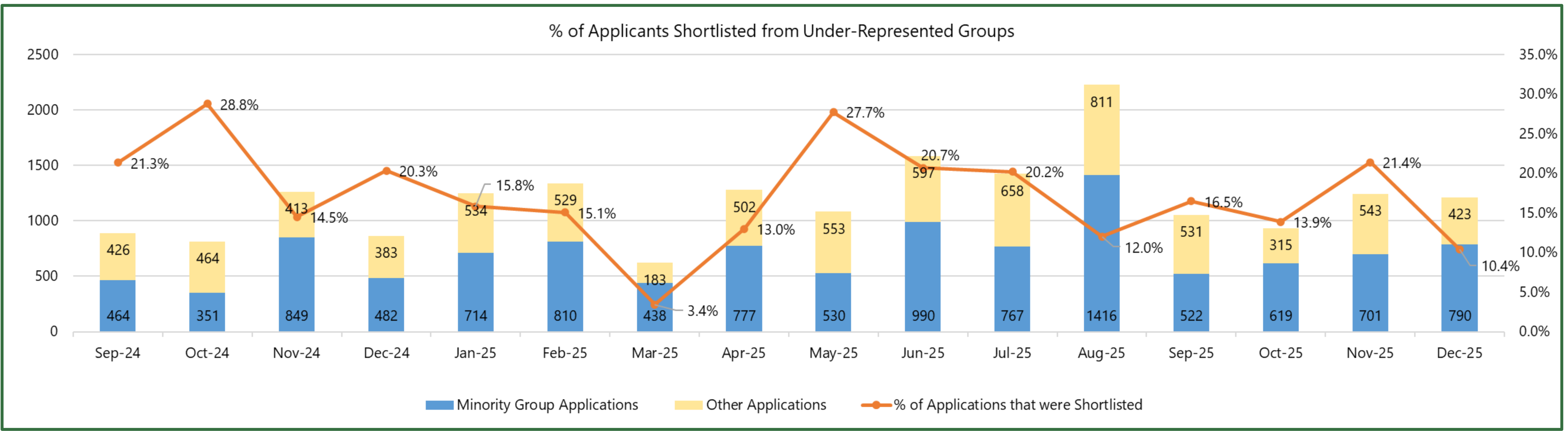
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC



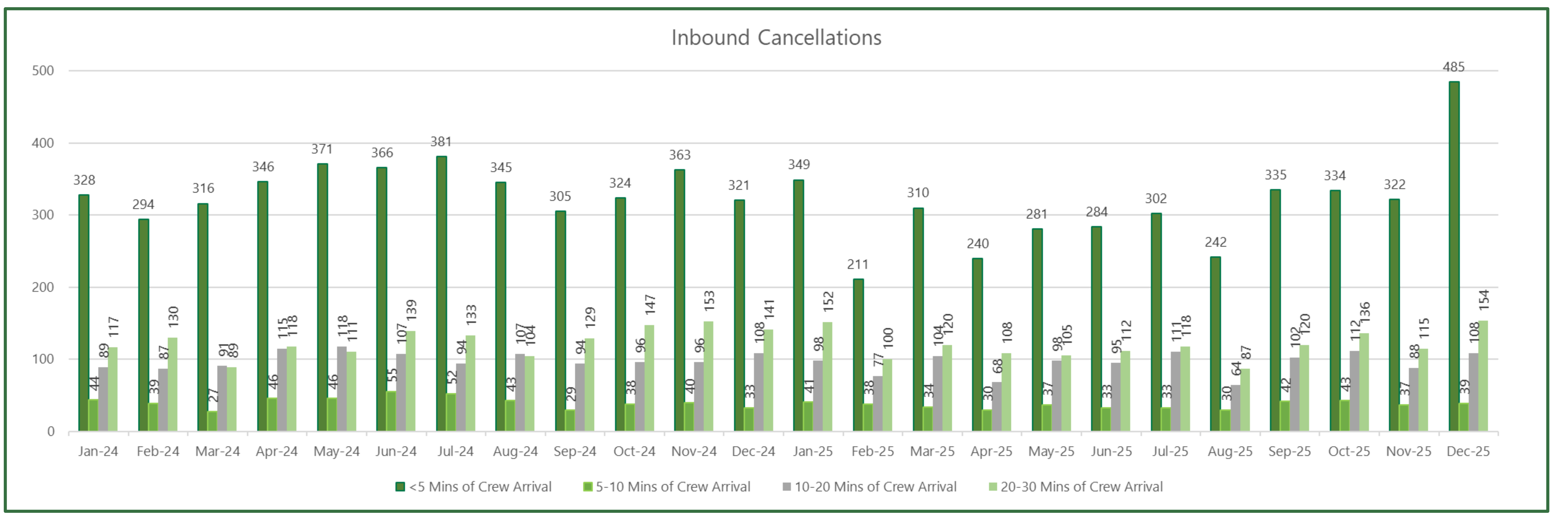


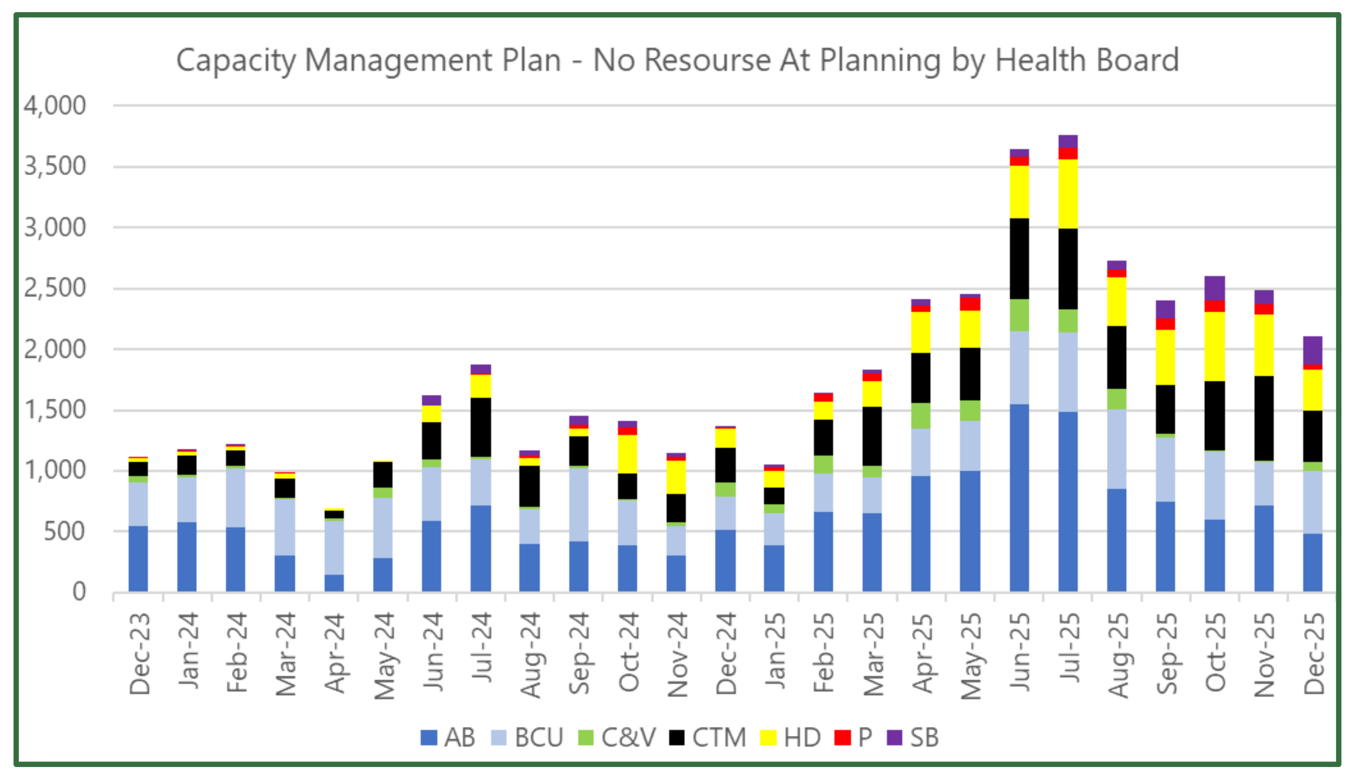
Finance, Resources and Value
Value: Ambulance Care Indicators

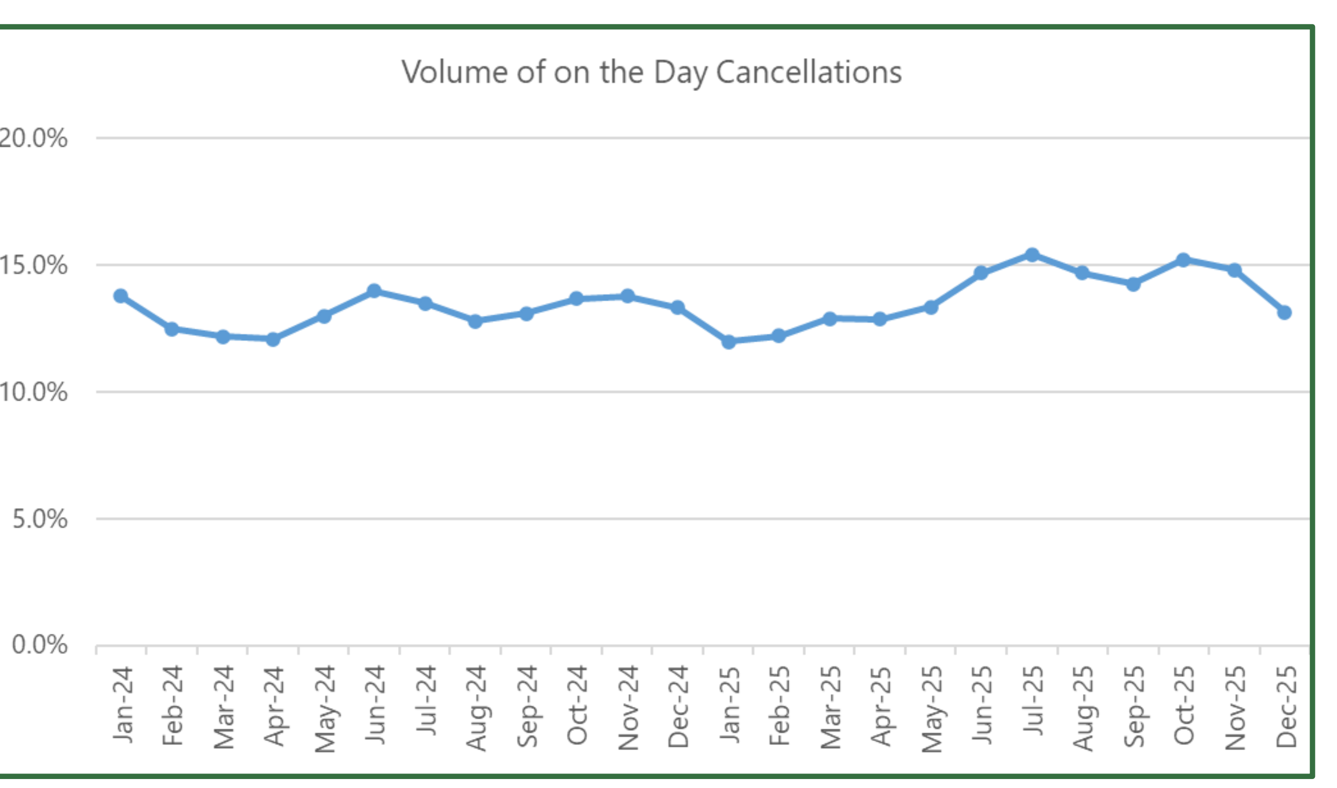
(Responsible Officer: Lee Brooks)

Cancellations
G

FPC





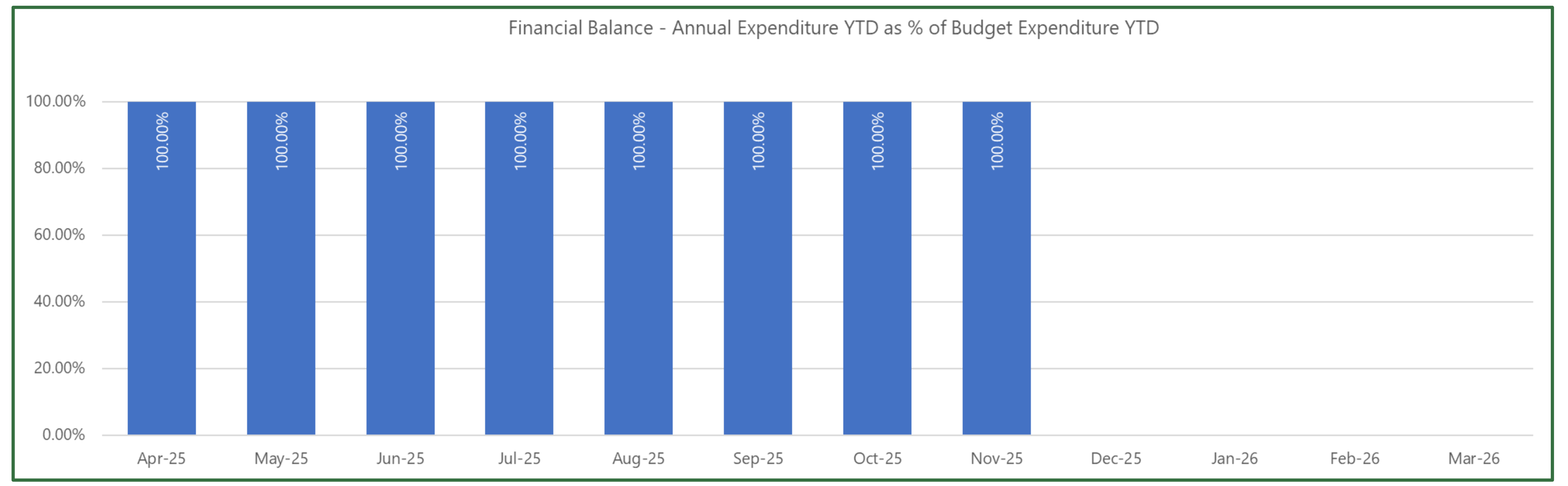


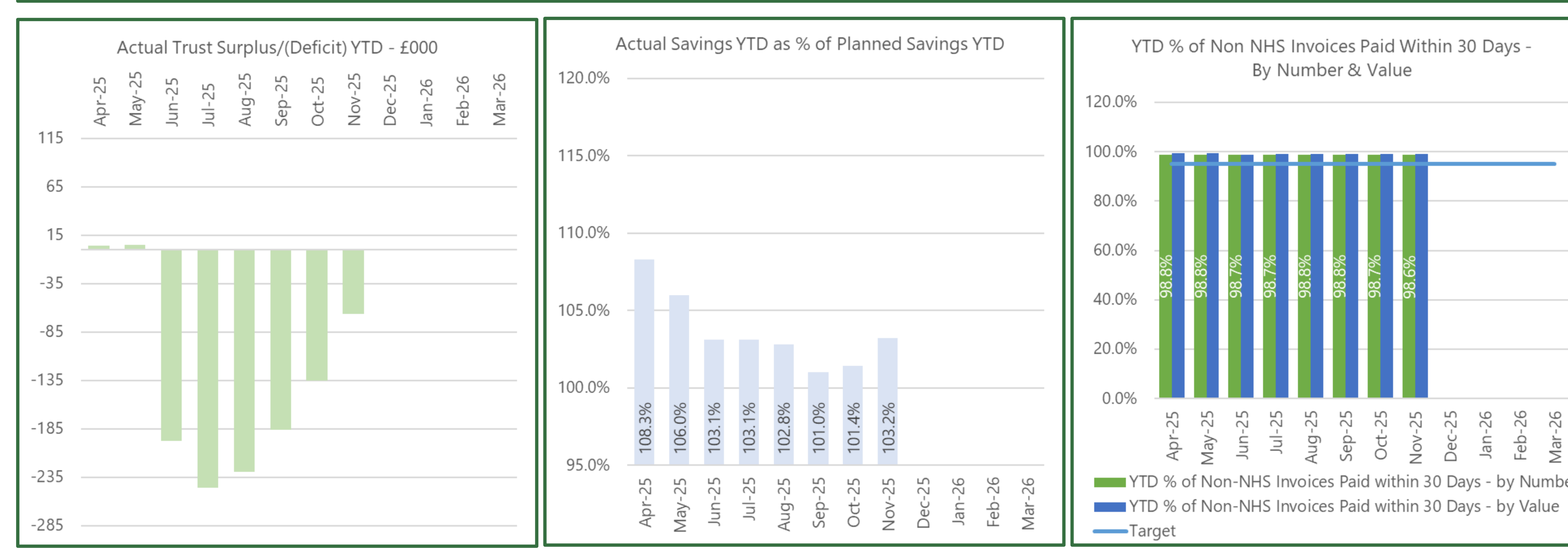
Finance, Resources and Value
Value - Finance Indicators

(Responsible Officer: Chris Turley)

G

FPC



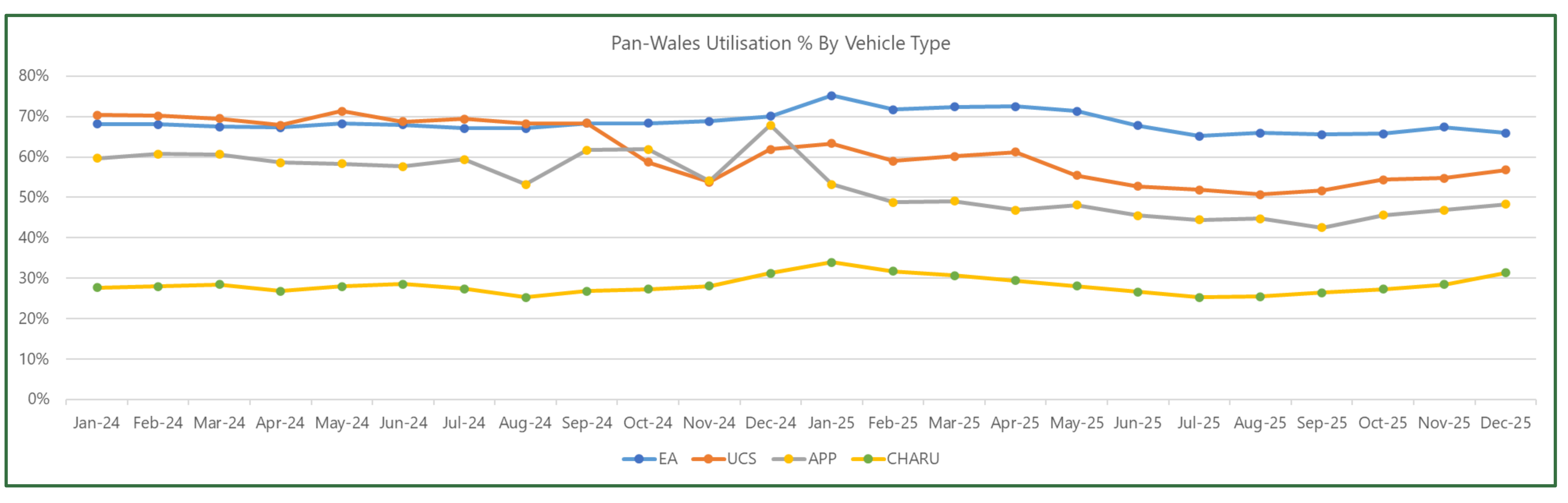


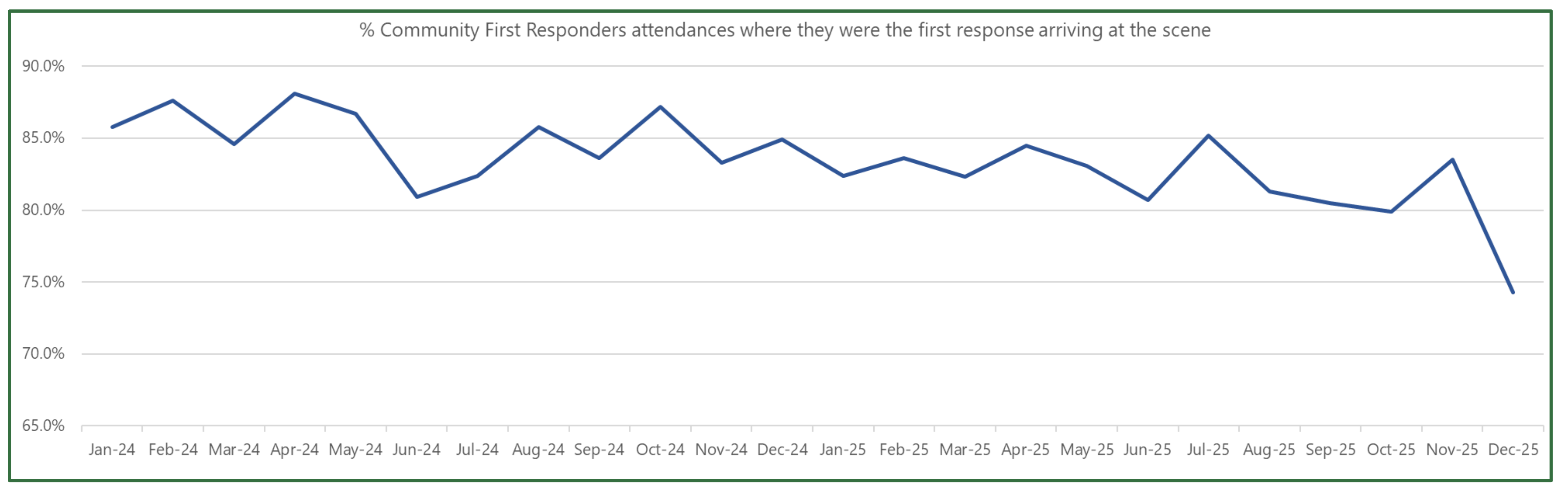
Finance, Resources and Value
EMS Utilisation

(Responsible Officer: Lee Brooks)

FPC

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

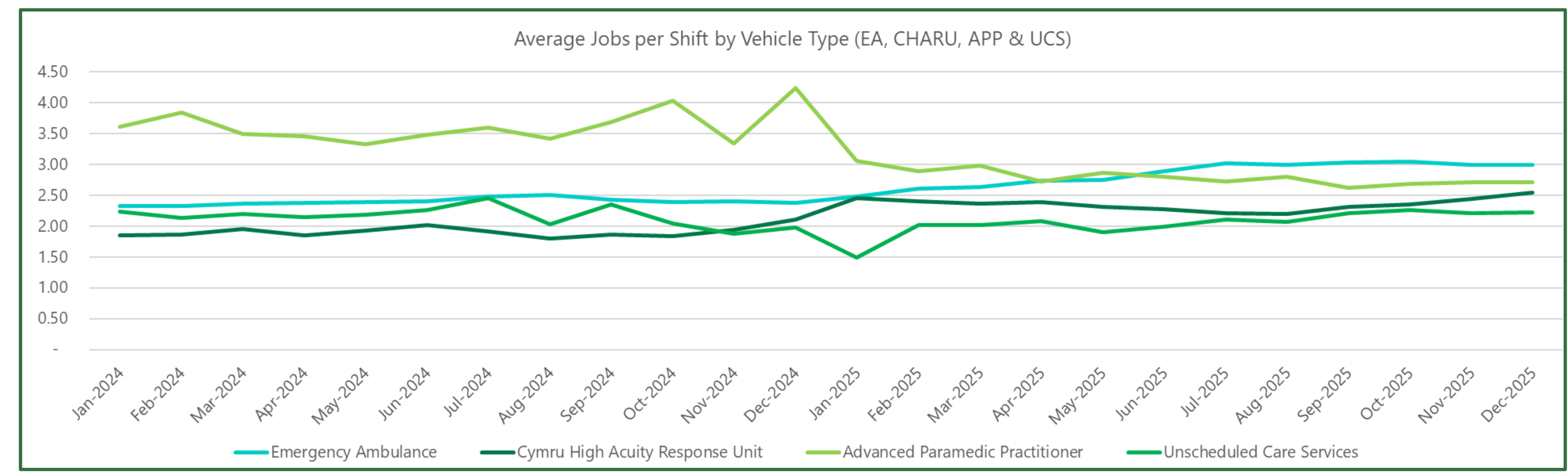


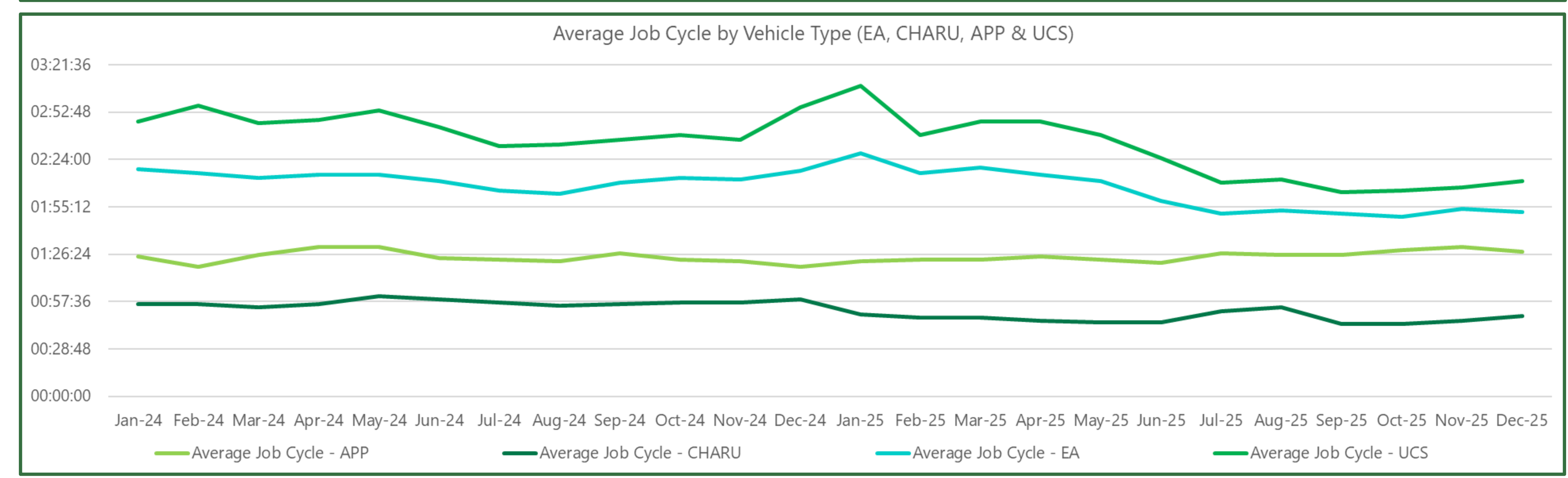


Finance, Resources and Value
Average Job/Shift Times

(Responsible Officer: Lee Brooks)

Jobs Per Shift
A





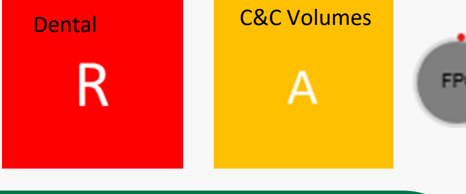
Analysis

Overall average jobs per shift was 2.86 in December 2025, a minimal increase from November 2025 (2.85). EAs averaged 2.99 jobs per shift and UCS crews 2.23. The D&C review conducted by ORH indicated that 3.2 jobs per shift was the optimum level for EAs if at full establishment and if handover was reduced to target levels.

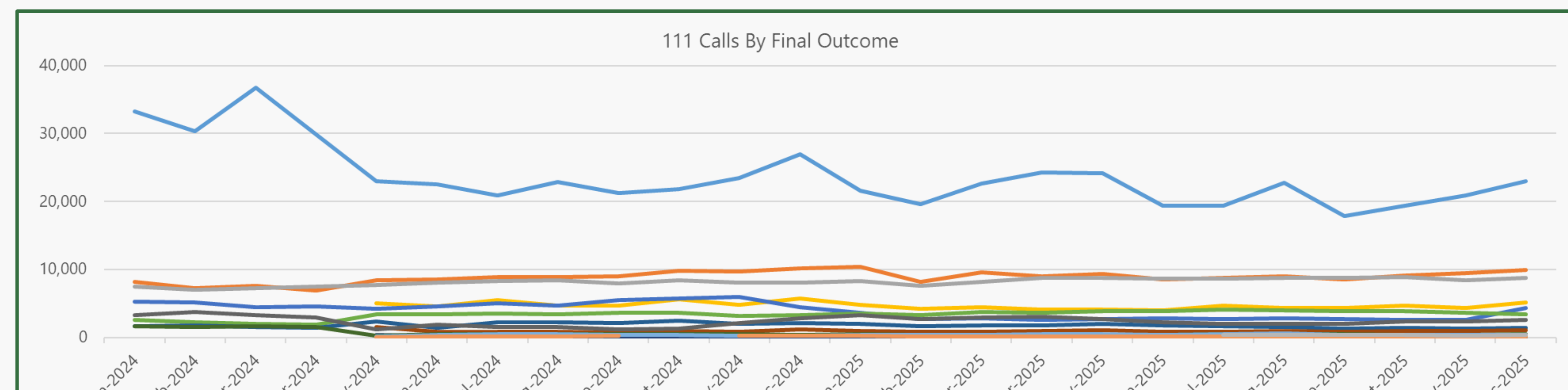
APPs attended on average 2.72 jobs per shift and CHARU's 2.55. We would expect CHARUs to be low, as they need to be free to respond very quickly, but it is not clear why APPs are so low. There are two key actions underway for APPs a) scheduling (that is responding to the code set they are designed to focus on, which is due on stream at the end of January and the APP re-roster, which is due to take place in Q4 and into Q1 next year.

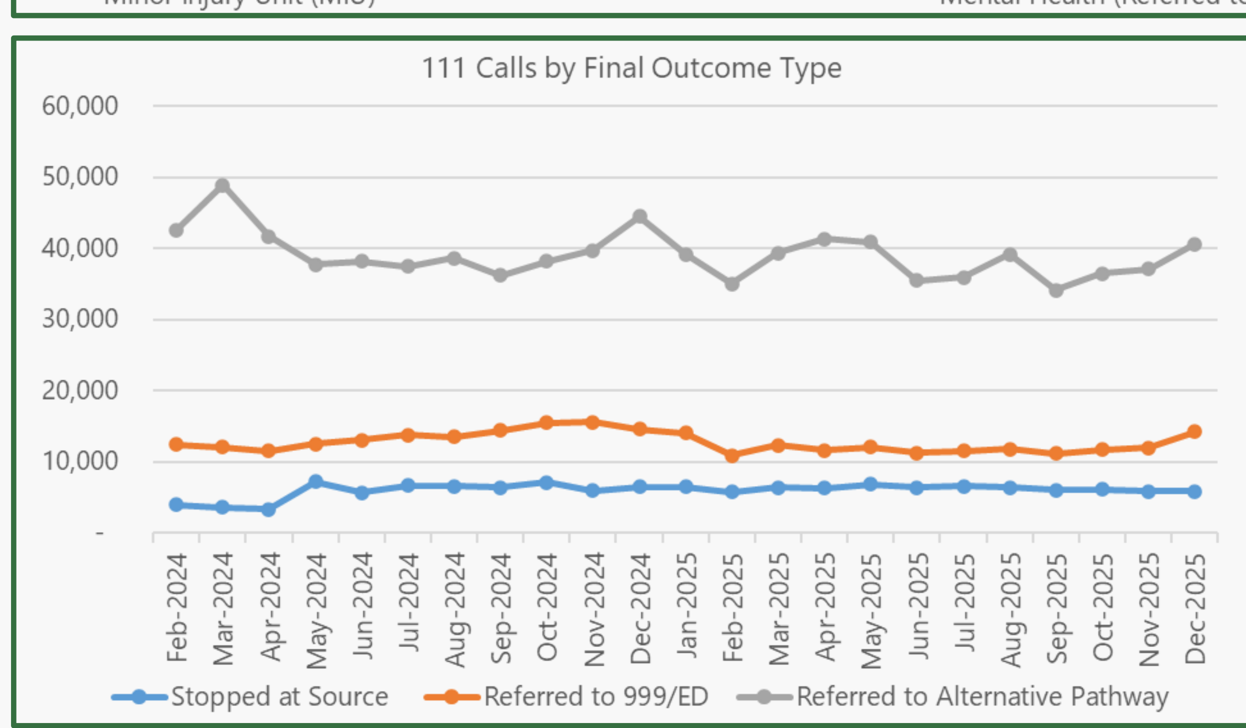
As demonstrated in the bottom graph, the average job cycle minimally increased in December 2025 for UCS (2 hours and 11 minutes) and CHARU (49 minutes). With both APPs (1 hour 28 minutes) and EAs (1 hours 52 minutes) decreasing minimally.

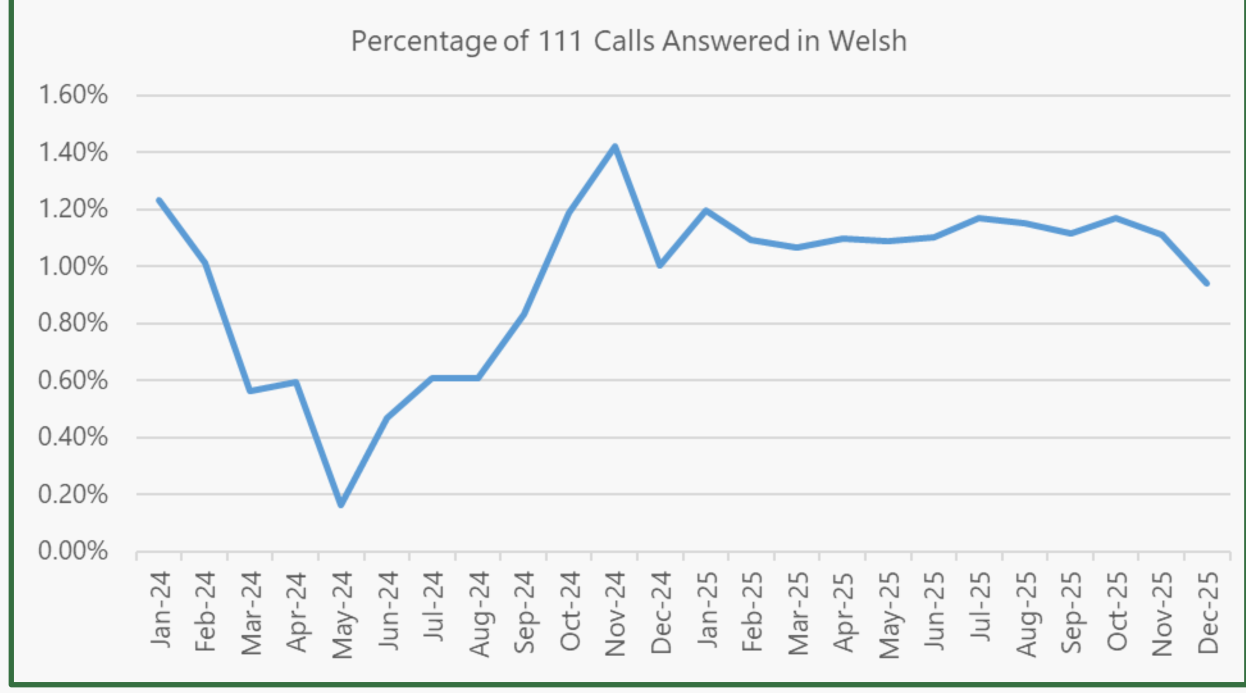
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced



(Responsible Officer: Lee Brooks)







Analysis

During December 2025, 67,565 calls were allocated into the 14 categories displayed in the graph opposite; an increase compared to the 60,824 seen during November 2025. However, data quality issues within 111 reporting have been addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 33.96% of all calls during December 2025, but there has been a material drop since the implementation of the new 111CAS system.

As the bottom left graph highlights, in December 2025, 5,860 calls were 'Stopped at Source', with no onward referral, a slight decrease from 5,884 in November 2025. 14,247 calls were referred to 999/ED in December 2025.

The percentage of 111 calls answered in Welsh decreased slightly from 1.11% in November 2025 to 0.94% in December 2025. This equated to 51.5% of all 111 calls being offered in Welsh being answered.

Remedial Plans and Actions

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

Expected Performance Trajectory

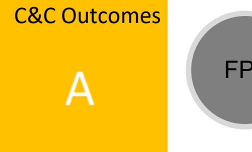
No performance trajectory is set at this time, as the Trust develops its measures and systems around these metrics. Once developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

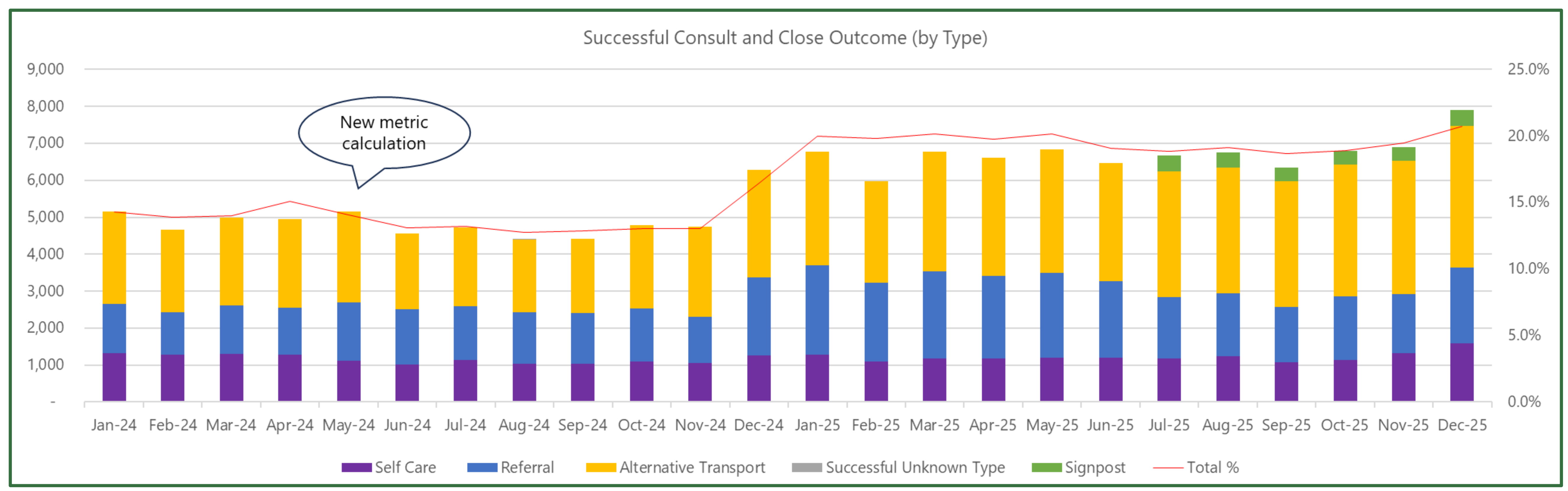
Partnerships / System Contribution
Consult & Close Indicators

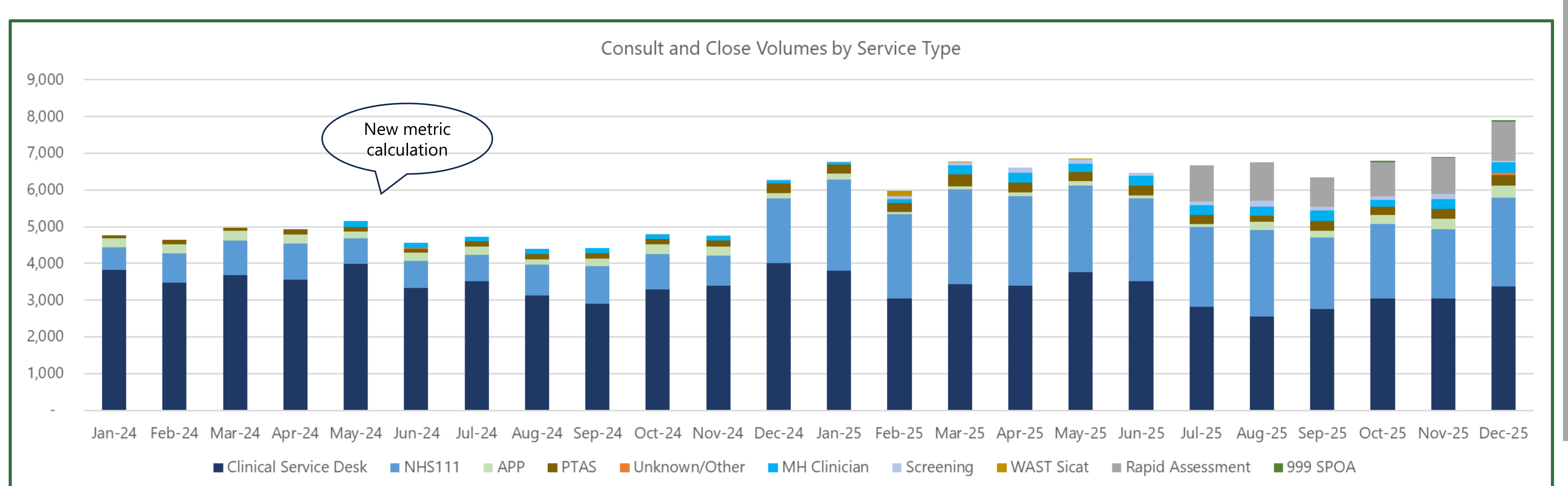
(Responsible Officer: Lee Brooks)

C&C Outcomes

A







Analysis

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

Contributions from Clinical Service Desk (CSD) (8.85%), NHS111 (6.34%), WAST APP (0.88%), Health Boards using Physician Triage and Streaming Service (PTAS) (0.77%), Mental Health Clinician (0.75%), Screening (0.12%), Rapid Assessment (2.82%) and 999 Single Point of Access (SPOA) (0.08%) achieved 20.8% in December 2025, a minimal increase compared to November 2025 (19.5%), not achieving the 22% target. In December 2025, the number of 999 calls resulting in a Consult and Close outcome was 7,901, up from 6,281 in December 2024.

Of the calls successfully closed in December 2025, 60 patients received an outcome of self-care; 1,075 patients were referred to other services (including to Minor Injury Units and SDEC), 934 were advised to seek alternative transport services to acquire treatment and 345 were signposted.

Remedial Plans and Actions

Work underway reviewing processes, has yielded efficiencies in remote clinical support.
Implementation of 15 recommendations from commissioner review.
Ambulance Performance Phase 2 go live.

Expected Performance Trajectory

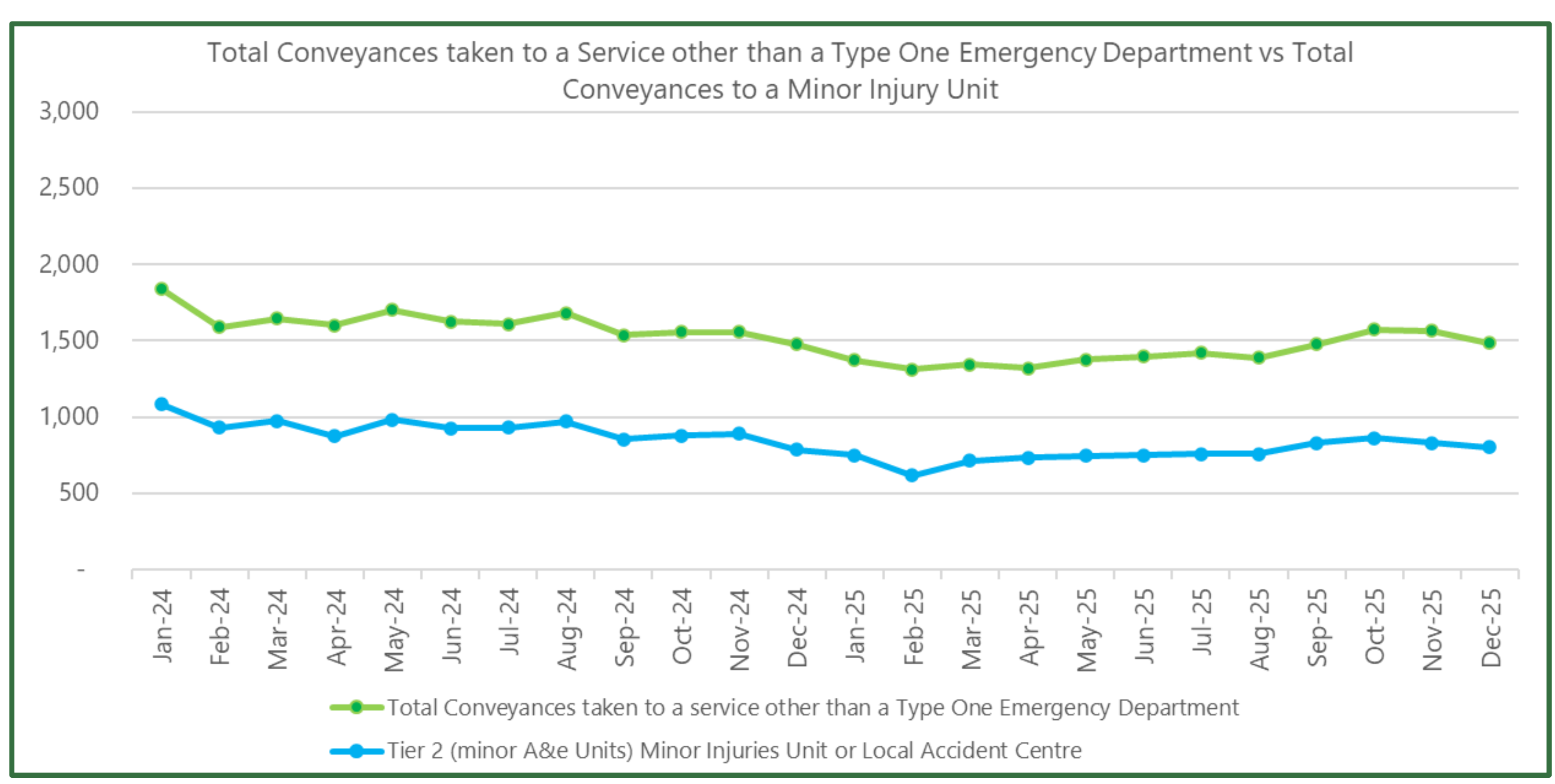
Further improvement is expected linked to CSD staff attendance (reduced abstractions and less vacancies) and the CMT model. The ambition remains 22%.

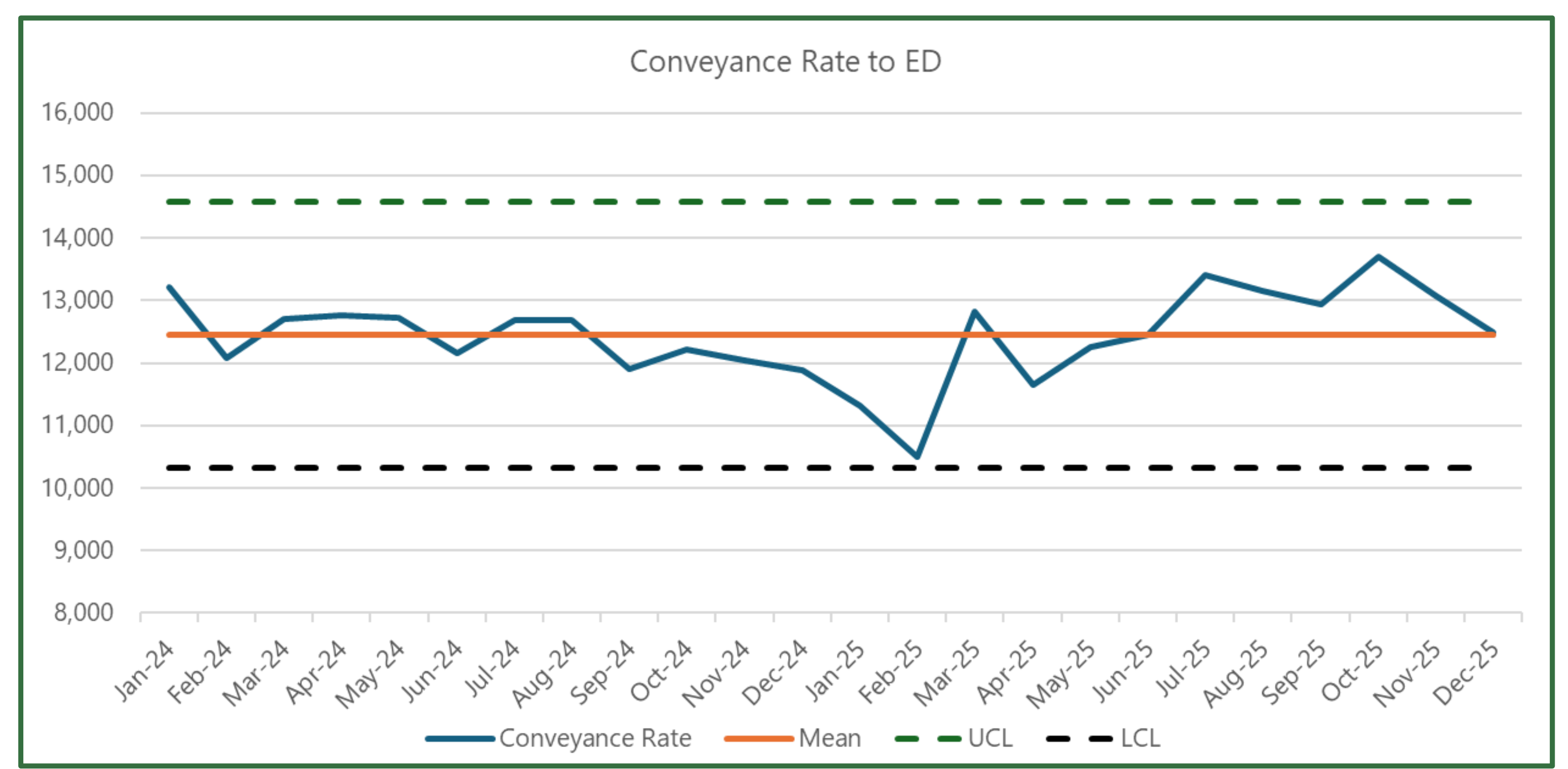
Partnerships / System Contribution
Conveyance to ED Indicators

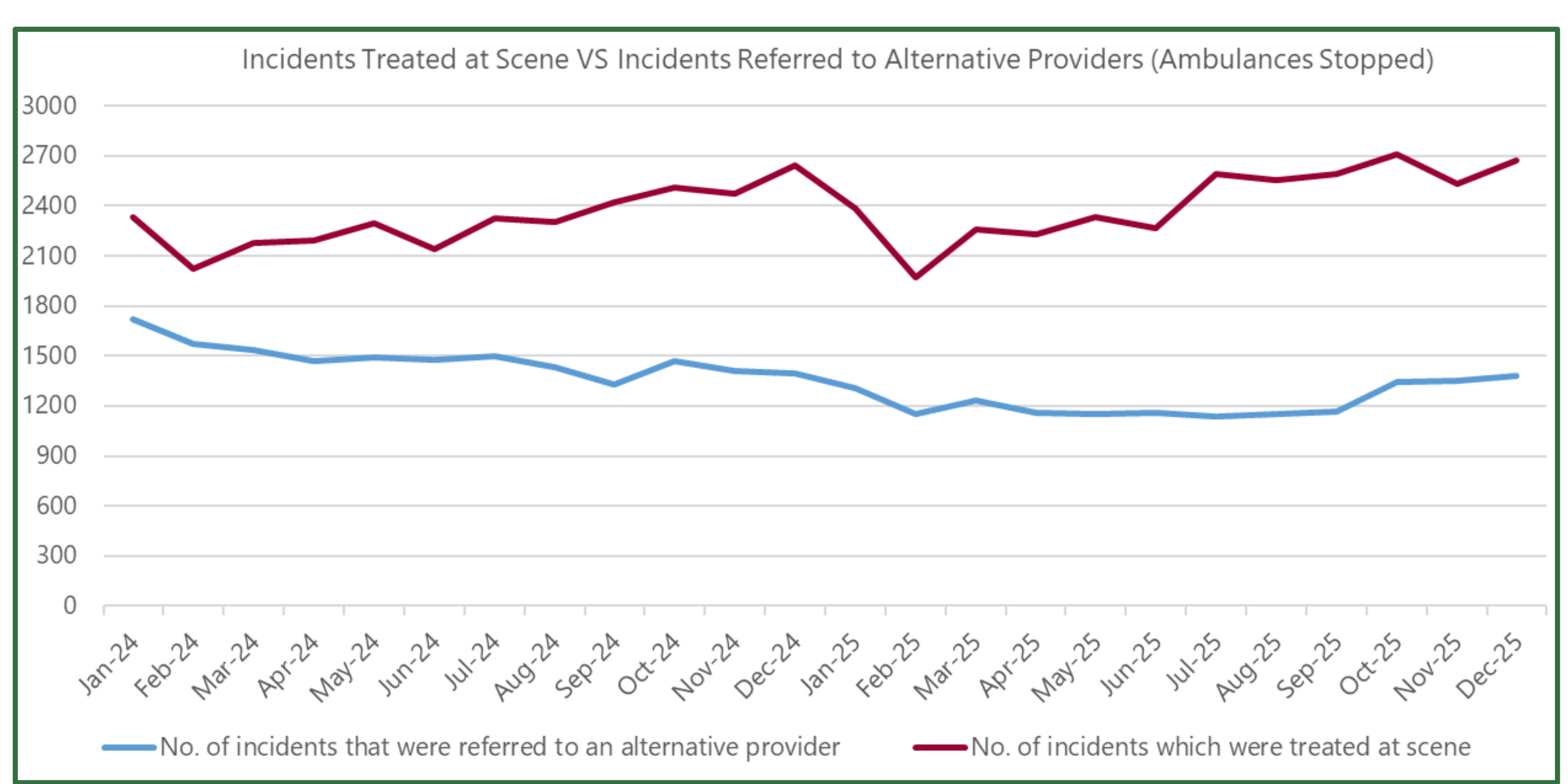
(Responsible Officer: Andy Swinburn)

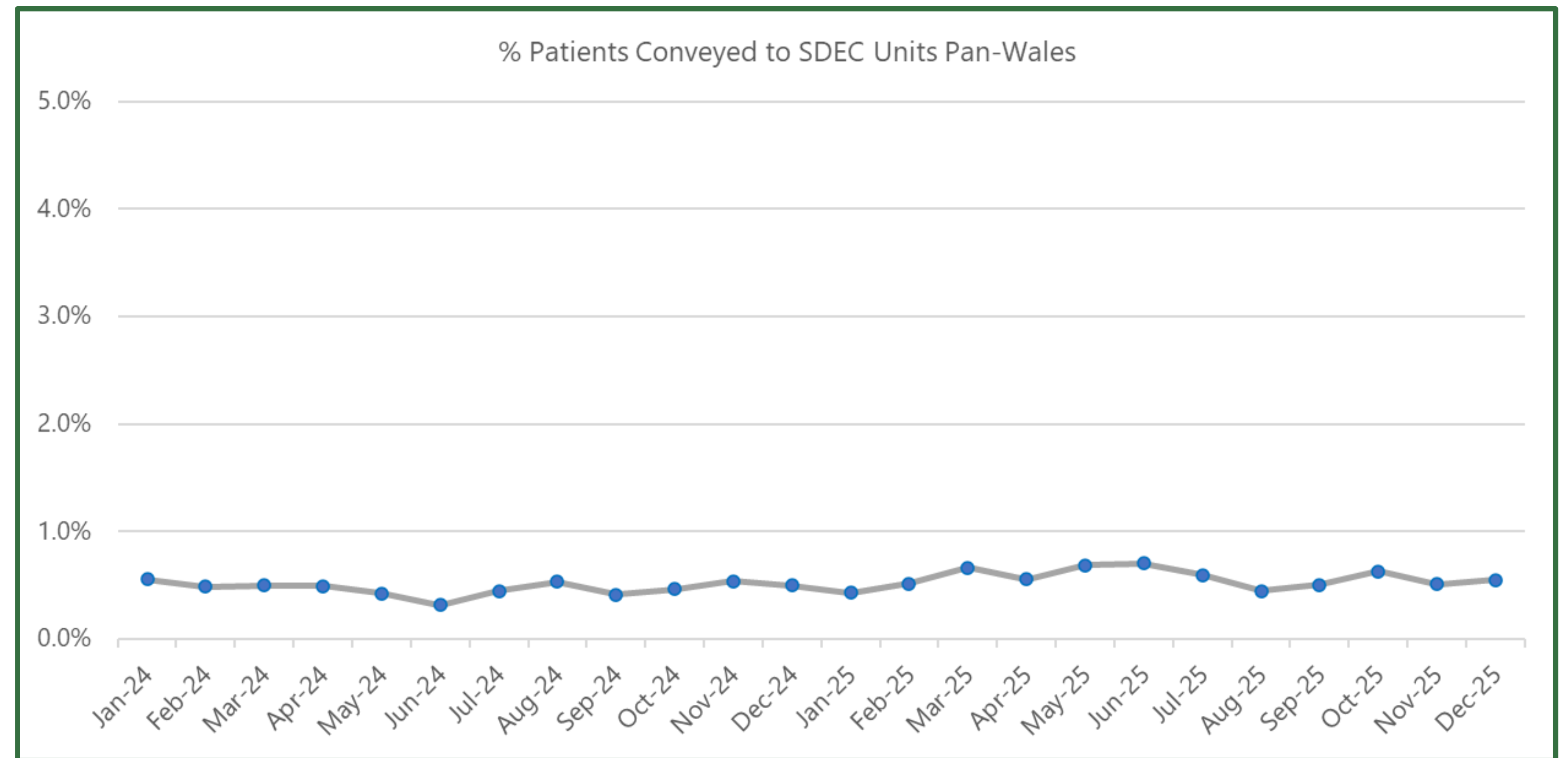
Conveyances
G

Ministerial Measure







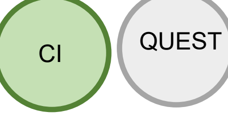


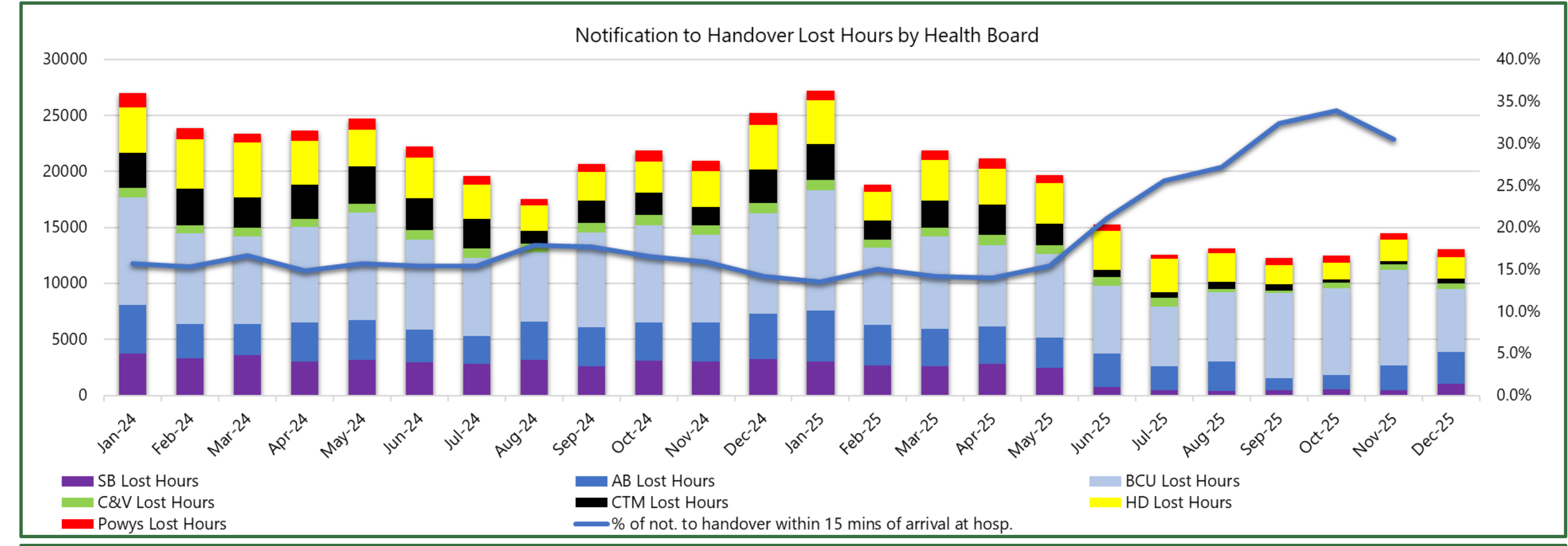
Partnerships / System Contribution
Handover Indicators

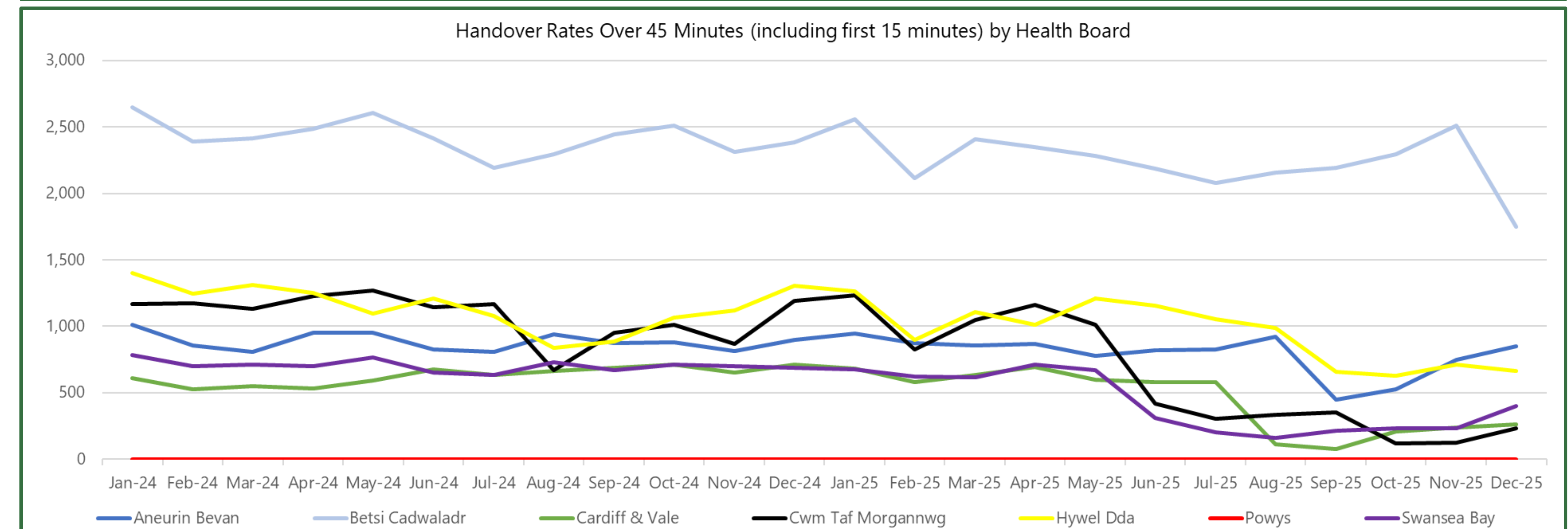
(Responsible Officer: Health Boards)

Lost Hours
R

CI







Analysis

202,043 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Jan-25 to Dec-25), compared to 270,801 hours over the same timeframe the previous year. There were 13,044 hours lost in December 2025, which is 48.2% lower than the 25,195 hours lost during December 2024 and is the fifth lowest monthly figure since December 2021. One health board has seen further reductions, compared to last month, Betsi Cadwaladr (34.42%).

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

- Grange University Hospital (ABUHB) at 2,856 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,345 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 1,901 lost hours
- Glangwilli Hospital (HDUHB) at 1,186 lost hours
- Ysbyty Glan Clwyd (BCUHB) at 1,176 lost hours

Notification to handover lost hours averaged 420.7 hours per day during December 2025 (31 days) compared to 483 hours per day (30 days) in November 2025.

In December 2025, the Trust could have responded to approximately 4,115 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

Remedial Plans and Actions

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

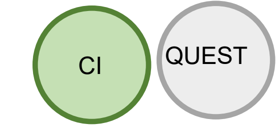
Expected Performance Trajectory

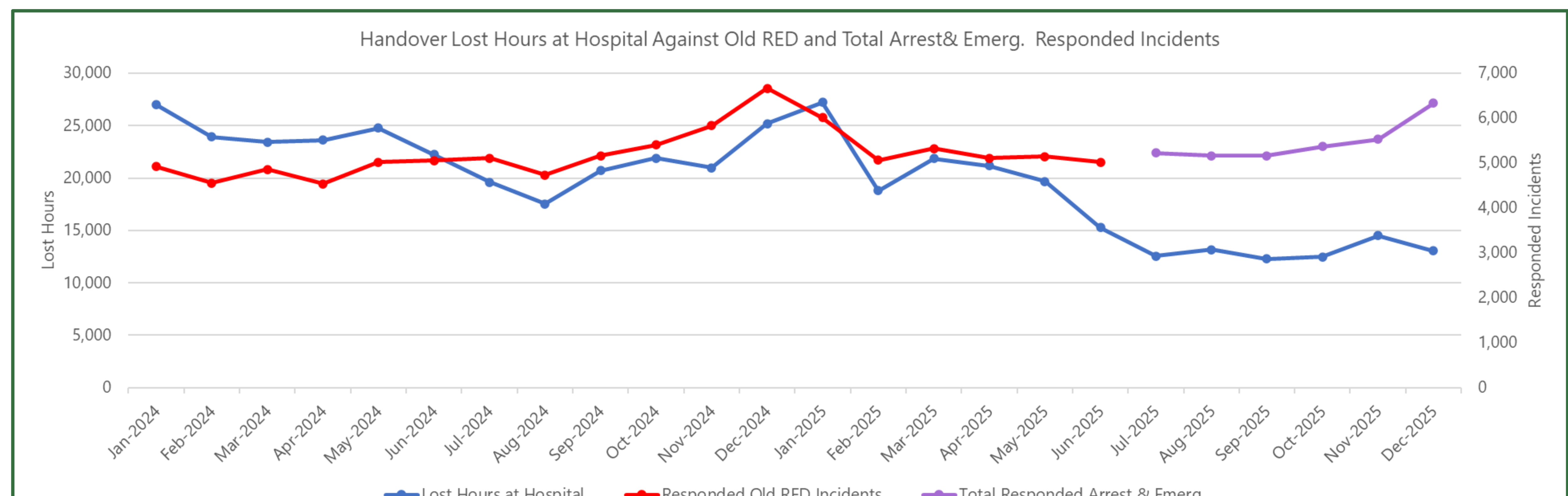
The likely expected ambition from Welsh Government is no waits over 45 minutes. W45 workshops have been facilitated with each health board by NHSWales Performance & Improvement (previously the NHS Executive).

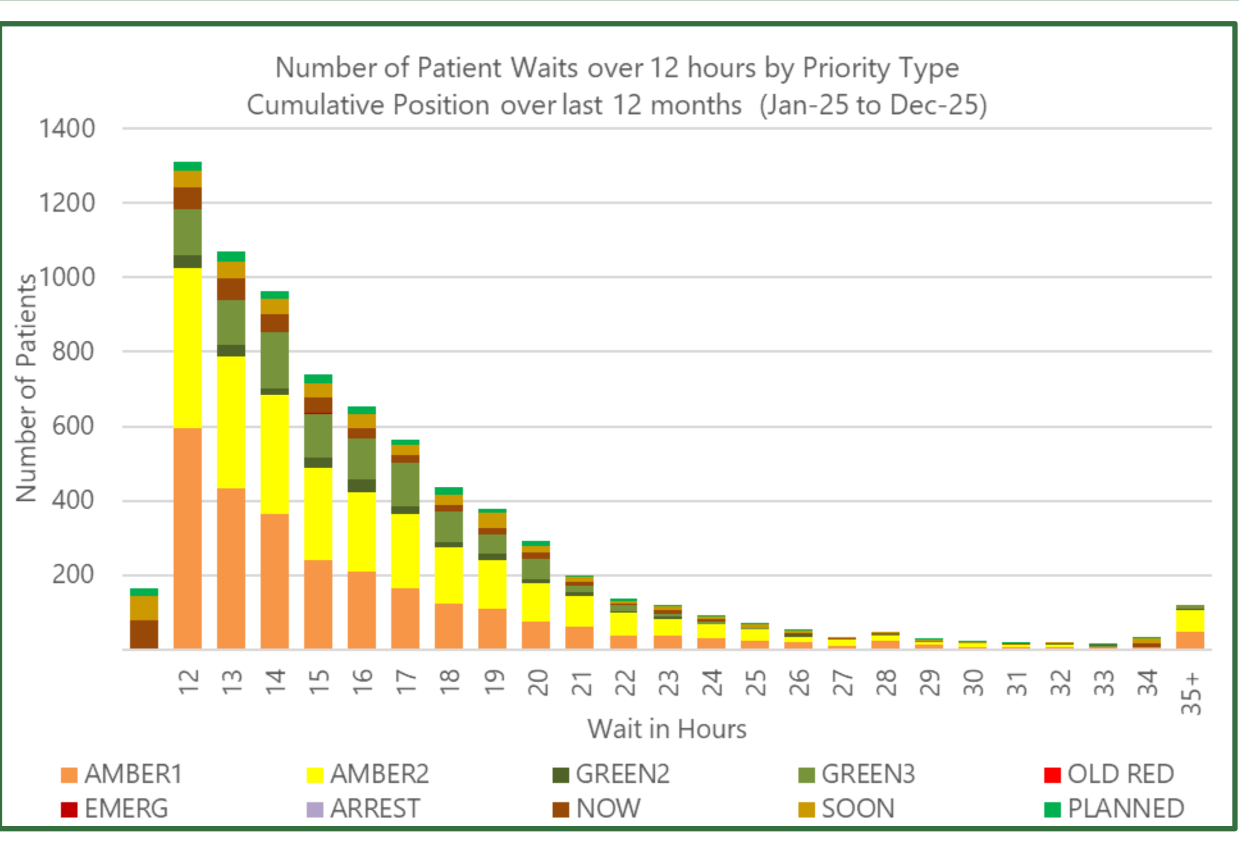
Partnerships / System Contribution

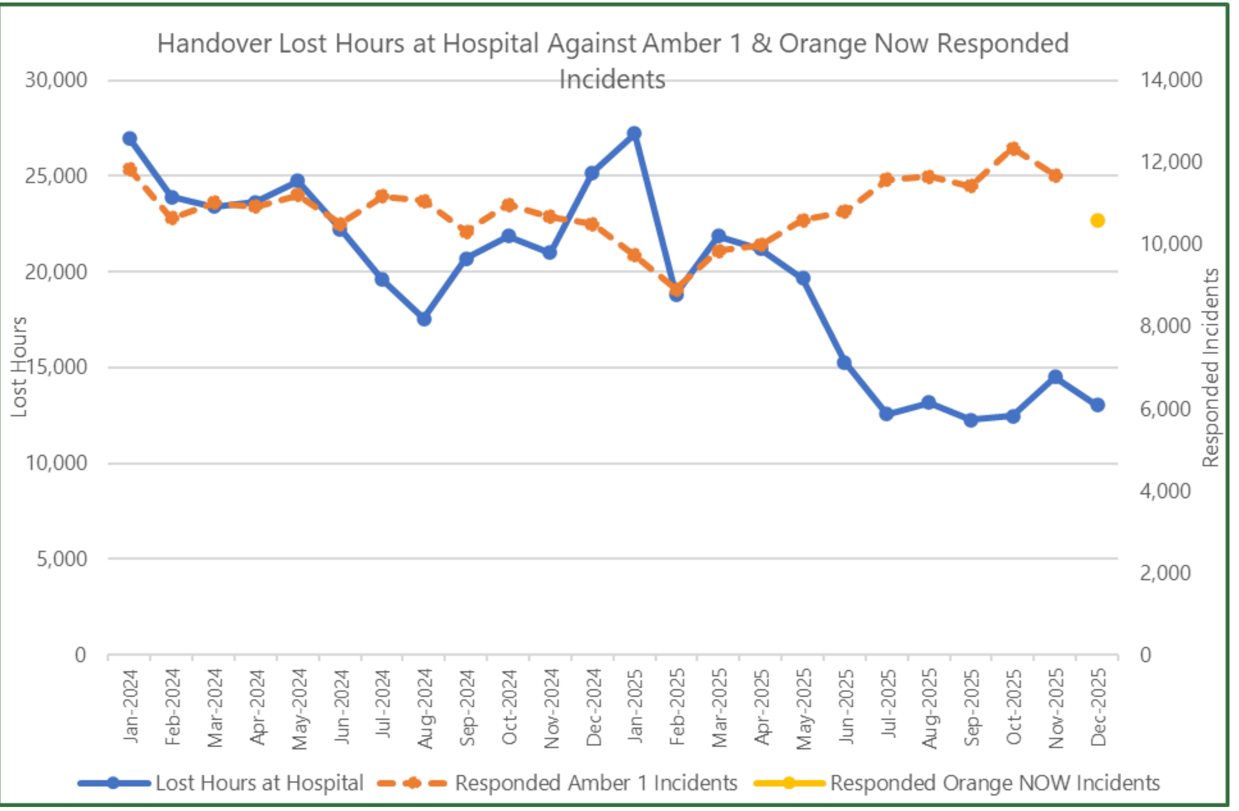
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)









Analysis

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

The bottom right graph illustrates, that there is also a correlation between lost hours decreasing and Amber 1 incidents being responded to.

In December 2025, 1,175 patients waited over 12 hours for an ambulance response.

Remedial Plans and Actions

NHSWales Performance & Improvement is currently leading on health board workshops on handover improvement, in line with the W45 ambition by by October 2025.

Expected Performance Trajectory

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

NB: there were a small number of Amber 1 incidents on 1st December 2025

**NB: Data correct at time of abstraction*

Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board
AOM	Area Operations Manager
APP	Advanced Paramedic Practitioner
AQI	Ambulance Quality Indicator
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board
CASC	Chief Ambulance Services Commissioner
CCC	Clinical Contact Centre
CCP	Complex Case Panel
CEO	Chief Executive Officer
CFR	Community First Responder
CI	Clinical Indicator
CHARU	Cymru High Acuity Response Unit
COOs	Chief Operating Officers
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Corona Virus Disease (2019)
CMT	Clinical Model Transformation
CSD	Clinical Service Desk
CSP	Clinical Safety Plan

Term	Definition
CTM / CTMHB	Cwm Taf Morgannwg Health Board
C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board
DAG	Delivery & Assurance Group
D&T	Discharge & Transfer
DU	Delivery Unit
EAP	Emergency Ambulance Practitioner
ED	Emergency Department
ELT	Executive Leadership Team
EMD	Emergency Medical Department
EMS	Emergency Medical services
ePCR	Electronic Patient Care Record
FTE	Full Time Equivalent
GDPR	General Data Protection Regulations
GPOOH	General Practitioner Out of Hours
GTN	Glyceryl Trinitrate
HB	Health Board
HCP	Health Care Professional
HD / HDHB	Hywel Dda / Hywel Dda Health Board

Term	Definition
HIW	Health Inspectorate Wales
HI	Health Informatics
H&W	Health & Wellbeing
HR	Human resources
HSE	Health and Safety Executive
IG	Information Governance
IMTP	Integrated Medium Term Plan
IPR	Integrated Performance Report
JCC	Joint Commissioning Committee
KPI	Key Performance Indicator
LTS	Long Term Strategy
MACA	Military Aid to the Civil Authority
MIU	Minor Injury Unit
MPDS	Medical Priority Dispatch System
NCCU	National Collaborative Commissioning Unit
NEPTS	Non-Emergency Patient Transport Services
NEWS	National Early Warning Score
NHS	National Health Service

Term	Definition
NHSDW	National Health Service Direct Wales
NPUC	National Programme for Unscheduled Care
NQPs	Newly Qualified Paramedic
NRI	Nationally Reportable Incident
OBC	Outline Business Case
OD	Organisational Development
ODU	Operational Delivery Unit
OH	Occupational Health
P / PHB	Powys / Powys Health Board
PCR / PCRs	Patient Care Record(s)
JRCALC	Joint Royal Colleges Ambulances Liaison Committee
PECI	Patient Engagement & community Involvement
POD	Patient Offload department
PPLH	Post Production Lost Hours
PSPP	Public Sector Purchase Programme
QPSE	Quality, Patient Safety & Experience
RCS	Rapid Clinical Screening
RICS	Remote Integrated Care Service

Term	Definition
ROSC	Return Of Spontaneous Circulation
RRV	Rapid Response Vehicle
SB / SBUHB	Swansea Bay / Swansea Bay Health Board
SCIF	Serious Concerns Incident Forum
STEMI	ST segment Evaluation Myocardial Infarction
TPT	Tactical Pandemic Team
TU	Trade Union
UCA	Unscheduled Care Assistant
UCS	Unscheduled Care System
UHP	Unit Hours Production
U/A RTB	Unavailable – return to Base
VPH	Vantage Point House (Cwmbran)
WAST	Welsh Ambulance Services University NHS Trust
WG	Welsh Government
WIIN	WAST Improvement & Innovation Network

Definition of Indicators

Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self-serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up, they are counted as "abandoned" as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	**PADR/Medical Appraisal**	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	**Duty of Candour**	A notifiable adverse outcome is any incident whereby harm (moderate harm, severe harm and death) is caused, which is unintended or unexpected and that the provision of the health care was or may have been a factor in the service user suffering that outcome.
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust's Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	**% Incidents Conveyed to Major EDs**	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	**Number of Handover Lost hours**	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	**Immediate Release requests**	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls

Agenda Item No.	12

REPORT TITLE

Integrated Medium Term Plan (IMTP) 2025/26 Quarter 3 Assurance Report

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh (Executive Director of Strategy, Planning & Performance)
Author(s) of report	James Houston (Assistant Director of Planning & 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 progress update and assurance on the 2025/26 quarter 3 (Q3) IMTP delivery position.

2. The Clinical Model Transformation (CMT) programme continues to progress at pace with strong progress made during the Q3 reporting period. A key highlight was the successful implementation of the phase 2 Ambulance Performance Framework (APF) and strong progress to develop the programme and work stream benefits scorecards. There continues to be positive progress across the directorate led IMTP deliverables. A total of 13 deliverables were marked as complete and 33 reported as green and on track for completion. There are 6 red reported deliverables that will be further scrutinised by the Strategic Transformation Board on the 26 January. As highlighted in the Q2 report, organisational capacity remains a key challenge, noting the prioritisation of key areas of work (including the APF) during this period and the impact of seasonal and system pressures.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Board is asked to:

NOTE progress against the quarter 3 IMTP deliverables.

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
20 January 2026	Finance & Performance Committee
29 January 2026	Trust Board

SITUATION

1. The purpose of this paper is to provide the Trust Board with a progress update and assurance on the 2025/26 quarter 3 IMTP delivery position.

BACKGROUND

2. The 2025/26 IMTP deliverables are monitored through two internal delivery mechanisms reporting into the Strategic Transformation Board (STB). Implementation of the Trust's Integrated Clinical Services Model is reported via the Clinical Model Transformation (CMT) Board, and the wider organisational deliverables are monitored via the Integrated Strategic Planning & Development Group (ISPDG).

ASSESSMENT

Clinical Model Transformation (CMT) Q3 Progress

3. The Clinical Model Transformation (CMT) Programme continues to progress in line with its strategic ambition to transition to an integrated, clinically led Clinical Services Model.

4. Following approval of the CMT **Programme Definition Document (PDD) and the CMT Board's Terms of Reference (ToR)** by the Strategic Transformation Board (STB, development of the programme's foundational documents is ongoing including the **CMT Programme Benefits Realisation Plan**. This document was presented for review at CMT Board in Dec-25, with a view to presenting a final document for endorsement at CMT Board in Jan-26.

5. Progress continues in demonstrating identified **benefits**, with all five work stream scorecards approved. The programme benefits scorecard is approved pending minor amendments. All scorecards have been submitted to IDS for digitisation. These outputs, along with logic benefits maps, will feed into the **Benefits Realisation Plan** noted above, ensuring that outcomes are measurable, attributable, and aligned with programme objectives.

6. In developing our Programme Vision, work is ongoing on the development of **Patient Personas**. These personas were presented to Clinical Advisory Group for review and to CMT Board in December for discussion. The patient personas were signed off by the CMT Board in Jan-26 to inform the development of key internal and external stakeholder collateral.

7. Work is due to begin in Jan-26 on **Programme Leadership Behaviours**. This is a collaborative effort with the Change Management team to develop role profiles for each of our programme leads via training and engagement.

8. **CMT programme deliverables** are undergoing a third review cycle (following review during support strategic discussions at the Executive Leadership Team (ELT) and Senior Leadership Community (SLC) session in Nov-25) to identify and record milestones against each agreed deliverable. These are expected to complete by early January to begin development of the IMTP narrative.

9. Fieldwork has concluded on the **CMT Audit** and early feedback is expected in late Dec-25. The report and subsequent action plan will be presented back to CMT Board in Jan-26.

10. The table below provides a high-level summary of progress against each CMT work stream.

11. A key area of positive progress to report is the successful implementation of Phase 2 of the Ambulance Performance Framework pilot. The Trust successfully launched the new Orange (Now), Yellow (Soon) and Green (Planned) call categories on the 2nd Dec replacing the previous Amber and Green categories. The implementation phase went smoothly, and operational command structures were stood down on the 4th-Dec, with any outstanding issues being managed through routine business channels.

12. *Table 1: Overview of the CMT Q3 Highlight report*

Workstream/Enabling Group		RAG	Notes
Digital Front-End		**Green**	On Track
Remote Integrated Care		**Amber**	Off Track; alignment of CSD and 111 to formally establish RICS has been deferred to Spring 2026 in order to prioritise MIS-led CAD changes aligned with Phase 2 Call Flow changes.
Urgent Community Response		**Yellow**	On Track (cautionary status)
Emergency Response	*Call Flow and Prioritisation*	**Green**	On Track
	Out of Hospital Cardiac Arrest	**Green**	On Track
Health Transport		**Amber**	Off Track; MIS-Cleric interface issues on hold due to supplier capacity until February 2026
CMT Metrics		**Yellow**	On Track (cautionary status)
Change Management		**Yellow**	On Track (cautionary status)
Partnerships & Engagement		**Green**	On Track

Directorate led IMTP Deliverables

13. To note that due to the reporting cycle of the Strategic Transformation Board, the Q3 IMTP highlight report will be presented and discussed at the next meeting on the 26th January (after the submission of the report to the Finance & Performance Committee and Trust Board). The updates provided in this report are in 'draft' status and STB will undertake the required review and scrutiny of reported progress with a focus on the deliverables reported as 'Red' and 'off track' to consider impact and mitigation.

14. During the Q3 reporting period directorates undertook an initial assessment and review of the 25/26 IMTP Deliverables as part of the planning for the 2026 – 2029 IMTP. This includes a consideration of the deliverables that are likely to 'roll over' into the next financial year with updated delivery milestones. This work is continuing at pace with refreshed IMTP deliverables submitted on the 2nd January for initial review and refinement as part of IMTP development process.

15. The table below provides a summary of the reported RAG status of all of the deliverables by directorate area.

Table 2: Overview of all 25/26 directorate level deliverables (Q3 RAG status)

Directorate/Objective	Green	Yellow	Amber	Red	Not Started	Complete
Operations	6		3		3	1
Finance & Corporate Resources	3		1	2		1
People & Culture	11		3		1	2
Partnerships & Engagement	2	1				5
Digital	5		8	1		
Quality, Safety & Patient Experience	4		5	3		1
Corporate Governance	2					3
SO6: Delivering exceptional value (SP&P and non-aligned deliverables)	1		4		2	

16. A total of 13 deliverables were reported as complete and 33 reported as Green and on-track. Some key highlights to report include the completion and submission of the **Fleet Business Justification Case (BJC)** and high delivery confidence for the **procurement and build for the 2025/26 vehicles** by the end of Q4. Strong progress has been made to strengthen **Welsh language compliance**. NEPTS **one way SMS functionality** has been implemented. A new **Head of Commercial** has been appointed to take forward the trusts commercial plan. The Trusts new **AI Steering** group launched in Oct and the first live operational deployment the **HART drone** took place successfully on the 26th Dec. A new IMTP deliverable has been escalated (in year) for reporting via the IMTP process to develop and implement a **'Putting Things Right' Improvement Recovery plan**. A programme board has been established in December, and work is continuing to develop the improvement plan.

17. A total of six deliverables were reported as 'Red' and 'off track' and will be discussed in the next Strategic Transformation Board on the 26th January to consider the risks, implications, mitigating actions and timescales. The 'red' reported deliverables include the **EMS & NEPTS CAD replacement business case** due to delays undertaking initial engagement and assignment of dedicated resource to help take this work forward. Engagement is planned for Q4 to consider the procurement activity for the 111, 999 and NEPTs CAD contracts. Work regarding **Population Health** is off track due to previously reported resource constraints. The 'Always on' Duty of Quality delivery timelines have been extended to factor in IDS capacity constraints. The **Estates SOP** is off track pending the completion of the sixfacet survey. Discussions are ongoing regarding the **resource and support requirements to enhance fleet de-carbonisation opportunities** as part of the de-carbonisation Delivery Action Plan (DAP). Proposed resource requirements have been submitted as an internal cost pressure for consideration as part of the 2026/27 financial plan.

18. Whilst many of the Amber reported deliverables are not due for completion in Q3, they have been cautionary flagged with an amber status due to potential issues completing the work within the projected delivery timescales. The underlying cause is linked back to organisational capacity where work to deliver the Clinical Model Transformation programme and preparatory work for the new Ambulance Performance Framework have taken organisational priority. This has been particularly prevalent for colleagues that have required critical involvement to enable this work including our Information and Digital Services (IDS) teams, where there is a known capacity constraint.

19. As part of the development of next year's IMTP, work is well underway to review and refresh the IMTP deliverables for 2026 – 2029. To support this process there will be a full review and 'end of year' position as part of the Q4 assurance report. This will include clear mapping outlining the deliverables that will be 'rolled forward', 'amended' or 'de-prioritised' for 2026/27 onwards. As part of this work, consideration will be given to review and continue to strengthen the monitoring approach for IMTP Directorate level deliverables for next year.

RECOMMENDATION(S)

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

NEXT STEPS

21. The next steps are as follows:

- STB to review the Q3 position on the 26 January.
- Undertake the Q4 progress report and complete the end of year closure report.
- Identify opportunities to improve IMTP monitoring and reporting process for the 2026/27 planning cycle.

Agenda Item No.	13

REPORT TITLE

Financial Performance as at Month 9 – 2025/26

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 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

PURPOSE OF REPORT

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

REPORT SUMMARY:

1. This paper presents to the Board the latest Financial Performance Report of the 2025/26 financial year, the reported position as at Month 9 (December 2025).

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

3. Key highlights from the report for the Committee to note are:
    - The Trust is reporting a small revenue year to date underspend/surplus of £0.180m. For month 9 (December 2025) the Trust is reporting an in month surplus of £0.246m;
    - 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 2025/26 financial year end;
    - Capital expenditure plans continue to be progressed with plans to fully achieve in year;
    - In line with the financial plans that support the IMTP, gross savings of £6.492m have been achieved in month 9 against a target of £6.362m;
    - Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.4% for the number, and 99.0% of the value of non-NHS invoices paid within 30 days.

RECOMMENDATION(S)

The Board is requested to:

1. **Note** and gain **assurance** in relation to the Month 9 revenue financial position and performance of the Trust as at 31st December 2025.

2. **Note** the delivery of the 2025/26 savings plan, and the context of this within the overall financial position of the Trust.

3. **Note** the capital programme for 2025/26.

4. **Note** the Month 9 Welsh Government monitoring returns submission (as required by WG).

ADDITIONAL PAPER(S)

The Board is requested to receive the following:

Annex 1 Monitoring return submitted to Welsh Government for month 9 – as required by WG (***available to view in the Reading Room)***

Annex 2 Monitoring return letter submitted to Welsh Government for month 9 – 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 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
20/01/2026	Finance and Performance Committee (presentation)

SITUATION

1. This report provides the Board with a summary of the revenue financial performance of the Trust as at 31st December 2025 (Month 9 2025/26), along with an update on the 2025/26 capital programme.

BACKGROUND

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

   - The cumulative revenue financial position reported is a **small underspend against budget of £0.180m**, based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2025/26. The underlying year-end forecast for 2025/26 is currently a balanced position;

   - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of **£6.492m** have been achieved against a target of **£6.362m**;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 98.4% for the number, and 99.0% of the value** of non-NHS invoices paid within 30 days.

3. The improvement in the Trust's in month position predominantly relates to confirmation from WG that the previously assumed and accounted for costs, associated with the increase in the in year Welsh Risk Pool costs, would be funded by WG, resulting in an in month improvement that has in part been offset by risk mitigation and some small elements of planned expenditure that had previously been held when these costs pressures emerged.

4. The Trust is continuing to forecast a year end breakeven this is on the back of detailed forecasting work that is being undertaken along with the Trust progressing with some elements of expenditure against schemes such as MAI and non-recurrent schemes, which aims to reduce cost pressures on next financial year.

5. 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 9 are set in line with the submitted IMTP and summarised later in this report. As we go through the next few months these will continue to be scrutinised and amended

accordingly, with mitigations and management plans in place. However given some of the above and that which would be expected at this point in the financial year now, some of the risk to breakeven has been reduced.

ASSESSMENT

REVENUE FINANCIAL PERFORMANCE – MONTH 9 2025/26

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

Revenue Financial Position for the period 1st April - 31st December				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-326,559	-242,123	-242,059	64
Expenditure				
Pay	245,426	182,879	180,779	-2,100
Non-pay	61,949	46,247	47,893	1,646
Total pay & non-pay expenditure	307,375	229,126	228,672	-454
Depreciation & Impairments / interest payable & receivable	19,184	12,997	13,208	211
Total	0	0	-179	-180

Income

7. Reported Income against the initial budget set to Month 9 shows an underachievement of **£0.064m**.

Pay Costs

8. Overall, the total pay variance at Month 9 is an underspend of **£2.100m**.

Non-pay Costs

9. The overall non-pay position at Month 9 is an overspend of **£1.646m**. In addition, for reporting purposes Depreciation, Impairment and interest is excluded from the above figure, overspend of **£0.211m,** hence the total overspend to budget of **£1.856m**.

Savings

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

11. Month 9 in month performance was, plan of £0.741m and £0.693m achieved, therefore an underachievement of £0.048m (recurrent underachievement of £0.059m and non-recurrent overachievement of £0.011m), as per the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Shemes	6,225	551	492	-59	4,656	4,454	-202	6,225	5,865	-360
Non Recurrent Schemes / Shemes	2,275	190	201	11	1,706	2,038	332	2,275	2,635	360
Overall Total	**8,500**	**741**	**693**	**-48**	**6,362**	**6,492**	**130**	**8,500**	**8,500**	**0**

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

12. The split between savings, net income generation and accountancy gains as at month 9 is shown on the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Savings (Cash releasing and Cost Aviod	8,350	712	688	-23	6,300	6,454	155	8,350	8,450	100
Net Income Generation	150	29	4	-25	62	37	-25	150	50	-100
Accountancy Gains	0	0	0	0	0	0	0	0	0	0
Overall Total	**8,500**	**741**	**693**	**-48**	**6,362**	**6,492**	**130**	**8,500**	**8,500**	**0**

13. ***Appendix 1*** provides the overall detail for Month 9 by theme. This is now further split over recurring and non-recurring schemes

Financial Performance by Directorate

14. Whilst there is an overall year to date deficit reported at Month 9, there are also some small variances between Directorates, as shown in the table below, when compared to the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature, but they will be continued to be closely monitored.

Financial position by Directorate @ 31st December	Annual Budget £000	Year to date Budget £000	Year to date Actual £000	Year to date Variance £000	Tolerance 5% %
Directorate					
Operations Directorate	222,426	166,903	165,224	-1,678	-1.0%
Chief Executive Directorate	2,180	1,673	1,687	14	0.8%
Corporate Governance	731	520	518	-2	-0.3%
Partnerships & Engagement Directorate	656	456	440	-16	-3.6%
Finance and Corporate Resources Directorate	37,703	27,748	28,309	561	2.0%
Planning and Performance Directorate	3,034	2,198	2,151	-47	-2.1%
Quality, Safety and Patient Experience Directorate	7,731	5,746	5,637	-109	-1.9%
Digital Directorate	16,345	10,992	11,041	50	0.5%
People and Culture	6,503	4,763	4,478	-285	-6.0%
Medical & Clinical Services Directorate	6,524	4,709	4,691	-18	-0.4%
Trust Reserves	931	258	747	488	189.1%
Trust Income (mainly JCC)	-304,764	-225,966	-225,104	862	0.4%
Overall Trust Position	**0**	**-0**	**-180**	**-180**	

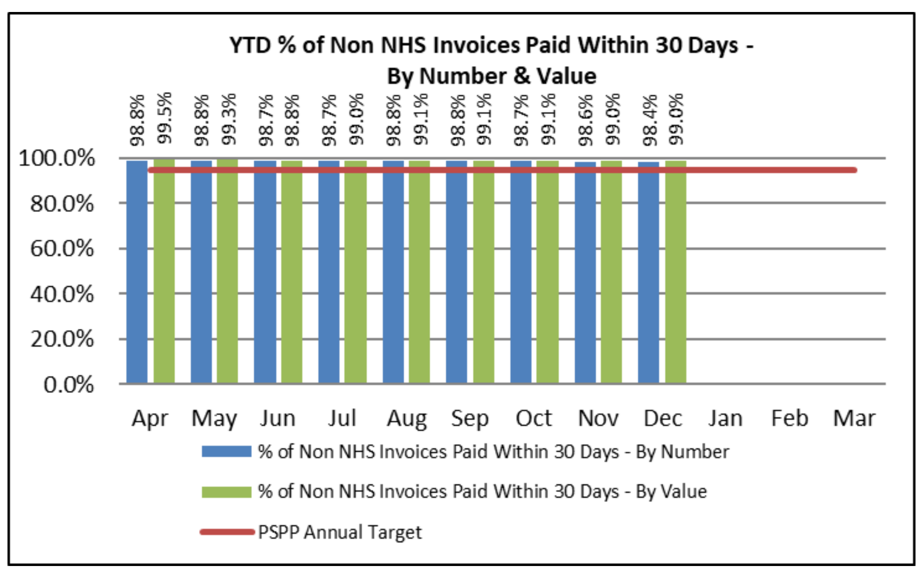
15. A brief commentary on significant key variances above is as follows: -

- Most directorates are either underspending or broadly in line with budget plan for Month 9 except for Trust reserves, Finance and Corporate Resources and Trust income. It is through these areas that the previously highlighted main drivers of the current YTD position are reported, as follows:
- Core budgets set for Finance and Corporate Resources at the 2025/26 financial year were balanced, following the reversal of the WRP assumptions the non-pay is currently overspent due to the following areas:
  - Interest receivable has been lower in year to date due to a reduction in rate from plan and also lower cash balances during the year.
  - General losses and special payments have been higher than budgeted
- Core budgets set for **Income** at the opening of the 2025/26 financial year included two main components
  1. Income from main commissioner (JCC) for core services provision of EMS, Ambulance Care and 111 related services
  2. Income from WG for the increased costs of the changes to Employers National Insurance from April 2025 which, as previously reported, is where a cost pressure has emerged since Month 3.

- Trust reserves due to rebasing some balance sheet provisions from 2024/25 for annual leave sold.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

16. Public Sector Payment Policy (PSPP) compliance to Month 9 was **98.4%** against the **95%** WG target set for non-NHS invoices by number and **99.0%** by value.



2025-26 CAPITAL PROGRAMME

17. At Month 9, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2025/26 is **£32.030m**. This includes **£26.082m** of All Wales Approved schemes and **£5.948m** for Discretionary schemes.

18. There is no suggestion at this stage of the financial year that this value will not be spent in full.

	Actual £'000	Plan £'000
All Wales Capital Programme: Schemes:		
ESMCP - Control Room Solutions	94	421
MDVS	0	72
Special Operational Response Teams (SORT) Enhancement Equipment	2	290
Welsh Ambulance Services NHS Trust – Vehicle Replacement Programme – 2025-26	6,701	22,452
TEF - Infrastructure	74	300
TEF - Decarbonisation	80	707
Replacement PC/Laptops, Server & Switch upgrades - End of Year Digital funding 2025-	0	550
EA Chassis 26-27 - End of Year funding 2025-26	0	1,290
Sub Total	**6,950**	**26,082**
Discretionary:		
I.T.	545	1,149
Equipment	147	250
Statutory Compliance	0	0
Estates	597	4,350
Other	23	180
Unallocated Discretionary Capital	0	19
Sub Total	**1,312**	**5,948**
Total	**8,262**	**32,030**
Less NBV reinvested		
Total Funding from WG	**8,262**	**32,030**

RISKS AND ASSUMPTIONS

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

20. There remain 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. The previously included medium risk of **£0.210m** that had been identified following the NWSSP risk sharing paper, has been removed following the commitment from WG to fund this.

22. Given the pressures the Trust feels every winter, the Trust has included a figure of **£0.500m** to cover any unfunded winter pressures; this has been deemed as a low risk, and reduced from Month 8 given we are moving out of the winter period and based on support provided from Commissioners over recent years.

23. The risk associated with the increase in handover delays (increase in overrun costs, due to HB reducing services) reduced to **£0.500m** (low risk), this will continue to be monitored closely based on the financial position of the HBs and how this could impact on the Trust if HB positions deteriorate.

24. As noted in prior months, in terms of the risk related to the costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if this recommendation is to be taken forward additional funding would be required in order to deliver. However, the risks to the services are much more than financial.

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

RECOMMENDATION

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

    It is recommended that the Board:

    - **Note** and gain **assurance** in relation to the Month 9 revenue financial position and performance of the Trust as at 31st December 2025.
    - **Note** the delivery of the 2025/26 savings plan, and the context of this within the overall financial position of the Trust.
    - **Note** the capital programme for 2025/26.
    - **Note** the Month 9 Welsh Government monitoring return submission (as required by WG).

NEXT STEPS

27. Monitor the ongoing revenue and capital position over the remaining months of the year, linking in with key stakeholders, to ensure delivery to plan.

28. Continue to closely monitor the 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.

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 25-26

Reporting Month 9

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprentice Income	50	4	4	0	37	37	0	50	50	0
Balance Sheet Flexibility	200	50	0	-50	150	50	-100	200	50	-150
Commercialisation Opportunities	100	25	0	-25	25	0	-25	100	0	-100
Disposals	250	30	30	0	145	145	0	250	250	0
End of Shift Overrun	100	7	7	0	78	76	-2	100	98	-2
Fuel	230	19	52	33	177	533	356	230	676	446
Interest Receivable	516	43	16	-27	387	149	-238	516	154	-362
Non Pay Local Schemes - Corporate	914	94	107	13	633	562	-71	914	827	-87
Non Pay Local Schemes - Operations	650	54	38	-17	483	381	-102	650	545	-105
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	216	229	13	2,491	2,471	-20	3,140	3,140	0
Pay Vacancy Management - Corporate	2,275	190	200	11	1,706	2,038	331	2,275	2,635	360
Pay Vacancy Management - Corporate 25-26	75	9	9	0	50	50	0	75	75	0
Totals	**8,500**	**741**	**693**	**-48**	**6,362**	**6,492**	**130**	**8,500**	**8,500**	**0**

Savings Performance by Theme 25-26 - Recurrent

Reporting Month 9

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprentice Income	50	4	4	0	37	37	0	50	50	0
Balance Sheet Flexibility	200	50	0	-50	150	50	-100	200	50	-150
Commercialisation Opportunities	100	25	0	-25	25	0	-25	100	0	-100
Disposals	250	30	30	0	145	145	0	250	250	0
End of Shift Overrun	100	7	7	0	78	76	-2	100	98	-2
Fuel	230	19	52	33	177	533	356	230	676	446
Interest Receivable	516	43	16	-27	387	149	-238	516	154	-362
Non Pay Local Schemes - Corporate	914	94	107	13	633	562	-71	914	827	-87
Non Pay Local Schemes - Operations	650	54	38	-17	483	381	-102	650	545	-105
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	216	229	13	2,491	2,471	-20	3,140	3,140	0
Pay Vacancy Management - Corporate	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate 25-26	75	9	9	0	50	50	0	75	75	0
Totals	**6,225**	**551**	**492**	**-59**	**4,656**	**4,454**	**-202**	**6,225**	**5,865**	**-360**

Savings Performance by Theme 25-26 - Non Recurrent

Reporting Month 9

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprentice Income	0	0	0	0	0	0	0	0	0	0
Balance Sheet Flexibility	0	0	0	0	0	0	0	0	0	0
Commercialisation Opportunities	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
End of Shift Overrun	0	0	0	0	0	0	0	0	0	0
Fuel	0	0	0	0	0	0	0	0	0	0
Interest Receivable	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Corporate	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Operations	0	0	0	0	0	0	0	0	0	0
Pay Cost Management (Variable / Net Vacancies) - Operations	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,275	190	200	11	1,706	2,038	331	2,275	2,635	360
Pay Vacancy Management - Corporate 25-26	0	0	0	0	0	0	0	0	0	0
Totals	**2,275**	**190**	**200**	**11**	**1,706**	**2,038**	**331**	**2,275**	**2,635**	**360**

Please note figures are rounded to the nearest whole number

Cadeirydd
Chair: Colin Dennis

Prif Weithredwr
Chief Executive: Jason Killens

Swyddfa Cyllid ac Adnoddau Corfforaethol

Finance and Corporate Resource Office

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

14th January 2026

Your ref:

Dear Andrea,

Re: DECEMBER 2025 (MONTH 09 2025/26) MONITORING RETURN

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

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

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

The Trust's performance against financial targets for month 09 2025/26 is as follows: -

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

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

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

Included within the income assumptions is the full pass through of 2024/25 pay funding and an assumed level of funding for Employers National Insurance contribution increase for 2025/26 funding (see below).

The resulting reported performance at month 9 as per Table B, is an underspend against budget of **£0.180m**

The reported total pay variance against plan as at month 9 is an underspend of **£2.100m**, set against the budgets.

The non-pay position at month 9 is a reported overspend of **£1.856m**.

Income at month 9 shows an underachievement of **£0.064m**.

2. Movement (Table A)

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

3. Underlying Position (Table A1)

Table A1 has been adjusted to agree with Table A

4. Risk (Table A2)

The risks have again been reviewed in detail and depending on the outcome of some of the issues highlighted elsewhere in this return, we may continue to move towards higher risks, as noted above, having to be reported, alongside ensuring that the Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.

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

Following confirmation in the letter received from Hywel Jones the medium risk that had been identified following the NWSSP risk sharing paper, has now been removed from the tables. **(Action Point 8.3)**

Given the pressures the Trust feels every winter, the Trust had included a figure of £1.000m to cover any unfunded winter pressures, however in light of the confirmation around the WRP funding requirement this has been in month reduced to £0.500m; this has been deemed as a low risk, based on support provided from Commissioners over recent years.

As noted in prior months returns, the risk related to the costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if this recommendation is to be taken forward additional funding would be required in order to deliver, however the risks to the services are much more than financial.

The risk associated with increased handover delays has also been reduced to £0.500m, whilst handover delays are increasing this is causing a performance impact and less of a financial impact, however this will be closely monitored to ensure this doesn't translate in future months to increased costs.

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

Given the Trust now has the ability to progress the spend which had previously been paused due the WRP increase, the Trust hasn't included any opportunity costs as the expenditure plan is now forecasted in the YTD position.

5. Monthly Profiles (Table B)

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

The increase in expenditure in Secondary Care Drugs in November related to one off spend to replace drugs which were held in our Omnicell machines where their shelf life had expired, along with the purchase of Flu vaccines, these were one off costs. **(Action Point 8.4)**

The expenditure on Other Private & Voluntary Sector is a variable area and depends on the requests from HB's and is also reactive to the WLI initiatives that WAST are delivering this year, Plans provided by the HB's are short term and hence why future months are static and get updated on a monthly basis. **(Action Point 8.5)**

As noted above an element of the risk associated with Winter pressures has now been removed from the risk tables, however part of the adjustment between both pay and non-pay relates to the above mentioned WLI initiative and winter pressures. **(Action Point 8.6)**

Other income was reviewed as part of the month 9 review **(Action Point 8.7)**

Interest receivable is linked to the amount of cash the Trust is holding in its interest bearing accounts as such if the Trust holds more money the amount of interest increases, therefore if expenditure varies to cashflow this increases the amount of interest received, in month 8 it was assumed some larger capital expenditure was going to incur earlier in the quarter. **(Action Point 8.8)**

The strategic depreciation has been reviewed and amended to align with the November non-cash submission. **(Action point 8.9)**

6. Expenditure Movement (Table B2)

Table B2 has been completed in accordance with the guidance.

As requested the £1.200m unplanned cost pressures as explained earlier in the financial year, relates to the change to the assumption in our financial plan in which the Trust had assumed that 100% of the employers NI increase would be funded by WG, per the allocation letter funding for 26-27 this is to be provided on the same basis as this financial year therefore this is a recurrent cost pressure.

In relation of the £1.879m (now £1.200m in month 9) unplanned expenditure reduction, this related in month 8 to the above mentioned mitigation of the £1.200m NI issues along with the c£679k pressure mainly in relation to the WRP, this resulted in planned expenditure being stopped, however since the letter from Hywel Jones the Trust has been able to start the process of mitigating potential pressures on next financial year and reduce the non-financial risks to the Trust around a small element of the Manchester Arena Inquiries recommendations. **(Action Point 8.1 & 8.2)**

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

Agency costs for month 9 totalled £0.067m. The current percentage of agency costs against the total pay figure remains very small, at 0.3%. This is to cover a small number of vacancies, in areas across the Trust which the Trust is having difficulties recruiting into, however it is hoped that some of these agency staff will be replaced by permanent staff in the near future. Due to the uncertainty that remains around some ICT funding that has been received on a non-recurrent basis, as such we are having to utilise agency staff in these roles to deliver the service, therefore there remains costs going into December and January, however as mentioned above these have non-recurrent funding and couldn't be appointed on a permanent basis.

The negative value, related to the reversal of an accrual in the early part of the financial year which is no longer required **(Action Point 8.10)**

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

Year to date at month 9 the Trust is reporting planned savings (including Income generation) of £6.362m and actual savings of £6.492m.

Pay savings continue to overachieve against plan and work is being undertaken to assess this against the year end position, as we see handover delays increase this could have an impact on variable pay as we progress through the closing months of the year however this is being reviewed monthly. **(Action Point 8.11)**

Savings schemes across multiple directorates and departments are consolidated within the return due to the small nature of some of the schemes as this would result in reporting decimal figures within the tables if these schemes were split out between all the directorates which make up the saving heading, also to do this now would require the restatement of all these tables as the budgets and plans are also consolidated, this could be something that we could look to incorporate in future years returns. **(Action Point 8.12)**

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

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

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

At month 9 there was 5 invoices over 11 weeks, more detailed comments have been provided in the narrative section and the Trust is actively chasing these invoices.

11. Cash flow (Table G)

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

RECEIPTS	Apr £,000	May £,000	Jun £,000	Jul £,000	Aug £,000	Sep £,000	Oct £,000	Nov £,000	Dec £,000	Jan £,000	Feb £,000	Mar £,000	Total £,000
other (specify in narrative)													
CRU Income	16	12	15	13	13	10	11	19	13	13	13	13	161
Other Non NHS Income	329	268	293	135	453	213	242	370	207	266	266	270	3,312
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	0	435	384	0	622	381	331	359	841	400	400	400	4,553
Risk Pool Refund	1,519	0	1,020	0	8	0	283	0	388	0	0	0	3,218
Total	1,864	715	1,712	148	1,096	604	867	748	1,449	679	679	683	11,244

12. Public Sector Payment Compliance (Table H)

This table has been completed in accordance with the guidance. The Trust endeavours to ensure that NHS invoices along with Non-NHS invoices are paid within targets.

The quarter 3 cumulative percentage of Non-NHS invoices paid within 30 days by number was 98.4% and 99.0% by value against a target of 95%.

13. Capital (Tables I, J and K)

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

Works are progressing well and expenditure is flowing through the ledger as expected, the Trust is still forecasting to achieve its CEL by the 31st March.

14. ELF (Table L)

The ELF column B has been amended to split the Capital expenditure and annual lease payment **(Action Point 8.13)**

15. Committee to receive Financial Monitoring Return

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

The month 9 Financial Monitoring Return will be presented to the Trust Board on 29th January 2025.

Governance arrangements for formal sign off of the monitoring return narrative in the absence of the Director of Finance or Chief Executive will be delegated to their Deputies but in exceptional circumstances could be signed by

a Senior Finance Manager and an Executive Director. Signatures on this return contain Edward Roberts, Acting Director of Finance and Emma Wood, Chief Executive.

16. Other Issues

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

As requested the email will include the Word version of this letter excluding the signatures

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

Yours sincerely

Edward Roberts
Acting Director of Finance

Emma Wood
Chief Executive

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

Structured Assessment 2025

Welsh Ambulance Services University NHS Trust

October 2025

About us

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

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Audit snapshot

What we looked at

1 We looked at how well the Welsh Ambulance Services University NHS Trust (the Trust) is governed and whether it makes the best use of its resources. We looked at four areas in particular:

- how well its board works;
- how it keeps track of risks, performance, service quality, and recommendations;
- how it produces key plans and strategies; and
- how it manages its finances.

2 We also looked at the Trust's progress in implementing recommendations from:

- previous structured assessment reports; and
- our 2024 report on cost savings.

Why this is important

3 NHS bodies continue to face a wide range of challenges associated with the need to modernise and transform services to deal with constrained finances, growing demand, treatment backlogs, workforce shortages, and an ageing estate. It is therefore more important than ever for the boards of NHS bodies to have strong corporate and financial governance arrangements in place. This helps provide assurance to themselves, the public, and key stakeholders that they are taking the right steps to deliver safe, high-quality services and to use public money wisely.

What we have found

4 We found that the Trust has an effective Board supported by good governance arrangements. Systems for providing the Board with assurance are effective and are being strengthened through further development of the board assurance framework. A new quality plan is being implemented, but its deliverability is likely to be challenging without dedicated funding. The Trust continues to report challenges to the achievement of key performance targets. Changes to how ambulances responses are measured were introduced during 2025, with a greater focus on patient outcomes. However, it is too early to know what impact the changes are having on service quality.

5 The Trust has a clear and approved Integrated Medium-Term Plan (IMTP) and has recently approved a set of wellbeing objectives. It is also undertaking a timely refresh of its long-term strategy. The Trust has a significant number of change programmes underway, with finite capacity to support them. It is therefore pausing the development of some corporate plans and deferring some planned activities to protect capacity for key priorities.

6 The Trust manages its finances well to meet its key financial duties during 2024-25. Positively, it is reducing its reliance on non-recurrent savings. Yet, the Trust is facing increasingly challenging financial pressures this year which creates risks to achieving its forecast breakeven position. However, there is a need to clarify the affordability of some of the Trust's strategic plans.

What we recommend

7 We have made four recommendations to the Trust within the following areas:

- Strengthening policy management
- Enhancing reporting of the current board assurance framework;
- Clarifying deliverability of its quality plan; and
- Reporting on any issues with the timely submission of Board and committee papers.

Key facts and figures

- Within the Welsh Government's Escalation and Intervention framework, the Trust is currently at level 1.

- In 2024-25, the Trust met its financial targets by breaking even on both revenue and capital spending.

- In 2024-25, the Trust aimed to save £6.42 million but ended up saving £6.84 million. However, £3.1 million came from staff vacancy savings.

- The Trust's 2024-25 financial statements were submitted for external audit on time, and the Auditor General issued an unqualified audit opinion on 27 June 2025.

- The Welsh Government issued a letter in August 2025 to confirm its approval of the Trust's 2025-28 Integrated Medium-Term Plan.

- Whilst the Trust is facing some unexpected in-year financial challenges, it continues to forecast a breakeven position for 2025-26.

- The Trust has fully implemented the four outstanding structured assessment recommendations since our last report.

Our findings

Board effectiveness and openness

Board and committees operate effectively, reflect on learning, and seek opportunity to continually improve. However, the Trust still needs to address its out-of-date policies

Public openness of board business

8 The Trust continues to conduct its business in a transparent way. The Board holds its public meetings in Cardiff. However, the Trust is exploring ways to rotate meeting locations across Wales to support it in further raising the Board's profile and connect more with staff across the country. Members of the public can send in questions before each meeting for the Board to consider. Our review shows that the Board responds to these questions clearly and effectively. The public can request to observe the Board live or watch the recordings after the meeting via links on the Trust website.

9 Although committee meetings are not broadcast or recorded, the public can still request to attend any public committee meeting. The Trust also routinely publishes Board and committee papers a week before each meeting on its website.

10 The Trust keeps private Board and committee sessions to a minimum, reserving them only for sensitive or confidential matters. After each Board and committee meeting, the Corporate Governance Team quickly publishes an Alert, Assure, Advise paper on the website. This paper highlights the key points discussed. The Trust then uploads the full minutes once they are confirmed at the following meeting.

Supporting effective board conduct

11 The Trust has clear and generally up-to-date governance arrangements that help the Board and its committees run effectively. This includes regular update and review of Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation (SoRD).

12 The Trust reports non-compliance with Standing Orders to the Audit, Risk and Assurance committee. Since the beginning of 2025, there have only been three reported breaches which were on digital procurement, staff payments, and non-approval of minutes. Although Standing Orders state that papers should be submitted at least five days before a Board or committee meeting, the Trust does not currently report any late submissions as a recorded breach of these rules. Whilst the submission of late papers is infrequent, reporting instances to the Audit, Risk Assurance Committee would improve transparency and promote timely submissions.

13 The Trust continues to publish up-to-date declarations of interests and its Register of Gifts and Hospitality on its website. The corporate team continue to raise awareness online and in ambulance stations of the requirement to make gifts and hospitality declarations.

14 In 2023, the Trust reported that only 14% of its policies were up to date. Although we saw improvement in 2024, progress has since slowed. At the current rate, the Trust expects that only 50% of policies will be in date by January 2026.

Board and committee meeting effectiveness

15 The Trust's Board and committees work effectively and are quorate. Their agendas are focussed on risk areas, and work programmes are up to date. The committee structure broadly aligns to the organisation's main goals and risks. To improve this further, the Trust has set up a task and finish group to consider how its committees work and how they could improve. In particular, this group has reflected on the role of the Academic Partnership Committee, now that the Trust has achieved University Trust status.

16 Board and committee meetings are well-run, with agendas focused on the organisation's biggest risks and important issues. Over the past year, key concerns have included growing financial pressures, long delays in handovers, and poor performance in handling complaints and investigations. There is still room for the Board to spend more time on long-term strategy, which is expected to happen as the Trust starts to review its strategic vision and board assurance framework in 2025–26.

17 Board and committee papers are timely and include clear, high-quality information. Presentations are easy to follow and come with cover papers that clearly set out the key issues, recommendations, and actions. Where helpful, the Corporate Governance Team also provides extra background information outside the main agenda through the newly established 'reading room' function which stores additional contextual papers. After meetings, committees continue to share important discussion points and issues with the Board through their Alert, Assure, and Advise Highlight Reports.

18 The Trust is now a named organisation under the Wellbeing of Future Generations Act (2015). It agreed its wellbeing objectives in March 2025 but is still in the early stages of applying sustainable development principles in committee meetings. The Trust recently added these goals to Board and committee cover papers. This should help authors and committees consider how discussions and decisions affect its wellbeing goals.

Hearing from staff and service users

19 The Trust continues to hear direct experiences from staff and patients at the start of meetings. The Quality, Experience and Safety (QuESt) committee hears patient stories and the People and Culture committee hears stories from staff. Stories are also shared at Board meetings, with patient and staff stories shown in turn. In 2024, the Trust has also improved the process for tracking actions and learning following staff stories which now mirrors the process used for patient stories.

20 There are good ongoing approaches for board members to listen to staff. Each month, the Chief Executive leads a 'live' session where staff from across the organisation can speak up and talk about important issues. Board members also meet staff through award events and visits. This includes the Annual General Meeting, staff awards and through the work of the Patient Experience and Community Involvement team. Board members we spoke to felt that they had good mechanisms in place to engage with and hear from staff and patients.

Board cohesion and continuous improvement

21 The Trust's Board has largely been stable during the past 12 months. It changed the Director of People and Culture role in November 2024, splitting the function into two. The Chief Executive Officer left the organisation in June 2025 and following interim arrangements, the new Chief Executive Officer started in October 2025. These changes have been well-managed, with cohesion across the Board evident within our observations and discussions with the Trust. There have been no new Non-Executive Directors in the past year. However, the Trust has joined the aspiring board programme, to develop new independent member expertise for the future.

22 The Board and its committees conduct yearly self-assessments to review how well they are working. the Audit, Risk and Assurance Committee took a new effectiveness approach this year with the aim of improving their committee engagement rates. A smaller sub-group of the Audit, Risk and Assurance Committee met throughout the year to address the numerous questions within the NAO Audit and Risk Assurance Committee Effectiveness Toolkit. At the March 2025 meeting of the committee members reviewed and discussed the feedback. The committee found that the process, whilst resource-intensive, strengthened the quality of feedback and resulted in a number of improvement actions for the committee.

23 The Trust has continued to run its own Board Development Programme during 2024–25. Its bi-monthly sessions were well attended, covering a range of topics. These have included the Wellbeing of Future Generations Act, the duty of quality and candour, and planning for the 2025–28 Integrated Medium Term Plan (IMTP). Board members told us they found the sessions useful.

24 Plans for an externally supported Board Development Programme are ongoing and out to tender during our review. The Trust hopes to have this programme in place by March 2026. Work is also continuing to improve induction programmes for committee members.

Providing board assurance

Recent and ongoing changes to assurance frameworks are supporting improvement, but there is more to do, including a need to ensure its quality plan is achievable within existing resources.

Managing strategic risks

25 The Trust’s Risk Management Transformation Programme (2021–24) concluded last year but work to strengthen the board assurance framework (BAF) is ongoing. Previous structured assessments have noted that the BAF has primarily focused on corporate risks, rather than the broader strategic risks linked to the Trust’s long-term objectives. This limits its effectiveness in supporting the Board’s oversight of risks to strategic delivery.

26 To improve its approach to risk, the Trust commissioned external consultants (BDO Ltd) in early 2024, in part to provide best practice guidance for developing a more strategic BAF. Although the Trust had planned to implement a revised digital version by now, a suitable automated solution has yet to be identified. Although progress had also been limited by resource constraints, the recent appointment of the dedicated Risk Manager is now bringing the capacity needed to bring the risk work back on track. The Trust’s plans to begin to update its long-term strategy during 2026-27 may offer a welcome opportunity to align the BAF with the development of potential new strategic objectives.

27 In the meantime, the Trust continues to provide regular oversight of the BAF. The full framework is reviewed by the Board and the Audit and Risk Assurance Committee, while other committees oversee the risks relevant to their areas of responsibility. In addition, the Board has reviewed its six risk appetite statements during board development sessions within the past 12 months.

28 The 2024–25 internal audit of risk management provided a reasonable assurance rating. It found that risk reporting to the Board and committees is effective but highlighted the need for further action once a revised BAF is in place, including updating key documents and delivering staff training.

29 Despite the earlier comment on the need to strengthen oversight of risk to strategic objectives, our review of the BAF found that it provides good coverage of corporate risks and the Trust regularly reviews controls and any gaps in assurance. However, there have been very few changes to risk scores during 2024–25 despite reasonable progress on mitigating actions. This is largely due to the influence of external factors, including handover delays which, whilst improved in recent months, remain high.

30 As the Trust develops a more strategic BAF, there is also an opportunity to enhance the clarity and usefulness of BAF reporting. For example, including a dashboard to track the status of actions and their impact on risk scores could help demonstrate progress more clearly and support more informed oversight.

Managing performance

31 The Trust approved its updated Quality and Performance Management Framework in March 2025. This improves the use of benchmarking, user surveys, consideration of the Trust's statutory duty of quality, and actions to address internal audit recommendations.

32 The Board and its committees regularly and appropriately oversee Trust performance. Each committee also receives reports specific to its responsibilities. The Trust reviews the metrics in its performance report every year to make sure they track progress effectively. In May 2025, Board members said they would prefer fewer, more focused measures that link better to the organisation's strategic goals. They also asked for better data quality and support to help them understand the data. The Trust is now working on these improvements.

33 The Trust has made good progress in rolling out new service models as part of its clinical transformation programme. However, the impact of these changes has not yet been formally reviewed, with a formal evaluation due to begin in autumn 2025.

34 The way that ambulance performance is measured has changed in recent months. The Welsh Government launched a revised Emergency Ambulance Performance Framework as part of a 12-month pilot[1]. The previous call categories of red, amber and green have been altered as described below:

- Purple: People who have had a cardiac or breathing arrest outside of hospital.
- Red: Other life-threatening emergencies, including serious illness or injury where there is a high risk of cardiac or breathing arrest.
- Orange: Urgent cases that need fast ambulance care, following clinical guidelines, and quick transport to hospital or a specialist centre.
- Yellow: Cases that need a clinical assessment. These may lead to hospital transport, referral to a community service, or treatment at the scene.
- Green: Less urgent cases that can be treated at the scene or referred to scheduled services for the right care.

These changes aim to support an increased performance focus on patient outcomes rather than response times. For example, the primary measure for purple calls will be the percentage of people to have a heartbeat restored after a cardiac arrest. As part of the new model, rapid clinical screening will be undertaken for all calls not classified as purple or red to assess the best method of treatment for that patient. At present, it is too early to know what effect this will have on performance. The Trust is currently collating various data to better understand any impact patient outcomes. This is challenging given that outcome data is stored across different Health Board systems across Wales.

[1] Purple and red categories went live from 1 July 2025 and the intention is for the orange, yellow and green categories to go live from 2 December 2025.

35 In addition to changes to performance measures and metrics, the Trust has also seen significant changes to some of its long-standing performance metrics in recent months. Notably, handover delays in June and July 2025 were the lowest they have been in four years, although the picture across Wales is still very variable. The number of patients who cancel their ambulance dispatch has also reduced significantly during the past 12 months. However, whilst performance for some clinical indicators such as return of spontaneous circulation are improving others, such as stroke call to door times, have worsened.

Monitoring quality and safety

36 In May 2025, the Trust launched a new strategic quality plan. The plan focuses on population health, value-based healthcare, and quality management systems. The accompanying implementation plan sets out the actions to deliver the plan over its three-year lifecycle. Whilst the Trust recognises the need to have sufficient staffing and financial resources to deliver the plan, the plan is not supported by any dedicated funding. As a result, achievement of the 121 listed actions to be delivered over three-years, is likely to be very difficult.

37 The Trust has clear accountability for clinical quality governance. The Senior Quality Team oversees delivery of the new strategic quality plan and the Quality Management Group supports the quality management system. However, we have previously highlighted concerns about low attendance at these group meetings. Our review of recent papers shows that attendance remains variable.

38 The QuESt Committee oversees a range of assurances and escalated concerns. These include issues highlighted by the Clinical Quality Governance Group, and through quality metrics in the putting things right report. The Trust has strengthened this report with better data, steps it is taking to meet its legal duty of candour, and organisational learning. The new learning from mortality report, published twice a year, shows that the Trust has a more systematic system in place to review and learn from patient deaths.

39 Although assurance processes have improved, quality metrics show underperformance in some areas. These include delays in responding to complaints, missed audit deadlines, and slow responses to concerns and coroners' reports. Despite the Putting Things Right team growing, there is a backlog of investigations, and both the Public Services Ombudsman and coroners have raised concerns. Almost 80% of learning from events reports are also submitted late. To address these issues, the Trust introduced a recovery action plan in August 2025. However, current capacity constraints may make delivery challenging. The Executive Leadership Team is closely monitoring progress and the Executive Director of Quality and Nursing reports regularly on this to QuESt Committee meetings.

Tracking and monitoring recommendations

40 The Trust is improving its arrangements to track and monitor recommendations. It has worked with Digital Health and Care Wales to build a new automated audit tracking system. Once implemented later in 2025, the Trust will train staff on its use and Audit, Risk and Assurance Committee members will be able to explore progress on recommendations more easily.

41 During the past twelve months, the Audit Risk and Assurance Committee has continued to use the current (Excel based) version of the tracker to track implementation of recommendations. While not being reported at two meetings over the last year, the data shows that the Trust is closing more audit recommendations on time, with fewer deadlines being pushed back. This suggests that the organisation is getting better at setting realistic timelines and following through on audit actions.

42 In 2024, we raised concerns that the Trust was closing some recommendations without enough evidence. However, things have improved. The three recommendations from our 2024 Structured Assessment were completed effectively and within the year. We also understand that the Trust is responding to and closing Internal Audit recommendations appropriately.

Preparing strategies and plans

The Trust has a clear long-term strategy, medium-term plan, and newly agreed wellbeing objectives, however capacity pressures are resulting in some plans being deferred or delayed.

Producing key strategies and plans

43 The Trust's 2018-30 strategy 'Delivering Excellence' appropriately outlines a vision to manage demand differently by changing how it delivers services. It focuses on supporting and treating more people in communities to reduce demand for emergency ambulance services. The Trust intends to refresh its strategy in 2026 and has started events in 2025 to help shape the new version. Following this, it will then develop a new supporting clinical strategy.

44 In 2024, the Trust launched a new clinical model transformation programme to improve how clinical care is delivered. The Trust leads this work, supported by commissioners and partners. The approach aligns to the strategic vision and aims to strengthen clinical support during calls and offer more options for face-to-face care. The Trust has made good progress in rolling out new service models as part of its clinical model transformation programme. It has not reviewed the impact of these changes although we understand a formal evaluation is due to begin in autumn 2025.

45 The Integrated Medium-Term Plan 2025-28 (IMTP) was shaped by internal and external feedback. This included patient stories, staff surveys, and talks with the Joint Commissioning Committee. The Trust also improved its engagement with Non-Executive Directors on the IMTP by holding two board development briefings in November and December 2024. The Finance and Performance Committee then received the full draft on 18 March 2025, prior to Board approval and submission to the Welsh Government. Welsh Government subsequently approved the IMTP. These steps show progress, but there's still room to improve, especially by sharing draft versions earlier, so members have more time to give feedback and inform its development, rather than providing scrutiny to a fully-formed plan.

46 On 30 June 2024, the Trust became one of the specified bodies under the Well-being of Future Generations (Wales) Act. Following this, the Trust has now set its first well-being objectives, based on the sustainable development principle. To help shape the objectives, the Trust, supported by a cross-directorate Task and Finish Group, asked for feedback through social media, Llais, and its citizens panel. However, the engagement only lasted 14 days and not many people responded. Alongside its IMTP 2025-28 the Board approved the Trust's three wellbeing objectives in March 2025, they are:

- a socially responsible and inclusive employer;
- an innovative and sustainable organisation; and
- a pro-active, accessible, and equitable care provider.

47 As an interim approach, the Trust has identified a small number of commitments under each well-being objective, aligned to the Trust's current goals and priorities. This is pragmatic given the Trust's plans update its long-term strategy in 2026. The Trust is also in the process of developing ways to measure progress against its wellbeing objectives which it intends to include in its next Annual Report. The Auditor General will include appropriate work in future years' audit plans at the Trust to assess the progress that is being made, in line with his statutory duties under the Act.

48 The Trust is prioritising the renewal of some plans and extending the life of others. During the past 12 months the Trust has developed a strategic quality plan 2025-28 and a health and wellbeing plan 2025-29. The People and Culture Plan was scheduled for review in 2025. However, the Trust will suggest to the Board that they keep using the current version, as it still meets the organisation's needs.

49 The Trust is managing several major change programmes. This is creating capacity pressures and potential risks. Transformation initiatives such as the clinical model transformation programme, responding to new performance measures, implementing the quality plan, and progressing policy reviews, along with IMTP actions require significant input from across the organisation. Internal Audit has raised concerns about limited capacity to support change and a lack of oversight for some projects. Board and committee discussions show members are aware of these pressures. In response, executive officers have recently held workshops to consider options such as delaying and deferring lower-priority actions within the IMTP.

Board assurance on partnership working

50 The Trust works closely with key partners to support shared goals. It is now part of every Regional Partnership Board (or their sub-groups) across Wales. It works with health boards locally and through national-level Joint Commissioning Committee and Six Goals Programme Board programmes.

51 The Trust reports partnership activities to the Board through IMTP updates, its avoidable harm paper, and CEO and Chair reports. In May, it introduced a new bi-annual engagement report, which gave the Board an overview of key partnership and engagement priorities. Future reports are expected to provide more detail, showing how priorities, such as wellbeing objectives and the new national ambulance performance framework are being put into practice.

Monitoring delivery of strategies/plans

52 The Trust’s arrangements for overseeing the delivery of corporate plans are reasonably effective. Each section of the IMTP clearly sets out what the Trust needs to do across the three years of the plan which supports the Strategic Transformation Board in its role of monitoring and reporting progress during the year.

53 The Finance and Performance Committee and the Board continue to challenge and support delivery of corporate plans. Committee scrutiny has led to the Trust strengthening reporting and accountability. This includes clarifying the role of operational groups and strengthening reporting on ministerial priorities using RAG[2] ratings. These changes demonstrate a clear commitment by the to ensure sufficient grip and oversight of plan delivery.

54 The Trust delivered most of its 2024-25 IMTP actions. This included the full rollout of Cymru High Acuity Response Units. The Trust is making reasonable progress in 2025-26, having delivered just over half of the actions planned for the first quarter of the year, but it had to defer a number to later dates due to capacity issues.

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[2] Red, Amber and Green

Managing finances

In-year finances are well-managed and there is a reducing reliance on one-off savings. However greater clarity is needed on the affordability of some plans.

Meeting financial objectives and duties

55 The Trust met its financial responsibilities in 2024–25. It recorded a small surplus of £70,000 and broke even over the three-year period from 2022 to 2025. the Trust also spent its capital budget as planned and went beyond the 95% target for complying with the Public Sector Payment Policy.

56 The Trust is showing a revenue deficit for the year so far. However, it still expects to break even by the end of the 2025–26 financial year. At the time of our review, capital spending plans were still being finalised, but the Trust is still forecasting that it will stay within budget this year. It is also on track to meet its targets under the Public Sector Payment Policy.

Financial planning arrangements

57 The Trust's financial planning has supported the achievement of a breakeven position in recent years. The Board approved the Trust's 2025-26 Financial Plan in March 2025 as part of the IMTP approval process, following scrutiny by the Finance and Performance Committee.

58 The financial plan for 2025–26 sets out the main financial risks and challenges. Like other NHS bodies, the Trust's financial plan has little room for unexpected costs or missed savings targets. Some known cost pressures have already materialised, such as the Welsh Government's decision not to fund the rise in employer national insurance. Other pressures, like higher costs from the Welsh Risk Pool were not expected when the Trust developed the plan. The Trust is keeping a close eye on these financial risks and regularly updates the Finance and Performance Committee and the Board on how it is managing them and mitigating a financial deficit at year-end.

59 The Trust has a good record for delivering savings. It overachieved against its 2024-25 overall savings target by £417,000. Positively, it relied less on non-recurrent savings than in previous years as 54% of the savings made in 2024-25 were recurrent. However, of the remaining 46% non-recurrent savings delivered, 97% came from vacant corporate roles.

60 The financial plan for 2025-26 includes an £8.5 million savings target. This equates to 2.7% of the Trust's income. Building on last year's success, the Trust expects 73% of the savings (£6.225 million) to come from recurring schemes that deliver long-term benefits. However, whilst it was over-achieving against its overall savings target at June 2025, its recurring saving schemes are under-delivering. There is again a reliance again on corporate vacancies to achieve the Trust's savings target, which is not a wholly sustainable position.

61 The Trust's financial planning would benefit from clearer costing and affordability checks across all plans, including its strategic quality plan. In addition, Board and committee observations during the year highlighted both ongoing operational pressures and ambitious goals for the Trust's digital services. To support progress, the Trust should show how its plans take account of the resources required, and explain how these will be funded, both through confirmed in-year budgets and commitments for future financial years.

Financial management arrangements

62 The Trust has a good approach to financial management. The Audit, Risk and Assurance Committee and the Board review its Standing Orders and Standing Financial Instructions regularly, most recently in September 2025. Issues of non-compliance are reported to the Audit, Risk and Assurance Committee. The Audit Risk and Assurance Committee also gets regular updates on the Trust's proactive and comprehensive counter-fraud programme of work and reports on high-value purchases, losses, special payments, and single tender actions.

63 However, reports on losses and payments and single tenders, while clear, could be improved by adding comparison charts and accompanying narrative to show and explain changes in volumes and values over time. This would help Audit Risk and Assurance Committee spot trends and outliers more easily.

64 Internal Audit reviewed the Trust's contract management arrangements in June 2025. They found that the Trust needs clearer and more consistent contract management processes. It also needs a way to work out how much time staff need to manage contracts properly, and to formally assign responsibility for this across the organisation. The Trust does not currently have a contract management system. In preparation for the audit, the Trust established a Task and Finish Group to map out existing contracts, though it informed the ARAC that it lacks both the resources and systems needed to maintain the contract register going forward. In responding to the findings of the audit, the Trust has raised awareness of policies and responsibilities for contract management through its staff intranet.

65 The Trust submitted its draft financial statements for 2024–25 on time, as required by Welsh Government. Our audit showed clear improvements in the quality of the accounts compared to the previous year. As a result, only a small number of minor errors were found, and quickly corrected by management. The revised financial statements were reviewed by Audit Risk and Assurance Committee and approved by the Board in meetings on 24 and 26 June 2025, respectively. The Auditor General issued an unqualified (clean) audit opinion on 27 June 2025.

Monitoring financial performance

66 There continues to be strong oversight of financial spending and savings performance. The Trust submits a detailed finance report to each meeting of the Finance and Performance Committee and the Board. The finance report provides a good overview of the current year performance, including a table showing how well recurrent and non-recurrent savings schemes are performing.

67 The Trust has made good progress in responding to recommendations on financial reporting from our Cost Savings Arrangements (2024) and Structured Assessment (2024) reviews. In response, it has strengthened the clarity of its savings and financial performance reporting.

68 Board members demonstrate a clear grasp of the current financial situation and provide a suitable level of scrutiny and challenge to support improvement during committee meetings. In May 2025, the Trust reported to the Audit Risk and Assurance Committee that they are working to develop a new finance dashboard which will further support analysis.

Recommendations

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

Recommendations

R1	To strengthen governance and transparency, the Trust should formally record and report any Board or committee papers submitted after the 5-day publication deadline as a breach of its Standing Orders **(Paragraph 12).**
R2	The Trust should update its policy on policies to make the review process more efficient and practical. This should include clearer steps and methods to convert policies into other types of written control documents (such as procedures or guidelines), where this better reflects their purpose and use(**Paragraph 14**).
R3	To strengthen strategic risk oversight, the Trust should ensure that BAF papers provide a clear, high-level summary of changes to risk scores over time. This should be accompanied by an up-to-date view of associated actions, including their current status and any slippage (**Paragraph 30**).

R4 To ensure the Strategic Quality Plan remains deliverable, the Trust should ensure the assurance provided to QuESt covers the impact of financial and staffing on implementation. This should include updates on whether these constraints are impacting the achievement of planned actions and strategic outcomes (**Paragraph 36**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas for the period May 2025 to September 2025:

- How well the board works.
- How well the board oversees risks, performance, and the quality and safety of services and tracks recommendations.
- How well the body prepares key strategies and plans.
- How well the body manages its finances.

We did not look at the body's operational arrangements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Board conduct its business appropriately, effectively, and transparently?
- Is there a sound corporate approach to managing risks, performance, and the quality and safety of services?
- Is there a sound corporate approach to producing strategic plans and overseeing their delivery?
- Is there a sound corporate approach to financial planning, management, and performance?

Criteria

Our audit questions were shaped by:

- Model Standing Orders, Reservation and Delegation of Powers.
- Model Standing Financial Instructions.

- Relevant Welsh Government health circulars and guidance.
- The Good Governance Guide for NHS Wales Boards (Second Edition).

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Standing Orders and Standing Financial Instructions.
- Key strategies and plans, including the IMTP.
- Key risk management documents, including the board assurance framework.
- Annual Report, including the Annual Governance Statement.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chair;
- Vice-Chair and Chair of the Charity Committee;
- Chair of Audit, Risk and Assurance Committee;
- Chair of Quality, Experience and Patient Safety Committee;
- Chair of Finance and Performance Committee;
- Chief Executive (June 2025);
- Interim Chief Executive (August 2025);
- Executive Director of Operations;
- Executive Director of Finance and Corporate Resources;
- Executive Director of Quality and Nursing;
- Director of Partnerships and Engagement;
- Director of Corporate Governance/Board Secretary; and

- Director of People.

We observed Board meetings as well as meetings of the following committees:

- Audit, Risk and Assurance Committee;
- Finance and Performance Committee;
- Quality, Experience and Patient Safety Committee; and
- People and Culture Committee.

2 Previous audit recommendations

Outstanding recommendations from previous structured assessment reports

The table below sets out the progress made by the Trust in implementing outstanding recommendations from previous structured assessment reports.

Recommendation	Status
2024 Recommendation 1 The Trust should ensure that Board members are given the opportunity, either within a formal meeting or through circulation outside of meetings, to discuss and scrutinise a draft version of the Integrated Medium-Term Plan ahead of its submission for formal ratification and approval. **Target completion date**: March 2025	Complete (**see paragraph 45**).
2024 Recommendation 2 The Trust should update its Quality and Performance Management Framework to reflect recent changes in key internal roles. **Target completion date**: May 2025	Complete (**see paragraph 31**).

Recommendation	Status
2024 Recommendation 3 The Trust should apply to staff stories the process it has in place for patient stories to provide clarity on how the Trust has recorded the story, how the story has been used for assurance or improvement purposes, and how the Trust has responded to the individual who shared their experience. **Target completion date**: May 2025	Complete. (**see paragraph 19**).
2023 Recommendation 2 Improve quarterly patient experience reporting to QuESt by ensuring a balance of both positive and negative feedback and providing information on what is being done to address the negative themes arising in the report **Target completion date**: September 2023	Complete.

Recommendations from our 2024 Review of Cost Savings Arrangements

The table below sets out the progress made by the Trust in implementing recommendations from our 2024 Review of Cost Savings Arrangements.

Recommendation	Status
2024 Recommendation 1 The Trust should strengthen its approach to identifying and delivering recurrent savings. This will enable it to reduce its reliance on nonrecurrent savings in areas such as vacancy management and place its financial savings plans on a more sustainable footing. **Target completion date**: March 2025	Compete (**see paragraph 59**)
2024 Recommendation 2 The Trust should ensure it takes forward work to address gaps in staff skill sets in respect of the identification and delivery of savings and efficiency opportunities **Target completion date**: June 2025	Complete.

Recommendation	Status
2024 Recommendation 3 The Trust should ensure that its savings reports to Board and F&PC, are consistent or provide a clear explanation of the differences between the reported savings performance. This will aid understanding, reduce confusion, and maintain the credibility of the Trust’s savings reporting. **Target completion date**: August 2025	Complete.
2024 Recommendation 4 The Trust should ensure that it fully implements the learning from its recent gateway review of its Financial Sustainability Programme. This will ensure that it further strengthens its savings arrangements and maximises its savings opportunities. **Target completion date**: June 2025	Complete.

3 Key terms in this report

Term	Description
Board assurance framework	A Board assurance framework sets out the risks linked to the organisation's strategic objectives, and the controls and assurances in place to manage those risks.
Clinical Plan	A Clinical Plan is a long-term plan that helps shape how healthcare services are designed and delivered to meet the needs of patients and communities.
Corporate Risk Register	A Corporate Risk Register sets out the organisation's significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Counter Fraud	Counter fraud refers to the activity undertaken by the organisation to prevent, detect, and investigate fraud, bribery, and corruption. This work is led by the NHS Counter Fraud Service (CFS) Wales, which operates under the NHS Wales Shared Services Partnership.

Term	Description
Integrated Medium Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Losses	Losses include things like theft, fraud, overpayments, or damage to property.
Quality Governance	Quality governance is the combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Register of Interests	The Register of Interests helps ensure transparency by recording any personal or business interests of Board members and staff that could influence decisions.
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation set out which responsibilities stay with the Board and which are passed to committees and executives, along with reporting arrangements to ensure proper oversight.

Term	Description
Single Tender Action	A Single Tender Action is when an organisation buys goods or services from one supplier without going through a competitive process, usually because there is only one suitable option or urgent need.
Special Payments	Special payments are one-off payments made in unusual situations – like compensation or goodwill gestures – that fall outside of the organisation's normal business activity.
Standing Financial Instructions	Standing Financial Instructions set out the financial responsibilities, policies, and procedures adopted by the organisation.
Standing Orders	Standing orders set out the rules and procedures by which the organisation operates and make decisions.
Well-being of Future Generations Act (2015)	This Act requires public bodies in Wales to work sustainably and collaboratively to improve well-being across social, economic, environmental, and cultural areas, by setting long-term goals (called well-being objectives), involving citizens, and making decisions that consider the impact on future generations.

About us

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

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

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

Welsh Ambulance Services University NHS Trust – Annual Audit Summary 2025

Date issued: December 2025

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Foreword

Adrian Crompton

Auditor General for Wales

I am pleased to share my Annual Audit Summary for the Welsh Ambulance Services University NHS Trust (the Trust). It summarises the main findings from my 2025 audit work undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004 and the Well-Being of Future Generations (Wales) Act 2015.

I provided opinions on whether the accounts were properly prepared and gave a true and fair view, in all material aspects, and whether expenditure and income have been used for the purposes intended and in accordance with the authorities which govern you.

My audit team has also assessed whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and acted in line with the sustainable development principle. In doing so, my audit team has undertaken my annual structured assessment work and reviewed urgent and emergency care services and digital transformation. As set out in my audit plan, these reviews have been carried out in line with the International Organisation of Supreme Audit Institutions (INTOSAI) standards.

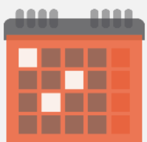
At the time of publishing this summary, the Trust was subject to Level 1 under the Welsh Government's escalation and intervention arrangements].

The detailed audit findings for each of my reviews are set out in the respective reports which my audit team have presented to the Audit, Risk and Assurance Committee throughout the year. The performance audit reports are available on the Audit Wales website and further links are available in the summary.

The Annual Audit Summary should be shared with the Board. I will then make the summary available to the public on the Audit Wales website.

I would like to extend my gratitude to the Trust's staff for their help and cooperation throughout my audit.

Your audit at a glance



I received the draft accounts and annual report ahead of the agreed deadlines of 2 May and 9 May 2025 respectively. The quality of the draft accounts and working papers was good.

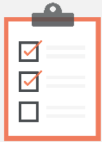
In advance of the agreed deadline of 30 June 2025 I issued an unqualified true and fair opinion, and an unqualified regularity opinion.

There were no uncorrected misstatements in the accounts.

There were no other significant issues to report.

My performance audit work found that the Board maintains effective governance and assurance, with well-run meetings and ongoing efforts to strengthen strategic risk oversight. The Trust consistently meets statutory financial duties and secures approval of its Integrated Medium Term Plan, while also setting wellbeing objectives during 2025. However, its capacity is stretched by major change programmes, highlighting the need for realistic and affordable plans. Despite efforts in urgent and emergency care, increased demand and ongoing delays continue to affect performance and patient outcomes.

My audit team made several recommendations to the Trust which focus on strengthening policy management, enhancing reporting to the Board and strengthening its information around alternative urgent and emergency care services.



There is still some work outstanding from my Audit Plan dated April 2025. My team expects to complete this work by March 2026.

Audit of accounts findings

Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides opinions on whether the accounts are properly prepared and give and true and fair view, in all material aspects, and the proper use ('regularity') of public monies.

My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

The draft accounts and annual report were presented for audit on 2 May and 9 May 2025 respectively. This was in line with the deadlines set by the Welsh Government. The quality of the draft accounts presented for audit was generally good.

My audit opinions

I must report issues arising from my work to those charged with governance for consideration before I issue my audit opinion on the accounts. I reported these issues within my Audit of Accounts Report to the Audit, Risk and Assurance Committee on 24 June 2025.

True and fair

A number of changes were made to the draft accounts arising from my audit work.

There were no uncorrected misstatements.

There were no other significant issues to report

My work did not identify any material weaknesses in internal controls (as relevant to my audit), and I made no recommendations.

I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them.

Regularity

The Trust is only allowed to receive income and incur expenditure in ways that follow the rules set by the authorities that govern it.

Further, where a Trust does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

The Trust met its first financial duty to break even over a three-year period ending 31 March 2025. All other material financial transactions were in accordance with authorities and used for the purposes intended, so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2024-25 accounts. The Trust met its second financial duty to have an approved three-year plan in place.

Whole of Government Accounts

I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position at 31 March 2025 and the return was prepared in accordance with the Treasury's instructions.

Performance audit findings

Structured assessment

My team looked at how well the Trust is governed and whether it makes the best use of its resources.

I found that the Trust has an effective Board supported by good governance arrangements. Systems for providing the Board with assurance are effective and are being strengthened through further development of the board assurance framework. A new quality plan is being implemented, but its deliverability is likely to be challenging without dedicated funding.

The Trust has a clear and approved Integrated Medium-Term Plan (IMTP) and has recently approved a set of wellbeing objectives. The Trust has a significant number of change programmes underway, with finite capacity to support them. It is therefore pausing the development of some corporate plans and deferring some planned activities to protect capacity for key priorities.

The Trust manages its finances well to meet its key financial duties during 2024-25. Positively, it is reducing its reliance on non-recurrent savings. Yet, the Trust is facing increasingly challenging financial pressures this year which creates risks to achieving its forecast breakeven position. However, there is a need to clarify the affordability of some of the Trust's strategic plans.

I made four recommendations focused on

- Strengthening policy management
- Enhancing reporting of the current board assurance framework;
- Clarifying deliverability of its quality plan; and
- Reporting on any issues with the timely submission of Board and committee papers.

Managing urgent and emergency demand

My team looked at how well the Trust is managing demand for urgent and emergency care to reduce unnecessary pressure on the system.

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

I made two recommendations focused on:

- Addressing outdated information on the 111 Wales website
- Working with health boards to maintain up-to-date information on its directories of service.

Performance audit work still underway

At the time of reporting, the following reviews from the 2025 Audit Plan were still underway at the Trust:

- digital transformation;
- estates management.
- Non Emergency Patient Transport Services.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use three lines of assurance to show how we achieve this. We have set up an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

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We welcome correspondence and telephone calls in Welsh and English.

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

Agenda Item No.	15

REPORT TITLE

2025/26 Quality Governance Reviews

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 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	Trish Mills, Director of Corporate Governance/Board Secretary

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 approach to the 2025 quality and governance reviews, previously referred to as effectiveness reviews, was revised following endorsement by the Audit, Risk and Assurance Committee (ARAC) of a programme of work to explore opportunities for further efficiencies within the board's governance framework.

2. To support this, a sub-group of the ARAC was established to oversee the review. The focus of the review was on reassessing the distribution of delegated responsibilities across the board's committees, with the aim of improving efficiency and effectiveness. This work responds directly to findings from the 2024/25 reviews, particularly those relating to Non-Executive Director (NED) availability, quorum challenges, the volume of meetings, and the transitional status of the Academic Partnerships Committee (APC).

3. The sub-group met three times. The review was driven by key project objectives:

   - Aligning committee remits more closely to the six strategic objectives
   - Improving efficiency and effectiveness in governance
   - Reducing meeting frequency and alleviating quorum/NED availability pressures
   - Ensuring strong scrutiny, challenge, and support through increased NED attendance on key committees
   - Balancing workloads and minimising disruption during a period of executive transition

4. A number of options were considered by ARAC at their 2 December 2025 meeting, with the preferred option to reduce the number of committees from seven to six, with each committee having four NEDs and a quorum of three. This includes the disbanding of the Academic Partnership Committee (APC) and a redistribution of (research, innovation, partnerships) to the Finance and Performance Committee (FPC) and the People and Culture Committee (PCC). Remit adjustments will be made to ARAC (resilience, cyber, information governance). This option meets the project's objectives, including improved NED attendance, reduced meeting frequency, and better alignment to strategic objectives.

5. The Board has stared a development and effectiveness programme with the Good Governance Institute and part of their scope will be a review of committee responsibilities and structures. Therefore ARAC was of the view that making major changes before that work is completed would be premature. Therefore, to allow this work to progress and potentially provide alternative structures/approaches, it is proposed that full implementation of Option 1 – particularly the major changes affecting FPC and ARAC and increasing NED membership – is deferred. Timing of this will depend on the outputs of the review but could take place in mid-2026/27.

6. Notwithstanding the broader work on committee structures, all board committees other than ARAC have undertaken reviews of their effectiveness from October to January November. They all reviewed their terms of reference and made minor amendments, which were endorsed by ARAC and are before the board at this meeting for approval. The Charity Committee's terms of reference is before the Corporate Trustee at their meeting on 29 January.

7. ARAC will undertake their quality and governance review in March aligned to the National Audit Office toolkit as they have done in previous years. The annual reports from all committees for 2025/26 will follow in May.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Board is requested to:

1. Note the issues considered with respect to the wider board committee framework changes and approve option 1, to be deferred until the outcomes of the externally facilitated board effectiveness review are received and considered (noting this may be mid-year in 2026/27).

2. Approve the changes to the terms of reference of the Quality, Patient Experience and Safety Committee, People and Culture Committee, Finance and Performance Committee, Remuneration Committee and Academic Partnership Committee (Annexes 2-6). The board is also requested to delegate approval of changes to director membership of committees to the committees themselves, to be reported through the AAA report.

3. Approve the proposal that the survey and the full governance review undertaken by the Good Governance Institute, together with the resulting outputs, will constitute the board's quality and governance review for 2025/26.

ADDITIONAL PAPER(S)

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

Annex 1 – Spread of board delegated committee remits for 2026/27

Annex 2 – Amended QUEST Committee terms of reference

Annex 3 – Amended People & Culture Committee terms of reference

Annex 4 – Amended Finance & Performance Committee terms of reference

Annex 5 – Amended Remuneration Committee terms of reference

Annex 6 – Amended Academic Partnership Committee terms of reference

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
As noted in the SBARN

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
16 July and 24 September	ELT discussions on 2025-26 reviews
25 July and 30 September	ARAC Sub-Group discussions on 2025-26 reviews
2 September 2025	ARAC update on quality and governance review
7 October 2025	APC meeting re quality and governance review
4 November 2025	QuEST meeting re quality and governance review
13 November 2025	PCC meeting re quality and governance review
18 November 2025	FPC meeting re quality and governance review
2 December 2025	ARAC meeting
29 January 2026	Trust Board

SITUATION

1. This paper seeks the board's approval to proposed changes to the board's committee framework.

2. Attached are the updated terms of reference for the Academic Partnership Committee (APC), the Quality, Patient Experience and Safety Committee (QuEST), the People and Culture Committee (PCC), Finance and Performance Committee (FPC), Remuneration Committee, and Academic Partnerships Committee. Changes are marked up and they are presented for approval following their recent quality and governance reviews (formerly known as effectiveness reviews) for 2025/26 and endorsement by Audit, Risk and Assurance Committee (ARAC).

BACKGROUND

3. Following the 2024/25 committee quality and governance reviews, ARAC identified opportunities to further streamline the Trust's governance structure. A project plan was initiated with the aim of ascertaining if the endorsed spread of board responsibilities could be redistributed in a way that is more efficient and effective. A sub-group of ARAC was formed to support this work and included the Non-Executive Directors (NEDs) of ARAC (Peter Curran, Ceri Jackson and Rhiannon Beaumont-Wood), Chris Turley and Trish Mills.

4. The project took account of the key concerns raised during the 2024/25 reviews which included NED availability and consequent quorum pressures, the transitional status of the APC post-university Trust status, and the high volume of meetings (52 ordinary meetings a year).

5. The review aimed to align committees wherever possible to our six strategic objectives, so they are best placed to drive progress, monitor outcomes and performance, and to respond to emerging priorities.

6. An update on this work was provided to board committees and the views of their members sought. Those committees (other than ARAC) also undertook their quality and governance reviews at that time and endorsed changes to their terms of reference.

ASSESSMENT

The Board's Committee Framework

7. From July to September the Executive Leadership Team (ELT) and the ARAC sub-group considered a number of issues and options, some of which fully met the objectives of the project and others that only partially met the scope. These included:

   7.1. Option 1 - reduce the number of committees from seven to six. Each committee would have four NEDs as members and a quorum of three. The APC would be disbanded. Its functions relating to research, innovation, and commercial partnerships would move to FPC, while its responsibilities for education partnerships and collaboration would move to PCC. To balance the extra responsibilities transferred to FPC, the areas of resilience, cyber security, and information governance (mainly internal controls) would transfer from FPC to this committee.

   There would be no change to the Charity Committee or Remuneration Committee.

   This option meets the vision of the project, including reduction in frequency (4 x APC meetings), desired NED attendance at four for each meeting and alignment to strategic objectives.

   7.2. Options 2-4 included variations on committee frequency, further remit reallocation, and consideration of a new research/innovation committee. Each has specific advantages or drawbacks, with some not fully aligning with all project objectives or raising particular concerns.

8. Taking account of the above, option 1 was favoured by the ELT and ARAC as it meets the project's objectives, including increased NED attendance, reduced meeting frequency, and better alignment to strategic objectives.

9. The Board has started a development and effectiveness programme with Good Governance Institute, with that programme reviewing whether the current number and scope of committees are right for an organisation of WAST's size and complexity. It will also look at whether the Board's focus, timing, and balance between strategy, performance, risk management, and culture are appropriate. The findings from this review (expected in Q1) are likely to influence both the remit and meeting frequency of some committees, especially FPC, where there is currently significant overlap with work going to the Board. This may lead to further changes to terms of reference mid-year. **Therefore, it is proposed that**

full implementation of Option 1 (particularly the major changes affecting FPC and ARAC and increasing NED attendance) is deferred. Timing of this will depend on the outputs of the review but could take place in mid-2026/27.

10. In light of this, ARAC has recommended that the board approve the following changes to its committee framework to take effect from 1 April 2026, with any material changes deferred until the outcomes from the Good Governance Institute review has been considered:

    - APC will continue to meet twice annually in 2026/27, with a focus on the research and development portfolio. This was agreed at the APC meeting in October and is reflected in their terms of reference.
    - APC delegated responsibilities relating to education partnerships and collaboration will transfer to PCC and those related to commercialisation will transfer to FPC. This was agreed at the PCC and FPC meetings in November and is reflected in their terms of reference
    - Minor changes are proposed for the Quality, Patient Safety and Experience Committee (QuEST) with the transfer of value based healthcare from FPC. This was agreed at the QuEST meeting in November and is reflected in their terms of reference.
    - No changes are proposed for the Charity or Remuneration Committees.
    - Membership and quorum will be maintained as it is currently with most committees having three members and a quorum of two. The terms of reference recognise that where there may only be two NEDs in a meeting due to sickness or absence is sub-optimal, but where absences are known in advance other NEDs will be co-opted in.

11. Annex 1 provides the board with an overview of the how the delegations will look across all committees in 2026/27 aligned to the above.

12. Where further changes to the committee framework and remits are recommended following the Good Governance Institute review, this will come back to ARAC and the board. This may mean a return to this issue in mid-2026/27.

Quality and Governance Reviews for Committees

13. In parallel with the work on the wider committee structures, each committee is required to complete an annual effectiveness review.

14. Given the extensive review undertaken in 2024/25, ARAC agreed that this year's approach would be qualitative. This included a survey of members to gather feedback on the proposed changes to the terms of reference (including membership) and to identify what is working well and where improvements could be made. The following four questions were asked of committee members and prescribed attendees:

- Are there any changes you wish to see to the terms of reference
- Are there any changes you would like to see to the committee's membership
- What works well in this committee
- What improvements would you recommend

15. Engagement with the surveys was not high; however, a good deal of qualitative information was obtained. There is nothing to escalate from any of the committees in the responses. The committee annual reports and cycles of business are being drafted for their next meetings, and these will come through to ARAC and the board in May as required under the Standing Orders.

16. The changes agreed to the committee's terms of reference are marked up at Annexes 2-6. The board is asked to approve these changes. There may be some movement of directors within some committees over the coming months, however the board is requested to delegate approve of those changes to the committees themselves.

Quality and Governance Reviews for ARAC and the Board

17. ARAC undertakes its annual quality and governance review in line with the National Audit Office (NAO) effectiveness toolkit.

18. During the next ARAC meeting members will have the opportunity to confirm and challenge the pre-completed questionnaire and discuss any areas identified by the sub-group.

19. In addition to this, the same survey will be conducted with ARAC based on the questions in paragraph 14 above.

20. It is proposed that the survey and the review undertaken by the Good Governance Institute, together with the resulting outputs, will constitute the board's quality and governance review for 2025/26.

RECOMMENDATION

21. The recommendation is as set out in the front cover above.

WAST BOARD COMMITTEE REMITS – 2026/27

Quality, Patient Experience and Safety Committee

QUEST related strategies/plans;
KPIs in remit (strategy and performance)
Safe Care, Equitable Care

- Duty of Quality and Duty of Candour
- QMS
- Health and Care Quality Standards
- Quality Impact Assessment
- Putting Things Right
- Safeguarding (including mental health and dementia)
- Infection prevention and control

Effective, Timely

- Clinical audit
- Mortality reviews
- Quality improvement
- Value based healthcare

Patient Centred

- Citizens voice/patient experience;

Learning across areas in remit
Clinical and quality governance
Clinical negligence & personal injury
Risks, audits, policies in remit

People and Culture Committee

PCC related strategies/plans
KPIs in remit (strategy and performance)
Culture:

- Speaking up safely
- Trust behaviours
- Health and wellbeing
- Partnership working (TUPs)
- Staff & volunteer experience
- Equality, diversity, and inclusion
- Health and safety

Capacity:

- Recruitment and retention
- Workforce plans

Capability:

- Staff development
- Leadership programmes
- Training and education
- Registration and revalidation

Risks, audits, policies in remit

Advisory Group (WASPT) reports to this Committee

Finance and Performance Committee

FPC related strategies/plans
Long term strategic direction
KPIs in remit (strategy and performance)
Finance:

- Capital and revenue monitoring
- Annual budgets
- Financial sustainability
- Business cases and PIRs

Commercial development/partnerships
Performance:

- Commissioners and WG targets
- MIQPR
- QPMF

Planning:

- IMTP endorsement and delivery
- Wellbeing objectives
- Demand and capacity

Infrastructure

- Estates and fleet
- Environment and sustainability

Digital:

- Systems
- Information governance
- Information security

Resilience:

- Major Incident Plan and Business Continuity Plan
- Cyber resilience & security

Risks, audits, policies in remit

Audit, Risk and Assurance Committee

Governance and assurance
Effective systems of

- Good governance
- Risk management and
- Internal control

Integrated Governance Programme
BAF
Annual Report
Audited financial accounts
Standing Orders and SFIs
Accounting policies
Assurance processes
Losses & special payments
Single tender actions
Internal audit
Audit Wales
Local Counter Fraud Service
Standards of business conduct
Patient's property
Policies in remit

Remuneration Committee

- Contractual arrangements for staff
- Appointment, termination, remuneration, terms of service and appraisal for Chief Executive; Executive Directors (including interim); Very Senior Managers
- Redundancy, VERs, Settlement settlements

Academic Partnerships Committee

- Research governance framework
- Research performance
- Risks, audits, policies in remit

Charity Committee

Charity strategy/plans
KPIs in remit (strategy and performance)
Charitable funds
Audited accounts/annual report
Fundraising
Approve bids over £5K, bursary over £3K
Risks, audits and policies in remit

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2025/26~~2026-27

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance 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 on its behalf by Committees*".

1.2. In line with Standing Orders, the Board shall nominate annually a Committee to be known as the Quality, Patient Experience and Safety Committee. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care Quality Standards 2023 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3. The Committee plays an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions.

2. PURPOSE

2.1. The Committee is responsible for scrutinising improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm.

2.2. The Committee will provide oversight of, and seek assurance on, statutory and regulatory compliance on areas within its remit.

2.3. 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.

2.4. 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.

2.5. 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

The Committee will:

Strategic Development and Delivery

3.1. Oversee and contribute to the development of the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

3.2. Consider the implications for quality, safety and equitable care in strategies and aligned plans.

3.3. Receive assurance on the implementation of strategies and plans within the remit of the Committee, with a particular focus on the impact of desired outcomes in those strategies and plans.

Safe Care, Equitable Care

3.4. Receive assurance on compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture.

3.5. Receive assurance that the Health and Care Quality Standards 2023 are embedded Trust wide with actions taken in relation to any identified non-compliance.

3.6. Receive assurance that there is a quality management system in place that ensures compliance with relevant standards and regulations, facilitates continuous improvements and processes, and enhances patient safety and patient experience.

3.7. Receive assurance that there is a process in place for quality impact assessments. Consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board.

3.8. Receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality safety, effectiveness and patient experience and seek assurance of the actions being taken by management to address these.

3.9. Receive assurance that the Trust is compliant with the Dementia Standards, Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.

3.10. Review the annual infection prevention and control plan and receive assurance on its implementation and the systems in place to ensure compliance with statutory and regulatory requirements for infection prevention and control.

3.11. Receive assurance that the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults.

3.12. Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration, and revalidation for staff.

3.13. Ensure that robust arrangements are in place for the review of patient safety incidents (to include near misses) to identify similarities or trends and areas for focused or organisation-wide learning.

3.14. Review and recommend to the Board the Trust's annual Duty of Candor and Quality Report(s) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.

3.15. Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.

Effective, Timely

3.16. Receive assurance that the care planned and provided across the breadth of the organisation's functions is evidence-based, clinically effective and quality driven and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.

3.17. Approve the Trust's clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit, Risk and Assurance Committee in this respect.

3.18. Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.

3.19. Receive assurance that there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation.

3.19.3.20. Receive assurance on delivery of core aims in relation to delivering value and development of value based healthcare in an out of hospital setting.

Patient Centred

3.20.3.21. Oversight of patient experience feedback, including themes, trends and learning, and approve the Patient Experience Plan on behalf of the Board.

3.21.3.22. Receive assurance that the organisation has a patient centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.

3.22.3.23. Receive assurance that the Patient Experience & Community Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt.

3.23.3.24. Receive assurance that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints, and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures.

3.24.3.25. Receive assurance that there is good collaborative team and partnership working to provide the best possible outcomes for its citizens.

3.25.3.26. Ensure any matters raised by the Executive Director of Quality & Nursing (including in their role as Caldicott Guardian), Executive Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully.

Risk and Audit

3.26.3.27. Oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the Committee.

~~3.27.~~3.28. Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation.

~~3.28.~~3.29. Receive and gain assurance from internal and external audits in their remit. The Committee will receive assurance that management actions to address recommendations are in place via the audit tracker and receive appropriate reporting as agreed by the Audit, Risk and Assurance Committee. This Committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations.

4. AUTHORITY

4.1. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

4.2. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

4.3. The Committee is authorised to approve Trust wide policies other than those policies reserved to the Board ~~in accordance with the policy for the Review, Development and Approval of Policies~~.

4.4. The Committee is authorised to approve the annual clinical audit plan.

Chair's Action

4.5. There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies

particularly given the current backlog.

4.6. In these circumstances, the Chair and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

4.7. 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

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

5. MEMBERSHIP AND QUORUM

5.1. The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around Committee membership. That includes that the designation of Chair, definition of member roles and powers, and terms and conditions of appointment are determined by the Board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as Committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2. The application of these provisions means that the designation of 'members' in NHS Wales Committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3. Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership.

Committee Membership

5.4. The Committee will comprise three Non-Executive Directors, one of whom will

be designated as Chair, and the following prescribed attendees:

- Executive Director of Quality and Nursing (Committee Lead)
- Executive Director of Paramedicine
- Executive Director of Operations
- Executive Director of Strategy, Planning and Performance
- Director of Digital Services
- Trade Union Partners (x 3)
- Chairs of Sub-Committees (where established)
- Director of Corporate Governance/Board Secretary

5.5. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

5.7. The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) to attend all or part of the meeting to assist with its discussions on any particular matter. The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

Quorum

5.8. The quorum for meetings of the Committee shall be two Non-Executive Directors.

5.9. While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore, other Non-Executive Directors of the Board may be co-opted to meetings where it is not possible for all three Non-Executive Directors to attend

Member Appointments

5.10. The membership of the Committee 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 Committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.11. Non-Executive Directors shall be appointed to hold office for a period of one year at a time, (membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

5.12. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

6. COMMITTEE MEETINGS

Secretariat and Support to Committee Members

6.1. The Director of Corporate Governance/Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
(b) ensure the provision of a programme of organisational development for Committee members, as part of the Trust's overall Board development programme.

Frequency of Meetings

6.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3. The Committee 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 any particular matter.

7. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

7.2. The Committee, through its Chair and members, shall work closely with the Board's other Committees and groups to provide advice and assurance to the Board through the:

(a) joint planning and co-ordination of Board and Committee business; and

(b) sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

7.3. The Committee will consider the assurance provided through the work of the Board's other Committees and sub-groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

7.4. The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1. The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes a written highlight report, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2. 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.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 6)

10. REVIEW

10.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

PEOPLE AND CULTURE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2025/26~~2026/27

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the board's behalf or to provide advice and assurance 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 on its behalf by committees*".

1.2. In line with Standing Orders, the board shall nominate annually a committee to be known as the People and Culture Committee. The detailed terms of reference and operating arrangements set by the board in respect of this committee are set out below.

1.3. The committee plays an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the board's behalf; and
- providing a forum where ideas can be explored in greater detail than board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the board on the issues within the committee's remit allow for more focused discussions.

2. PURPOSE

2.1. The purpose of the People and Culture Committee ('the committee') is to enable scrutiny and review of the Trust's arrangements for all matters pertaining to its workforce, both paid and volunteer, and organisational culture and behaviour to a level of depth and detail not possible in Board meetings. The Committee will provide assurance to the Board of the Trust's leadership arrangements; behaviours and culture; training, education and development; equality, diversity and inclusion; health, safety and welfare; people and culture related partnerships and engagement; the Welsh Ambulance Services Partnership Team (advisory group); and Welsh Language, in accordance with its stated objectives and the requirements and standards determined by the Welsh Government, the NHS in Wales and other regulatory bodies.

2.2. The Committee will provide evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to all matters relating to staff and staffing of the Trust.

2.3. 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.

2.4. 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.

2.5. 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

The Committee will, in respect of its role in providing advice and assurance to the Board:

Strategic Development and Delivery

3.1. Oversee and contribute to the development of the Trust's strategies and plans as they relate to people and culture and ensure they are aligned to the 2030 Delivering Excellence Long Term Plan.

3.2. Receive assurance on the implementation of strategies and plans within the remit of the committee, with a particular focus on the impact of desired outcomes in those strategies and plans.

3.3. Receive and consider projects of major strategic organisational change where there is a significant impact on our people's health and wellbeing, and cultural change.

Culture

3.4. Receive assurance that the Trust's behaviours are embedded, ensuring a continued journey of positive culture change.

3.5. Consider the experience of our people, including volunteers, and seek assurance of the effectiveness of mechanisms used for measuring, and for hearing and acting upon their experiences.

3.6. Receive assurance that there is a robust plan in place for the health and wellbeing of our people and monitor the effectiveness of arrangements in place to support and protect the mental, physical, and financial wellbeing of staff.

3.7. Receive assurance that Trust management and Trade Union Partners continue to develop and build a shared understanding and common purpose through formal and informal consultative partnership working to ensure the efficiency

and success of the Trust for the benefit of all. Review any partnership agreements with Trade Union Partners.

3.8. With respect to equality, diversity and inclusion the committee will:

(a) Oversee and contribute to the development of the Trust's equality, diversity and inclusion plan

(b) Receive assurance on its implementation and desired outcomes

(c) champion and support the plan and the work of the equality, diversity, and inclusion networks

(d) Receive assurance that there are effective arrangements are in place to meet the Welsh Language Standards and that the culture of Wales and the Welsh language is promoted within the Trust.

3.9. With respect to speaking up safely the committee will:

(a) Receive assurance that arrangements are in place to allow staff to raise concerns in confidence

(b) Ensure that those processes allow any such concerns to be investigated proportionately and independently

(c) Receive assurance that the learning from such concerns is considered and applied.

3.10. Receive assurance that the Trust has in place appropriate policies and procedures for its people and approve people and culture policies.

Capacity

3.11. Receive assurance on the development and implementation of the Trust's recruitment and retention plans, including those for volunteers.

3.12. Receive assurance that workforce and resourcing plans are fit for purpose and ensures the right resources and skills mix in the right place at the right time (both clinical and non-clinical)

Capability

~~3.13.~~ Ensure that the Trust has comprehensive leadership development and succession planning programmes in place to support leaders at all levels of the organisation and which is designed to reinforce the culture the Trust is

seeking to achieve.

3.13. Provide oversight of the Trust's approach to education, training, and development for all staff, ensuring programmes are comprehensive, accessible, and aligned with organisational priorities and values

3.14. Ensure the Trust maintains strong, collaborative relationships with its education partners, and ~~Receive~~ review and endorse the commissioning intentions for training and education through HEIW and other relevant bodies.~~s~~

3.15. Receive assurance that professional standards of registration and revalidation are maintained.

3.16. Advise the board on a set of key performance indicators (KPIs) for the responsibilities in its remit and monitor performance. These KPIs may include but not be limited to sickness absence, performance appraisal reviews, statutory and mandatory training, incidents of violence and aggression, disciplinaries and suspensions, turnover and recruitment; enabling deep dives to take place into specific areas of concern.

3.17. Ensure the Trust is discharging its statutory responsibilities, including but not limited to health and safety; equality, diversity, and inclusion; relevant Health and Care Quality Standards requirements; and that professional standards of registration and revalidation are maintained.

Risk and Audit

3.18. oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the committee.

3.19. Receive and gain assurance from internal and external audits in their remit. The committee will receive assurance that management actions to address recommendations are in place via the audit tracker and receive appropriate reporting as agreed by the Audit, Risk and Assurance Committee. This committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations.

4. AUTHORITY

4.1. The committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the committee.

4.2. The committee is authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

4.3. The committee is authorised to approve Trust wide policies other than those policies reserved to the Board~~in accordance with the policy for the Review, Development and Approval of Policies~~.

Chair's Action

4.4. There may, occasionally, be circumstances where decisions which would normally be made by the committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

4.5. In these circumstances, the Chair and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

4.6. 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

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

4.8. The Welsh Ambulance Services Partnership Team (WASPT) is an advisory group of the Board and was re-constituted in November 2022 following the pandemic. The Board has agreed that WASPT is a sub-committee of this Committee and as such reports regularly by way of a AAA highlight report. Similarly, issues raised are reported, and where necessary escalated, to the Board by way of this Committee's AAA highlight report.

5. MEMBERSHIP AND QUORUM

5.1. The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around committee membership. That includes that the designation of Chair, definition of member roles and powers and terms and conditions of appointment are determined by the board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2. The application of these provisions means that the designation of 'members' in NHS Wales committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3. Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership

Committee Membership

5.4. The committee will comprise four Non-Executive Directors, one of whom will be designated as Chair, and the following prescribed attendees:

- Director of People (Joint Executive Lead)
- Director of Cultural Change (Joint Executive Lead)
- Executive Director of Finance and Corporate Resources
- Executive Director of Operations
- Director of Partnerships and Engagement
- Executive Director of Paramedicine
- Deputy Director of Nursing, Quality and Governance

- Assistant Director of Planning and Transformation
- Freedom to Speak Up Guardian
- Trade Union Partners (x4)
- Chairs of Sub-Committees (or their nominee)
- Director of Corporate Governance/Board Secretary
- Head of Workforce Education and Development

5.5. In the absence of the committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

5.7. The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) to attend all or part of the meeting to assist with its discussions on any particular matter. The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

Quorum

5.8. The quorum for meetings of the committee shall be two Non-Executive Directors.

5.9. While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore, other Non-Executive Directors of the board may be co-opted to meetings where it is not possible for all three Non-Executive Directors to attend

Member Appointments

5.10. The membership of the Committee 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 committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.11. Non-Executive Directors shall be appointed to hold office for a period of one year at a time, (membership being reviewed by the Chairman of the board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the board.

5.12. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

6. COMMITTEE MEETINGS

Secretariat and Support to Committee Members

6.1. The Director of Corporate Governance/Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme.

Frequency of Meetings

6.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of board Business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3. The Committee 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 any particular matter.

7. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1. The Committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.2. The Committee, through its Chair and members, shall work closely with the board's other committees and groups to provide advice and assurance to the board through the:

(a) joint planning and co-ordination of board and Committee business; and

(b) sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall assurance framework.

7.3. The Committee will consider the assurance provided through the work of the board's other committees and sub-groups to meet its responsibilities for advising the board on the adequacy of the Trust's overall framework of assurance.

7.4. The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1. The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes a written highlight report, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2. 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.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 6)

10. REVIEW

10.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2025/26~~2026/27

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The board may and, where directed by the Welsh Government must, appoint committees of the Trust either to undertake specific functions on the board's behalf or to provide advice and assurance 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 on its behalf by committees*".

1.2. In line with Standing Orders the board shall nominate annually a committee to be known as the **Finance and Performance Committee** (the 'committee'). The detailed terms of reference and operating arrangements set by the board in respect of this committee are set out below.

1.3. committees play an important role in supporting the board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the board's behalf; and
- providing a forum where ideas can be explored in greater detail than board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the board on the issues within the committee's remit allow for more focused discussions by the board.

2. PURPOSE

The purpose of the Finance and Performance committee is to enable scrutiny and review of the Trust's arrangements in respect of the:

2.1 overall financial position (both capital and revenue) of the Trust and its compliance with statutory financial duties;

2.2 ability of the Trust to deliver on its core objectives as set out in the Integrated Medium Term Plan (IMTP);

2.3 monitoring of the IMTP and ensuring achievement of key milestones;

2.4 robustness of any cost improvement measures and delivery of key strategies and plans;

2.5 ensure development of the long term strategy and delivery of the Trust's strategic aims in relation to value and efficiency, including an increased focus on benchmarking;

2.6 scrutinise business cases for capital and other investment;

2.7 oversight of the development and implementation of the digital, estates, fleet, and environmental strategies; information governance and information security; and business continuity including emergency preparedness, resilience and response, cyber security, and cyber resilience.

2.8 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.

2.9 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.

2.10 In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this committee will adopting 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

With regard to its role in providing advice and assurance to the board, the committee will specifically:

Strategic Development and Delivery

Long Term Strategy

3.1 Oversee and contribute to the development of the Trust's long term strategic direction and make recommendations to the board for its approval, including any adjustments to the Trust's current long term strategy, Delivering Excellence: Our Vision for 2030.

3.2 Oversee and contribute to the development of the Trust's Integrated Medium Term Plan (IMTP) and ensure alignment of that plan to deliver the long-term strategy.

3.3 Monitor and review progress against the IMTP.

Long Term Plans

3.4 Oversee and contribute to the development of the long term plans associated with Delivering Excellence: Our Vision for 2030, including but not limited to:

- Estates plan
- Fleet plan

- Digital plan
- Environmental plan
- Commercial development plan
- Wellbeing objectives

3.5 Hold a central overview of all long term plans that align to the long term strategy. These plans will be reviewed for alignment by the relevant committee first and their implementation will be guided by the IMTP or relevant local directorate plans.

Finance

3.6 Oversee and contribute to the financial strategy, in relation to both revenue and capital.

3.7 Monitor the Trust's in-year and forecast revenue financial position against budget and review and make appropriate recommendations for corrective action where required.

3.8 Monitor progress against the Trust's capital programmes including for estates, fleet and digital

3.9 Receive, review and ensure mitigation of financial risks of delivery of plans;

3.10 Review progress against the Trust's annual operating framework and make recommendations to the board in relation to development of the annual financial plan and budget setting and financial strategy, financial sustainability programmes, efficiency review implementation and required savings targets.

3.11 Review performance against the relevant Welsh Government financial requirements.

3.12 In accordance with the Scheme of Reservation and Delegation:
- Review all business cases and contract awards for approval by the board and
- Consider whether post implementation evaluations of the above will return for key learning points.

Commercial

3.13 Receive assurance on the development of commercial partnerships and the Trust's commercial framework when developed.

~~**Value Based Healthcare**~~

~~3.14 Receive assurance on delivery of core aims in relation to delivering value and development of value based health care in an out of hospital setting.~~

Performance

~~3.15~~3.14 Review performance against targets and standards set by Commissioners and/or Welsh Government for the Trust and, where appropriate, against national ambulance quality indicators.

~~3.16~~3.15 Review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework.

~~3.17~~3.16 Endorse (and recommend to the board) and monitor progress and ensure the development of robust intelligent targets against:

- Board level key performance indicators (KPIs) in the Monthly Integrated Quality and Performance Report (MIQPR).
- KPIs reporting outside of the MIQPR including digital systems and information governance and information security

~~3.18~~3.17 Monitor and review plans to recover areas of underperformance, reviewing where appropriate associated KPIs as part of any deep dives, and providing assurance to the board and escalating to the board or a relevant committee as required.

Planning

~~3.19~~3.18 Monitor the effectiveness of commissioning arrangements.

~~3.20~~3.19 Review and consider matters relating to demand and capacity including proposals for reviews in this area and recommendations arising from such reviews.

Infrastructure

3.213.20 Review proposals for acquisition, disposal, and change of use of land/buildings.

3.223.21 Receive assurance on compliance with environmental regulations and national targets in relation to the environment and sustainability.

3.233.22 Receive assurance on compliance with fire safety and waste regulations.

Business Continuity and Cyber

3.243.23 Oversight and scrutiny of the Major Incident Plan and Business Continuity Plan and receive assurance that such plans are effective.

3.253.24 Oversight and scrutiny of cyber resilience including assurance on awareness and training of WAST staff and volunteers; maintenance of upgrades/updates of systems, and replacement of legacy/high-risk systems.

3.263.25 Oversight and scrutiny of cyber security including assurance of regular monitoring of risks and threats, business continuity planning and engagement with national cyber centres and stakeholders.

Information Governance and Information Security

3.273.26 Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety, and security of information to support the delivery of high quality, safe healthcare across the organisation.

3.283.27 Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.

3.293.28 Receive assurance on, and review effectiveness of the Trust's information security protocols.

3.303.29 Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.

Policies

~~3.31~~3.30 Approval of policies within the remit of the committee

Risk and Audit

~~3.32~~3.31 Oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the committee.

~~3.33~~3.32 Receive and gain assurance from internal and external audits in their remit. The committee will receive assurance that management actions to address recommendations are in place via the audit tracker and receive appropriate reporting as agreed by the Audit, Risk and Assurance committee. This committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations.

4. AUTHORITY

4.1 The committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the committee.

4.2 The committee is authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

4.3 The committee is authorised to approve Trust wide policies other than those policies reserved to the Board~~in accordance with the policy for the Review, Development and Approval of Policies~~.

Chair's Action

4.4 There may, occasionally, be circumstances where decisions which would normally be made by the committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

4.5 In these circumstances, the Chair, and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the committee after first consulting with at least two other Members (Non-Executive Directors).

4.6 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.

4.7 **Sub-committees**
The committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of committee business. Formal sub-committees may only be established with the agreement of the board.

5. MEMBERSHIP AND QUORUM

5.1 The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around committee membership. That includes that the designation of Chair, definition of member roles and powers and terms and conditions of appointment are determined by the board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2 The application of these provisions means that the designation of 'members' in NHS Wales committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3 Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership.

Committee Membership

5.4 The will comprise three Non-Executive Directors, one of whom will be designated as Chair, and the following prescribed attendees :

- Executive Director of Finance and Corporate Resources (Joint committee Lead)
- Executive Director of Strategy, Planning and Performance (Joint committee Lead)
- Executive Director of Operations
- Executive Director of Quality and Nursing
- Director of People
- Director of Digital
- Trade Union Partners (x 2)
- Director of Corporate Governance/Board Secretary
- Head of Commercial (when appointed)
- Chairs of Sub-committees (if any)

5.5 In the absence of the committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6 Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

5.7 The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) attend all or part of the meeting to assist with its discussions on any particular matter. The Committee

may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

Quorum

5.8 The quorum for meetings of the committee shall be two Non-Executive Directors.

5.9 While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore, other Non-Executive Directors of the board may be co-opted to meetings where it is not possible for all three Non-Executive Directors to attend.

Member Appointments

5.10 The membership of the committee 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 committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.11 Non-Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the board.

5.12 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration committee.

6. COMMITTEE MEETINGS

Secretariat and Support to committee Members

6.1 The Director of Corporate Governance/Board Secretary, on behalf of the committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

Frequency of Meetings

6.2 Meetings shall be held bi-monthly or otherwise as the Chair of the committee deems necessary, consistent with the Trust's annual plan of board business. Meeting agendas, papers and minutes shall be circulated no less than seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3 The committee 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 any particular matter.

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1 The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.2 The committee, through its Chair and members, shall work closely with the board's other committees and groups to provide advice and assurance to the board through the:

- joint planning and co-ordination of board and committee business; and
- sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall assurance framework.

7.3 The committee will consider the assurance provided through the work of the board's other committees and sub-groups to meet its responsibilities for advising the board on the adequacy of the Trust's overall framework of assurance.

7.4 The committee shall embed the Trust's corporate standards, priorities, and requirements, e.g. equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The committee Chair shall:

(a) report formally, regularly and on a timely basis to the board and the Chief Executive (Accountable Officer) on the committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports where appropriate throughout the year;

(b) bring to the board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2 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.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in the Trust’s Standing Orders are equally applicable to the operation of the committee, except in the following areas:

- Quorum (as set out in section 5)

10. REVIEW

10.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

REMUNERATION COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS
~~2025/26~~2026/27

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The board may and, where directed by the Welsh Government must, appoint committees of the Trust either to undertake specific functions on the board's behalf or to provide advice and assurance 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 on its behalf by committees*".

1.2. In line with Standing Orders, the board shall nominate annually a committee to be known as the **Remuneration Committee**. The detailed terms of reference and operating arrangements set by the board in respect of this committee are set out below.

1.3. The board committees play an important role in supporting the board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the board's behalf; and
- providing a forum where ideas can be explored in greater detail than board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the board on the issues within the committee's remit allow for more focused discussions.

2. PURPOSE

The purpose of the Remuneration Committee (the committee) is to:

2.1. Approve on behalf of the board matters relating to the appointment, termination, remuneration, terms of service and appraisal for the Chief Executive, Executive Directors, and other senior staff (including Interim Director roles) within the framework set by the Welsh Government and in accordance with the Standing Orders; and

2.2. Approve proposals regarding termination arrangements, including those under the Voluntary Early Release Scheme, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.

2.3. Provide assurance to the board in relation to the Trust's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.

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 POWERS AND AUTHORITY

The committee will support the board with regard to its responsibilities for remuneration and terms of service and will:

3.1. Provide assurance to the board in relation to the Trust's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales. The committee will review the annual Remuneration Report and approve its contents, by way of email circulation where necessary.

3.2. Approve the remuneration and terms of service for the Chief Executive, Executive Directors, and other Very Senior Managers (VSMs) not covered by Agenda for Change, ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government, are applied consistently.

3.3. Approve the appointment of the Chief Executive and Executive Directors (officer members of the board) and where applicable, interim appointments to those roles.

3.4. Terminate appointments and suspend officer members in accordance with the provision of regulations.

3.5. Consider the annual objectives and outturn position for the Chief Executive Officer and receive assurance on cascading of those objectives to the Executive Leadership Team.

3.6. Approve the appointment, appraisal, discipline and dismissal of any other board level appointments (including where applicable, interim appointments to these roles) and other senior employees, in accordance with Welsh

Government Ministerial instructions, e.g., the Director of Corporate Governance/Board Secretary.

3.7. Consider and approve redundancy and Voluntary Early Release (VERs) applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.

3.8. Approve proposals for novel employment and pay cases, such as settlement agreements, overtime payments, and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

Risk and Audit

3.9. The committee will monitor the principal risks relevant to its remit and consider the control and mitigation of high level related risks and provide assurance to the board that such risks are being effectively controlled and managed. It will also review any audits relevant to its remit.

4. AUTHORITY

4.1. The committee is authorised to approve those matters listed above.

4.2. The committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the committee.

4.3. The committee is authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

Chair's Action

4.4. There may, occasionally, be circumstances where decisions which would normally be made by the committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the committee. This is

most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

4.5. In these circumstances, the Chair, and the Lead Executive (Director of People and Culture), supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the committee after first consulting with at least two other Members (Non-Executive Directors).

4.6. 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

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

5. MEMBERSHIP AND QUORUM

5.1. The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around committee membership. That includes that the designation of Chair, definition of member roles and powers and terms and conditions of appointment are determined by the board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2. The application of these provisions means that the designation of 'members' in NHS Wales committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3. Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership.

Committee Membership

5.4. The committee will comprise of the Trust Board Chair and all Non-Executive Directors including the Audit, Risk and Assurance Committee Chair, and the following prescribed attendees

- Chief Executive
- Director of People (Committee Lead)
- Director of Corporate Governance/Board Secretary
- Trade Union Partner (x2)

Depending upon the sensitivities being discussed, the Chair may request that core attendees are not in attendance.

5.5. The committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter. In particular, the Executive Director of Finance and Corporate Resources may be asked to attend where VERS or other settlement applications are being considered.

5.6. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

Quorum

5.7. At least three members of the committee must be present to achieve a quorum. In the absence of the committee Chair, one of those in attendance must be designated as Chair of the meeting.

Member Appointments

5.8. The membership of the committee 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 committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.9. Non-Executive Directors shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the board on

an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the board.

5.10. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

6. COMMITTEE MEETINGS

Secretariat and Support to Committee Members

6.1. The Director of Corporate Governance/Board Secretary, on behalf of the committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme.

Frequency of Meetings

6.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the committee deems necessary, consistent with the Trust's annual plan of board Business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3. The committee 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 any particular matter.

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1. The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.2. The committee, through its Chair and members, shall work closely with the board's other committees and groups to provide advice and assurance to the board through the:

(a) Joint planning and co-ordination of board and committee business; and
(b) Sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall assurance framework.

7.3. The committee will consider the assurance provided through the work of the board's other committees and subgroups to meet its responsibilities for advising the board on the adequacy of the Trust's overall framework of assurance.

7.4. The committee shall embed the Trust's corporate standards, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1. The committee Chair shall:

(a) report formally, regularly and on a timely basis to the board and the Chief Executive (Accountable Officer) on the committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports where appropriate throughout the year, while retaining discretion to limit or delay reporting if the matters discussed are particularly sensitive.;
(b) bring to the board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the committee; and
(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2. 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.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the committee, except in the following areas:

- Quorum (as set out in section 5)
- The committee meets in private due to the sensitivity of its deliberations.

10. REVIEW

10.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

ACADEMIC PARTNERSHIP COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2024-25~~2026-27

1. INTRODUCTION

1.1 The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance 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 on its behalf by committees*".

1.2 In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the Academic Partnership Committee.

1.3 The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

1.4 The Trust has made a commitment to recognise the importance of partnership working with a full range of academic partners and has established an Academic Partnership Committee to facilitate and develop this work and its

remit is hereby set out in these formal terms of reference and operating arrangements.

2. PURPOSE

~~2.1 The delegated powers and authority set out in these terms of reference reflects the maturing University Trust Status (UTS) journey and the fact that this committee approaches its remit with a mixture of *scrutiny* (particularly with respect to refreshed UTS priorities, obtaining and maintaining UTS status), *partnering* (ensuring the right partners are on the Committee, that appropriate arrangements are in place with partners), *connecting* (existing and new partners to research/programmes of work in WAST), and *inquisitorial* (drilling down into elements of the priorities and other programmes where we are partnering with academic and industry to foster and promote).~~

~~2.2~~2.1 The Committee recognises the wealth of knowledge, expertise and skill within the Trust, as well as the need to ensure that skill and expertise is maintained at the forefront of clinical and professional excellence. It will ensure that its work is not predicated just on the development and support of clinical staff but, rather, of everyone across the organisation, whether they be in a clinical, professional, or corporate role.

~~2.3 The Committee will Facilitate a forward-looking organisational culture with partners which:~~
~~(a) promotes quality improvement across all activities;~~
~~(b) is rich in educational activities and staff development opportunities;~~
~~(c) helps attract and retain the very best staff, including internationally leading clinical academics;~~
~~(d) facilitates research, grant capture by clinicians and academics and the translation of evidence research findings into practice;~~
~~(e) encourages innovation and modernisation;~~
~~(f) encourages multi-disciplinary work and access to new and emergent fields of research and evidence based practice;~~
~~(g) builds capacity for translational research that allows all parties to compete at an international level;~~

(h) integrates education, research and practice that looks beyond targets and entrenched ways of working, fostering a culture of learning and innovation based on evidence and best practice;
(i) facilitates wealth and economic growth in the region and beyond;
(j) supports the capture and analysis of the service user experience;
(k) develops health informatics opportunities to achieve their potential;
(l) Supports strategic planned lines of enquiry enabling knowledge creation.
(m)use of digital technology to enhance our services.

2.42.2 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.

2.52.3 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.

3. DELEGATED POWERS AND AUTHORITY

The committee will support the board with regardWith regard to its role in providing advice and assurance to the Board, the Committee will:to the following:

3.1 Promote and support the exploration of opportunities with higher and further education, wider education providers and commercial partners across and beyond Wales to:

~~(a) develop collaborative activities in relation to clinical and non-clinical services, research, and development, teaching and education, innovation and improvement, and commercial opportunities; and~~
~~(b) influence programme design.~~

~~3.2 Promote and support collaboration with key partners in health, social care, local authorities, and the third sector, as well as patients and patient representative groups, developing opportunities for widening access and increasing participation in health and social care education amongst local communities.~~

~~3.3 Ensure appropriate arrangements are in place with partner organisations that establishes role, responsibilities, and expectations, and supports the achievement of the highest standards of health, clinical care, research, innovation, and health care education. Depending on the nature of the projects the risk to the parties should be understood and the appropriate mitigated action taken.~~

~~3.4 Oversee and contribute to the development of submissions to Welsh Government for University Trust Status and ensure the ongoing maintenance of that status and compliance with any conditions from Welsh Government.~~

~~3.5 Review and agree programmes of work aligned to University Trust Status, ensuring that they:~~

~~(a) explore and identify opportunities for the development of the whole workforce;~~
~~(b) are appropriately resourced, and where possible maximise the benefits of shared resources and expertise, and availability of grants;~~
~~(c) are clear where Board level scrutiny will take place, whether that is at this Committee or another Board Committee, to avoid duplication and support coalescence of Board oversight.~~

3.1 Oversee ~~To over~~ the strategic direction and development of research and innovation activities within the Trust, and to oversee the implementation of the research governance framework in accordance with the Health and Care Research Wales Research Governance Framework.

3.63.2 Monitor plans to build capacity for the whole workforce whether they be in a clinical, professional, or corporate role, to participate in research; that opportunities to do so are being promoted; and that the workforce is encouraged to be professionally inquisitive.

3.7 Oversee the implementation of the research governance framework in accordance with the Health and Care Research Wales Research Governance Framework.

Principal Risks and Audits

3.83.3 The Committee will monitor the principal risks relevant to its remit. It will consider the controls and mitigations of related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

3.93.4 The Committee will receiveReceive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.

4. AUTHORITY

Authority

4.1 The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

4.2 The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

4.3 The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies. other than those policies reserved to the Board.

Chair's Action

4.4 There may, occasionally, be circumstances where decisions which would normally be made by the committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

4.5 In these circumstances, the Chair, and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the committee after first consulting with at least two other Members (Non-Executive Directors).

4.6 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.

There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

4.3 In these circumstances, the Chair and the Lead Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

4.4 The 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 The committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of committee business. Formal sub-

committees may only be established with the agreement of the board. ~~The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business.~~

~~4.~~5. MEMBERSHIP AND QUORUM

~~**Members**~~

5.1. The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around committee membership. That includes that the designation of Chair, definition of member roles and powers and terms and conditions of appointment are determined by the board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2. The application of these provisions means that the designation of 'members' in NHS Wales committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3. Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership.

Committee Membership

5.4 The ~~core membership is a minimum of three members comprising:~~ membership of the committee will comprise:

Members:

- ~~Chair Non-Executive Director~~
- ~~Members Two other Non-Executive Directors of the Board.~~ Three Non-Executive Directors one of whom will be designated as Chair

Prescribed attendees:

Prescribed Attendees

4.2 The core membership will be supported by the attendance of the following at each meeting: -

- Director of Partnerships and Engagement (Committee Lead)
- Director of People and Culture
- Executive Director of Paramedicine
- Director of Digital Services
- Assistant Director for Quality and Nursing (Quality Governance)Deputy Director of Remote Clinical Care
- Assistant Director of Clinical Development
- Assistant Director of Research and Innovation
- Head of Strategy Development
- Head of Workforce Education & Development
- Director of Corporate Governance/Board Secretary
- Up to two Trade Union Partners

5.5 In the absence of the committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6 Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

5.7 The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) attend all or part of the meeting to assist with its discussions on any particular matter. The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

Other Directors and staff members will be invited to attend, either by the

~~Committee or to present individual reports.~~

~~With the permission of the Chair, those in attendance may send a deputy in their place. This, however, does not affect the right of the Chair to require those listed above to attend.~~

~~The Committee may also co-opt additional 'external' invitees from outside the organisation to provide specialist skills, knowledge and expertise.~~

~~Secretariat~~

~~4.3 Secretary as determined by the Board Secretary~~

Quorum

5.8 The quorum for meetings of the committee shall be two Non-Executive Directors.

5.9 While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore, other Non-Executive Directors of the board may be co-opted to meetings where it is not possible for all three Non-Executive Directors to attend.

Member Appointments

5.10 The membership of the committee 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 committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.11 Non-Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the board.

5.12 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration committee.

~~4.4 The membership of the Committee 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 committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.~~

~~4.5 Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board. The Board should consider rotating a proportion of the Committee's membership after three or four years' service so as to ensure the Committee is continuously refreshed whilst maintaining continuity.~~

~~4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.~~

~~4.7 Should any Non-Executive Director on the Board be unable to attend a meeting of a Committee the member may consider appointing a substitute member to attend the meeting in his/her place. The substitute member will assume, upon appointment, full delegated responsibility on behalf of the substituted member and will be eligible to vote, as necessary on any matter before the Committee and will be counted as part of the quorum for that meeting. To instigate a substitution arrangement, the member of the Committee must notify the Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.~~

~~Support to Committee Members~~

~~4.8 The Board Secretary, on behalf of the Committee Chair shall arrange for the provision of advice and support to committee members on any aspect related~~

~~to the conduct of their role.~~

~~5.~~6. COMMITTEE MEETINGS

Secretariat and Support to committee Members

6.1 The Director of Corporate Governance/Board Secretary, on behalf of the committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

Frequency of Meetings

6.2 Meetings shall be held bi-monthly or otherwise as the Chair of the committee deems necessary, consistent with the Trust's annual plan of board business. Meeting agendas, papers and minutes shall be circulated no less than seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3 The committee 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 any particular matter.

~~Quorum~~

~~5.1 At least two core members must be present to ensure the quorum of the committee, one of whom should be the committee Chair or Vice Chair.~~

~~Frequency of Meetings~~

~~5.2 Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business.~~

~~**Withdrawal of individuals in attendance**~~

~~5.3 The Committee 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 any particular matter.~~

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1 The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.2 The committee, through its Chair and members, shall work closely with the board's other committees and groups to provide advice and assurance to the board through the:

- joint planning and co-ordination of board and committee business; and
- sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall assurance framework.

7.3 The committee will consider the assurance provided through the work of the board's other committees and sub-groups to meet its responsibilities for advising the board on the adequacy of the Trust's overall framework of assurance.

7.4 The committee shall embed the Trust's corporate standards, priorities, and requirements, e.g. equality and human rights through the conduct of its business.

~~6.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.~~

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of appropriate information;

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

6.3 The Committee shall embed the Trust's corporate standards, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

6.8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The cCommittee Chair shall:

(a) report formally, regularly and on a timely basis to the board and the Chief Executive (Accountable Officer) on the committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports where appropriate throughout the year;

(b) bring to the board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

(a) report formally to each Board meeting (as appropriate) on the Committee's activities, in a manner agreed by the Board. This includes a written highlight report, the submission of approved Committee minutes,

(b) bring to the Board's specific attention any significant matter under consideration by the Committee; and
ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (as Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the presentation of an annual report, operation and/or reputation of the Trust.

7.2

8.2 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.

The 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.

7.9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum – (as set out in section 5)

8.10. REVIEW

910.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

Agenda Item No.	16

REPORT TITLE

Governance Report – January 2026 including:
Board and Committee Calendar 2026/27, 2027/28

MEETING

Name of meeting	Trust Board
Date of meeting	29 January 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	Alex Payne, Corporate Governance Manager

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report sets out where applicable the **Chair's Action's** taken since the last Board meeting and corresponding ratifications required**, use of the Trust Seal**, **decisions made in private session and any other governance matters**. There have been no decisions made by Chair's Action since the last meeting of the Trust Board, nor has there been any use of the Trust Seal to report.

2. **Trust Seal application approvals:**

2.1 The Trust Board is asked to approve the application of the Trust Seal on each of the documents relating to the following transactions. It is noted that the Trust Board is asked to approve the application of the Trust Seal *only*:

2.1.1 Approval *of the application of the Trust Seal* on the Lease Agreement relating to **Unit 15, Aberaman Park Industrial Estate,** Aberdare between the Welsh Ambulance Services University NHS Trust and CIP Threadneedle UK Property Nominee No 1 Limited AND CIP Threadneedle UK Property Nominee No 2 Limited.

2.1.2 Approval *of the application of the Trust Seal* on the Lease Agreement for the contract for sale of leasehold land with vacant possession, **Unit 25, Samlet Road, Swansea Enterprise Park**, Swansea, SA7 9AF between Velindre University National Health Service and the Welsh Ambulance Services University NHS Trust.

2.1.3 Approval *of the application of the Trust Seal* on the Lease Agreement **AND** on the related Deed of Surrender of Lease relating to **Unit 8 Cyfarthfa Industrial Estate,** Merthyr Tydfil, CF47 8PE between Vennercrest Limited and the Welsh Ambulance Services University NHS Trust.

2.1.4 Approval *of the application of the Trust Seal* on the Counterpart Lease relating to premises at **Units 32 and 33 Gelli Industrial Estate** between United UK PROPCO 2 Ltd and between the Welsh Ambulance Services University NHS Trust.

Decisions in Private Session

3. The decisions made in private at the closed board meeting on 27 November 2025 were: -
3.1 The approval of the Vehicle Procurement Business Justification Case for 2026/27;
3.2 The approval of a contract for a passenger transport system for Ambulance Care.

2026/27 and 2027/28 Board and Committee Calendar

4. Standing Orders require that the Board approves its annual plan of Board business by March each year. The 2026/27 and 2027/28 calendar has been presented in Annex 1 for consideration and approval.

5. The placement of board and committee meetings follows the same placement as in previous years, with the Trust Board and Board Development meetings being on the last Thursday of the month they are held in, for example. The placement of all of the other meetings is detailed within Annex 1.

6. The only material change to the meeting arrangements is in response to the 2025/26 committee effectiveness reviews, which is that the Academic Partnership Committee is scheduled to have two meetings during 2026/27 as opposed to four. All other practical considerations are in line with 2025/26.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Board is requested to:

1. Receive and note the report;
2. Approve the application of the Trust Seal for the five requests detailed;
3. Approve the 2026/27 and 2027/28 Board and Committee Calendar.

ADDITIONAL PAPER(S)

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

Annex 1 Board and Committee dates 2026/27-27/28

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

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
29 January 2026	Trust Board

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

Annex 1: Proposed Board and Committee Dates for 2026-27 and 2027-28

		2026/27								2027/28						
Meeting	**Frequency**	**Mtg 1**	**Mtg 2**	**Mtg 3**	**Mtg 4**	**Mtg 5**	**Mtg 6**	**Mtg 7**		**Mtg 1**	**Mtg 2**	**Mtg 3**	**Mtg 4**	**Mtg 5**	**Mtg 6**	**Mtg 7**
Trust Board	Bi-monthly	28-May-26	25-Jun-26	30-Jul-26	24-Sep-26	26-Nov-26	28-Jan-27	25-Mar-27		27-May-27	24-Jun-27	29-Jul-27	30-Sep-27	25-Nov-27	27-Jan-28	30-Mar-28
Board Development	Bi-monthly	30-Apr-26	25-Jun-26	29-Oct-26	17-Dec-26	25-Feb-27				29-Apr-27	24-Jun-27	28-Oct-27	16-Dec-27	24-Feb-28		
Corporate Trustee	Bi-annually	28-May-26	30-Jul-26	26-Nov-26	28-Jan-27					27-May-27	24-Jun-27	29-Jul-27	25-Nov-27	27-Jan-28		
Charity Committee	Quarterly	02-Apr-26	02-Jul-26	01-Oct-26	14-Jan-27					01-Apr-27	05-Jul-27	07-Oct-27	13-Jan-28			
Academic Partnership Committee	3 per annum	06-Mar-26	08-Sep-26							09-Mar-27						
People and Culture Committee	Quarterly	05-May-26	11-Aug-26	10-Nov-26	09-Feb-27					11-May-27	10-Aug-27	10-Nov-27	08-Feb-28			
Quality Patient Experience & Safety Committee	Quarterly	07-May-26	06-Aug-26	05-Nov-26	04-Feb-27					06-May-27	05-Aug-27	04-Nov-27	03-Feb-28			
Finance and Performance Committee	Bi-monthly	19-May-26	21-Jul-26	15-Sep-26	17-Nov-26	19-Jan-27	16-Mar-27			18-May-27	20-Jul-27	21-Sep-26	16-Nov-27	17-Feb-28	21-Mar-28	
Remuneration Committee	4 p/a	09-Jun-26	08-Oct-26	01-Dec-26	02-Mar-27					03-Jun-27	05-Oct-27	09-Dec-27	03-Mar-28			
Audit, Risk and Assurance Committee	5 p/a	28-Apr-26	23-Jun-26	03-Sep-26	03-Dec-26	04-Mar-27				27-Apr-27	22-Jun-27	02-Sep-27	02-Dec-27	02-Mar-28		
WASPT	Bi-monthly	21-Apr-26	18-Jun-26	20-Aug-26	22-Oct-26	08-Dec-26	18-Feb-27			22-Apr-27	17-Jun-27	19-Aug-27	21-Oct-27	07-Dec-27	17-Feb-28	
Annual General Meeting	Annually	30-Jul-26								29-Jul-27						

*Extraordinary Trust Board meetings have been scheduled in June 2027 and 2028 with the June Board Development Days, to approve the respective financial years' annual report and accounts.
* The Trust Annual General Meeting has been programmed for the same day as Trust Board in July of 2026 and 2027, respectively.

AUDIT, RISK AND ASSURANCE COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. The papers for these meetings can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	29 January 2026
Committee Meeting Date	2 December 2025
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS
ALERT (Alert the Board to areas of attention)
1. The **2025 (core) Structured Assessment** was presented at this meeting and will also be presented to the board at its January meeting. The committee expressed strong assurance and satisfaction with the structured assessment, noting the positive findings and minimal recommendations. Members expressed confidence in the ongoing improvement trajectory.
ADVISE (Detail any areas of on-going monitoring, approvals, or new developments to be communicated)
2. A **pre-meeting** was held with Audit Wales, Internal Audit and the committee Chair ahead of the meeting. 3. Members **reflected** that, despite technical issues and more members joining online than in person, it was a good meeting. The papers, presentations and scrutiny were excellent.
ASSURE (Detail here any areas of assurance the Committee has received)
4. Members supported the direction of travel presented in the **Quality Governance Review for 2025/26** endorsing all seven recommendations described in the preferred option one. They noted the further recommendation to defer material changes pending the externally facilitated board effectiveness review. A separate paper will be presented to the Board on this matter at the January meeting. The committee also endorsed the terms of reference for the People and Culture, the Finance and Performance, and the Quality Patient Experience and Safety Committees. These will be attached to the stand-alone paper for board approval in January.

5. **Audit Wales** updated the committee on progress, including:

   - The Independent Examination of the Charity's annual report and accounts is due to start in December with the intention of certifying and filing by the Charity Commission deadline of 31 January.

   - Part three of the Review of Unscheduled Care (national arrangements and leadership structures) has experienced a delay and is being drafted. Members were assured this will be available at the March 2026 meeting.

   - The non-core Structed Assessment - Deeper Dive Review of Digital Transformation - is also at the drafting stage, with its presentation due at that March 2026 meeting.

   - The National Fraud Initiative (NFI) 2024/25 is underway. This biennial UK-wide counter-fraud exercise helps prevent and detect fraud by electronically sharing and matching data sets. Members were assured that WAST actively engages with the NFI, reviewing matches on a risk basis despite limited resources and no fraud cases found in recent years. Further assurances on credit and cyber fraud related matches were received.

6. **Internal Audit** reported steady progress against the 2025/26 plan with most KPIs showing as green; including report turnaround by management. Whilst a couple of reports have slipped there is confidence that the audit plan will be completed by June. The follow-up review of internal audit recommendations that is usually held in Q4 is now taking place throughout the year, and good progress was noted with appropriate closure of recommendations.

7. The following **Internal Audit** reviews were completed during the quarter and presented to the Committee. Members reviewed the action plans that accompanied the audits and were assured they were appropriate and timely.

   - **Mandatory In-Service Training (MIST) – Reasonable Assurance**. The purpose of this review was to evaluate the impact and effectiveness of the new MIST days. The focus was on how well these arrangements support compliance with statutory and mandatory training requirements.

     The committee welcomed the audit and accepted the findings, with management actions underway and timelines considered realistic given current resource constraints. The committee was broadly assured but noted concerns about the length of time required to close some actions, particularly those dependent on digital resources and the training needs analysis. It was confirmed that statutory compliance targets are being met, and the main risk relates to individuals with significant non-compliance, not the organisation overall. The committee highlighted the need for improved communication of guidance to staff and for robust assurance on the quality of on-the-job learning. Digital resource constraints and recruitment challenges were acknowledged, with ongoing efforts to mitigate these through automation and transparency.

     The People and Culture Committee will review this alongside the usual mandatory training compliance KPIs at its January meeting.

- **Clinical Equipment – Reasonable Assurance**. The purpose of this review was to evaluate the effectiveness of the arrangements put in place to record, monitor and replace clinical equipment within the Trust. For this review, the focus was on portable clinical equipment used in patient care and transport. Members heard that significant improvements have been noted in relation to the health and safety concerns that were raised in a similar 2019 limited assurance audit, as well as improvements regarding acceptance testing and the maintenance records held.

  The committee was assured that actions to address overdue WAST defibrillator servicing are underway and that overdue devices are not concentrated in any one area. The feasibility study for RFID tagging is in progress and will support improved asset tracking.

  The Quality, Patient Experience and Safety Committee will review this at its January meeting.

- **Integrated Medium Term Plan (IMTP) Development Process – Substantial Assurance**. This was a review of the process undertaken for the development of the IMTP, including the mechanisms to identify priorities, engagement with stakeholders and alignment to national criteria.

  Members highlighted that the lack of a formal forum for joint strategic planning with Health Boards and partners limits system-wide strategic vision. While more engagement is planned, there is no immediate solution for the next financial year. Early engagement and cross-checking of priorities are being pursued. The committee agreed to continue advocating for better partnership working, with future national programmes potentially offering improved collaboration. The Finance and Performance Committee reviewed this audit at its November meeting.

8. There has been slippage in the 2025/26 policy work programme, with several policies deferred and 29 still outstanding for quarters 3 and 4, making year-end completion unlikely. With just under 54% of policies within review date, a further update is needed in March. Members welcomed the planned policy transformation programme for 2026/27, which aims to streamline processes.

9. The Losses and Special Payments were reviewed for the period from 01 April – 31 October 2025 and noted as being -£1.918 million. This relates to actual payments made, less the reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the provision.

10. The committee reviewed the Q2 2025/26 Audit Tracker and were assured that a positive audit culture is developing, with more audits closed on their original date, reflecting more realistic timelines. Directors or deputies confirmed that the seven audit actions on their final deadlines are achievable and that associated risks are not increasing.

11. The committee's cycle of business monitoring report was reviewed with no matters to escalate.

12. In private session the Committee received the **local counter fraud** update and the **tender update** and single tender awards. Of note for the board:

    - There were 10 investigations closed in this period (11 last quarter), with nine new referrals having been received (seven last quarter).
    - A recent Counter Fraud Awareness Survey found that while over 95 percent of staff are aware of Local Counter Fraud Specialists and know where to find policies, only 62 percent are confident about reporting suspected fraud, with some uncertainty about reporting channels. Fewer than half received training or communications in the past year, though those who did reported increased

awareness. Regular updates and clearer communications, featuring WAST specific examples, especially via Siren and online platforms, will be introduced to improve engagement.

- Members were provided with an overview of the new corporate offence of the failure to prevent fraud under the Economic Crime and Corporate Transparency Act 2023. The Act creates an offence where the Trust may be criminally liable where an employee or agent commits fraud intending to benefit the Trust when there are no reasonable fraud prevention procedures in place. Members were assured that measures were in place in line with the Counter Fraud Standards, although options to enhance diligence will still be considered
- Ten new tenders were issues during the reporting period 1 August to 31 October 2025 and 13 awarded. There was one request to waive Standing Financial Instructions related to continuing with an existing supplier for business continuity purposes.

RISK MANAGEMENT

13. Members were assured in respect of the Trust's principal risks with no material changes this period. In private session, Members received assurance on the details of Risk 620 and Risk 260 noting that there were no material changes during this period.
14. Members welcomed the seven risk appetite statements approved by the board, noting the implementation and embedding principles will be included in next year's work program along with options for a digital risk platform and a specific focus on the impact of actions on risk scores.

COMMITTEE AGENDA FOR MEETING IN DECEMBER 2025		
Internal Audit: - Progress report - MIST audit report - Clinical equipment audit report - IMTP development process audit report	Audit Wales: - Update report - Structured Assessment 2025 - National Fraud Initiative 2024/25	Board and committee quality governance reviews 2025/26
Risk Management and BAF	Audit tracker Q2 2025/26	Bi-annual policy report
Losses and special payments	Cycle of business monitoring report and priorities update	

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

COMMITTEE ATTENDANCE						
Name	**1 May 2025[1]**	**24 Jun 2025[2]**	**2 Sep 2025**	**2 Dec 2025[3]**	**2 Mar 2026**	
Peter Curran						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Chris Turley			Ed Roberts	Ed Roberts		
Audit Wales	Fflur Jones	Fflur Jones	Fflur Jones	Fflur Jones		
Julie Boalch						
Judith Bryce	Jon Sweet		Pete Brown			
Christian Fox				Hugh Parry		
Carl Kneeshaw						
Osian Lloyd						
Trish Mills						
Liam Williams		Wendy Herbert		Wendy Herbert		
Carl Window						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] The chairs of the Finance and Performance Committee (Jayne Beeslee) and QUEST (Bethan Evans) were in attendance for the committee effectiveness reviews

[2] Jason Killens, CEO, joined for the presentation and endorsement of the annual report and audited accounts

[3] Emma Wood, CEO joined this meeting

REMUNERATION COMMITTEE TO PUBLIC TRUST BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. Meetings of the Remuneration Committee are held in private session.

Trust Board Meeting Date	29 January 2026
Committee Meeting Date	4 December 2025
Chair	Colin Dennis

KEY ESCALATION AND DISCUSSION POINTS
ALERT (Key issues/risk for the Board's attention)
1. No alerts from this meeting.
ADVISE (Areas of on-going monitoring, approvals, decisions, or new developments to be communicated)
2. The committee ratified a Chair's Action taken on 25 September regarding a **settlement agreement** and approved a further proposal to enter into a settlement agreement.
ASSURE (Areas of assurance the Committee has received)
3. The **Chief Executive's objectives for 2025/26** were agreed, noting that Emma Wood commenced in post on 1 October. Progress against the objectives will be reviewed in meetings with the Chair and Chief Executive in quarters three and four with the final outturn position being reported to this committee in quarter one of 2026/27. 4. The Committee held the first part of its **Quality Governance Review** for 2025/26. Most members expressed satisfaction with the committee's current membership and terms of reference. Feedback highlights the value of brief, well-structured meetings, clear agendas, and strong member engagement. Membership will be reviewed in line with the upcoming external effectiveness review. Terms of reference were approved with minor changes. 5. The committee **cycle of business** report was received with no escalations.

RISKS
Risks Discussed: N/A

AGENDA	
Ratification of Chair's Action	CEO Objectives 2025/26
Settlement of ET	Committee Quality and Governance Review
Committee monitoring report and cycle of business	

COMMITTEE ATTENDANCE						
Name	**15 May 2025[1]**	**3 June 2025[2]**	**11 July 2025[3]**	**25 July 2025[4]**	**3 Sept 2025**	**4 Dec 2025**
Colin Dennis						
Rhiannon Beaumont Wood						
Peter Curran						
Bethan Evans						
Prof. Hayley Hutchings						
Ceri Jackson						
Hannah Rowan						
Jayne Beeslee						
Jason Killens						
Rachel Marsh						
Emma Wood						
Carl Kneeshaw						
Trish Mills				Recused for JD item		
Hugh Parry						
Damon Turner						

	Attended
	Sent Deputy
	Apologies
	No longer a member.

[1] Extraordinary meeting
[2] Jason Killens was recused for the discussion on the CEO's outturn position for 2024/25
[3] Extraordinary meeting
[4] Extraordinary meeting

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

FINANCE AND PERFORMANCE COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. The papers for these meetings can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	29 January 2026
Committee Meeting Date	20 January 2026
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Development of the **2026-29 IMTP** is on track for submission to Welsh Government on 31 March 2026 with a number of further touchpoints for the board in February and March. The financial year 2026-27 is expected to be the most financially challenging for the Trust in many years, with a maximum 1.11% uplift already offset by unavoidable pressures, including employers National Insurance and Welsh Risk Pool contributions. Further challenges include non-pay inflation, digital contract costs, cost pressures, and substantial savings targets requiring difficult investment and disinvestment decisions. A closed board session is scheduled for 29 January 2026 to address these issues. Members were assured on the transparent view and the executive team's methodical approach to preparation of the IMTP and budget for final approval at Board, notwithstanding the magnitude of the challenge ahead.

ADVISE

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

2. December's Board Development received a presentation on options for the **revised Monthly Integrated Quality and Performance Report (MIQPR),** based on feedback received from NEDs and Executives. The following actions were agreed and are being progressed:

   - review of current set of KPIs against the Trust's strategic objectives, with a view to reducing the number of KPIs
   - disaggregate the MQIPR into committee specific KPIs but retain the overall scorecard for each committee in order to avoid silo working
   - report by exception where KPIs are off target and for KPIs that are on target, graphs will be provided in an appendix with no supporting narrative
   - retain the balanced scorecard as a way of achieving strategic alignment in a quantitative form
   - seek to add a more predictive element to the reporting

- remove use of upward/downward trend as a target and replace with agreed benchmarks/targets
- with respect to greater use of SPC the Trust's analysts will have the discretion to determine the best way of visualising the data

These changes will take place over a number of months, with full go live in Q1, once the 2026-29 IMTP has been agreed.

3. Members **reflected** that the meeting felt more like a virtual Teams meeting than hybrid, with most participants joining remotely and only a few attending in person. It was suggested that if a hybrid format is intended, greater in-person attendance would be helpful; although it was acknowledged there are reasons for the current attendance pattern.

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:

4. With respect to the **financial position for months 8 and 9 2025/26.** The month 8 position was noted, and the committee took assurance from the update. The Trust is reporting a revenue year to date deficit of £66,000 and a small in month surplus of £69,000 for month 8 2025/26. In line with the balanced financial plan approved as part of the 2025-28 IMTP the Trust is forecasting to breakeven by the year-end. Gross savings of £5.800m have been achieved in month 8 against a target of £5.621m. The committee heard that for month 9 financial position shows a year-to-date revenue underspend of £180,000 and a monthly surplus of £246,000.

5. Welsh Government's decision to fund the increase in the Welsh Risk Pool forecast improved the Trust's reported position and enabled acceleration of some expenditure that would otherwise have impacted next year. The Trust continues to forecast a break-even year-end, with the capital plan progressing well against a £32 million budget. Gross savings achieved are £6.492 million, exceeding the £6.362 million target, and payment performance remains strong at 98.4%. Members commended the strong financial management demonstrated by the Trust.

6. With respect to the **MIQPR for November/December 2025** with members discussing 111 call abandonment rates and noting that the KPI requires 95% of 111 calls to be answered within 60 seconds which is not realistic given performance has been below that level for some time. Members were assured that proposals have been made to commissioners to shift to a median and 90th percentile measure, aligned with other performance frameworks and noted that the target is not achievable as modelling indicated that the service is 22 FTE short of what would be required to reach target, even before demand peaks.

7. The committee received the **Integrated Medium Term Plan (IMTP) Q3 Assurance Report** and noted that the plan for 2025/26 was ambitious, with strong delivery evident, particularly in relation to the Clinical Model Transformation programme. Members also recognised that delivering at this pace and scale has required sustained effort, dedication, and resilience from staff, and expressed their thanks and appreciation for this commitment. Committee asked what strategic ambitions were most

at risk of not being delivered. The AD Commissioning & Performance agreed to take this question away and obtain an answer in time for Trust Board.

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

Operations Directorate Q3 Update

8. The Committee heard of the Covid Module 1 associated attendance at the Senedd's Public Accounts and Public Administration Committee in December 2025. The Committee thanked the Executive Director of Operations for his attendance, who shared that preparation was essential to provide meaningful responses to the questions posed.

9. With respect to WAST's participation in Exercise Pegasus the committee heard of the repeated challenges associated with attending multiple LRFs simultaneously and that it was felt there was not sufficient internal exercising of the plan. The intention is to strengthen internal exercising ahead of next winter.

10. The first operational deployment of the HART drone provided further assurance of innovation value, particularly through enhanced multi agency data sharing.

11. Members commended the continued work to modernise clinical safety communications, following national media scrutiny. The introduction of clinician led text messaging to patients has reduced uncertainty and duplicate 999 calls, with further enhancements in development. Early outcomes from the falls desk trial are promising, supporting future expansion.

12. Handover delays in December resulted in more than 13,000 lost hours, with some waits exceeding 24 hours. The NHS Wales directive to Health Boards to deliver the best in three month performance is unlikely to be met, and further guidance is awaited from the centre. The two week winter "reset" demonstrated system benefits through earlier discharges and higher transfer activity, informing future planning.

13. The committee also noted the October 111 digital outage, reinforcing the importance of a reliable digital front end, and received assurance that the implementation of the second phase of the ambulance performance framework had been clinically safe, with incidents linked to demand and capacity constraints rather than the model itself.

Non-Emergency Patient Transport Service (NEPTS) Capacity Management

14. The Quality, Patient Experience and Safety Committee (QUEST) asked this committee to take a deeper dive into the action underway to address persistent high demand for NEPTS, noting the resultant level of complaints relating to unmet patient need.

    - Within this context, the committee's discussion on NEPTS capacity confirmed that the service continues to operate within significant limitations, with demand regularly exceeding available and funded capacity. In 2025, NEPTS completed 552,602 journeys. 184,901 journeys were cancelled. 7.6% of total demand was cancelled by health boards. 5.1% was cancelled by service users themselves. CMP cancellations amounted to 3.9%.
    - Members noted the impact of reduced volunteer availability, longer journey distances, and

increasingly complex patient requirements, all of which contribute to cancellations, delays, and poor patient experience. These issues directly align with the concerns raised through PTR and the Quest action regarding unmet need and potential patient harm.

- The committee reviewed internal actions already underway, including roster optimisation, efficiency improvements, and closer monitoring of activity patterns. While these measures were recognised as necessary and appropriate, the committee emphasised that they will not fully bridge the gap between capacity and rising demand. As a result, the committee concluded that system level engagement, particularly with health boards and commissioners, remains essential. Ongoing discussions through the JCC were highlighted as key to exploring eligibility criteria, funding arrangements, and wider opportunities for service redesign.
- Non-Executive Director triangulation confirmed that these points align with their own experiences, providing further assurance that the constraints and risks are well understood and that the actions being taken are proportionate. In addressing the QUEST action directly, the committee confirmed that the organisation is taking reasonable and responsible steps to mitigate patient harm and improve the service. However, the committee acknowledged that, given current demand and capacity pressures, some level of poor patient experience is likely to continue.

15. The **Digital KPIs** relating to data and analytics, ICT systems, digital services, projects & programmes, and details on the progress against the Digital Plan were presented. Members noted that current vacancies in the digital team were directly linked to delivery challenges and lowlights in the KPI report, impacting pace and skill availability for key projects. Staff readiness and future workforce planning discussed, emphasising the need for digital roles to align with the People and Culture Plan, including human-centred design, adoption, and benefit realization, to ensure the digital strategy supports organizational goals.   There were no issues of escalation to the board.

16. The **Information Governance (IG)** report issues of note included three key alerts. These concerned the missing DPIA for the Paxton ID system, which is now being addressed, strengthening of disaster recovery and business continuity arrangements, and a significant backlog in records management. Prioritisation and risk escalation are underway and there were no issues of escalation to the board. Other issues included:

    - Reported data breaches have increased due to better visibility and reporting culture rather than more incidents.
    - The IG toolkit submission remains on track, with only CCTV compliance outstanding.
    - FOI performance is being affected by the complexity and volume of multi directorate requests. The team is reviewing processes, use of exemptions, and options to push back on requests that require creating new information, alongside considerations of capacity. The rising influence of AI on FOI activity was noted, including more complex and potentially litigation driven requests. Forthcoming regulatory changes, including the listening to people regulations, may help manage this.

    The committee was invited to consider which digital and information governance KPIs it wishes to monitor to support effective escalation and strategic oversight, which it will do in the new financial year.

Fire Safety

17. Assurance was taken from the annual fire safety update, which confirmed good compliance across the estate. Fire risk assessments are current for all sites, undertaken by an external provider, and all resulting actions are categorised and being progressed. The Trust is fully compliant with up to date EICR electrical testing certificates, and there has been a continued increase in trained fire marshals, with overall ESR fire safety compliance at 81.86%. Updates to the Fire Safety Policy are planned for submission through internal governance groups by January 2026, and Internal Audit has completed a review of fire safety which is scheduled for Finance and Performance Committee in March.

18. An alert was noted in relation to specific estate based actions, including the need to address emergency lighting flick tests in the south, with options currently under risk assessment. While weekly fire alarm testing is being completed at larger corporate sites, contact centres, and several ambulance stations, arrangements for nominated site leads to undertake testing across the remaining estate are still to be finalised.

19. Ambition was demonstrated through ongoing work to strengthen fire safety management, including ensuring that annual fire drills are completed at all sites and that consistent records are maintained. This forms part of a wider programme designed to improve assurance and standardise compliance across the estate.

20. Concerns were raised about previous non-compliance, with many sites lacking fire drills, and the need for more frequent reporting rather than just annual updates. It was agreed that exception reporting or interim updates would be considered to ensure ongoing committee assurance without overburdening resources, especially given the small size and low occupancy of many sites. There are no escalations to the board however the committee will have a six-month check-in on progress, and follow up on integration into broader infrastructure reporting, balancing risk and practicality.

21. Members received the **Decarbonisation update** and the ongoing delivery of the action plan. Future resourcing will need to be proportionate as new measures are introduced considering the challenging financial position and priorities for next year.

22. The **committee's annual priorities** are progressing well, and it was noted that the Waste Management update report was delayed from September and would be presented in March.

RISKS

The committee received the **Risk and Board Assurance Framework report** noting that **Risk 623** (Data Protection) has achieved its target score of 10 (2x5) reducing from (15 (3x5) and will be managed at a directorate level.

The new approach to **Risk 542** (Decarbonisation) and the disaggregation of internal and external factors continues and will be presented at a later meeting.

Financial risks were discussed throughout in the context of ongoing pressures, including the need to revisit **Risk 139** (financial sustainability). This is expected to increase in score given the challenging financial climate. Members acknowledged that the financial risks are significant and reiterated the pivotal

role the committee will play in navigating the future financial situation.

New risks are being considered in relation to the records management backlog and AI/FOI exemptions.

In private session, Members received assurance on the detail of **Risk 260** noting that there were no material changes during this period.

COMMITTEE AGENDA FOR MEETING		
Operations Update for Q3	NEPTS Capacity Management	Financial position M8 and M9 2025/26
MIQPR	Digital reporting	Information governance report
IMTP Q3 assurance report and 26-29 development update including financial plan	Fire safety annual report	Environment, decarbonisation and sustainability update
Risk management and BAF	Committee cycle and priorities update	

COMMITTEE ATTENDANCE						
Name	**20 May 2025**	**21 Jul 2025**	**16 Sep 2025**	**18 Nov 2025[1]**	**20 Jan 2026**	**17 Mar 2026**
Jayne Beeslee (Chair)						
Bethan Evans					Colin Dennis	
Peter Curran			[2]			
Chris Turley			Ed Roberts	Ed Robers		
Rachel Marsh	Hugh Bennett	Hugh Bennett	Estelle Hitchon	Hugh Bennett	Hugh Bennett	
Lee Brooks				Judith Bryce		
Liam Williams	Wendy Herbert	Wendy Herbert				
Carl Kneeshaw						
Jonny Sammut			From 1022			
Trish Mills						
Hugh Parry				[3]		
Damon Turner						
Matt Dugdale						

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Emma Wood, Chief Executive Officer joined for this meeting.
[2] Peter Curran left the meeting at 10.25. Rhiannon Beaumon-Wood joined at 10.30 and was counted towards quorum.
[3] Left for items 6 and 7

ACADEMIC PARTNERSHIP 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.

Trust Board Meeting Date	29 January 2026
Committee Meeting Date	20 January 2026: Chair's actions
Chair	Hannah Rowan

KEY ESCALATION AND DISCUSSION POINTS
ALERT (Alert the Board to areas of attention)
1. As the next Committee meeting is scheduled for early March, two items—the **revised Committee terms of reference for 2026/27 and the Responsible Research Development Five Year Plan 2025-30**—were reviewed and endorsed by Chair's Action. The Chair's Action request was issued on the 14 January 2026 for consideration. 2. It was necessary to transact these matters via Chair's Action due to the timing of the next APC meeting and predominantly the need to approve and submit the Responsible Research Development Five Year Plan 2025-30 to Health and Care Research Wales before March. 3. The endorsements were confirmed 20 January 2026, and the research plan is annexed for approval by the Board. The terms of reference have been presented to the Trust Board separately for approval, with the update on the wider Board quality governance review at the 29 January 2026 meeting.
ADVISE (Detail any areas of on-going monitoring, approvals, or new developments to be communicated)
n/a
ASSURE (Detail here any areas of assurance the Committee has received)
n/a
RISKS
n/a

RESPONSIBLE RESEARCH, DEVELOPMENT AND INNOVATION (RD&I)

THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST 5 YEAR PLAN 2025 - 2030

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Improvements in **Responsible financial stewardship** will be improved by: 20

Improvements in **Responsible** communications, visibility and impact will be **measured** by: 22

Forward

The Welsh Ambulance Services University NHS Trust (WAST) has a longstanding reputation of developing and delivering high quality Research Development and Innovation (RD&I). In recognition of the role in Education and RD&I, WAST was awarded **University Trust Status** in 2024, which has raised the profile of RD&I across the organisation. Rapid progress has been made in the breadth and scale of RD&I, providing opportunities to tackle complex challenges faced by WAST, across healthcare in Wales and beyond. WAST holds a wealth of RD&I talent within its multiprofessional workforce, along with its leaders with international influence in digital, clinical practice, management and remote care, who's impact continues to transform care and multiply through developing the next generation of RD&I leaders.

Professor Nigel Rees (QAM) – Assistant Director of Research & Innovation

There has never been a better time to conduct high quality RD&I in WAST through the environment we have influenced in the development of NHS Wales and Welsh Government policy to support embedding of RD&I across the NHS, creating more equal access to training and resources. The WAST RD&I Office and PERU has a wealth of experience, capability and networks to support RD&I across WAST, but we remain vigilant to contemporary challenges and opportunities while recognising the need to build on our successes.

Everybody has a role to play in **RD&I**, and the opportunities for development, and higher quality care it brings. This is **Your plan** which outlines improvements we will make and needs **You** to achieve its ambitions. Let's all work **together** to deliver this plan over the next five years and continue to embed **Responsible RD&I** across WAST to improve the **right care** in the **right place**, wherever and whenever it is needed for the **People of Wales** and beyond.

As the research champion Non-Executive Director for WAST, I am delighted to endorse this Responsible Research, Development and Innovation (RD&I) 5 Year Plan and I welcome WAST's plan to implement it over the next five years. Working as an academic with the Health Services Research field, I know that evidence-based research is key to driving the implementation of new treatments and ways of working and that organisations with active research portfolios are safer, more cost-effective and have better patient outcomes.

Professor Hayley Hutchings
Research Champion Non-Executive Director

This 5-year plan is based on sound policy initiatives such as the UK Policy Framework for Health and Social Care and the PRIORITY project, which WAST was an integral part of. The plan is based on wide engagement across WAST and presents a clear plan with measurable targets. This plan builds upon the recent award of University Trust Status to WAST but recognises that undertaking RD&I should be done responsibly. This responsibility covers governance, finance, inclusivity and support, increasing capacity and capability, patient involvement, communication and impact.

Since joining WAST I have seen evidence of great enthusiasm for RD&I and strong expertise within the areas of digital, clinical practice and management and remote care which have a major impact on care provision and patient outcomes. We now need to support and develop our workforce to ensure that we continue to conduct research of the utmost rigour and support our staff in doing so.

Executive Summary

It has been well established that Research Development and Innovation (RD&I) active organisations are safer, more cost effective and have better clinical outcomes. In recent years efforts have been made to embed RD&I across the Welsh Ambulance Services University NHS Trust (WAST) and the wider NHS through policy initiatives such as the NHS R&D Framework, PRIORITY Project and Innovation framework. RD&I however, needs to be conducted in a responsible manner, and UKRI (2025a) define responsible innovation as:

> *"a process that takes the wider impacts of research and innovation into account. It aims to ensure that unintended negative impacts are avoided, that barriers to dissemination, adoption and diffusion of research and innovation are reduced, and that the positive societal and economic benefits of research and innovation are fully realised"*

Along with the ongoing RD&I policies and initiatives noted above, WAST has engaged in a multiyear service improvement, exploring opportunities to embed RD&I, that has involved 102 station visits, 32 Emergency Department Visits and 6 workshops. Our RD&I plan has synthesised the findings of this service improvement with the recommendation of policy and guidance into the following key areas and respective plans for improvement:

- **Responsible** Governance and policy, supported by transparent structures and systems
- **Responsible** financial stewardship
- Cultivating an inclusive, supportive and **Responsible** approach to growing RD&I capacity and capability of our workforce through distributed leadership, partnership and collaboration
- **Responsible** RD&I development, delivery and decision making that is Patient and Public centred
- **Responsible** communications, visibility and impact

Introduction

Health care organisations with greater Research Development and Innovation (RD&I) activity have better clinical outcomes, even after adjustment for staffing and structural factors (Ozdemir et al. 2015, Boaz et al 2015, Jonker & Fisher 2018). Other benefits from being an RD&I active organisation include safer, more efficient and higher quality patient care with better experiences, opportunities for the workforce to improve their skill sets and retention/attraction of the highest calibre of colleagues.

RD&I active organisations foster the development of an evaluative, questioning culture and an atmosphere of scientific challenge and reflection. The RD&I conducted in health organisations can result in new and cutting-edge treatments, technologies and care for the population, resulting the generation of additional income and ultimately more efficient and effective care. RD&I can improve the safety of our people and the communities we serve, which is a high priority at a time when the physical, psychological and well-being challenges have never been so great.

The UK Policy Framework for Health and Social Care Research

The Health Research Authority (HRA) regulates health and social care research to protect the interests of patients and the public. This policy framework sets out principles of good practice in the management and conduct of health and social care research in the UK. These principles protect and promote the interests of patients, service users and the public in health and social care research, by describing ethical conduct and proportionate, assurance-based management of health and social care research, to support and facilitate high-quality research in the UK that has the confidence of patients, service users and the public.

WAST and all individuals conducting health and social care research have responsibilities under this policy framework, which applies to research involving staff, patients, service users or their relatives or carers. WAST continues to adhere to the

highest scientific and ethical standards and principles outlined within this policy framework.

Principles that apply to all health and social care research

1. Safety
2. Competence
3. Scientific and Ethical Conduct
4. Patient, Service User and Public Involvement
5. Integrity, Quality and Transparency
6. Protocol
7. Legality
8. Benefits and risks
9. Approval
10. Information about research
11. Accessible findings
12. Choice
13. Insurance and indemnity
14. Respect for privacy
15. Compliance
16. Justified intervention
17. Ongoing provision of treatment
18. Integrity of the care record
19. Duty of care

Figure 1 - Principles that apply to all health and social care research

Responsible RD&I

UK Research and Innovation (UKRI) is one of the UK-wide funding agencies that invests in science and research. It consists of the UK seven research councils, Innovate UK, and the research and knowledge exchange functions of the Higher Education Funding Council. The UKRI recognise responsible innovation to be a process that seeks to promote creativity and opportunities for science and innovation that are socially desirable and undertaken in the public interest. RD&I has the ability, not only to produce understanding, knowledge and value, but also unintended:

- **Consequences**
- **Questions**
- **Ethical dilemmas**

- **Social transformations**

Responsible innovation recognises that RD&I can highlight questions and quandaries that means the potential impacts are unpredictable whether they are beneficial or detrimental, some innovation can result in beneficial impacts but also have a hidden cost that is detrimental.

Health and Social Care Innovation Wales brings people together to explore ideas and challenges that can help shape the future of health and social care in Wales. It is committed to fostering innovative solutions that improve health and social care outcomes and is here to provide support for innovators every step of the way. The Health and Social Care Innovation Wales Innovation Framework guides health and social care organisations across Wales in fostering, scaling, and managing innovation, providing the tools and processes needed to transform the delivery of health and social care in Wales.

Figure 2 - The Innovation Framework

In 2021 the policy paper Saving and Improving Lives: The Future of UK Clinical Research Delivery (DHSC 2021) was published. This clearly states that research is the single most important way of improving healthcare by embedding clinical research at the heart of patient care across the NHS, making participation as easy as possible and ensuring all

health and care colleagues feel empowered to support research. Despite WAST being a leading RD&I active ambulance trust across the UK many challenges and opportunities continue in the development and delivery of RD&I in WAST.

The WAST long term strategic framework for 2030 '*Delivering Excellence*', set out a vision for the future of the WAST, which includes an aspiration to be at the forefront of research to drive forward innovations in clinical practice and wider organisational delivery. This was further reflected in the WAST 2024 annual report which reported how the WAST clinical strategy was undergoing review to reflect the changed context WAST now operates within and committed to developing a dedicated Research & Innovation plan. We have since continued the co-production of this plan with a wide range of groups and individuals.

This has been achieved through a service evaluation we have been engaged in over the past two years, involving continuous engagement with our people and partners within and outside of WAST. The engagement activities included staff interviews, workshops at multiple locations across Wales, focused meetings and presentations at external workshops and conferences.

Figure 3 - Embedding Research in WAST coding themes

Through this engagement, and our rigorous process of data collection and analysis, themes have emerged that are grounded in the experiences of embedding R&I that we aim to address through this and ongoing plans (Figure 3).

WAST R&I continue to contribute to high level NHS Wales R&I Strategic developments included in Making research careers work: a review of career pathways in health and social care in Wales [13] and the following range of initiatives are tackling the variety of complex issues revealed by this report, including:

Figure 4 - The ten pillars outlining the features of a research supportive NHS organisation – Research matters – what excellence looks like in NHS Wales (2023).

We have synthesized the findings of policy and our service evaluation.

Vision

The findings of our service improvement have been synthesised with the recommendations of policy and guidance into the following vision:

To embed high quality and responsible Research, Development and Innovation across WAST, to provide the right care in the right place, wherever and whenever it is needed.

Our vision will be achieved through our plans for improvement across the following key areas:

Responsible governance and policy (supported by transparent structures and systems)

Responsible Research, Development and Innovation (RD&I) involves creating value for society responsibly, by delivering high quality, trustworthy research, while remaining vigilant to potential social, environmental, ethical, and regulatory requirements and challenges. Researchers must anticipate, reflect, engage, and act on the broader ethical and societal implications, and value of their work. This applies to the whole research lifecycle, not only to research outputs.

Research and scientific innovation has the ability to not only produce knowledge and value, but may also have unintended consequences, raise questions, ethical dilemmas or lead to social transformations. We are committed to the UKRI Framework (2025b) for responsible RD&I and its principles, following the AREA approach of **Anticipate, reflect, engage, act (AREA).**

Responsible Governance and policy will be improved by:

- Expecting those engaged in RD&I in WAST to conduct their work to the highest scientific and ethical standard in a legal manner and balance the risks and benefits of RD&I with social and environmental responsibility.
- Fostering an approach to conducting RD&I that anticipates and assesses potential implications and societal expectations including in the wider public interest, engaging various stakeholders, including the public.

- Creating spaces and processes to explore RD&I that leads to social transformations in an open, inclusive way, carefully considering the ethical dilemmas they present that goes beyond the statutory and regulatory.
- Developing an approach to the sponsorship of R&I that is transparent, regulatory compliant, and fit for the current context WAST operates within.
- Encouraging questioning, broader deliberation, dialogue, engagement and debate in an inclusive way.
- Nurturing and promoting partnerships with other disciplines and spheres of expertise and facilitating training to enable these skills to be developed and taken forward.
- Being vigilant to potential social, environmental, ethical and regulatory challenges which arise from new research at the limits of our knowledge and seeks to broaden debate at an early stage.

Responsible financial stewardship

The NHS R&D Finance Policy (2025) describes the requirements and systems in place for the costing, management, accountability and distribution of all research related funding and income within NHS organisations across Wales. Participating in RD&I can provide significant and substantial potential savings to the NHS and should be recognised widely as an additional benefit in supporting high quality RD&I. This is a valuable source of 'potential funding' for investment into both research capacity and infrastructure as well as general clinical service provision.

Through support from partner organisations such as Health and Care Research Wales, WAST have therefore established a rigorous financial management process for research income and expenditure to ensure:

- Expert accounting input is involved in costing and monitoring of finances related to RD&I.

- The appropriate use of RD&I related income and demonstrate how the RD&I Office adhere to Standing Financial Instructions.
- Maintain and demonstrate financial probity in all matters concerning RD&I governance.

Responsible financial stewardship will be improved by:

- Adherence to the principles for meeting patient care costs associated with externally funded research as outlined in policies and guidelines such as the Welsh Government Guidance: Attributing the costs of health and social care research & development (AcoRD) 4, SoECAT (Schedule of Events Cost Attribution Template)
- Use of the model Non-Commercial Agreement (mNCA) or Organisational Information Document (OID) to detail how payments will be managed.
- Exploring options for Programme investment funding including:
    - Wales commercial research delivery funding (via the Voluntary Pricing Access and Growth (VPAG) funding allocated to Wales)
    - Savings to the NHS and health community
    - Charitable funding for research
- In conjunction with Finance support, we will explore the broadening of RD&I Office held Investigator/departmental accounts for RD&I related income for further investment.
- We will continue to collaborate across our organisation to exploit opportunities for responsible RD&I commercialisation, focussing on areas with significant potential such as devices, pharmaceutical and digital technologies.

We will make every penny count, by ensuring appropriate cost attribution, recovery and allocation.

Cultivating an inclusive, supportive and **Responsible** approach to growing RD&I (capacity and capability of our workforce through distributed leadership, partnership and collaboration)

We recognise that our people are our greatest asset, and the wealth of talent that currently exists presents opportunities to grow our capacity and capability in RD&I to

improve the efficiency and effectiveness of the services we provide. We will continue to embed R&I across WAST, ensuring that our approach provides equitable opportunities to contribute to the development and delivery of RD&I. We will seek to increase equitable access across the multiple groups, removing any organisational, structural and geographical barriers. WAST has historically had a small number of RD&I leaders, and we aim to change this by growing the number of principal and chief investigators, which is integral to the vision for developing research capacity and capability among health and social care professionals, as described in the NHS R&D framework in Wales (Health and Care Research Wales 2023).

This approach also builds on the findings of Making research careers work (Health and Care Research Wales 2022). This plan coincides with the implementation of the PRIORITY Project strategic research action plan, which will be implemented to harness the collective capacity of nurses, midwives and allied health professionals (AHP) for optimal impact on research development and delivery. The plan also draws on the principles within Innovation framework and toolkit of: Inclusivity inclusion, careers, culture, infrastructure and collaboration.

Inclusive, supportive and **Responsible** growth of RD&I capacity and capability will be improved by:

- Further embedding of the NHS R&D Framework and PRIORITY project recommendations across WAST, and reciprocal increased organisational reporting of activity to the RD&I Office, HCRW, Welsh Government and the public.
- Increased awareness and engagement in RD&I across all of WAST, by increasing the number of RD&I Development Groups across WAST.
- Developing joint appointments with universities, such as clinical academics, teaching or practice facilitator roles.
- Expanding access across the workforce to RD&I training, mentorship and seed funding opportunities, for instance, from HCRW, HEIs and research active third sector opportunities, such as those offered by the HCRW Faculty.

- Establishing a PERU Early Fellowship scheme involving WAST RD&I leaders and being aligned to organisational priorities.
- Supporting increased pre-registration learners' engagement with RD&I through collaborative working with higher education institutions (HEIs) to increase the teaching contribution of WAST staff within academic programmes, RD&I placements and contribution from HEIs to WAST RD&I.
- Collaboratively working with staff representatives, professional bodies and regulators to raise the expectation of RD&I in Job plans and descriptions, clearly describing related knowledge, skills and expectations at each A4C band. Evidence of this should be captured through the WAST PADR process and professional revalidation.
- Increased participation of RD&I in organisational inductions, training and staff development events.
- Embedding RD&I champions within practice settings to promote a culture of inclusive research.
- Growing the number of RD&I leaders, supporting with protected time, mentoring opportunities and exposure to ongoing RD&I.

Responsible RD&I development (delivery and decision making that is Patient and Public centred)

Involving the public in designing, delivering, and reporting of RD&I builds trust, supports more relevant and reliable results and leads to better outcomes. HCRW and members of WAST have supported the development, testing and launch of the UK Standards for Public Involvement in Research. These Standards are designed to improve the quality and consistency of public involvement and will be a key resource to support the delivery of our ambitions for public involvement and public engagement in WAST and wider health and social care research in Wales. We draw on these standards by creating inclusive opportunities, working together, supporting and learning, good communication, achieving impact and good governance. All our RD&I in WAST has strong patient and public involvement, and we will continue to ensure this for all future research.

Responsible RD&I development, delivery will be improved by:

- Offering public involvement opportunities that are accessible and that reach people and groups according to research needs.
- RD&I will be informed by a diversity of public experience and insight, so that it leads to treatments and services which reflect these needs.
- Working together towards a common purpose, where different perspectives are respected, and in a way that values all contributions, and that builds and sustains mutually respectful and productive relationships.
- Offering and promoting support and learning opportunities that build confidence and skills for public involvement in research.
- Removing practical and social barriers that stop members of the public and research professionals from making the most of public involvement in research.
- Use plain language for well-timed and relevant communications, as part of involvement plans and activities.
- Communicate with a wider audience about public involvement and research, using a broad range of approaches that are accessible and appealing.
- Seek improvement by identifying and sharing the difference that public involvement makes to research.
- Understand the changes, benefits and learning gained from the insights and experiences of patients, carers and the public. Involve the public in research management, governance, regulation, leadership and decision making.
- Public involvement in research governance can help research be more transparent and gain public trust.
- Providing clear expectations for patient and public involvement in the development and delivery of RD&I in WAST.
- Signpost to the wide range of resources available across the sector
- Improve the ways in which public involvement is embedded throughout the health and social care research landscape in Wales.
- Enhance the ways in which public engagement can promote the vital contribution that the public make to health and social care research, and offer inclusive, open opportunities to take part in research, welcoming of many different perspectives

- Creating a shared plan for improving public involvement and public engagement in health and social care research.

Responsible communications, visibility and impact:

Communication was the most prominent theme within our service evaluation, and we must do better. Within this service evaluation 'in person' was deemed to be the most valued and effective mode of communication. Our service evaluation offered an opportunity to actively communicate with our people and partners and served as a two-way process of sharing information on a wide range of areas such as the outcome of studies and policy developments. We also received important feedback which has been important to understand the challenges of recruitment into studies for instance.

Responsible communications, visibility and impact will be improved by:

- Organisational wide recognition of the crucial role of responsible, effective communication, visibility and impact plays in promoting transparency, engaging stakeholders, and facilitating dialogue about the potential impacts of new ways of working, innovations and technologies that are aligned with societal needs.
- Transparent and consistent organisational signposting (where appropriate) to the RD&I Office for review, tracking and reporting through the WAST RD&I tracker and HCRW/WG annual performance reporting, along with the IMTP and directorate-wide plans.
- Increasing the breadth and nature of communicating and mobilising knowledge through dissemination, through mechanisms such as peer reviewed publications conference presentations, guidelines and evidence informed policy and practice

How will we know our plans for **improving** are working?

We have developed measures to provide clear, trackable, and actionable goals that increase the likelihood of success. These measures are outlined in appendix A. We will

ensure that our plan is actionable and will focus all of our efforts and resources towards achieving concrete results and providing a structured approach to planning and execution.

Summary

The journey to embed responsible RD&I within every level of WAST builds on solid foundations but has a very long way to go. Moving forward, this plan will continue to require ongoing engagement, feedback and collaboration across WAST and beyond. As we implement the objectives outlined within this plan, all in WAST are encouraged to actively participate—whether through engaging in new RD&I projects, leadership, learning or supporting an RD&I-positive culture within their teams. Working together, we can create a future where RD&I is embedded within practice, driving innovation, improving patient care, expanding career development and satisfaction, and strengthening the role of pharmacy within the broader healthcare landscape, paving the way for the next generation of researchers and innovators

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Appendix A –Measurement framework

Improvements in **Responsible Governance and policy** will be **measured** by:

- In year one we will convene a forum to ensure that RD&I is conducted to the highest scientific and ethical standards which balances the risks and benefits of RD&I in a responsible manner following the AREA approach of **Anticipate, reflect, engage, act (AREA).**
- In year one we will introduce a WAST Sponsorship policy and suite of SOP's.
- We will increase RD&I partnerships and Research Development Groups by 20% by year 5. This will monitor external and internally sponsored studies.
- By year two we will have introduced a new Intellectual Property policy.

Improvements in **Responsible financial stewardship** will be improved by:

- 10% increase in commercial income from the current level by 2030
- Adherence to Standing Financial Instructions and probity in all matters concerning RD&I governance will be measured by financial monthly reporting to HCRW
- Adherence to AcoRD will be evidenced by all WAST sponsored studies including a fully executed SoECAT, completed by WAST RD&I Office.
- By year five there will be a 10% increase in use of the model Non-Commercial Agreement (mNCA) and/or Organisational Information Document (OID)
- We will achieve a 10% increase in Charitable funding for research by year three.
- We will broaden by 10% RD&I Office held Investigator/departmental accounts for RD&I related income for further investment.

Improvements in i**nclusive, supportive and Responsible growth of RD&I capacity and capability** will be **measured** by:

- 10% increase in the total number of open and recruiting commercial and non-commercial portfolio studies from its current base by 2030.

- 10% increase in recruitment to time and target metrics from the current level by 10% by 2030.
- All directorates reporting RD&I activity to the RD&I Office for onward presentation/reporting to HCRW, Welsh Government and the public.
- 20% increase in the number of RD&I Development Groups across WAST by year five.
- 10% increase joint appointments with universities, such as clinical academics, teaching or practice facilitator roles.
- In year one we will establishment a PERU Early Fellowship scheme involving WAST RD&I leaders and being aligned to organisational priorities.
- We will increase by 10% the teaching contribution of WAST staff within academic programmes, RD&I placements and contribution from HEIs to WAST RD&I.
- We will capture (in a qualitative form) evidence of RD&I captured through WAST PADR process and professional revalidation.
- In year two we will have included RD&I within organisational inductions, training and staff development events.
- By year three we will have a network of RD&I champions within practice settings.
- By year two we will have identified a senior representative for RD&I in each directorate.
- We will have a 50% growth in the number of RD&I leaders, as measured by number of Principal and Chief Investigators on HCRW portfolio studies.

Improvements in **Responsible RD&I development, delivery** will be **measured** by:

- By year three, 50% of WAST sponsored studies will include public involvement prior to submission for funding.
- We will increase RD&I learning opportunities by 10% and ensure they are communicated to staff to build confidence and skills.
- We will create and adopt and SOP for Patient and public involvement in WAST RD&I.

Improvements in **Responsible** communications, visibility and impact will be **measured** by:

- Increased transparency, tracking and reporting of RD&I by 10% increase in RD&I tracker and HCRW/WG annual performance reporting.
- A qualitative measure of evidence of RD&I in all IMTP and directorate-wide plans by year five.
- Increasing mobilising knowledge through 10% increase in peer reviewed publications conference presentations.
- Increase the number of WAST Sponsored studies from its current level by 20% by 2030.

CONFIRMED MINUTES OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OPEN MEETING HELD AT CARDIFF MRD AND REMOTELY VIA MICROSOFT TEAMS ON 2 SEPTEMBER 2025

MEMBERS PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Rhiannon-Beaumont-Wood	Non-Executive Director
Ceri Jackson	Non-Executive Director

PRESCRIBED ATTENDEES

Julie Boalch	Assistant Director of Corporate Governance & Risk
Christian Fox	Trade Union Representative
Fflur Jones	Audit Wales
Carl Kneeshaw	Director of People
Trish Mills	Director of Corporate Governance/Board Secretary
Osian Lloyd	Head of Internal Audit, NWSSP Internal Audit
Damon Turner	Trade Union Representative
Liam Williams	Executive Director of Quality & Nursing
Carl Window	Local Counter Fraud Manager

IN ATTENDANCE:

Peter Brown	Assistant Director of Operations, Operations Transformation
Jonathan Chippendale	Assistant Director of Clinical Development *(Item 11)*
Sarah Harland	Corporate Governance Officer
Estelle Hitchon	Interim Executive Director Planning & Performance/ Director of Partnerships and Engagement
Angie Lewis	Director of Culture Change *(Item 6.2.2)*
Amy Lord	Audit Wales
Elliot Miller	Operations Support Manager *(Item 6.2.1)*
Alex Payne	Corporate Governance Manager
Jessica Price	Deputy Head of Financial Accounting
Felicity Quance	Deputy Head of Internal Audit, NWSSP Internal Audit
Ed Roberts	Interim Assistant Director of Finance

APOLOGIES:

Judith Bryce	Assistant Director of Operations, National Operations & Support
Yvonne Thomas	Audit Wales
Chris Turley	Executive Director of Finance & Corporate Services

OBSERVING:

Dan King — Risk Manager

1. WELCOME, APOLOGIES AND QUORUM

1.1 The Chair welcomed members and apologies were noted.

1.2 It was confirmed the meeting met quorum.

The Committee RESOLVED to:
The apologies were noted, and the committee were assured the meeting was quorate.

2. DECLARATIONS OF INTEREST

2.1 No interests were declared.

3. MINUTES OF THE LAST MEETING 24 JUNE 2025

3.1 The Minutes from the meeting of the Audit Risk and Assurance Committee (ARAC) held on 24 June 2025 were agreed as a correct record with no amendments requested.

The Committee RESOLVED to:
The minutes of the open meeting held on 24 June 2025 were confirmed as a correct record.

4. ACTION LOG AND AAA HIGHLIGHT REPORT

4.1 The Action Log was considered.

4.2 The Committee AAA Highlight Report from the meeting held on 24 June 2025 was noted.

The Committee RESOLVED to:
Consideration was given to the Action Log and the Highlight Report from the meeting held on 24 June 2025 was noted.

5. STANDING FINANCIAL INSTRUCTIONS CHANGES: SOCIAL PARTNERSHIP AND PUBLIC PROCUREMENT ACT (2023)

5.1 Chris Turley explained that recent updates in public sector procurement legislation (across England and Wales) have led to changes in the Standing Financial Instructions (SFIs), particularly affecting procurement processes. Chris assured the committee that these changes will not significantly affect costs or the types of providers the Trust works with, but the primary impact is on process documentation and transparency, especially for the procurement function managed by Shared Services.

5.2 Chris reported that, alongside legislative changes, Shared Services have taken the opportunity to review and enhance their processes, introducing some improvements not directly tied to the new legislation.

5.3 Both Chris Turley and Ed Roberts clarified that the differentiation between in-scope and out-of-scope health services is more relevant to health boards as commissioners, not the Trust, since the Trust rarely procures health services directly. Ed emphasised that the Trust relies on Shared Services for procurement guidance, and in nearly all cases, the standard Procurement Act route will apply.

5.4 The committee acknowledged challenges, such as balancing financial constraints with social value and the ability of small and medium-sized enterprises (SMEs) to meet new requirements, but agreed the changes provide more tools to support the Welsh economy where possible. The committee endorsed the changes to Chapter 11 of the SFIs, which will then go to the Board for formal approval.

The Committee RESOLVED to:
The Committee endorsed the amendments to Chapter 11 of the Standing Financial Instructions and recommended progression to the Trust Board for Trust Board.

6.1 INTERNAL AUDIT PROGRESS REPORT

6.1.1 Osian Lloyd provided a progress update on the current audit plan, reporting that two final reports have been issued, six reviews are in progress and three are at the planning stage (further details are available in the appendix).

6.1.2 Osian confirmed that there are no concerns regarding the delivery of the plan at this stage. Additionally, Osian clarified a change in the plan focus, specifically confirming the scope for the capital audit, and referenced a separate agenda item for further detail *(Item 6.3)*.

6.1.3 Osian highlighted improved feedback return rates, which is due to the switch from word documents to electronic forms, and reported that all recent Key Performance Indicators are green, which indicates a good start to the year.

6.1.4 There was feedback that the graph in section 2 of the report was difficult to interpret, and it was suggested that it should be revisited to ensure it is easy to understand.

6.1.5 Finally, Osian invited the committee to note the progress and approve the confirmation of the scope for the Capital Provision audit. As stated in the report, this audit will focus on the Ambulance Replacement Programme, and it

will assess the Trust's arrangements for managing and controlling the refresh of the Trust fleet.

The Committee RESOLVED to:
The Committee noted the Report and approved the proposed changes at section 3 in relation to the scope of the Capital Provision audit within 2025/26.

6.2 INTERNAL AUDIT REPORTS

6.2.1 **Manchester Arena Inquiry (MAI) – Substantial Assurance**

6.2.1.1 Felicity Quance reported that the audit reviewed the Trust's progress in addressing recommendations, validating actions and governance arrangements. The review focused on 68 recommendations impacting the Trust, with a sample of 10 examined in detail. The audit found strong governance and proactive implementation, resulting in substantial assurance. One issue was noted regarding training compliance, though overall rates were acceptable for Emergency Medical Services (EMS) response. There were 18recommendations outstanding due to required financial investment, which have been referred for further funding consideration and are reflected in the risk register.

6.2.1.2 Peter Brown acknowledged the positive audit outcome and credited the team, especially Elliot Miller, for their work on the Manchester Arena recommendations. Peter added that monitoring of training compliance through senior leadership and EMS management groups is ongoing and advised that there is also ongoing engagement with Joint Commissioning Committee (JCC) and health board colleagues regarding outstanding recommendations.

6.2.1.3 Elliot Miller reported on recent engagement sessions with the JCC to present findings, with further follow-up sessions planned. The JCC is expected to provide answers on outstanding recommendations later in the year, and Elliot confirmed that actions are already underway to address the audit's training compliance issue, with remedial plans being developed. Elliot shared that Judith Bryce expressed satisfaction with the audit outcome and believes it will strengthen submissions to commissioners.

6.2.1.4 Rhiannon Beaumont-Wood enquired about plans for refresher Mandatory In-Service Training (MIST). Peter advised that the new 10-second triage approach encourages more frequent use of these skills in everyday incidents, helping maintain competence. Elliot Miller explained that the submission to commissioners included a request for additional funding for specific training and exercising for resilience and major incident response, as current resources and priorities limit internal delivery. Elliot also advised that Welsh Government is setting up a national programme for joint testing and

exercising among the tri-services (police, fire and ambulance), which will help staff practice these skills more frequently, especially in large scale incidents.

6.2.2 Organisational Change Policy (OCP) – Reasonable Assurance

6.2.2.1 Felicity Quance reported that the audit reviewed the Trust's processes for managing organisational change, focusing on compliance with national policy and employment legislation. Felicity advised that the People and Culture Directorate is handling approximately 100 active Organisational Change Processes; including 9 in one area and emphasised the need for better resource capacity to support effective delivery. The audit found that processes are developing, but require clearer guidance, improved planning, consistent application and better monitoring; including an OCP tracker. Felicity highlighted the need for structured learning and lessons learned to support continuous improvement.

6.2.2.2 Carl Kneeshaw welcomed the audit as a valuable opportunity to improve processes and foster a culture of continuous improvement in change management and confirmed acceptance of the audit findings and reported that work is progressing; with deadlines considered realistic given current resources and associated due dates. Carl emphasised the importance of lessons learned and measuring return on investment through quarterly post OCP reviews to assess outcomes and identify improvements. Carl added that this approach supports the Trust's organisational strategy, and that additional assurance will be provided through regular reporting to the People and Culture Committee, including staff survey feedback and updates on change initiatives.

6.2.2.3 Angie Lewis thanked NWSSP for running the audit and acknowledged the challenge of expanding the audit's scope from OCP processes to broader organisational change management. Angie appreciated the recognition that the Trust is at an early stage of embedding effective people change management and valued the challenge to focus on lessons learned and benefits realisation. Angie highlighted that over 75 people are now trained in change management techniques and expressed hope that a future audit would reflect a more strategic approach to change management beyond the formal OCP process.

The Committee RESOLVED to:
Noted the Manchester Arena Inquiry (MAI) and Organisational Change Policy (OCP) Internal Audit Reports and the committee were assured by the reports presented.

6.3 Proposed Amendment to the 2025/26 Internal Audit Plan

6.3.1 Trish Mills reported that following a review of the internal audit programme for this year, it is proposed that Clinical Prioritisation and Assessment

Software (CPAS) is audited in place of the planned Remote Clinical Support review, due to the number of high-level changes currently flowing through CPAS. It is proposed to postpone the Remote Clinical Support internal audit to the Q1 in 2026/27 internal audit programme.

6.3.2 Trish advised that it will be recommended that the following are reviewed to ensure that this is a robust and fit for purpose process that underpins the Trust's clinical transformation:

- Dispatch Cross Reference (DCR) Table Change Management Policy
- Request for change process
- Record keeping of changes for enquiries (Inc. coronary inquest)
- CPAS governance structure

6.3.3 Ceri Jackson asked for more context on the risks and rationale, emphasising the audit's connection to supporting patients at home and the importance of the CPAS system in the transformation agenda. Trish clarified that the audit would focus on the governance and workflow of CPAS, which is central to the Clinical Model Transformation, and offered to seek further details from Andy Swinburn if required.

6.3.4 Liam Williams explained that CPAS is critical for prioritising and assuring clinical transformation work and deferring the Remote Clinical Support audit allows more time for systemic changes to be embedded, improving future audit assurance. Peter Brown added that, over the past 18 months, the number of clinical systems overseen by CPAS has doubled, increasing complexity and risk, especially with new tools and innovative practices. This substantial change in the CPAS landscape justifies the audit's prioritisation.

6.3.5 . Following this discussion, and receipt of the additional context regarding the proposed amendment, the committee agreed to proceed with the proposed amendment to the 2025-26 internal audit plan to include the CPAS internal audit as opposed to the Remote Clinical Support.

The Committee RESOLVED to:

1. **Approved the change to the audit programme for 2025-2026 to cover CPAS instead of Remote Clinical Support.**
2. **Approved the transfer of the Remote Clinical Support audit to next year's audit programme plan.**

7. AUDIT WALES UPDATE REPORT

7.1 Amy Lord confirmed that the main annual financial audit was completed and reported to the committee in June 2025, and that there are no significant new updates on the accounts at this meeting.

7.2 Fflur Jones reported that the performance audit programme is progressing as planned, with the Structured Assessment nearing completion, and it is expected to be presented at the December committee meeting. Ongoing work includes national unscheduled care, local digital transformation and upcoming reviews of estates and non-emergency patient transport. Fflur also highlighted recent publications and a current consultation on the fee scheme, inviting feedback via a link in the paper.

The Committee RESOLVED to:
The Committee were assured by the Audit Wales Update Report.

8. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

8.1 Julie Boalch introduced the Risk Management and Board Assurance Framework (BAF) report, outlining progress on the risk management programme, assurance on principal risk activity and an updated Risk Management Policy.

8.2 Dan King was also welcomed as the new Risk Manager and is already supporting work on evaluating an electronic risk management system for the next financial year.

8.3 Julie reported good progress on developing Risk Appetite Statements, which have been discussed at Strategic Transformation Board and Executive Leadership Team, and are scheduled for Trust Board approval following a development session.

8.4 Julie also provided an update that work is ongoing to differentiate between factors within and outside the Trust's control for key risks, specifically referencing risks 223 and 224. Julie explained that the template used for these risks is being applied to the decarbonisation risk, with collaboration with Joe Williams and Dan King. The next steps include exploring how to score internal and external factors separately, which will not affect the overall agreed risk score, but will provide more clarity on what is controllable. The output of this work is expected to be available in the next reporting cycle.

8.5 Julie reported no material changes to principal risks, and the current risk activity was recently reviewed by the Trust Board and ELT. Julie highlighted that new risks are forthcoming, and a reduction in the score for risk 160 *(High absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service)* is anticipated. Trending data on risk scores was presented, with plans to develop a heat map for better visualisation. Julie clarified that risks dropping off the trending data are either mitigated/closed or transferred to directorate risk registers, and she will improve clarity around this in future reports.

8.6 Estelle Hitchon highlighted that the reputational risk (risk 201) has remained high and suggested disaggregating it into separate risks for patient harm and stakeholder/political issues, as their scores and mitigation may differ. Trish Mills and Rhiannon Beaumont-Wood emphasised that adopting risk appetite statements will help contextualise risk trends and improve interpretation of risk data.

8.7 Rhiannon also raised the importance of reviewing the likelihood assessment for 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)*, given its prominence on global risk registers. Julie responded that there had been a robust conversation at ELT about testing the likelihood and impact if the cyber risk were to materialise. Julie gave assurance that actions are in place and potential additional measures were discussed, and while she could not comment on technical details, Julie confirmed that the ELT had thoroughly considered the risk. Julie added that the detailed risk information is included in the closed session, but a high-level update is provided in the open session.

The Committee RESOLVED to:

1. **Received assurance on progress of the 2025/26 Risk Management work programme and timelines.**
2. **Reviewed the six draft Risk Appetite Statements ahead of Board Development Day on 19 September 2025.**
3. **Noted the continued work on repositioning of Risk 223 and 224.**
4. **Received assurance on the review and attention to the principal risk, including their review at ADLT, ELT and at relevant Committees.**
5. **Noted the rating and mitigating actions for each principal risk.**

8.1 RISK MANAGEMENT POLICY

8.1.1 Julie Boalch introduced the Risk Management Policy, explaining there were only minor changes around committee and job titles, with no content changes. The committee endorsed the Risk Management Policy for Trust Board approval.

The Committee RESOLVED to: Endorsed the Risk Management Policy for approval by Trust Board.

9. 2025/26 EFFECTIVENESS REVIEW, INCLUDING PROGRESS FROM PART II 24/25 REVIEW

9.1 Trish Mills presented the 2025/26 effectiveness review update, explaining that the process started early this year to streamline committee structures and better align them with strategic objectives and the Board Assurance Framework (BAF). The review builds on the comprehensive 2024/25 part II review, which was in-depth and mapped committees to strategic objectives.

9.2 Early assessment suggests no changes are needed for the Charity and Remuneration Committees, minimal changes for People & Culture and Quest, but more significant changes are likely for the Finance & Performance and Audit Risk and Assurance Committees, especially regarding research and innovation responsibilities if the Academic Partnership Committee is discontinued.

9.3 The review also includes updating the skills matrix to actively consider the composition of the committees and whether any changes are required. Any changes will not be implemented until April 2026. For this year, the effectiveness review will be more streamlined, focusing on two questions for each committee; what works well and what doesn't, in addition to views on terms of reference and membership.

9.4 The review will be renamed as a 'Quality and Governance Reviews' to reflect the requirement for the Trust to apply the Duty of Quality and our approach to continuous improvement. Trish will bring an update to the committee in December, before proposals are taken to the Trust Board for approval early in 2026.

The Committee RESOLVED to:

1. **Noted the update and progress.**
2. **Agreed that this current review of committee remits together with a simple questionnaire of all committees in Q3 constitutes the 2025/26 effectiveness review, now referred to as Quality and Governance Reviews.**

10.1 INTEGRATED GOVERNANCE PROGRAMME
THE DYNAMIC INTEGRATED SYSTEM OF GOVERNANCE AND OVERSIGHT

10.1 Trish Mills updated the committee on progress with the Integrated Governance Programme, highlighting completion of Q1 deliverables, including the rollout of new report templates and writing guidance. Trish highlighted that a mixed use of old and new templates will continue temporarily, but full adoption is planned from April 2026.

10.2 Work on Q2 deliverables is underway, and the main focus is now on developing the integrated governance handbook for Q3, which will clarify accountability arrangements and map governance and assurance frameworks. Trish invited committee feedback on the proposed structure and direction of the handbook, which will be further developed with member input and brought back in March 2026.

10.3 The Chair expressed strong support for the Integrated Governance Programme, commending the team's work and its potential value for the organisation.

10.4 Rhiannon Beaumont-Wood enquired about opportunities for Non-Executive Directors to use AI tools to support their roles, Trish confirmed that AI for governance is included in the programme, with a Board Development session planned later in the year.

The Committee RESOLVED to:

1. **Received assurance on progress of the programme and the 2025/26 deliverables and noted the roll-out of the new report templates and writing guidance.**
2. **Provided feedback on the direction of travel and outline of the IGP handbook.**

10.2 MID YEAR REVIEW OF CHANGES TO COMMITTEE OPERATING ARRANGEMENTS

10.2.1 Trish Mills provided an update on the mid-year review of changes to committee operating arrangements, which stem from the 2024-25 board and committee effectiveness reviews. The report confirms that progress is on track, with most planned changes being implemented as scheduled.

10.2.2 One exception to this is the paper on the 'Three Lines of Defence' in which had been planned for completion in October 2025; which will now be incorporated into the forthcoming integrated governance handbook to avoid duplication. The review highlights that all other committee changes are proceeding as planned, and the committee was asked to note and take assurance from this progress update.

10.2.3 Trish Mills queried with Chris Turley whether the new finance dashboard is being developed as a local initiative or as part of a sector-wide standardisation, and questioned its usefulness and the likelihood of a national solution versus developing their own. Chris Turley explained that it is a bit of both: there is ongoing work across Wales to refresh the financial system, but it's not mandated. The Trust has been working on its own dashboards for continuous improvement and value, aiming for more dashboard-based reporting at board and committee levels. Ed Roberts explained he has advocated for a standardised, "one version of the truth" dashboard across NHS Wales, with automatic monthly reporting, however, this has been delayed several times. If there is no national outcome soon (likely by Christmas), the Trust will develop its own internal dashboard, as many NHS Wales trusts currently use custom dashboards.

The Committee RESOLVED to: Reviewed and discussed the bi-annual update on agreed changes to operating arrangements for the board and committees for 2025/26 and were assured from the update provided on the progress against the actions.

11. AUDIT TRACKER 2025/26 QUARTER 1

11.1 Trish Mills updated the committee on the Audit Tracker Quarter 1 (Q1), which highlighted a reduction in closure rates for internal audit actions (23% in Q1 compared to 51% in Q4), but a significant improvement in closing actions on time (70% in Q1 versus 26% in Q4), reflecting more realistic implementation dates. The tracker anticipates a busy Q3 and Q4 due to actions scheduled for completion and new audits commencing.

11.2 Updates were provided on actions at their final revised date as follows:

11.2.1 <u>Audit Action 635 111 *(Commissioning Final Advisory Report)*</u>
The committee agreed that the current JCC structures and roles provide better clarity and assurance than the previous arrangement, and if all are satisfied, the action can be closed.

11.2.2 <u>Audit Action 035-24/25 *(Exposure to Fumes)*</u>
Liam Williams reported that the revised completion date for the diesel emissions action is set for December 2025 and expressed confidence in meeting this deadline. Liam explained that some outstanding actions are due to the need for board development days, and the creation of materials by the provider SOCOTEC UK, which has been secured. Additional work is required on the data build, with the team focused on Phase 1 Clinical Model Transformation implementation, and Liam plans to verify progress. Liam also shared positive news that the Trust is currently experiencing the lowest levels of handover delays in many years, which relates to the root cause of the diesel emissions issue.

11.2.3 <u>Audit Action 701 *(Clinical Audit)*</u>
Jonathan Chippendale explained that the action regarding the inclusion of clinical audit in communications is delayed due to the undecided publication platform for the clinical plan. However, all the required content for the clinical audit section is already written and available. Jonathan suggested that sharing this content now could satisfy the audit action, with formal publication to follow once the platform is finalised. The Chair asked for the timeline for publication, and Jonathan clarified that while the publication date is uncertain, the content is ready and can be shared immediately. The committee agreed that Jonathan Chippendale should share the written content for the clinical audit section as evidence to satisfy action 701, and that the action would be formally closed at the next (December) meeting once this evidence is reviewed.

11.2.4 <u>Audit *Actions* 681/683/684/686/003-24/25 *(Electronic Patient Care Records ePCR) Clinical Compliance*</u>
No update was provided on these outstanding actions, and it was asked that the Finance and Performance Committee consider the position at its upcoming meeting, instead.

11.3 Trish Mills explained that some audit actions, specifically those under paragraph 18, were incorrectly included in the tracker because they had already been closed. Trish clarified that the follow-up audit each year reviews closed actions to ensure they are appropriately closed, and there was a misalignment where these actions were mistakenly put back on the tracker. Trish apologised for the error and confirmed that these actions should not have been reopened

11.4 Progress on external audit actions was also noted, with 45% closure and revised dates for Welsh Risk Pool actions managed to avoid overloading teams.

11.5 Trish Mills asked committee members to review paragraph 32, which outlines the Power BI reporting being developed for the audit tracker, and to provide feedback on whether the proposed reporting is appropriate or if they would like more or less information included, as this is the stage when adjustments can be made before finalising the SharePoint list and Power BI dashboard. Trish emphasised that this feedback is important now, as the reporting structure is being built, but noted that it is not set in stone and can be adjusted if needed. Trish also clarified that the reporting will cover both internal and external audit actions. In response to Trish's question about Power BI reporting, it was suggested that the reporting should include both internal and external audit actions, this was noted as an observation to ensure comprehensive coverage in the dashboard. No other specific suggestions or requests for changes to the reporting were made by the committee at that time.

The Committee RESOLVED that:

1. **Noted the significant progress made in closing audit actions by their first date during 2025/26 Q1.**
2. **Noted and discussed the 12 internal audit actions for which final revised dates have been applied in quarter, and updates from the Directors responsible for these audits.**
3. **Noted the first revised dates applied to 17 of the 32 external audit actions related to the Welsh Risk Pool (WRP) Concerns Assessment 2024.**
4. **Received assurance that the management of actions for the audits within the purview of this Committee (at Annexes 2a- 2c in the reading room), and overall (at Annexes 1a-1d in the reading room, are**

being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale.

12. POLICY REPORT (Bi-annual)

12.1 Trish Mills introduced the six-monthly update on the policy report and advised that the number of policies on the priority list decreased from 62 to 55 after Executive Leadership Team (ELT) review, with 7 deferred to next year. Trish acknowledged some slippage in the programme, particularly in the first two quarters, but stated that most delayed policies now have new dates set within governance processes. The expected completion rate is now around 85%, rather than the original 95%, due to workload shifting to later Quarters. Compliance within date policies has improved from 14% to 46% and is projected to reach 50% after upcoming committee approvals, with governance and escalation processes in place to monitor progress.

12.2 Rhiannon Beaumont-Wood sought clarification on the Quality Assurance Framework for the Clinical Desk policy, specifically regarding clinical risk exposure during its deferral. Peter Brown explained that the main reason for deferring the Quality Assurance Framework for the Clinical Desk policy is the ongoing replacement of Clinical Support Desk with the new Remote Integrated Care Service (RICS), which will be ready in quarter 4. Peter clarified that the current (extant) policy and arrangements will remain in effect until the new one is implemented, and the team's efforts are focused on ensuring that the new policy is ready for the future service.

12.3 The Chair accepted the revised target as reasonable and expressed confidence that remaining policies would be caught up next year, however an update on the policy programme was requested for the meeting on 02 December 2025, rather than waiting until the end of the financial year.

The Committee RESOLVED to:

1. **Noted the adjustment to the 2025/26 Policy Work Programme and that the review dates of several high priority policies are being recalibrated.**
2. **Received assurance on the progress to bring the Trust's Policies up to date and requested an update at the meeting on 2 December 2025.**
3. **Noted the direction of travel of the Policy Transformation Programme and requested an update at the meeting on 2 December 2025.**

13. ASSURANCE TO ARAC ON SPEAKING UP SAFELY FRAMEWORK (FROM CHAIR OF PEOPLE AND CULTURE COMMITTEE)

13.1 As Chair of the People and Culture Committee, Ceri Jackson provided assurance to the committee on the delivery of the Speaking Up Safely framework, highlighting significant progress in embedding a culture where staff and volunteers can raise concerns confidentially. The Trust appointed a

full-time lead Speaking Up Safely Guardian, which has been pivotal in advancing the policy, and staff can now speak up through various channels.

13.2 Rhiannon enquired about the structure of the Speaking Up Safely guardians, specifically if there are local champions in addition to the dedicated lead guardian, and how these roles function within the organization. Carl Kneeshaw responded that currently there is a lead guardian, recruitment is underway for an additional guardian, and there is administrative support, aiming for a team of three guardians as considered best practice for ambulance services. Carl explained that while the plan is to eventually have local champions, the approach is to build incrementally, ensuring alignment with other staff networks and avoiding duplication or undermining of line managers.

13. Rhiannon also highlighted the importance of clear pathways and signposting for staff, and asked about the target number of formal guardian roles. Carl reiterated the evolving nature of the model, the importance of signposting, and the need to balance local champions with existing support structures.

The Committee RESOLVED that:
Received assurance on the arrangement for Speaking Up Safety at the Trust and noted that the People and Culture Committee will continue its oversight of this area, reporting annually to the ARAC.

14. ASSURANCE TO ARAC ON NEAR MISS AND LOW HARM INTELLIGENCE FRAMEWORK (FROM CHAIR OF QUEST COMMITTEE)

14.1 As Non-Executive Director Member of the QuEST Committee, Ceri Jackson provided assurance to the committee on the near miss and low harm intelligence framework, on behalf of the Chair, Bethan Evans.

14.2 Following discussion regarding concerns around the identified challenges, the committee were not assured of the position due to what was articulated in the paper. The resulting agreement was to feed back to Bethan and to bring a further update in March 2026.

14.3 The Chair insisted on a six-month update for ongoing oversight, therefore Trish Mills suggested that, instead of scheduling a fixed six-month report to ARAC, the committee should use the AAA (alert, advise, assure) process to formally request Quest to keep the Putting Things Right recovery plan and related near miss/low harm reporting under review, with an action for an update in six months. This would allow Quest to escalate any concerns or lack of progress to ARAC as needed, ensuring the issue remains visible and appropriately monitored.

The Committee RESOLVED that:

1. **Members considered the current position, and the concerns arising from this regarding the Trust's current ability to adequately record and report near miss and low harm incidents.**
2. **Members noted the Committee's receipt of the PTR Organisational Recovery Plan as part of its ongoing scrutiny of the issue, and it was agreed the committee will receive a six-month update for ongoing oversite at the meeting on 2 March 2026.**

15. LOSSES AND SPECIAL PAYMENTS

15.1 Chris Turley provided a summary of the losses and special payments report for the period from 1 April 2025 - 31 July 2025 and reported as being -£1.812 million. Chris explained that this relates to actual payments made, less the reimbursements received from the Welsh Risk Pool, and does not relate to any adjustments made to the provision. During the 4-month period to July 2025 the reimbursements received exceeded payment made by £1.812m.

The Committee RESOLVED to:
Noted the Losses and Special Payments Report.

16. CYCLE OF BUSINESS MONITORING REPORT AND PRIORITIES UPDATE 2025/26

16.1 The Committee's Cycle of Business Monitoring Report and Priorities update were noted.

The Committee RESOLVED to:
Noted the Cycle of Business Monitoring Report and Priorities Update.

17. ALL-WALES AUDIT COMMITTEE CHAIR'S REPORT 2024/25

The All-Wales Audit Committee Chair's (AWACC) report was received, which reflected on activity over the last year. Peter Curran, Chair of ARAC, has taken over the Chair of AWACC for 12 months and will consider a reset to the group's approach following a survey of members and their expectations for its remit.

The Committee RESOLVED to:
The All-Wales Audit Committee Chair's Report 2024/25 was received.

18. JOINT DIRECTORATE NOTICE (Ref: 006-25)

20.1 The Joint Directorate Notice was received for information. Chris Turley clarified that the notice was a recommendation from a previous internal audit advisory report, and that many recommendations had been addressed through this.

20.2 Rhiannon Beaumont-Wood enquired about monitoring the impact on individuals assigned as contract managers, expressing concern about whether the responsibility might disproportionately affect some people, and also asked about the total number of contracts involved.

20.3 Chris Turley advised that the focus is on areas of the business with fewer contracts, not those with established processes, estates or digital, and that the intent is to ensure coverage in areas where contract management is not a dedicated role but part of broader responsibilities. Rhiannon acknowledged the explanation and emphasised the importance of monitoring for unanticipated impacts.

The Committee RESOLVED to:
The Joint Directorate Notice (Ref:006-25) was received.

19. REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

19.1 The Chair reflected that the meeting was very open, with lively discussion, and acknowledged the continued maturity in risk management and integrated governance. The Chair also highlighted the value of the internal and external audit reports and was pleased to see progress, especially with many items in the "green."

19.2 Ceri Jackson praised the excellent and succinct reporting, which positively impacted the discussion, and highlighted significant progress and ambition in governance. Rhiannon Beaumont-Wood agreed it was an excellent meeting, emphasising the benefits of working in partnership with auditors to support continuous improvement and the value of using audit to its full potential.

20. ANY OTHER BUSINESS

20.1 None declared.

21. DATE OF THE NEXT MEETING

21.1 The next meeting is scheduled for the 2 December 2025.

The meeting closed at 12:45pm

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST
CONFIRMED MINUTES OF THE EXTRAORDINARY OPEN MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HELD ON 10 OCTOBER 2025 VIA TEAMS

MEMBERS PRESENT:

Bethan Evans	Non-Executive Director and Chair
Rhiannon Beaumont-Wood	Non-Executive Director

PRESCRIBED ATTENDEES:

Lee Brooks	Executive Director of Operations
Henry Garrard	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning & Performance
Hugh Parry	Trade Union Partner
Andy Swinburn	Executive Director of Paramedicine
Liam Williams	Executive Director of Quality and Nursing

ATTENDEES:

Claire Appleton	Assistant Director of Putting Things Right
Jayne Beeslee	Non-Executive Director
Julie Boalch	Assistant Director of Corporate Governance and Risk
Hugh Bennett	Assistant Director of Commissioning and Performance
Kate Blackmore	Assistant Director of Quality Governance
Jonathan Chippendale	Assistant Director of Clinical Development
Colin Dennis	Chair of the Trust Board
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Sarah Harland	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Emma Wood	Chief Executive

APOLOGIES:

Ceri Jackson	Non-Executive Director and Vice Chair of the Board
Mark Marsden	Trade Union Partner
Trish Mills	Director of Corporate Governance/Board Secretary
Angela Mutlow	Director of Operations, Llais
Jonny Sammut	Director of Digital Services

1. WELCOME AND APOLOGIES

1.1 The Chair opened the extraordinary meeting of the Quality, Patient Experience and Safety Committee, convened to consider a single significant agenda item *Call Categorisation Phase Two*, and to review and endorse the Quality Impact Assessment and Equality Impact Assessment.

1.2 Apologies were duly noted and the Chair welcomed members, extending a warm welcome to Emma Wood, the newly appointed Chief Executive, as well as Colin Dennis and Jayne Beeslee, who do not ordinarily attend meetings of this Committee.

1.3 The Chair confirmed the meeting met quorum.

The Committee RESOLVED to: Members were welcomed, apologies were duly noted and it was confirmed the meeting met quorum.

2. DECLARATIONS OF INTEREST

2.1 There were no further declarations of interest to those already listed in the Register.

3. MINUTES FROM THE OPEN MEETING 5 AUGUST 2025

3.1 The minutes from the meeting held on 5 August 2025 were received. Rhiannon Beaumont-Wood requested a minor amendment to Item 9.4, to read "in the emergency assessment unit despite *apparent* available beds". Subject to this amendment, the minutes were accepted as a correct record.

The Committee RESOLVED to: Approve the minutes of the open meeting held on 5 August 2025, which were accepted as correct record, subject to a minor amendment to Item 9.4.

4. CALL CATEGORISATION: PHASE TWO INCIDENT CODING (ORANGE/YELLOW/GREEN) ASSURANCE PACK – QUALITY IMPACT ASSESSMENT AND EQUALITY IMPACT ASSESSMENT

4.1 Liam Williams explained that the Phase Two Performance Framework Quality Impact Assessment (QIA) builds on feedback from Phase One to enhance robustness and clarity, with the Remote Integrated Care Service as a key enabler. Liam credited colleagues for a thorough multi-professional review, describing extensive intelligence gathering and acknowledged ongoing refinement of measures based on Phase One data. Liam expressed confidence in the QIA's readiness for approval. Lee Brooks added that there was a robust discussion at the Finance and Performance Committee on the 16 September 20525, which considered the model's intent and design.

4.2 Key highlights from the ensuing discussion were as follows:

4.2.1 The Chair referenced previous discussions on Phase Two, noting both challenges and assurances on the QIA and Equality Impact Assessment (EqIA) documents, and requested clarification regarding minor amendments from the Clinical Quality Governance Group (CQGG). Liam confirmed the papers were submitted in advance and that CQGG's requested amendments were clarifications rather than substantive changes.

4.2.2 Rhiannon Beaumont-Wood commended the quality and thoroughness of the QIA, while raising concerns regarding the resilience of the remote clinical workforce and emphasising the need for ongoing staff development, robust audit capability and continuous data monitoring. In response, Liam outlined investments in training, education and audit functions, describing efforts to balance assurance with clinician autonomy, and highlighted ongoing work to use process data for continuous improvement and targeted education.

4.2.3 Andy Swinburn emphasised that moving to remote clinical practice requires shifting from process metrics to clinical indicators, with Phase Two continuing improvements having begun in Phase One. Andy stressed the need for embedding these changes and ongoing leadership for resilience.

4.2.4 Lee Brooks explained that the Clinical Model Transformation is separate from the Ambulance Performance Framework, but both share synergies and staff have already adapted to the new patient flow. Lee emphasised the need to review staff capacity and update modelling after implementation. Phase Two will require extra staff support due to new categories, with lessons from Phase One informing this. Support for clinicians will continue beyond the initial go-live period. Lee also highlighted plans to merge Clinical Support Desk (CSD) and 111 into the Remote Integrated Care Service (RICS), backed by investment in a new Computer Aided Dispatch (CAD) system, and ongoing efforts to strengthen team supervision, peer support and training, all expected to be in place before the CAD launch. These changes will help guide the model's future direction.

4.2.5 The Chair raised concerns regarding staff morale and burnout, with Hugh Parry and Henry Garrard emphasising the need for sustained support as winter approaches. Liam, Lee and Andy responded that remote care workflows and enhanced categorisation are expected to improve staff experience and patient prioritisation; and highlighted

ongoing engagement, training and leadership support, stressing that all decisions are guided by a commitment to safety for patients and staff.

4.2.6 The Chair recognised the safety driven approach and requested assurance on the clarity and timing of external communications for the upcoming changes. Members were assured that a suite of communication materials is being developed, including resources for health staff, stakeholders, and the public, with animations and other tools to explain the changes and address the risks associated with the rollout of Phase Two. Coordination with government is underway to align the communications with ministerial announcements regarding the progression to this next phase.

4.2.7 The Committee sought and received assurance that robust monitoring would be in place to detect any increase in patient safety incidents, rather than waiting for scheduled audits; which includes a rapid review of incidents and escalation of concerns. Specifically, the Committee were assured that the learning from Phase One had led to a more dynamic and responsive consideration following any concerns being raised.

4.2.8 The Chair sought assurance regarding how the new model would affect accessibility and quality of access for patients with complex needs, such as those with learning disabilities. Andy explained that, unlike previous algorithm-led models, the involvement of Clinical Navigators and senior clinicians early in the process now enables more bespoke interventions for individuals with unique needs, emphasising the link between the Clinical Model Transformation programme and core categorisation phases. Liam highlighted ongoing initiatives to support people with complex needs, including dementia, mental health and a learning disability register; with further advice to be provided at go live, all underpinned by broader clinical development efforts.

4.2.9 Jayne Beeslee commended the quality of the assessments and progress since the Finance and Performance Committee, and was assured on escalation processes for system pressures and expressed confidence in the Executives' oversight and delivery of the call categorisation changes

4.2.10 The Committee agreed to endorse and recommend for approval the Ambulance Performance Framework Phase 2 Quality Impact Assessment and the Emergency Response Workstream Equality Impact Assessment for Call Categorisation Phase Two to the Trust Board on 23 October 2025. Rachel Marsh confirmed that a paper will come to the Trust Board covering assurance around all aspects of the change, not just the QIA and EqIA, and noted a specific group chaired by Estelle

Hitchon which is working on internal and external communications. Rachel deferred to Liam and Lee for more recent updates.

The Committee RESOLVED to:
Endorse and recommended for approval the Quality Impact Assessment and Equality Impact Assessment for Call Categorisation Phase Two to the Trust Board on 23 October 2025.

5. KEY MESSAGES FOR THE BOARD

5.1 The Chair summarised the endorsement and recommendation as the key message for the Trust Board.

6. REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

6.1 The Chair thanked all contributors for their work and open discussion, robust scrutiny and assurance process for the Call Categorisation Phase Two.

7. ANY OTHER BUSINESS

7.1 None declared.

8. DATE OF THE NEXT MEETING

8.1 The next meeting is scheduled for 04 November 2025.

The meeting concluded at 5:10pm.

MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 18 NOVEMBER 2025 IN THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Hugh Bennett	Assistant Director, Commissioning and Performance
Judith Bryce	Assistant Director of Operations
Julie Boalch	Assistant Director of Corporate Governance and Risk (Joined at Item 89/25)
Matt Dugdale	Head of Commercial Development
Carl Kneeshaw	Director of People
Osian Lloyd	Head of Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
David Murphy	Audit Wales (Joined at Item 85/25 and left at 86/25)
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner (Left at Item 85/25 and rejoined at 84/25)
Alex Payne	Corporate Governance Manager
Ed Roberts	Assistant Director of Finance and Corporate Resources
Jonny Sammut	Director of Digital Services
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing
Emma Wood	Chief Executive

APOLOGIES:

Lee Brooks	Executive Director of Operations
James Houston	Assistant Director of Planning and Transformation Strategy, Planning & Performance
Fflur Jones	Audit Wales
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Chris Turley	Executive Director of Finance and Corporate Resources

80/25 PROCEDURAL MATTERS

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

Minutes: The minutes of the open session held on 16 September 2025 were considered by the Committee and subject to an amendment to the finance section confirmed as a correct record.

Matters Arising: Action originated from the Quality, Patient Experience and Safety Committee (QuEST) meeting on 4 November 2025: Patient Story. The Putting Things Right Report and Alison Clarke's lived experience highlighted the ongoing high demand for Non Emergency Patient Transport Services (NEPTS), which continued to generate complaints about unmet patient needs. Despite support through emotional mapping, enhanced data visibility, and efforts to encourage on-the-spot resolution, complaint levels have not declined. QuEST Committee Members discussed the impact on patient care and have asked the Finance and Performance Committee (FPC) to review current actions and plans to improve service delivery, particularly around eligibility criteria and the challenges patients face due to cancellations and limited capacity. Bethan Evans, the Chair of QuEST, suggested that a thorough examination of this issue would be valuable and that it would be more appropriately addressed at the FPC.

Action Log:

Action 53/25: Quality and Performance Management Framework (QPMF) Logic Benefits Map. *In terms of the QPMF benefits map and the benefits measures it was agreed that the QPMF Steering Group would consider this in further detail. It was agreed an update would be provided at the next meeting following discussion at the QPMG Steering Group*. The meeting was held on 7 October 2025, and a mock-up of the revised benefits map was currently being considered by the FPC Chair. Members recognised that the Chair of FPC and Peter Curran would review the revised benefits in further detail, and it was agreed that a further update would be provided at the FPC meeting on 20 January 2026. Action to remain open

Action 67/25: Phase 2 Go Live of Clinical Model Transformation. *It was agreed that ahead of the extraordinary board meeting (23 October 2025), an extraordinary meeting of the Quality, Patient Experience and Safety Committee (QUEST) will be held to consider the QIA and EqIA, Trish Mills would arrange the Extraordinary QuEST meeting.* The QuEST Extraordinary Meeting was arranged and took place on 10 October 2025. Action closed.

Action 68/25: Monthly Integrated Quality Performance Report (MIQPR). *It was agreed that Jonny Sammut would collaborate with Mark Thomas to explore ways to enhance the presentation of the visuals in the report for improved clarity.* A wider update of the MIQPR is in progress. Hugh Bennett noted that he and Jonny Sammut will attend a meeting on Monday, 24 November 2025, to hear Non Executive Director (NED) feedback. The MIQPR

visuals will be updated prior to this meeting. It was agreed that this action can now be closed.

Committee Highlight Report: The Committee highlight report dated 16 September 2025 was received.

The Committee:

1. **Approved the minutes of the Finance and Performance Committee held on 16 September 2025 subject to a minor amendment to the finance section regarding duplication of text.**
2. **Considered the Action log and noted the update as described above.**
3. **Received the Committee highlight report dated 16 September 2025.**

81/25 OPERATIONS UPDATE

Judith Bryce updated the Committee on several points:

The Manchester Arena inquiry will be discussed further during today's closed session. However, it was worth noting that the Trust had its fifth scrutiny session with the Commissioners in September and was now expecting their response by December 2025.

On 07 October 2025, the Hazardous Area Response Team (HART) participated in *Exercise Tendley 2*, a multi-agency major incident scenario planned and delivered by South Wales Police. The exercise simulated a multi-vehicle road traffic collision involving a coach carrying high-risk football supporters and featured 40 live casualty actors.

The HART drone was now being utilised regularly in a training environment to ensure pilots maintain regular flying hours. In August, the drone capability was successfully demonstrated to the Senior Leadership Team, with live streaming.

The Trust’s support for Yorkshire Ambulance Service (YAS) has concluded and since its inception on 07 April 2025, the Trust had dealt with over twenty-two thousand calls.

While recruitment and retention was stable in some regions, pressures arose when ambulances were diverted to urban centres during hospital handover delays, reducing rural coverage. A task and finish group was addressing these issues, including recruitment, retention, and tailored operational procedures.

The Committee acknowledged that work was also underway to strengthen the Trust’s rural service offer to ensure equitable response times and outcomes.

Members also noted that hospital handover delays contributed to staff overruns, affecting well-being and increasing costs, particularly in rural settings. The forthcoming ”release to respond” policy will require rapid adaptation by health boards.

Hugh Bennett added he was currently engaged in several modelling projects focused on shift overruns. The team was actively supporting operations and colleagues and were undertaking additional modelling to explore potential strategies for addressing overruns.

Members anticipated further deterioration in handover delays in the coming weeks due to the current level of infections and the likelihood that these will continue to rise. The next few months were therefore expected to present significant challenges for the Trust and health boards.

Emma Wood added that in terms of the Wait-45 initiative, both the cabinet Secretary and the NHS Chief Executive have recently raised the issue in the media. An official response will be released during the winter, so health boards must start preparing now; and will probably have four to five weeks to get ready. The situation was clearly unsustainable, so it was critical that they use this preparation period to figure out what changes were necessary to address this issue.

Hugh Parry expressed concern regarding shift overruns, noting a significant disparity between rural and urban areas, which was having an overall impact on the Trust.

Trish Mills recommended that a broader discussion should be held to determine the most appropriate forum to discuss this issue, given the various impacts involved. She will evaluate which forum is best suited for this discussion, considering the comments and concerns raised, and will seek input and assurance from each Committee based on their respective perspectives.

The Committee noted the update.

82/25 FINANCIAL POSITION FOR MONTH FIVE AND MONTH SIX 2025/26

MONTH SIX 2025/26

The month 6 position was noted, and the committee took assurance from the update. The Trust was reporting a revenue year to date deficit of £186k and a small in month surplus of £43k for month 6 2025/26. In line with the balanced financial plan approved as part of the 2025-28 IMTP the Trust is forecasting to breakeven by the year-end. Gross savings of £4.260m have been achieved in month 6 against the target of £4.216m

MONTH SEVEN 2025/26

A PowerPoint presentation update was given by Ed Roberts who provided the Committee with the following details:

The committee noted that for month 7 the Trust was showing a revenue overspend of £135k but delivered an in-month surplus of £51k. Capital expenditure plans continue to be progressed with plans to fully achieve in year.

The key financial risks included the volatility of handover delays and quantifying the cost of shift overruns, which could impact the forecast if they deteriorate over Winter, as well as ongoing uncertainties around the Welsh Risk Pool costs; with a potential additional cost pressure of £330k not yet confirmed.

The Committee also noted the importance of managing the timing of capital spend, given the significant outflows expected in the final months of the year; but received assurance that all procurement and delivery plans were in place.

In line with the Financial Savings Plan the target was £4.9m and the Trust achieved £4.97m and so an overachievement of circa £68,000, which again was positive given the pressures being seen across the rest of the system.

The public sector payment policy was on track for month 7 and the Trust had achieved 98.7% against the 95% target.

Most directorates were currently rated Amber for financial performance, which was generally positive. There have been some changes, but none were cause for concern.

The Trust continues to report the primary risks identified in month 7, consistent with previous months. However, following a reassessment based on the most recent intelligence available, the total reported risk now amounted to £2.5m.

With respect to savings, the Trust continued to exceed expectations both for the current month and cumulatively for the year. While the forecast assumes the Trust will meet the £8.5m savings target by year end, appropriate schemes were being actively pursued with potential for further overachievement.

There was some movement between recurrent and non-recurrent items, and as usual, there were noticeable changes in savings schemes. These adjustments were currently balanced according to forecasts, and further changes were anticipated as the financial year progressed.

Ed Roberts highlighted the capital forecast and as previously noted, the total budget for the year was £30.19m, comprising £5.948m from discretionary sources and £24.242m from all-Wales funding, the majority of which supported the vehicle replacement programme for 2025/2026. He added that all projects were currently on schedule.

Peter Curran queried if it had been determined when reduced shifts result in cashable savings, rather than just efficiency gains and has an analysis been done in this regard. Ed Roberts advised this was based on a shift by shift basis and based on rosters and therefore would be difficult to determine exactly. It was agreed that Ed Roberts would discuss this with Peter Curran in more detail outside of the meeting.

Members held a discussion which considered the recurrent and non-recurrent savings identified with the committee emphasising the importance of focusing on sustainable, recurrent savings. They also recognised the need to maintain close oversight of key risks

and the impact of operational pressures on financial performance was emphasised for future monitoring.

Jonny Sammut informed members that discussions were ongoing with Welsh Government about several discretionary schemes for end-of-year funding. Eight proposals have been submitted totalling approximately £1.7m, covering replacements for PCs and laptops, Wi-Fi improvements, server data storage upgrades, and video conferencing equipment, all aimed at addressing ongoing staff challenges.

Members reviewed the financial implications of shift overruns for the Trust and agreed that an analysis of this matter would be included in the Finance Report at the upcoming Committee meeting in January 2026.

The Committee:

1. **Noted and gained assurance in relation to the Month 6 revenue financial position and performance of the Trust as of 30 September 2025.**
2. **Noted the delivery of the 2025/26 savings plan, and the context of this within the overall financial position of the Trust.**
3. **Noted the capital programme for 2025/26.**
4. **Noted the Month 6 Welsh Government monitoring returns submission (as required by WG).**
5. **Noted the Month 7 position.**

83/25 FINANCIAL SUSTAINABILITY PROGRAMME GOVERNANCE GROUP MEETING UPDATE

Carl Kneeshaw presented the report and gave substantive assurance on the Financial Sustainability Programme, which had focused on strengthening long-term financial resilience.

He added that the group has reorganised into three streams: opportunity identification, commercial strategy, and financial planning, with an emphasis on embedding accountability across all directorates. A commercial strategy steering group will be formed, and the committee endorsed the aim to deliver a plan by the next fiscal year.

Furthermore, external partnerships, particularly in digital and technology, were being explored to drive income and innovation. Next year's savings target was at least £9m, potentially rising to £10–15m. Carl added that directorates were modelling plans accordingly, with all proposals subject to board approval and alignment with strategic priorities.

In terms of the Administrative and Service review, Carl confirmed that all 24 recommendations from the original 2023 review have been implemented and incorporated into indirect plans with any outstanding items closed.

Carl confirmed that the new Head of Commercial Development, Matt Dugdale, joined the Trust on 6 October 2025 and he has commenced work on drafting a commercial plan. The plan will be developed around a more sustainable approach utilising applicable ideas and profitable opportunities. The Head of Commercial Development will now work with the Executive Director of Strategy, Planning and Performance to establish a Commercial Steering Group to develop what good looks like and a forecast of what income may be possible from commercial development.

Following the contract agreement with Omnicell in September 2021, the Trust selected the Supply X Inventory Management System for rollout across NHS Wales, beginning with five Make Ready Depots (MRDs). A dedicated working group, including stakeholders from the Trust and NHS Wales Shared Services Partnership, oversaw the implementation. Supply X integrates with Oracle to automate stock control and optimise inventory levels and has now been successfully deployed across all five MRD sites, with full stocktakes completed.

Going forward, Members acknowledged that senior leaders within the Trust will be reminded of their financial sustainability responsibilities and updated on governance activities within Opportunities, Commercial, and Financial Planning groups. The Trust's financial status and initial settlement information for 2025/26 will be provided, along with group discussions on cost-saving models. Furthermore, implementation of the new governance structure will progress, including forming the Commercial Development and Projects Opportunities Groups, while work continued the Service Review and Supply X.

Matt Dugdale added there was a lot of opportunities within the commercial space and his team was moving at pace and will share plans to the Committee in future updates.

Bethan Evans requested information regarding the timeline for developing this commercial plan and sought clarification about any potential external collaborators. Matt Dugdale commented that the plan will be in place for the start of the new fiscal year. In terms of partnerships the Trust would be looking at partners in Wales and in the digital space and the national bodies such as innovate UK that might help with funding streams linked to research and development as well.

Peter Curran queried how this group was coordinating with ELT and those handling budget models and the IMTP. This year, £8.5m was set as the financial sustainability goal. He asked when and how will next year's target be determined, and what criteria ensure it was reasonable.

Emma Wood mentioned that we do not yet know the settlement amount, but it will probably be around £9m. Ultimately, where the budget ends up will be decided by the board and Directorates will be asked to model their share of the savings plan. The Financial Sustainability Group needs to conduct testing, going through various scenario plans and aligning them with the IMTP, then reporting back to the board. Ultimately, all major decisions and responsibilities will rest with the board.

Ed Roberts commented that modelling has begun for all known costs for the year, including full-year impacts and inflationary increases. It was noted that ICT costs were rising faster than expected, so that was being factored in. The finance team was preparing projections for December, whilst awaiting the Welsh Government's allocation letter, which was likely to signal a nearly flat uplift of around 2.2%, including pay awards.

The Chair asked that in future papers, it would be helpful to include a brief reminder of the governance structure, as its development was important. The Committee will look forward to upcoming papers, including financial sustainability updates, which were expected at least every other meeting. However, if there were any January updates, even a short paper would be appreciated given how quickly things were progressing this financial year.

The Committee took assurance from the update.

84/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT – AUGUST/SEPTEMBER 2025

Hugh Bennett outlined the main points of the report:

1. The overall performance remained broadly stable, with improvements in patient cancellations, consult and close rates, and handover delays. Whilst performance has improved, winter pressures will be challenging.

2. The 999 call answering times during September 2025 saw the 95th percentile decreasing to 18 seconds, compared to 23 seconds in August 2025.

3. 111 Clinical response: clinical ring back times for patients with the highest priority remained above target at 99.1%. Response times for lower priority calls showed a minimal decrease, reducing to 71.4% and 65.1% for P2CT and P3CT respectively.

4. Major upcoming changes include new clinical response categories (orange, yellow, green, the biggest change in a decade) and rostering reviews in Q4.

5. A JCC commissioning review was underway, offering an opportunity to clarify operational realities, particularly handover delays.

6. Early data shows a positive link between reduced handover hours and jobs per shift, though further analysis and benchmarking were needed.

Bethan Evans inquired if the Trust was prepared to start phase two and was everything in place to deliver the expected performance. Hugh Bennett responded by stating that as vice chair of the core categorisation task and Finish group, he was chairing the meeting this afternoon; the group will review the final checklist and go through the operations order outlining all the necessary arrangements.

The Committee Considered the August/September 2025 Integrated Quality and Performance Report, and the actions being taken and determined that the report provided sufficient assurance.

85/25 DIGITAL REPORTING

The Digital KPIs relating to data and analytics, ICT systems, digital services, projects & programmes, and details on the progress against the Digital Plan were presented. Of note:

Digital teams face significant pressure from competing priorities and limited capacity whilst the teams continue to prioritise the Clinical Model Transformation.

Additional capacity in the digital team will be in place with 26 roles at various stages of the recruitment process. Several challenges had been posed by high volumes of applications, a large proportion of which were AI generated, which was being felt across all directorates. A related risk is being developed.

The Trust were engaging in a national project to unify the multiple Directories of Service managed around NHS Wales.

With the new Head of Digital Business Change & Benefits due to commence in post early December, the final arrangements were in preparation for Digital Trial Information Platform (DTIP). This included the development of the triage and prioritisation process, Key Performance Indicators (KPI)s and governance (including the Terms of Reference, standing agenda items and membership)

Jonny Sammut suggested a future deep-dive session on AI-driven cyber threats for the committee, given the fast-moving nature of these risks and the need for better understanding and questioning, which was supported by the chair.

Peter Curran asked about recruitment risks and IT department future proofing. Jonny Sammut commented that delays were affecting the Trust, with shortlisting 300 applications being a major effort. The Trust was using AI to assist, but it takes time and often highlights candidates who look good on paper, making it challenging to identify real talent. The Team was working with the Director of People to address this issue.

The Committee acknowledged the contents of the paper and agreed it provided assurance on the progress of the Digital Plan activities, IMTP commitments and CMT involvement of the Digital Directorate teams.

86/25 INFORMATION GOVERNANCE REPORT

Jonny Sammut introduced the Information Governance (IG) Report which highlighted key updates including the IG toolkit compliance at 90% which was commended. Other issues of note included:

Dormant account numbers have been significantly reduced from around to 3,000 to 464, with ongoing work to refine definitions.

New Key Performance Indicators (KPI)s have been introduced for reporting timeliness and data quality awareness. The latest version of the KPI report sees the addition of new Data Quality metrics related to the timeliness of reporting to Commissioners and Welsh Government, as well as monitoring of the new Data Quality awareness training which was released Trust-wide early October.

Recent data breaches linked to social media use have prompted a new awareness campaign. Additionally, a proposal was made to run a deepfake simulation campaign to test staff awareness of cyber threats that may come through various media and communication channels.

IG Copilot Assistant: a Copilot AI-agent has been developed and was being trialled to support the IG team with data protection query related demand. The tool allows users to ask questions and provides tailored guidance, including direct links to internal and the Information Commissioner's Office (ICO) resources.

Expired Mandatory Training: in August, 290 members of staff were identified as having overdue mandatory IG training and therefore were non-compliant. After reminder letters were sent, the number reduced to 194; however, some of these staff members have not completed their mandatory IG training for several years, so further communication and escalation was deemed necessary.

WhatsApp usage: there have been several recent data breaches involving the use of WhatsApp, raising concerns about its widespread use for sharing of sensitive information between colleagues.

The Trust's Records Team was under extreme pressure, with a 34% increase in records requests in September 2025 compared to September 2024.

The Committee discussed the data breaches on WhatsApp usage and inquired about the wider use of social media. Jonny Sammut advised that a range of advisory statements have been issued on Siren, the policy was up to date and will be brought up at a WAST live session going forward.

Damon Turner added that the Trust must be mindful that staff were using their own mobile devices.

The Committee Considered the contents of the paper and were assured it gave assurance on the progress of the Trust's Information Governance arrangements and related specialist activities for Data Quality, Records Management, Freedom of Information requests and Information Security.

87/25 INTERNAL AUDIT: IMTP DEVELOPMENT PRACTICES (Q1 -Q2)

Hugh Bennett presented the internal audit report on the IMTP development process which had been given a substantial assurance rating. A single IMTP Development Group now coordinates planning across directorates through existing governance structures.

The overall process reflected political uncertainty post-2026 elections and a difficult financial outlook. To address change fatigue and capacity constraints, the focus had shifted to consolidating priorities and realising benefits, informed by staff and board feedback. Engagement was now embedded in existing meetings with increased board involvement. Directorates have reviewed deliverables for completion, rollover, or cessation, and identified new priorities. Despite capacity challenges, development remained on track for submission by 31 March 2026.

Trish Mills had received assurance that the three recommendations within the report were expected to be completed by the December deadlines.

The Committee received the Internal Audit Report on IMTP Development Practices (Q1-Q2)

88/25 INTEGRATED MEDIUM TERM PLAN (IMTP) PROGRESS REPORT AND DEVELOPING THE 2026/27 INTEGRATED MEDIUM TERM PLAN (IMTP) (REFRESHED APPROACH)

Hugh Bennett presented the Committee with the Integrated Medium Term Plan (IMTP) Q2 Assurance Report with a focus for this committee on the outcome measures for the strategic objectives (what good looks like) and the go live assurance process for phase two of the Ambulance Performance Framework.

The Clinical Model Transformation (CMT) Programme was progressing well, with key documents and processes now embedded. While the programme advanced at pace and IMTP deliverables showed positive progress, organisational capacity continued to be a constraint.

Hugh Bennett assured Members that all plans were in place and progressing well for go-live of phase 2 of the CMT in December 2025.

The Chair addressed comments about being too critical regarding "amber" ratings, noting there was nothing wrong with an amber rating. This category drew needed attention and was not common in programme management, which usually used only green or amber.

Judith Bryce, in addressing the Trust’s level of preparedness for phase two advised that the team was fully briefed on the operations plan and a comprehensive command structure has been established.

The Chair asked what 'good' should look like and why the Trust focused on certain areas. Trish Mills explained that, based on the IMTP, it was defined what 'good' means for each strategic objective to enable measurement and clarify discussions about strategic risk.

Developing the 2026/27 Integrated Medium Term Plan (IMTP) (refreshed approach)

Hugh Bennett explained that the purpose of this paper was to provide the Committee with an update and overview of the urgent work undertaken to refresh the organisational approach to develop the 2026/27 Integrated Medium Term Plan (IMTP).

It was to be noted that the planning guidance has been developed at pace and was included in draft form for information, following an initial review by the Strategic Transformation Board (STB) on 03 November 2025. A final review was required with key groups in readiness for final sign off and approval at the next STB meeting

The Committee:

1. **Noted progress for the quarter 2 IMTP deliverables (CMT & Directorate level reported deliverables).**
2. **Noted the Go Live approach for implementing Phase 2 of the Ambulance Performance Framework.**
3. **Noted the 'What good looks like' outcome measures.**
4. **Noted the update provided in this report in terms of Developing the 2026/27 Integrated Medium Term Plan (IMTP) (refreshed approach)**
5. **Noted the IMTP development approach described in the draft IMTP Planning Guidance (subject to further refinement and approval).**

89/25 COMMITTEE QUALITY AND GOVERNANCE REVIEW

Trish Mills reminded Members that the Committee has held the first part of its Quality Governance Review (formerly effectiveness review) for 2025/26.

Most major changes to the committee's terms of reference will be deferred until after the external board effectiveness review, however members agreed that the commercial partnerships element of the Academic Partnerships Committee's remit appropriately sat in this committee.

The improvements in quality and volume of reports were recognised. The presence and contribution of Non-Executive Directors were consistently valued, with positive feedback on their breadth of experience, scrutiny, and support, which strengthened the committee's operations.

The review will be driven by key project objectives:

- Aligning committee remits more closely to the six strategic objectives
- Improving efficiency and effectiveness in governance

- Reducing meeting frequency and alleviating quorum/Non-Executive Director (NED) availability pressures
- Ensuring strong scrutiny, challenge, and support through increased NED attendance on key committees
- Balancing workloads and minimising disruption during a period of executive transition

Members were keen to ensure that duplication with the board and other committees was avoided. The Committee terms of reference were approved, and the committee's annual report will be reviewed in March 2026.

Trish Mills added that it will be recommended to the Audit, risk and Assurance Committee (ARAC) that the following changes to the Board's committee framework take effect from 1 April 2026, with any material changes deferred until the external provider has reported back to the Board on committee structures:

- The Academic Partnership Committee (APC) will continue to meet twice annually in 2026/27, with a focus on the research and development portfolio. This was agreed at the APC meeting on 7 October.
- APC delegated responsibilities relating to education partnerships and collaboration will transfer to PCC and those related to commercialisation will transfer to FPC.
- Four NEDs will be asked to attend each of the following committees: Finance and Performance Committee (FPC), Quality, Patient Safety and Experience Committee (QUEST), People and Culture Committee (PCC) and ARAC. This will ensure a quorum of three per meeting. The board skills mix has been updated, and the Trust Chair and NEDs will hold discussions in October on their committee commitments.
- Minor changes are proposed for the QUEST committee with the transfer of value based healthcare from FPC.
- No changes are proposed for the Charity or Remuneration Committees.

Trish Mills referenced the questions that were asked during the recent survey

1. Are there any changes you wish to see to the terms of reference
2. Are there any changes you would like to see to the committee's membership
3. What works well in this committee
4. What improvements would you recommend

Members noted that the answers to these questions were contained in the report and further discussed each one in more detail during the meeting.

Trish Mills added that standing orders require the Trust to review the committee's effectiveness every year, and they must be documented in the annual report.

Trish Mills presented the FPC Terms of refence drawing out salient points for their attention which were approved.

The Chair, reflecting on the comments, raised a valid point that the Committee has effectively managed situations where actions were taken from the QuEST Committee at this meeting, and she recalled in the past six months, the Committee also assigned an action to the PCC. This demonstrated the ability to handle those points of intersection appropriately.

The Chair further added that in terms of development, it was important to balance the committee's overall needs with those of individuals, especially for new Non-Executive Directors who face a steep learning curve. The goal was to distinguish between gaining specific knowledge and understanding the broader dynamics and behaviours that make us an effective committee and board. I appreciate all the work done so far and look forward to seeing the results.

The Committee recorded a note of thanks to Trish Mills and her team for their efforts behind the scenes in producing this work.

The Committee:

1. **Noted the wider board committee framework changes proposed and provide feedback on the recommendations.**
2. **Noted the responses to the survey, inviting members who did not have an opportunity to complete the survey to provide further feedback.**
3. **Approved changes to the terms of reference.**

90/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

The committee received the Risk and Board Assurance Framework report noting that all risks have undergone their quarterly review, with no material changes to scores.

Financial risks were discussed throughout in the context of ongoing pressures, including the need to revisit Risk 139. (*Failure to Deliver our Statutory Financial Duties in accordance with legislation)*

Members acknowledged that financial risks were significant, especially given the challenging outlook highlighting the pivotal role the committee will play in navigating the future financial situation.

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*) will be reviewed for possible integration into the new stakeholder risk, which has been disaggregated from the Trust's reputational risk.

Members discussed the ongoing work to distinguish and score risks and factors that were within the Trust's control versus those that were externally monitored, with research on best practices underway for scoring these dimensions. Risk 542 (*Failure to deliver the*

Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan) will be presented at the next meeting showcasing the new approach.

Peter Curran requested an update on future risk developments, such as the decarbonisation risk. Julie Boalch responded that a workshop was planned and research on scoring was in progress; although this will not affect the overall risk score, it will provide better insights into how the score was changing. The decarbonisation risk will be discussed at the January meeting, where the new template will highlight factors both within and outside of the Trust's control.

Jonny Sammut suggested a future deep-dive session on AI-driven cyber threats for the committee, given the fast-moving nature of these risks and the need for better understanding and questioning.

Judith Bryce advised that on 28 October 2025 the Operations Directorate reviewed the Risk 223 (*the Trust's inability to reach patients in the community causing patient harm and death)* and made the recommendation in reducing the score from the likelihood of harm occurring from 25 to 20. Julie Boalch suggested that this should probably be included in the FPC AAA, since reductions in scores need to follow governance protocols involving the ELT, which will meet in December. The Committee should consider adding a note under "risk" in the AAA to indicate that a reduction in risk was anticipated. This issue can then be addressed more formally during the next review. Trish Mills suggested it would be more appropriate for this to reported through the QuEST AAA because Risk 223 was monitored by that committee.

The Committee Considered the contents of the report including:

- **a. The controls in place against the risks.**
- **b. The actions described to further mitigate the risks.**

91/25 AUDIT TRACKER - SEPTEMBER 2025 (2025/26 Q2)

Trish Mills updated the Committee on the audit tracker for Q2 with good progress on closures. Where there were extensions of dates members were assured that they were appropriate and realistic.

In terms of the External Audit recommendations, one had been closed with two not due during this cycle.

Peter Curran inquired if the revised due dates on the vehicle accident management recommendations, by December any update are they likely to be implemented
Judith Bryce advised a group was looking at this and was acutely aware of deadlines and was confident this would be achieved.

The Committee:

1. **Received assurance on the monitoring of management actions to address recommendations in the Tracker and the rationale for the closure of actions.**

2. **Raised minor concerns regarding the impact on the risks raised in audits by extending the dates for completion of management actions relating to the Vehicle Accident Management audit.**

3. **Noted the progress reported against the remaining 2024/25 Data Quality internal audit recommendations which now concludes the actions associated with this audit.**

92/25 POLICY FOR APPROVAL

Trish Mills explained that the Estates, Environmental and Facilities Management Policy was with the Committee for approval and had followed a robust governance process.

Trish Mills added the Trust was aiming to streamline policy approvals by delegating most decisions and only bringing essential policies. A review of this process was planned for next year and will be discussed with the ELT; more details will follow. For now, this policy was here for approval, though there was strong interest in shifting policies away due to the thorough oversight they already received.

The Chair advised the Committee should focus on policies that were more strategic.

The Committee approved the Estates, Environmental and Facilities Management Policy.

93/25 COMMITTEE CYCLE OF BUSINESS MONITORING REPORT AND PRIORITIES UPDATE

Trish Mills advised that the Committee's annual priorities were reviewed and were progressing well.

The Committee noted the update to the Committee Cycle of Business Monitoring Report and Committee Priorities.

94/25 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

The Chair drew out the actions that were agreed during the meeting.

1. Operations Update - Impact of Shift Overruns: Trish Mills proposed a wider discussion on the most suitable forum, taking into account various impacts on the shift overruns both from a rural and urban perspective and will determine where to discuss this. The discussion will also ensure that each Committee's perspective is addressed.

2. Finance report - Shift overruns cost analysis - Members reviewed the financial implications of shift overruns for the Trust and agreed that an analysis of this matter would be included in the Finance Report at the upcoming Committee meeting in January 2026.

3. Digital Reporting - Jonny Sammut suggested a future deep-dive session on AI-driven cyber threats for the committee, given the fast-moving nature of these risks and the need for better understanding and questioning.

Members reflected that that the committee was currently well-positioned, with strong in-year financial management and effective agenda planning, but faced significant future challenges such as financial pressures, cyber risks, and changes within Welsh Government.

The committee's pivotal role in steering through these headwinds while also grasping opportunities for innovation and resource optimisation was acknowledged. The effective and efficient flow of the meeting was commended; with discussions regarding risk management embedded throughout.

Meeting concluded at 12:50

Date of Next Meeting: 20 January 2026