Bundle Trust Board (Open Session) 29 May 2025

Agenda attachments

ITEM 00 Agenda Cymru
ITEM 00 Agenda 29 May 2025

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apologies and Quorum

2 Declarations of Interest
ITEM 02 Board Member Register of Interests - Updated 26 March 2025

3 Minutes of the Last Meeting:
3.1 Trust Board 27 March 2025
3.2 Trust Board, Extraordinary meeting 7 May 2025
ITEM 03.1 2025-03-27 Trust Board Minutes DRAFT
ITEM 03.2 2025-05-07 Trust Board Minutes DRAFT1

4 Action Log & Matters Arising
ITEM 04 Action Log

5 09:35 - Chair and Vice Chair's Report
ITEM 05 Chair's and Vice-Chair's Report to Board - May 2025

6 09:40 - Chief Executive's Report
ITEM 06 CEO Report to Trust Board - May 2025

7 10:00 - Questions from Members of the Public

8 10:10 - Staff/Patient Story 'Dylan's Story'
8.1 Follow up on previous staff/patient story - Volunteer Car Service - Verbal Update

8.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

9 10:30 - Actions to Mitigate Avoidable Patient Harm
ITEM 09 Patient Harm Realtime Mitigations may 2025 final
ITEM 09.1 Patient Harm Dashboard MoC 20250520(1)

10 10:50 - Risk Management and Board Assurance Framework
ITEM 10 Executive Summary Risk Management Report Trust Board 290525

11 11:00 - Monthly Integrated Quality and Performance Report (MIQPR), including Annual Review of Metrics
ITEM 11 MIQPR SBAR TB March April 2025
ITEM 11.1 MIQPR TB March April 2025

11.1 11:15 - COMFORT BREAK

12 11:30 - Integrated Medium Term Plan (IMTP) Delivery/Assurance End of year report
ITEM 12 2505 - Executive Summary - IMTP Delivery & Assurance End of Year Report_v1.0

13 11:40 - Finance Report Month 12 2024/25
ITEM 13.1 Finance Update Month 1, 2025/26
ITEM 13 Finance Report Month 1 2526 - TB Final
ITEM 13.1 Finance Report Month 12 24-25 FINAL TB

14 12:00 - 2024/25 Annual Board and Committee Effectiveness Review (to include Annual Board Visits Report)
ITEM 14 SBAR to May 2025 Board on Effectiveness Reviews 24-25
ITEM 14.1 Annex 01 - Committee remits delegated by Board 25-26
ITEM 14.2 Annex 02 APC annual report 2024-25
ITEM 14.3 Annex 03a ARAC annual report 2024-25
ITEM 14.4 Annex 03b ARAC terms of reference for 2025-26 for approval
ITEM 14.5 Annex 04a FPC annual report 2024-25
ITEM 14.6 Annex 04b FPC terms of reference 2025-26 for approval
ITEM 14.7 Annex 05a PCC annual report 2024-25
ITEM 14.8 Annex 05b PCC terms of reference for 2025-26 for approval
ITEM 14.9 Annex 06a QuEST annual report 2024-25
ITEM 14.10 Annex 06b QuEST terms of reference for 2025-26 for approval
ITEM 14.11 Annex 07a RemCom annual report 2024-25
ITEM 14.12 Annex 07b RemCom terms of reference for 2025-26 for approval

ITEM 14.13 Annex 08 - Changes to board and committee operating arrangements 2025-26
ITEM 14.14 Annex 09 - Progress report on changes to operating arrangements completed in 2024-25
ITEM 14.15 Annex 10 - Board Visits Heatmap

15 12:15 - Audit Wales Detailed Annual Audit Plan
ITEM 15 WAST Detailed Audit Plan 2024-25 (Final)

16 12:25 - Partnerships and Engagement report May 2025
ITEM 16 PEBoardReportMay25

17 12:40 - Governance Report
ITEM 17 Governance Report - May 2025
ITEM 17.1 Trust Board Ambulance Performance Framework May_25 FINAL V0.5
ITEM17~1
ITEM 17.2. CMT Programme EQIA Definition Document_v1

18 12:50 - Board Committee Reports
ITEM 18.1 Highlight report ARAC 1 May 2025
ITEM 18.2 QuEST AAA 9 May 2025
ITEM 18.2a - Strategic Quality Plan 2025-2028 - QuESt Endorsed
ITEM 18.2b Annex 4 - Quality Plan EQIA
ITEM 18.3 People and Culture Committee AAA Highlight Report 15 May 2025
ITEM 18.3a Staff Survey Appendix
ITEM 18.3b Annual Report 24-25
ITEM 18.4 Remuneration Committee AAA Report 15 May 2025 Public Board
ITEM 18.5 Finance and Performance Committee Highlight Report May 2025

18.1 CONSENT ITEMS

19 Minutes of Board Committees
ITEM 19.1 - 4 February 2025 - Quality, Patient Experience and Safety Committee
ITEM 19.2 - 18 February 2025- People and Culture Committee
ITEM 19.3 - 6 March 2025 - Audit, Risk and Assurance Committee
ITEM 19.4 - 18 March 2025- Finance and Performance Committee
ITEM 19.1 2025-02-04 QUEST OPEN MINUTES pdf
ITEM 19.2 2025-02-18 PCC Open confirmed Minutes
ITEM 19.3 2025-03-06 ARAC OPEN Minutes
ITEM 19.4 2025-03-18 OPEN F and P Minutes

20 JCC Highlight Report 18 March 2025
ITEM 20 JCC Highlight Report - JCC 18 March 2025

20.1 13:10 - CLOSING ITEMS

21 Reflections and Summary of Decisions/Actions

22 Any Other Business

23 Exclusion of the press and members of the public.

24 Date & Time of the Next Meeting: 31 July 2025

25 Acronyms
ITEM 25 Acronyms 2024 (2)

Hyd y cyfarfod:	03:55	Statws yr agenda:	DRAFFT	BWRDD ADORED YR YMDDIRIEDOLAETH - 29 MAI 2025					Dyddiad cau ar gyfer papurau: 20 Mai 2025	
Amser	Munudau a neilltuwyd	Agendum	Wedi'i dderbyn?	Teitl	Eitem ar gyfer	Cais am eitem gan	Fformat	Papur a baratowyd gan	Eitem wedi'i chyflwyno gan	Cydweithwyr i'w cynnwys
				EITEMAU AGORIADOL						
		1	Amh	Croeso gan y Cadeirydd, Ymddiheuriadau a Chworwm	Gwybodaeth	Sefydlog	Ar lafar	Amherthnasol	Cadeirydd	
		2	Amh	Datganiadau o Fuddiant	I ddatgan gwrthdaro	Sefydlog	Ar lafar	Amherthnasol	Cadeirydd	
09:30	00:05	3	Amh	Cofnodion y Cyfarfod Diwethaf: 3.1 Bwrdd yr Ymddiriedolaeth 27 Mawrth 2025	Cymeradwyaeth	Sefydlog	Papur	Amherthnasol	Cadeirydd	
		4	Amh	Log Camau Gweithredu (Dim camau gweithredu agored) a Materion yn Codi	Trafodaeth	Sefydlog	Papur	Amherthnasol	Cadeirydd	
09:35	00:05	5		Adroddiad y Cadeirydd a'r Is-gadeirydd	Gwybodaeth	Sefydlog	Papur	CorGov	Cadeirydd, Is-gadeirydd	Alex Payne
09:40	00:20	6		Adroddiad y Prif Swyddog Gweithredol	Gwybodaeth	Sefydlog	Papur	Swyddfa'r Prif Swyddog Gweithredc	Prif Swyddog Gweithredol	Keith Ellingham
10:00	00:10	7	Amh	Cwestiynau gan Aelodau'r Cyhoedd	Gwybodaeth	Sefydlog	Ar lafar	Partneriaethau	Estelle Hitchon	
10:10	00:20	8		Stori staff/cleifion 'Stori Dylan' Stori Dylan - mae'r stori hon hefyd wedi'i threfnu ar gyfer cyfarfod y Quest ar 9 Mai.	Gwybodaeth	Sefydlog	Ar lafar	QPSE	Liam Williams	Leanne Hawker
		8.1		Dilyn i fyny ar stori staff/claf blaenorol - Gwasanaeth Ceir Gwirfoddol	Sicrwydd	Sefydlog	Ar lafar	Ops	Lee Brooks	
				EITEMAU AT GYFER CYMERADWYAETH, SICRWYDD A THRAFODAETH						
10:30	00:20	9		Camau i Liniaru Niwed Cleifion y Gellir ei Osgoi	Sicrwydd	Sefydlog	Papur	SPP	Jason Killens	Rachel Marsh, Hugh Bennett
10:50	00:10	10		Diweddariad ar Drawsnewid Model Clinigol - i'w gadarnhau yn dilyn cyfarfod y Bwrdd ar 7 Mai	Sicrwydd	Ad hoc	Papur	SPP	Rachel Marsh	Hugh Bennett, Alex Crawford
11:00	00:10	11		Rheoli Risg a Fframwaith Sicrwydd y Bwrdd	Sicrwydd	Sefydlog	Papur	CorGov	Trish Mills	Julie Boalch
11:10	00:15	12		Adroddiad Ansawdd a Pherfformiad Integredig Misol (MIQPR) Adolygiad Blynyddol o Fetrigau	Sicrwydd Cymeradwyaeth	Sefydlog	Papur	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Melanie O'Connor
11:25	00:15			EGWYL						
11:40	00:10	13		Sefyllfa Diwedd Blwyddyn Cynllun Tymor Canolig Integredig 2024/25 a Chynllun Sicrwydd Ymlaen Llaw ar gyfer 2025/26	Sicrwydd	CoB	Papur	SPP	Rachel Marsh	Alex Crawford
11:50	00:10	14		Diweddariad Cyllid Mis 12, 2024/25	Sicrwydd	Sefydlog	Papur	FinCor	Chris Turley	Edward Roberts
12:00	00:10	15		Diweddariad Cyllid Mis 1, 2025/26	Sicrwydd	Sefydlog	Papur	FinCor	Chris Turley	Edward Roberts
12:10	00:15	16		Adolygiad Effeithiolrwydd Blynyddol 2024/25 o'r Bwrdd a'i Bwyllgorau Cylch Gorchwyl	Sicrwydd Cymeradwyaeth	CoB	Papur	CorGov	Trish Mills	Alex Payne
12:25	00:10	17		Cynllun Archwilio Blynyddol Archwilio Cymru 2025/26	Cymeradwyaeth	CoB	Papur	CorGov	Fflur Jones	Trish Mills Lisa Trounce
12:35	00:15	18		Adroddiad Partneriaethau ac Ymgysylltu. Yn gysylltiedig â risg 201 (Colli hyder rhanddeiliaid sy'n niweidio enw da'r Ymddiriedolaeth).	Sicrwydd	Blaengynllun	Papur	Partneriaethau	Estelle Hitchon	
12:50	00:10	19		Adroddiad Llywodraethu (i gynnwys Adroddiad Ymweliadau Bwrdd Blynyddol)	Cymeradwyaeth	Yn ôl y gofyn	Papur	CorGov	Trish Mills	Alex Payne
		20		Adroddiadau Pwyllgorau'r Bwrdd:	Sicrwydd	Sefydlog	Papur	CorGov		
		20.1		1 Mai 2025 - Y Pwyllgor Archwilio, Risg a Sicrwydd	Sicrwydd	Sefydlog	Papur	CorGov	Peter Curran	
13:00	00:20	20.2		9 Mai 2025 Y Pwyllgor Ansawdd, Cleifion a Phrofiad	Sicrwydd	Sefydlog	Papur	CorGov	Bethan Evans	
		20.3		15 Mai - Y Pwyllgor Pobl a Diwylliant	Sicrwydd	Sefydlog	Papur	CorGov	Ceri Jackson	
		20.4		20 Mai 2025 - Y Pwyllgor Cyllid a Pherfformiad	Sicrwydd	Sefydlog	Papur	CorGov	Jayne Beeslee	
				EITEMAU CYDSYNIAD Mae'r eitemau sy'n dilyn er gwybodaeth yn unig. Os bydd aelod yn dymuno trafod unrhyw rai o'r eitemau hyn gofynnir iddo hysbysu'r Cadeirydd fel y gellir neilltuo amser i wneud hynny.						
13:20	00:00	21	Amh	Cofnodion Pwyllgorau'r Bwrdd: 4 Chwefror 2025 - Y Pwyllgor Ansawdd, Profiad Cleifion a Diogelwch 18 Chwefror 2025 - Y Pwyllgor Pobl a Diwylliant 6 Mawrth 2025 - Y Pwyllgor Archwilio, Risg a Sicrwydd 18 Mawrth 2025 - Y Pwyllgor Cyllid a Pherfformiad	Gwybodaeth	Sefydlog	Papur	CorGov	Cadeirydd	
		22	09/04/2025	Adroddiad Uchafbwyntiau'r Cyd-bwyllgor Comisiynu 18 Mawrth 2025	Gwybodaeth	Sefydlog	Papur	CorGov	Cadeirydd	
				EITEMAU CAU						
		23	Amh	Myfyrdodau a Chrynodeb o Benderfyniadau/Camau Gweithredu	Trafodaeth	Sefydlog	Ar lafar	Amherthnasol	Cadeirydd	
		24	Amh	Unrhyw Fater Arall	Trafodaeth	Sefydlog	Ar lafar	Amherthnasol	Cadeirydd	

13:20	00:05	25	Amh	Gwahardd y wasg ac aelodau'r cyhoedd. Gwahodd y wasg a'r cyhoedd i adael y cyfarfod oherwydd natur gyfrinachol y busnes sydd ar fin cael ei drafod (yn unol ag Adran 1(2) o Ddeddf Cyrff Cyhoeddus (Mynediad i Gyfarfodydd) 1960).	Cymeradwyaeth	Sefydlog	Ar lafar	Amherthnasol	Cadeirydd	
		26	Amh	Dyddiad ac Amser y Cyfarfod Nesaf: 31 Gorffennaf 2025	Gwybodaeth	Sefydlog	Ar lafar	Amherthnasol	Cadeirydd	
		27	Amh	Acronymau	Gwybodaeth	Sefydlog	Papur	Amherthnasol	Cadeirydd	
13:25	**03:55**			**DIWEDD Y CYFARFOD**						

PRIF GYFLWYNWYR

Enw	Swydd
Jayne Beeslee	Cyfarwyddwr Anweithredol; Cadeirydd y Pwyllgor Cyllid a Pherfformiad
Lee Brooks	Cyfarwyddwr Gweithredol Gweithrediadau
Peter Curran	Cyfarwyddwr Anweithredol, Is-gadeirydd a Chadeirydd ARAC
Colin Dennis	Cadeirydd Bwrdd yr Ymddiriedolaeth
Bethan Evans	Cyfarwyddwr Anweithredol, Cadeirydd QuEST
Estelle Hitchon	Cyfarwyddwr Partneriaethau
Ceri Jackson	Cyfarwyddwr Anweithredol, Is-gadeirydd y Bwrdd a Chadeirydd PCC
Jason Killens	Prif Swyddog Gweithredol
Angela Lewis	Cyfarwyddwr Newid Diwylliant
Rachel Marsh	Cyfarwyddwr Gweithredol Strategaeth, Cynllunio a Pherfformiad
Trish Mills	Cyfarwyddwr Llywodraethu Corfforaethol/Ysgrifennydd y Bwrdd
Chris Turley	Cyfarwyddwr Gweithredol Cyllid ac Adnoddau Corfforaethol
Fflur Jones	Archwilio Cymru

Length of Meeting:	03:45	Agenda Status:	OPEN TRUST BOARD - 29 MAY 2025					Deadline for papers: 20 May 2025	
Time	**Mins allotted**	**Agendum**	**Title**	**Item for**	**Item requested by**	**Format**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**
			OPENING ITEMS						
		1	Chair's Welcome, Apologies and Quorum	Information	Standing	Verbal	n/a	Chair	
		2	Declarations of Interest	To State Conflicts	Standing	Verbal	n/a	Chair	
09:30	00:05	3	Minutes of the Last Meeting: 3.1 Trust Board 27 March 2025 3.2 Trust Board, Extraordinary meeting 7 May 2025	Approval	Standing	Paper	n/a	Chair	
		4	Action Log & Matters Arising	Discussion	Standing	Paper	n/a	Chair	
09:35	00:05	5	Chair and Vice Chair's Report	Information	Standing	Paper	CorGov	Chair, Vice Chair	Alex Payne
09:40	00:20	6	Chief Executive's Report	Information	Standing	Paper	CEO Office	CEO	Keith Ellingham
10:00	00:10	7	Questions from Members of the Public	Information	Standing	Verbal	Partnerships	Estelle Hitchon	
10:10	00:20	8	Staff/Patient Story 'Dylan's Story'	Information	Standing	Verbal	QPSE	Liam Williams	Leanne Hawker
		8.1	Follow up on previous staff/patient story - Volunteer Car Service	Assurance	Standing	Verbal	Ops	Lee Brooks	
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
10:30	00:20	9	Actions to Mitigate Avoidable Patient Harm	Assurance	Standing	Paper	SPP	Jason Killens	Rachel Marsh, Hugh Bennett
10:50	00:10	10	Risk Management and Board Assurance Framework	Assurance	Standing	Paper	CorGov	Trish Mills	Julie Boalch
11:00	00:15	11	Monthly Integrated Quality and Performance Report (MIQPR), including Annual Review of Metrics	Assurance Approval	Standing	Paper	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Georgia Tizzard, Melanie O'Connor
11:15	00:15		COMFORT BREAK						
11:30	00:10	12	Integrated Medium Term Plan (IMTP) Delivery/Assurance End of year report	Assurance	CoB	Paper	SPP	Rachel Marsh	Alex Crawford
11:40	00:20	13	Finance Update Month 12, 2024/25 Finance Update Month 1, 2025/26	Assurance	Standing	Paper	FinCor	Chris Turley	Edward Roberts
12:00	00:15	14	2024/25 Annual Board and Committee Effectiveness Review Committee Terms of Reference	Assurance Approval	CoB	Paper	CorGov	Trish Mills	Alex Payne
12:15	00:10	15	Audit Wales Detailed Annual Audit Plan	Approval	CoB	Paper	CorGov	Fflur Jones	Trish Mills Lisa Trounce
12:25	00:15	16	Partnerships and Engagement report May 2025	Assurance	Forward Planner	Paper	Partnerships	Estelle Hitchon	
12:40	00:10	17	Governance Report 17.1 Clinical Model Transformation - 07 May Trust Board Meeting Paper 17.2 Clinical Model Transformation - EqIA	Approval	As required.	Paper	CorGov	Trish Mills	Alex Payne
		18	Board Committee Reports:	Assurance	Standing	Paper	CorGov		
		18.1	1 May 2025 - Audit, Risk and Assurance Committee	Assurance	Standing	Paper	CorGov	Peter Curran	
12:50	00:20	18.2	9 May 2025 Quality, Patient and Experience Committee	Assurance	Standing	Paper	CorGov	Bethan Evans	
		18.3	15 May 2025 - People and Culture Committee	Assurance	Standing	Paper	CorGov	Ceri Jackson	
		18.4	15 May 2025 - Remuneration Committee	Assurance	Standing	Paper	CorGov	Colin Dennis	
		18.5	20 May 2025 - Finance and Performance Committee	Assurance	Standing	Paper	CorGov	Jayne Beeslee	
			CONSENT ITEMS The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.						
13:10	00:00	19	Minutes of Board Committees: 4 February 2025 - Quality, Patient Experience and Safety Committee 18 February 2025- People and Culture Committee 6 March 2025 - Audit, Risk and Assurance Committee 18 March 2025- Finance and Performance Committee	Information	Standing	Paper	CorGov	Chair	
		20	JCC Highlight Report 18 March 2025	Information	Standing	Paper	CorGov	Chair	
			CLOSING ITEMS						
		21	Reflections and Summary of Decisions/Actions	Discussion	Standing	Verbal	n/a	Chair	
		22	Any Other Business	Discussion	Standing	Verbal	n/a	Chair	

13:10	00:05	23	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	
		24	Date & Time of the Next Meeting: 31 July 2025	Information	Standing	Verbal	n/a	Chair	
		25	Acronyms	Information	Standing	Paper	n/a	Chair	
13:15	**03:45**		**CLOSE**						

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Non-Executive Director, Chair of Finance and Performance Committee
Lee Brooks	Executive Director of Operations
Peter Curran	Non - Executive Director, Vice Chair and Chair of ARAC
Colin Dennis	Chair of the Trust Board
Bethan Evans	Non-Executive Director, Chair of QuEST
Estelle Hitchon	Director of Partnerships
Ceri Jackson	Non - Executive Director, Vice Chair and Chair of PCC
Jason Killens	Chief Executive Officer
Angela Lewis	Director of Culture Change
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Chris Turley	Executive Director of Finance and Corporate Resources

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 1995		
		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		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Interim 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		
		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		
		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	Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at RHA (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 - Springfield (Barqoed) Limited.	Directorships	12 March 2020		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
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		
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		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		

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

Meeting started at 09:30

PRESENT:

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

ATTENDEES:

Fflur Jones	Audit Wales (Virtual) (Item 36/25 only)
Angela Mutlow	Director of Operations, Llais (Voice) Wales (Virtual) (Left at Item 35/25)
Steve Owen	Corporate Governance Officer (Virtual)
Alex Payne	Corporate Governance Manager
Yvonne Thomas	Audit Wales (Virtual) (Item 36/25 only)

BSL INTERPRETERS:

Anthony Evans
Rachel Williams

DRAFT

APOLOGIES:

Hannah Rowan Non-Executive Director

18/25 WELCOME AND APOLOGIES FOR ABSENCE

Welcome and Apologies:
The Chair welcomed all to the meeting, apologies were received from Hannah Rowan. He added that Teams Townhall was now being used for Live Streaming.

Declarations of Interest:
The Board noted that all declarations of interest were formally recorded on the Trust's Register of Interests.

RESOLVED: That

(1) The declarations of interest on the Trust's Register of Interests were formally recorded.
(2) The apologies of Hannah Rowan was noted.

19/25 PROCEDURAL MATTERS

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

Minutes: The Minutes of the Board meeting held on 30 January 2025 were presented and confirmed as a correct record.

Action Log: Action Number 07/25a - Actions to Mitigate Avoidable Patient Harm (Revised Reporting) *There was a discussion about the dashboard's ability to contextualise the volume of Red and Amber 1 responded incidents and Ceri Jackson asked if this was possible. Rachel Marsh advised that some of this data was available in the Monthly Integrated Quality Performance Report (MIQPR), however agreed to consider adjustments to the dashboard to provide a better sense of context within the MIQPR*. Rachel Marsh explained that the team have considered whether it was possible to add in more detail about activity, and because the data element of the harm report needed to be succinct and the number of metrics kept to a minimum, the data was therefore not included, adding that it was already in the MIQPR. Rachel also added this would be kept under review to ensure that the harm report was as meaningful as possible. Action Closed.

RESOLVED: That

(1) The Minutes of the Board meeting held on 30 January 2025 were confirmed as a correct record.

(2) The update on the action as described was noted.

20/25 CHAIR AND VICE CHAIR'S REPORT

The report of the Chair and Vice Chair was presented as read. Ceri Jacskon recalled details of her impromptu visit to the Royal Glamorgan on Tuesday which was welcomed by the staff.

RESOLVED: The update was noted.

21/25 CHIEF EXECUTIVE'S UPDATE

In presenting his report, Jason Killens drew the Board's attention to the following areas:

1. The Trust hosted a visit by the Cabinet Secretary for Health and Social Care. During the visit, Mr Miles observed colleagues in the Operational Delivery Unit and Clinical Contact Centre. He also joined paramedics on an emergency ambulance responding to calls in the Aneurin Bevan University Health Board area.

2. As the Chair of the Association of Ambulance Chief Executives (AACE), the CEO hosted the Ambulance Leadership Forum (ALF) Conference 2025. The conference provided a platform for leaders in the ambulance service to discuss the latest advancements, challenges, and strategies in the field. The Trust delivered several workshops at the conference including one main stage event together with Trade Union partners.

3. Manchester Arena Inquiry. Following the Trust's submission in August 2024 to Commissioners reflecting the Trust's evidence base to address those Inquiry recommendations which required investment, a process for scrutiny by Commissioners will be undertaken.

4. Clinical Model Transformation. On 6 February 2025, the Trust implemented the next phase of its Rapid Clinical Screening model and were now screening in the region of 5,000 calls per week. Initial data shows that around 65% of incidents screened were appropriate for some form of remote clinical intervention.

5. The Virtual Assistant (previously referred to as ChatBot) development was underway with contracts signed and testing now in progress.

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6. The announcement by the Cabinet Secretary for Health and Social Care of a change to the Trust's performance framework was preceded by a significant amount of engagement and preparatory work.

Angela Mutlow sought clarification on what communications were being aimed at the public to give them an understanding of the new targets. Jason Killens added that whilst there has been an announcement of the target change the next step was to finalise further details through the Clinical Model Transformation programme before publicly effecting the change. Estelle Hitchon added there will be collaboration with the Llais team to ensure the public receives clear and appropriate information.

Ceri Jackson was interested to find out what the learning for the Trust had been following the ALF conference. In terms of ALF reflections, there was a good session around the research papers, mental health, and discussion around a joint meeting to take place with the National Ambulance Services Medical Directors Group (NASMED) regarding transformation, Community Welfare Responders and opportunities with AI to collaborate with all sectors going forward.

Rhiannon Beaumont-Wood queried whether there were plans to bring the 111 element and the clinical desk element from Thanet House. Jason Killens explained that co-location was happening, but the timing and the physical estate opportunities were posing a challenge going forward.

RESOLVED: That the update was noted.

22/25 QUESTIONS FROM MEMBERS OF THE PUBLIC

Estelle Hitchon confirmed there was a question from Catherine Foulkes the MP for Monmouthshire, who asked if there was any update on the situation with ambulances waiting outside the Grange hospital.

Lee Brooks highlighted there were some serious issues within the Aneurin Bevan Health Board area, particularly regarding the delays experienced by patients. He explained that earlier clinical involvement in the 999 pathway to address these delays of Rapid Clinical Screening, where paramedics and nurses in control rooms quickly assess 999 calls to ensure patients received the most appropriate care, was part of the focus on reducing the need for emergency department (ED) conveyance. This initiative amongst others was a way in which the Trust could reduce delays.

RESOLVED: The Board noted the question raised.

DRAFT

23/25 STAFF/PATIENT STORY – VOLUNTER CAR SERVICE FOR ONCOLOGY PATIENTS

Prior to the video, Lee Brooks highlighted the impressive work of the Volunteer Car Service (VCS), which covered over 1.5 million miles last year, transporting patients to appointments across and beyond Wales. This service was crucial for many, especially those undergoing regular and intensive treatments like renal dialysis and oncology.

To improve the experience for oncology patients and make volunteering more rewarding, a pilot programme was introduced. This programme pairs a VCS driver with a patient for the duration of their oncology treatment. This initiative aimed to provide consistent and compassionate support for patients during a challenging time in their lives.

In the video, the Board heard from Howard Wiltsher, one of the dedicated volunteer drivers, Michael Samuels, a patient benefiting from the service, and Nicola Lloyd, a supporting staff member, discussing the positive impacts of this pilot programme across North Wales.

Angela Mutlow asked whether the Trust intended to roll this out across other parts of Wales. Lee Brooks was enthusiastic about expanding the VCS, however the pandemic unfortunately led to a reduction in the number of volunteers, partly due to the age and demographic profile of the drivers at that time.

Since then, efforts have been made to rebuild the volunteer base, with a target of reaching 200 drivers by the end of this financial year. The ambition was to extend the pilot programme, which pairs drivers with oncology patients, into a standard approach for the VCS.

Rhiannon Beaumont-Wood questioned in terms of vulnerable patients, how, from a safeguarding perspective patients were empowered to speak up. Lee Brooks explained there were mechanisms to support VCS drivers as they come into regular contact with patients over extended periods. This involved training drivers to recognise signs and signals that may indicate changes in a patient's condition.

Additionally, the Trust was mindful of the welfare and well-being of the drivers themselves. Regular contact with patients, especially those undergoing intensive treatments, can be emotionally challenging. The Trust was exploring ways to offer training and resources to help drivers identify vital signs and symptoms, ensuring they can respond appropriately if a patient's condition deteriorates.

RESOLVED: The Staff/Patient story was noted.

DRAFT

24/25 ACTIONS TO MITIGATE AVOIDABLE PATIENT HARM

Jason Killens drew the Board's attention to the following areas:

There has been an Increase in consult and close rates, since Rapid clinical screening was introduced. The number of red patients reached in 8 minutes in January was 22% more than the rolling two year average. Handover delays were the single biggest issue and the single biggest driver of the avoidable harm. In January 27,000 hours were lost to handover delays, up 22% on the 2 year average.

The Chair added that the external challenges limited the efforts to improve ambulance efficiency and patient handover times in Wales. Despite changes in triage processes and efforts to maximise ambulance effectiveness, the impact has been limited due to factors beyond the Trust's control.

Rachel Marsh referred to a new task force announced by the Cabinet Secretary, which was clinically led and aimed at working quickly to reduce handover delays and before next winter. Jason Killens advised that the next report to the Board will focus on several touchpoints aimed at delivering and improving delays.

The Chair highlighted a critical issue: approximately 500 patients per month were experiencing harm due to handover delays. This was a significant concern, as it not only affected those patients but also impacted the broader community.

Liam Williams stressed the importance of timely intervention for patients, particularly those who have experienced falls and fractures. Delays in getting these patients to surgery can significantly impact their recovery and ability to return to their previous level of independence. Liam added that following the Cabinet Secretary's visit it was felt they left with a deeper understanding of the Trust's capabilities and deliverability.

Members held a discussion which focused on several issues emerging when patients spend a long time in the back of an ambulance. Prolonged waits could lead to worsening of the patient's condition, especially if they required urgent medical intervention. Paramedics and other emergency personnel face increased stress and burnout due to the pressure of managing patients in suboptimal conditions for extended periods.

Bethan Evans sought further details on the winter summit being hosted by the Cabinet Secretary. Jason Killens mentioned that the Trust was preparing a summary of lessons learned from last winter to help focus on the upcoming year. Some of the high-impact opportunities being explored included exploiting digital opportunities by leveraging digital solutions to improve healthcare delivery and patient outcomes.

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The Chair summarised by stating the importance of doing everything within the Trust's power to address the issues at hand, whilst also recognising the limitations imposed by external agencies. He highlighted the Cabinet Secretary's awareness of the problem and the establishment of a dedicated group to tackle ambulance handover delays.

The Chair asked that future reports include a narrative on the progress of and feedback from the Cabinet Secretary's Ambulance Patient Handover Improvement Implementation (APHID) Group which was addressing handover delays.

RESOLVED: The Board

(1) NOTED that the Trust's clinical model transformation is beginning to take effect.
(2) NOTED the continued level of avoidable patient harm in the 999-emergency care pathway.
(3) NOTED the strategic imperative to continue delivering the clinical model transformation programme at pace, supported by early tactical planning for winter 2025/26.

25/26 RISK MANAGEMENT AND BOARD ASSURNACE FRAMEWORK

Trish Mills explained the purpose of the report was to provide assurance in respect of the management of the Trust's principal risks.

Risks 223 (*the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) remain at the highest score of 25. The score was not based on the volume of cases of catastrophic harm, it was based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing these delays.

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* has increased in score from 15 (3x5) to 20 (4x5). This was due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations. This risk and rationale for the increase was reviewed by the Finance and Performance Committee (FPC) on 18 March 2025.

Ceri Jackson sought further clarification that the risks had been updated and of the processes involved. Trish Mills explained the governance process and gave assurance that risks whose score was 15 to 20 were reviewed on a quarterly basis and the others on a two month or quarterly basis as they reduced in score.

RESOLVED: Members considered and discussed the contents of the report and:

(1) Noted the ongoing repositioning of Risks 223 and 224.
(2) Noted the increase in score for Risk 260 from 15 (3x5) 20 (4x5). The detail will be discussed in Closed Session of Finance & Performance Committee.
(3) Received assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees.
(4) Noted the ratings and mitigating actions for each principal risk.

26/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

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

1. The 111 call abandonment rate in February 2025 was 5.6% lower than during February 2024. The Trust recently procured a third party to undertake a joint (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and staffing capacity.

2. Ambulance Care (Patient Experience): Oncology performance in January 2025 was 77.7%, achieving the 70% target. Renal performance improved to 73.3% which was also above target. Advanced discharge & transfer journey performance decreased minimally to 80% and remains below its 95% target. Overall demand for Non-Emergency Patient Transport Services (NEPTS) continued to increase.

RESOLVED: The Trust Board received the Monthly Integrated Quality and Performance Report for January/February 2025 and were content it provided sufficient assurance.

27/25 QUALITY PERFORMANCE MANAGEMENT FRAMEWORK – REFRESH

Rachel Marsh explained that the purpose of this report was to obtain approval for the re-fresh of the current Quality & Performance Management Framework (QPMF) which had been endorsed at the Finance and Performance Committee (FPC) meeting on 18 March 2025.

At this stage of the meeting Jayne Beeslee, Chair of the FPC, drew the Board's attention to elements within the highlight report from the FPC meeting of 18 March 2025:

- The Integrated Medium Term Plan (IMTP) for 2025-28 and the financial plan for 2025/26 were received and endorsed for board approval.

- The financial position has been broadly stable for several months, with a forecast to land at a break-even position.

RESOLVED: The Board:

(1) Noted FPC's endorsement of the QPMF Re-fresh.
(2) Approved the Q&PMF 2025-28.

28/25 INTEGRATED MEDIUM-TERM PLAN (IMTP) 2025-2028 (INCLUDING FINANCIAL PLAN FOR 2025/26)

Rachel Marsh explained the purpose of the report was to update the Board on progress in developing the 2025-2028 Integrated Medium-Term Plan (IMTP) in the context of NHS Wales Planning Framework and the Joint Commissioning Committee (JCC) Commissioning Intentions for 2025/26 and that the Board approved the plan, subject to final proof reading prior to Welsh Government submission by 31 March 2025.

The FPC were assured at their meeting that the IMTP and the process to develop it this year:

1. Aligned with the Trust's long-term strategy, demonstrating a clear link between the actions and strategic objectives.
2. Balanced ambition with deliverability.
3. It was underpinned by a credible, sustainable financial plan.
4. It took appropriate account of patient outcomes and workforce wellbeing.
5. The Plan identified and mitigated risk.
6. It showed appropriate engagement with stakeholders.

In the next few months, a vision statement and business case will be finalised and agreed upon with WG and Commissioners. This will initiate a journey towards a significantly different and radical approach to emergency response services. Starting on 1 July 2025, a new system for measuring emergency response will be implemented. This system will focus on "Purple arrest" and "Red emergency" categories.

By the end of this year, a single integrated team of remote clinicians will be established. This team will be supported by a larger number of Community Welfare Responders (CWR) and enhanced by remote monitoring and technological capabilities. The plan includes significant work from management, education, and leadership perspectives to enable this integration which will improve the delivery of remote integrated care.

There will be a continued investment, albeit at a reduced rate compared to previous years, in various alternative on-scene response options such as Advanced Paramedic Practitioners, palliative care, mental health services, and falls.

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In terms of our people, work was focussed around three main areas: culture, capacity, and capability. One of the key priorities included 'The WAST Way', which was the leadership and management development framework with the aim of developing and enabling leaders in every part of the Trust to work better with their teams.

As an integrated plan, the planning approach will consider the workforce, fleet, estate, digital and financial resources required to deliver the IMTP. At the same time, it took account of the system wide developments which impact on the Trust's ability to deliver services to the quality expected.

The plan outlines financial sustainability, improved productivity, and maximising resource use. Innovation, particularly in digital transformation, was critical for achieving these goals. Health boards were encouraged to collaborate regionally to provide higher-quality and more accessible care, which will have clear implications for ambulance services.

In summary, Rachel Marsh concluded that the plan was ambitious and aimed for significant transformation, but it was not without risks, particularly financial and collaborative challenges. The plan itself was very clear on what was currently assumed as income and funding to support the Trust's estimated expenditure in 2025/26 and what savings were currently required and assessed as being deliverable, for the Trust to deliver on its statutory duty to breakeven. Rachel Marsh added a letter of support for the plan has been received from the Commissioners; and noted they have indicated further savings may be required going forward.

Chris Turley updated the Board on the following points from the financial plan:

1. The financial plan included an assumed 1.77% uplift from the Health Board's allocation, amounting to approximately £5.2 million. This does not cover the full-year effect of everything put in place this year, including the EMT band 5 impacts.
2. The plan required significant savings, with an £8.5 million savings target necessary to achieve a break-even position. There was confidence in delivering around £6.5 million of the required savings, with ongoing work to identify the remaining £2 million.
3. The plan included detailed estimates of cost and income movements, inflationary pressures, and other cost pressures for the next year.
4. There was a risk associated with the JCC's financial position, which may require further savings discussions.
5. Included in the plan was high level detail and some of the built in assumptions regarding the next two financial years.

Rachel Marsh added that progress has been made in aligning the top-down strategy with bottom-up delivery. She was pleased to report that the deliverables created by local teams were meeting priorities and there was strong engagement from commissioners.

Rachel Marsh confirmed there has been some positive impact of the actions taken. Rapid clinical screening, especially for conditions like strokes, was a crucial step in improving patient outcomes. The growth of community resources that can respond quickly and take observations was also a significant move towards better patient care.

Jayne Beeslee outlined the discussions from the Finance and Performance Committee's perspective who acknowledged the significant efforts of the Executive Leadership Team and other teams in developing the plan.

The Chair thanked those concerned, noting there had been a lot of scrutiny on the plan prior to this point, also noting an Equality Impact Assessment was attached.

RESOLVED: The Board:

(1) Noted the progress made in developing this year's IMTP.
(2) Approved the IMTP for submission to Welsh Government by 31 March 2025.
(3) Approved the Financial Plan for 2025/26.

29/35 WELLBEING OBJECTIVES

Estelle Hitchon provided an overview of the well-being objectives, noting their long-term nature and alignment with the ethos of the Well-being of Future Generations Act. She mentioned that the objectives were designed to reflect the Trust's contribution to the act's goals. The wellbeing objectives were as follows:

- Objective One: A Socially Responsible and Inclusive Employer
- Objective Two: An Innovative and Sustainable Organisation
- Objective Three: A Pro-active, Accessible and Equitable Care Provider

Estelle Hitchon highlighted the Trust's proactive approach, noting that they have been working in the spirit of the act since its inception in 2015. It was noted that a Task and Finish Group was established to develop the objectives, which included membership of Trade Union Partners. The Objectives were endorsed by the Finance and Performance Committee at its meeting on the 18 March 2025.

Estelle Hitchon commented on how future iterations of the IMTP can better support communities and the economy in Wales, particularly through employment and volunteering opportunities.

In respect of objective three, it was asked why the word 'inclusive' was not used. Estelle Hitchon explained that the term equitable was chosen to emphasise addressing disparities in access to services, particularly in rural areas where availability can differ significantly. The Board approved the revised wellbeing objectives.

RESOLVED: The Board

(1) Noted the process of setting the wellbeing objectives, including the feedback received through the process of staff and public engagement and the response made to that feedback.

(2) Noted the endorsement by Finance and Performance Committee of the wellbeing objectives.

(3) Approved the wellbeing objectives for adoption and publication by 31 March 2025.

30/25 INITIAL 2025/26 REVENUE BUDGET

Chris Turley added that further to the detail provided in the finance section of the IMTP this paper provided additional analysis of how the proposed balanced financial plan for 2025/2026 was translated into delegated budgets, the key assumptions made, and any remaining choices required in doing so.

The current planned income for the Trust for the financial year 2025/26, as per the financial plan within the IMTP, totalled £310.6m of which £291.5m was via JCC commissioned services of EMS, Ambulance Care and 111 services, £7.9m from other NHS Welsh Organisations, £10.1m from WG and £0.9m from other sources, of which £0.150m was assumed to be delivered via the Trust's Savings programme.

The Trust Board was asked to approve the initial 2025/26 revenue budget, building on the Trust's Financial Plan included in the IMTP as endorsed by the FPC on 18 March 2025.

Peter Curran highlighted the challenge of accommodating unplanned costs, specifically mentioning EMT banding, which was initially thought to be manageable but now had implications for the 2025/26 budget. He commended the team for achieving a balanced budget, while noting the need to remain cautious about future financial risks.

The Board approved the initial 2025/26 Revenue Budget.

RESOLVED: The Board approved the initial 2025/26 revenue budget, building on the WAST Financial Plan included in the IMTP and as endorsed the meeting of the Finance & Performance Committee on 18 March 2025.

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31/25 INTEGRATED MEDIUM TERM PLAN (IMTP) DELIVERY/ASSURANCE PROGRESS UPDATE

Rachel Marsh advised that the report provided an update on the Clinical Model Transformation (CMT) programme and interim position for quarter four on the Directorate-led IMTP portfolio, including the Cabinet Secretary Priorities set by WG.

RESOLVED: That the Board

(1) Noted the progress in identifying 'what good looks like' through the continuing development of high level outcomes measures.
(2) Noted the CMT programme progress update.
(3) Noted the Directorate-led IMTP interim position for Q4.
Noted the update against the Cabinet Secretary's priorities set out in the 2024-27 planning framework.

32/25 FINANCE UPDATE MONTH 11

This update presented to the Board was the latest Financial Performance Report of the 2024/25 financial year, key highlights to note were:

1. The Trust was reporting a small revenue surplus (£42k) for month 11 2024/25.
2. In line with the balanced financial plan approved as part of the submitted 2023-26 IMTP, the Trust was forecasting to breakeven for the 2024/25.
3. Capital expenditure plans were on track to fully deliver spend plans in year.
4. In line with the financial plans that support the IMTP, gross savings of £6.317m have been achieved in month 11 against a target of £5.975m.
5. Public Sector Payment Policy was on track with performance, against a target of 95%, of 97.6% for the number, and 98.7% of the value of non-NHS invoices paid within 30 days.

Capital Update: At Month 11, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2024/25 was £20.449m. This included £14.994m of All Wales Approved schemes and £5.455m for Discretionary schemes.

RESOLVED: The Board:

(1) Noted and gained assurance in relation to the Month 11 revenue financial position and performance of the Trust as at 28 February 2025.
(2) Noted the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust.
(3) Noted the capital programme update for 2024/25, and
(4) Noted the Month 11 Welsh Government monitoring returns submission included within *Appendices 1 – 2* (as required by WG).

33/25 SPEAKING UP SAFELY UPDATE (6 MONTHLY)

Angela Lewis presented the report giving an overview of progress and activity in relation to the Speaking Up Safely (SUS) agenda, during the period July – December 2024 which included:

1. Creation of Speaking Up Database to enable more effective record keeping and data analysis.
2. Engagement activities undertaken (Speaking Up Week, CEO Roadshows, University students, at hospitals).
3. Appointment of SUS and Culture Change Project Support Manager to enable more proactive work on the SUS agenda.
4. Commencement of internal audit with the aim of further enhancing provision.

Several themes had emerged from the data gleaned during this reporting period:

1. Barriers to escalation and reporting.
2. Cultural and psychological safety concerns.
3. Additional training particularly in relation to safeguarding and sexual safety.
4. Positive recognition and impact of SUS.

Following a query in terms of safeguarding, Liam Williams clarified the safeguarding process was well-defined for reporting safeguarding concerns. Staff report concerns through Datix, marking them as highly confidential. These reports were reviewed by safeguarding, Putting Things Right (PTR) and people services.

Angela Lewis added there was a focus on improving how leaders handle conversations with their staff, particularly around discipline, performance, and other sensitive issues. It was also about ensuring that leaders conduct conversations in a clear and purposeful manner, while considering the perspective of staff.
The Board were reassured that cases related to bullying and harassment were decreasing, but it was still important to be mindful of these issues.

RESOLVED: The Board noted the update.

34/25 2024 NHS WALES STAFF SURVEY

Angela Lewis presented a high level summary of the results from the recent NHS Wales Staff Survey. It was noted that whilst the Trust's engagement index score had dropped slightly, this could have declined much further. This suggested our focus on people, culture and enhancing colleague experience was to some extent mitigating the risk our operating context poses to engagement. This slight downward trend was reflected at an All Wales level, with the overall staff engagement index score down from 73% in 2023 to 72% in 2024.

Last year, lowest scores were associated with: Workload, burnout, emotional strain, presenteeism and wellbeing concerns, and lack of involvement and autonomy. This year it was:

1. Work-related stress remained a significant issue.
2. Many respondents report feeling drained and frustrated, impacting work-life balance.
3. Some respondents still feel unable to take time off when sick.
4. A proportion continue to report feeling disconnected from decisions that affect them.

Jason Killens added that given the short time between this and the previous survey (6 months), it was great to see improvements in how colleagues felt about the workplace and the initiatives the Trust has been focusing on. However, it continues to be very concerning to hear about the challenges with violence and aggression in the workplace, especially abuse towards colleagues. He added that reducing systemic pressure would significantly improve workplace experiences for everyone.

Bethan Evans acknowledged there had been historical investment in training and development for frontline managers and queried if this investment was continuing. Angela Lewis added that those "crucial conversations" and effective one-to-one interactions were part of the core manager essentials at the Trust.

RESOLVED: That Trust Board:

(1) Noted the contents of the report.
(2) Commented on insights shared.
(3) Supported the proposed approach to engaging with colleagues.

35/25 AUDIT WALES - ANNUAL REPORT 2024/25

Fflur Jones presented the Audit Wales Annual Report for 2024 which included the audit of accounts and the audit of arrangements for securing efficiency, effectiveness and economy of the use of resources. Each of the reports have been considered by the Audit, Risk and Assurance Committee (ARAC) during the year.

The audit of the 2023/24 accounts went well overall, with the accounts being appropriately prepared and materially accurate. There were no material weaknesses in internal controls. An unqualified opinion was issued, indicating that the financial statements were fairly presented.

The cost savings review highlighted the Trust's excellent track record in delivering savings but identified areas for improvement in how savings were identified and reported. In terms of the Quality Governance Follow-Up, progress has been made on

the recommendations from the 2022 review, but further work was needed to ensure that reported information provided effective and regular assurance.

In terms of the Structured Assessment the Trust efforts to improve governance arrangements and maintain strong financial performance were noted. Recent work to enhance the clinical model was also positively noted. A small number of recommendations were made and these were being progressed.

There were two ongoing performance audits: Managing Demand for Urgent Emergency Care and Digital Services. Both audits will be reported to the ARAC in due course.

RESOLVED: **The Board received the Audit Wales annual report 2024/25**.

36/25 EDUCATION COMMISSIONING 2026-2027

Carl Kneeshaw presented the report and drew the Board's attention to the following:

Health Education and Improvement Wales (HEIW) required each NHS Wales organisation to provide an annual Education Commissioning Return. This enabled HEIW to consider the Trust's future workforce requirements. It will also assist preparation and planning requirements for Higher Education Institutes commissioned to deliver related training and WG in allocating funding.

This Educational Commissioning exercise was aimed at clinical and related roles within the NHS. Submission of the draft Trust education commissioning numbers to HEIW took place on 29 January 2025. Final, Trust Board approved education commissioning numbers must be submitted to HEIW by 31 March 2025.

Carl Kneeshaw confirmed the courses remained fit for purpose, thanks to the ongoing relationship with HEIW and the involvement of the Trust's education and development team.

RESOLVED: The Board

(1) Noted and Approved the content of the report.
(2) Recommended a letter was sent to HEIW confirming Trust Board endorsement of the final numbers.

37/25 GOVERNANCE REPORT

Trish Mills presented the report and asked the Board to approve the changes to the Standing Orders and Scheme of Reservation and Delegation, as detailed in the supporting paper.

The Board were also asked to note the decision made in private and the chair's action taken in February 2025 (which will be approved in private session).

RESOLVED: The Board:

(1) Approved the changes to the Standing Orders and Scheme of Reservation and Delegation, as detailed in the supporting paper in Annex 1.
(2) Noted the decision made in private and the chair's action taken in February 2025 (which will be approved in private session).

38/25 BOARD COMMITTEE REPORTS

The following Committee highlight reports were received.

4 February 2025 - Quality, Patient Experience and Safety Committee (QuEST)
The Chair of QuEST Bethan Evans drew the Board's attention to the key points:

1. The meeting included the importance of data as intelligence to drive continuous improvements for patient safety.
2. The Challenges Datix 'Once for Wales' Concerns Management System were discussed.
3. The patient story regarded Gemma, who shared their experience as a profoundly deaf British Sign Language (BSL) user in accessing healthcare.
4. The following policies were approved: Safeguarding children and adults at risk of harm policy and Violence against women, domestic abuse and sexual violence policy.
5. A revised Putting Things Right (PTR) Report for Q3 2024-25 was received.
6. The Audit Wales Quality Governance Follow Up Review report was received and presented by Audit Wales.
7. The Infection Prevention and Control Annual Report for 2023/24 was received, emphasising improved compliance.
8. The internal audit on Patient Experience and Community Involvement was received.
9. The Committee's annual effectiveness review was held, with a revised approach taken across all committees.
10. Risks Discussed: The Trust's two highest scoring 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 remain unchanged at a score of 25.

DRAFT

18 February 2025 - People and Culture Committee (PCC)
The Chair of PCC Ceri Jackson drew the Board's attention to the following key points:

1. Mark Churchill, a colleague from Ambulance Care spoke to the committee of his role.
2. The report from the Director of Cultural Change and the Director of People was received.
3. The Q2 Operational Update from the Executive Director of Operations highlighted several initiatives related to our people and our culture.
4. The Committee welcomed the new leadership and management framework - Our WAST Way - which will launch in Q1/Q2 2025/26.
5. The Exposure to Fumes and Resourcing Policy Internal Audits were received.
6. The four risks within the remit of this Committee were reviewed.

6 March 2025 - Audit, Risk and Assurance Committee (ARAC)
The Chair of ARAC Peter Curran drew the Board's attention to the following key points:

1. The 2025/26 Internal Audit Plan was approved.
2. The Audit Wales Follow Up Review of Quality Governance Arrangements was received following a review at QuEST.
3. There were six Internal Audits completed during the current quarter presented to the Committee. Vehicle Accident Management, Exposure to fumes, Patient Experience and Community Involvement, Rollout of Penthrox, 111 Digital Operations and Energy Management.
4. The Integrated Governance Programme was introduced to the committee.
5. An update was received on the revised Audit Tracker from the Q3 2024/25 reporting period.
6. The committee received assurance against the Risk Management Transformation Programme and noted the progress made to date with the board in the development of a suite of risk appetite statements aligned to the Trust's six strategic objectives.

13 March 2025 - Remuneration Committee
The Chair of the Remuneration Committee Colin Dennis drew the Board's attention to the following areas:

1. An update was provided on the position with Executive and Senior Pay.
2. The committee approved one Voluntary Early Release Scheme (VERS) application.
3. The committee's cycle of business monitoring report was received.

18 March 2025 - Finance and Performance Committee (FPC)
Jayne Beeslee, Chair of FPC advised the details had been covered earlier in the agenda.

RESOLVED: The Board Received the above Committee Highlight Reports and received assurance that each of the Committees had fulfilled their Terms of Reference, and that matters of concern had been escalated in line with the Alert, Advise, and Assure process.

39/25 MINUTES OF COMMITTEES

The following Committee minutes were received:

5 November 2024 - Quality, Patient Experience and Safety Committee
14 November 2024 - People and Culture Committee
21 November 2024 - Audit, Risk and Assurance Committee
16 January 2025 Finance and Performance Committee

Other Committees: The following Committee minutes were received:

NHS Wales Shared Services Partnership Committee (SSPC) Assurance report Dated 21 November 2024 and the Highlight Report from the JCC - 21 January 2025

RESOLVED: The

(1) Committee Minutes were received: 5 November 2024 - Quality, Patient Experience and Safety Committee ,14 November 2024 - People and Culture Committee, 21 November 2024 - Audit, Risk and Assurance Committee and 16 January 2025 Finance and Performance Committee.
(2) NHS SSPC Assurance report Dated 21 November 2024 and Highlight Report from the Joint Commissioning Committee (JCC) - 21 January 2025 were received.

40/25 REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

The Board welcomed the discussions on the IMTP.

41/25 EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC – 27 MARCH 2025

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

RESOLVED: The Board would meet in private on 27 March 2025.

Date of next meeting: 29 May 2025

Meeting closed at 14:25.

MINUTES OF THE OPEN MEETING OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST BOARD, HELD on WEDNESDAY 7 MAY 2025 MEETING HELD VIA TEAMS

Meeting started at 11:00

This meeting was originally scheduled for a Closed Session and was now designated for the Open Session

PRESENT:

Colin Dennis	Non-Executive Director and Chair of the Board
Jason Killens	Chief Executive
Rhiannon Beaumont-Wood	Non-Executive Director
Jayne Beeslee	Non-Executive Director
Lee Brooks	Executive Director of Operations
Professor Hayley Hutchings	Non-Executive Director
Estelle Hitchon	Director of Partnerships and Engagement
James Houston	Head of Strategy Development
Ceri Jackson	Vice Chair and 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
Hugh Parry	Trade Union Partner
Hannah Rowan	Non-Executive Director
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing

ATTENDEES:

Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager

APOLOGIES:

Peter Curran	Non-Executive Director
Bethan Evans	Non-Executive Director
Carl Kneeshaw	Director of People
Damon Turner	Trade Union Partner

DRAFT

42/25 WELCOME AND APOLOGIES FOR ABSENCE

The Chair confirmed that the meeting, initially scheduled as a closed session, was now an open board meeting and was being audio recorded for transparency.

Welcome and Apologies:
The Chair welcomed all to the meeting, apologies were received from Peter Curran, Bethan Evans, Carl Kneeshaw and Damon Turner.

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

RESOLVED: That

(1) The declarations of interest on the Trust's Register of Interests were formally recorded.
(2) The apologies of Peter Curran, Bethan Evans, Carl Kneeshaw and Damon Turner was noted.

43/25 NEW AMBULANCE PERFORMANCE FRAMEWORK

Prior to the beginning of the update the Chair sought clarification if the report was for approval or assurance. Rachel confirmed that the paper included two recommendations; to note the Cabinet Secretary's request and to take assurance that the Trust was ready to implement the changes safely. It was determined that the wording of the recommendations would be clarified following the discussion of this item but that the Board were not required to approve the framework changes.

Trish Mills mentioned that the EqIA (Equality Impact Assessment) for the Equality, Diversity, & Inclusion Definition Document – Clinical Model Transformation (CMT) Programme should be noted in the minutes, even though the front cover does not refer to it as Appendix 2. Rachel Marsh confirmed that the EqIA has been completed and was included in the papers. It went through the CMT Board on 06 May (not 07 May as stated) and was approved by that group.

Rachel Marsh explained that the rationale of holding the extraordinary meeting was due to the Joint Commissiong Committee (JCC) meeting in a fortnight, (prior to the scheduled Trust Board meeting on 29 May). The JCC considered it would be helpful to have the board's assurance on this preparedness so that it can be reflected in their discussions.

DRAFT

In terms of the report Rachel Marsh explained that the proposed changes to the Ambulance Framework were accepted by the Cabinet Secretary for Health & Social Care in March. It was agreed that the changes would be tested for a 12-month pilot period commencing on 01 July 2025. A decision regarding the permanent introduction of the changes will be subject to the findings of a detailed evaluation.

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

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

PURPLE ARREST: Refers to incidents where a person is in cardiac or respiratory arrest.
RED EMERGENCY : Refers to incidents where a person is at risk of cardiac or respiratory arrest.
RCS0: incidents that have been deemed suitable for rapid clinical screening.

The Purple Arrest category included a bundle of measures focused upon improving clinical outcomes for patients in cardiac or respiratory arrest.

The overarching clinical outcome measure for the Purple Arrest category was the percentage of Return of Spontaneous Circulation (ROSC) along with key measures across each link in the chain of survival. These clinically focussed measures will shift the emphasis from the speed of an ambulance response to a broader system response focussed on clinical effectiveness and improving patient outcomes.

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

Rachel Marsh assured the Board there was a strong project management framework within its Clinical Model Transformation structure. Quality and Equality Impact Assessments were being conducted. Significant efforts were being made to define new data items and establish performance reporting metrics. Systems and processes were being developed to ensure the safety of these changes.

The project was set to 'go live' on 01 July 2025 and will run as a 12-month pilot. An external contract was being established to evaluate the revised performance framework changes. Tenders have been received, and the shortlisting and interviewing process for the evaluation partner will take place in the next fortnight.

Rachel Marsh added that having reviewed the Red category, there was now a commitment to review how the Trust measured patients in the current Amber and Green categories. The second meeting of the review group took place yesterday, and work was progressing quickly. The findings will be presented to the board in due course.

Lee Brooks confirmed, following the query by the Chair, that the response letter to the Welsh Government was being drafted, and was due by 31 May. This was discussed in the CMT board meeting.

The Chair further enquired of most likely obstacles for not hitting the 1 July deadline, mentioning training, Computer Aided Dispatch (CAD) system updates, and standard operating procedures as potential concerns. The highest risk in regard to delivery is in relation to the changes required in the CAD system. However, the Board was assured that a significant amount of work was underway to ensure readiness, and the supplier was on track with the timeline with regard to the delivery of the changes. Lee Brooks said that there were no issues to escalate at this time, therefore.

Ceri Jackson inquired about a contingency plan if the changes cannot be implemented by 01 July 2025, asking if it would be possible to delay the implementation. Ceri also asked about recording results for Purple arrest and Red emergency categories, particularly when the 20-minute target was missed, and the implications from those cases. Additionally, she asked how the new process was affecting staff.

In response to the first question from Ceri, Rachel Marsh advised that while the goal was to implement the changes by 01 July 2025, there were no dependencies on the wider healthcare system in Wales so a delay would be possible, if necessary. However, the Trust was working hard to meet the 01 July 2025 deadline.

In response to the second question from Ceri, Andy Swinburn explained that the 90th percentile will be recorded, which provided a good indication of performance. Andy added that this approach will help the Trust understand the outcomes for the calls that do not meet the 20-minute target. He added that the team has not yet given detailed thought to measuring 100% of all calls. Lee Brooks noted that the team currently performed "missed Red analysis" to understand the reasons behind missed targets. This analysis will be modified to include "missed arrest" and "missed emergency" once the new categories were implemented.

Lee Brooks observed there has been limited feedback from staff following the announcement. He stated that the teams will design the training in May and deliver it in June. This period will likely offer more insights into the staff's reception of the new processes. Lee Brooks stated that quality monitoring aspects would be included in the oversight arrangements.

Rhiannon Beaumont-Wood noted that the required delivery of training could be considered a risk and asked of the number of individuals who required training. She asked if it was possible to stagger the start for those who have completed the training, in case the entire group cannot be trained by the deadline. She asked about the timeline for the evaluation noting that the tendering process for the evaluation partner had already begun.

Rachel Marsh stated that certain elements of the new system, including CAD modifications and data definitions, will remain stable throughout the 12-month pilot period. The evaluation process will be instrumental in assessing and gaining insights from the implementation.

Liam Williams added there was a dedicated architecture within the programme governance to support ongoing learning, including the Clinical Advisory Group, which reviews incidents and assessments. Liam outlined the timeline for the evaluation tender, noting that four suppliers have been shortlisted. The supplier presentations are scheduled for the 06 June 2025. The selected partner will be contracted for a three year period.

Lee Brooks stated that the training component was still under development and would be evaluated once completed. He noted that the training requirement was not extensive, primarily affecting Emergency Service Dispatchers. Lee stated that readiness checks will determine whether people were trained and prepared by 01 July 2025.

Trish Mills advised that instead of asking the Board 'to note' the requirement for the Trust to alter its model and service delivery, the Trust Board should 'endorse' it. She reasoned that 'endorse' signalled alignment and was less passive than the proposed recommendation. It was reiterated that the Board had received the Clinical Model Transformation EDI definition document, which served as the EqIA for the revised ambulance performance framework, which contributed to the assurance taken by the Board with this decision.

RESOLVED: The board

(1) Endorsed the requirement for the Trust to alter its model of service delivery and reporting to meet Welsh Government instructions.

(2) was assured that the organisational preparedness met with the appropriate requirements to implement the changes safely and effectively.

Date of next meeting: 29 May 2025

Meeting closed at 11:35

ACTION LOG

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST BOARD

Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
27 March 2025	Actions to Mitigate Avoidable Patient Harm	The Chair asked that future reports include a narrative on the progress of and feedback from the Cabinet Secretary's Ambulance Patient Handover Improvement Implementation (APHID) Group which was addressing handover delays.	Rachel Marsh	29 May 2025	Update for 29 May 2025 Details to be included in report/Verbal update	Complete

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

CHAIR AND VICE-CHAIR'S REPORT

MEETING	Trust Board
DATE	29 May 2025
EXECUTIVE	Colin Dennis, Chair of the Trust Board Ceri Jackson, Vice Chair of the Trust Board
AUTHOR	Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

CHAIR'S REPORT

1. I wish to express my sincere congratulations to Jason Killens, Chief Executive of the Trust, on his recent appointment as Chief Executive of the London Ambulance Service. Jason's formal announcement can be read on the Trust website, here. I have already begun engaging with recruiters to advertise the vacancy and will be working closely with colleagues to progress this activity over the coming weeks.

2. The Board held a Board Development Day on the 24 April 2025 which included a session on the Trust's Monthly Integrated Quality and Performance Framework (MIQPR) reporting. The Board discussed how the MIQPR integrates with broader metrics received by the board committees and the importance effectively analysing and scrutinising the data it contains.

3. Since our last meeting I have been busy, with the following activity: -
   - Regular meetings and briefings with Jason Killens, Chief Executive, and other Executives;
   - Regular meetings with Ceri Jackson, Vice-Chair;
   - Panel membership of the WAST Live events;
   - Attended a Cabinet Secretary priorities event on the 07 April;
   - Attended three of the April Chief Executive Roadshows (Llandudno, Wrexham [08 April] and Cwmbran [11 April]);
   - Held the Non-Executive Directors' annual appraisals;
   - Attended meeting with TUs on the 16 April;
   - Attended the Board Development Day on the 24 April;

- Attended an event on the 29 April in relation to the publication of the Ministerial Advisory Group Report on NHS Wales Performance and Productivity;
- Chaired a public meeting of the Trust Board on the 07 May;
- Attended a WASPT Joint Chairs Working Group on the 09 May;
- Chaired a meeting of the Remuneration Committee on the 15 May;
- Attended the Finance and Performance Committee on the 20 May;
- Attended the NHS Wales Chair Peer Group meeting;
- Routine monthly meetings with Non-Executive Director colleagues;
- Routine meetings with Trade Union colleagues.

VICE-CHAIR'S REPORT

4. Since our last meeting I have been busy with the following activity: -
   - Attended the Trust's Social Partnership Conference on the 31 March;
   - Attended the Charity Committee meeting on the 02 April;
   - Attended a Cabinet Secretary priorities event on the 07 April;
   - Visit to Bangor Station and Rideout with CHARU on 07 April;
   - Attended Staff Roadshows in Llandudno and Wrexham on 08 April;
   - Attended Vice-Chair's Peer Group on the 09 April;
   - Attended meeting with Mental Health Lead on the 14 April;
   - Attended meeting with TUs on the 16 April;
   - Attended the Board Development Day on the 24 April;
   - Attended the Audit, Risk and Assurance Committee on the 01 May;
   - Attended the public meeting of the Trust Board on the 07 May;
   - Attended the QuEST Committee meeting on the 09 May;
   - Chaired the People and Culture Committee meeting on the 15 May;
   - Attended the Remuneration Committee on the 15 May;
   - Held routine meetings with people and culture colleagues;
   - Routine monthly meetings with non-executive director colleagues.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Not applicable.

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

AGENDA ITEM No	**06**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**One**

CHIEF EXECUTIVE REPORT: MAY 2025

MEETING	Trust Board
DATE	29th May 2025
EXECUTIVE	Jason Killens, Chief Executive
AUTHOR	Jason Killens, Chief Executive
CONTACT	Jason.Killens@wales.nhs.uk

EXECUTIVE SUMMARY

This report is presented to the Trust Board to provide awareness of the Chief Executive's activities and key service issues since the last Trust Board meeting held on the 27th of March 2025. It is intended that this report will provide a useful briefing on current issues and is structured by directorate function.

RECOMMENDATION

That Trust Board note the contents of this report.

KEY ISSUES/IMPLICATIONS

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

REPORT APPROVAL ROUTE

The Trust Board meeting held on 29th May 2025.

REPORT APPENDICES

An SBAR is attached.

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Yes	Financial Implications	N/A

Environmental/Sustainability	Yes	Legal Implications	N/A
Estate	Yes	Patient Safety/Safeguarding	Yes
Ethical Matters	Yes	Risks (Inc. Reputational)	N/A
Health Improvement	Yes	Socio Economic Duty	Yes
Health and Safety	N/A	TU Partner Consultation	N/A

Annex 1

SITUATION

1. This report provides an update to the Trust Board on recent key activities, matters of interest and material issues since my last report dated 27th of March 2025.

BACKGROUND

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

ASSESSMENT

3. CHIEF EXECUTIVE

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

- Attending frequent meetings with key stakeholders such as NHS Wales CEOs, the Director General of NHS Wales, Blue Light Service Leaders, Trade Union Partners, Commissioners, AACE, EASC, JCC and senior elected representatives.
- I attended the first Trust Ifta event celebrating the start of Ramadan for our Muslim colleagues. The day consisted of engaging with staff to learn more about Muslim culture, joining colleagues for the breaking of the fast, where they shared authentic food, and witnessing staff in prayer.
- I hosted Jeremy Miles, MS, Cabinet Secretary for Health and Social Care, for a Listen and Learn day at Vantage Point House. The purpose of this event was to provide a comprehensive overview of our services. Jeremy had the opportunity to observe the 999 call handlers, clinical desks, NEPTs, and 111 call handlers, culminating in a ride-along experience.
- I conducted the CEO staff roadshows, starting in Llandudno and concluding in Cwmbran. These roadshows allowed me to engage directly with staff, listen to their concerns, share organisational updates, and reinforce WAST's vision and goals. The roadshows were well-received and fostered a sense of unity and motivation among the staff.
- We hosted the inaugural Social Partnership Conference at Cardiff City Stadium. The event, organised in collaboration with trade union partners, featured a series of workshops and keynote speeches from prominent

figures in the field of social partnership. Jack Sargeant MS, Minister for Culture, Skills and Social Partnership, delivered the opening address.

- As the Chair of the Association of Ambulance Chief Executives (AACE), I hosted the ALF Conference 2025. The conference provided a platform for ambulance service leaders to discuss the latest advancements, challenges, and strategies in the field. I engaged in insightful discussions and gained valuable insights to drive improvements within WAST and the wider ambulance service community.
- I attended Good Morning Britain to give an in-studio live interview on ambulance service assaults that have seen a 15% increase from the previous year. I have also written to health ministers in England, Scotland, Wales, and Northern Ireland to seek support in exploring what more can be done from a policy, prevention, and response perspective to protect ambulance workers.
- We hosted the ELT and SLC 2-day event at Swansea. This event brought together the Executive leadership group and the senior leadership community from across our organisation to share insights, experiences, and best practices in leadership.

OPERATIONS DIRECTORATE

Manchester Arena Inquiry (MAI) Scrutiny

1. Following the submission of WAST's consideration to the MAI recommendations in August 2024 to commissioners with a copy to the NHS Executive, a series of scrutiny workshops have taken place with commissioners over March and April. These sessions have allowed the commissioners, who called upon the expertise of EPRR leads from Health Boards, to scrutinise the detail in the submission before considering and providing their formal response which is expected back to the Trust in August 2025. The Trust has also requested that commissioners and NHS Executive confirm which components of the submission are to be considered by each body.

2. Whilst every effort has been made to deliver all MAI recommendations by the end of the 2024/25 financial year, four recommendations that were initially on track for completion, have experienced some slippage due to factors beyond the project's control. These recommendations have now been transitioned to Corporate Risk 641 for ongoing management.

3. The actions required are within WAST's capacity to implement and do not currently necessitate additional funding. Work continues on all four recommendations, with two expected to be fully completed by the end of

May 2025. This will leave a total of 20 outstanding recommendations on the Corporate Risk register, 18 of which relate to submissions to commissioners.

HART Drone Pilot

4. HART are introducing a drone capability to their list of assets to assist the team and Trust when responding to certain types of incidents. The incidents where the use of a drone will be beneficial are as follows:
    - Large incidents to gain spatial situational awareness
    - Incidents where operating environments may be hazardous - drone to be used to gain situation awareness and aid in risk assessments (water rescue incidents during nighttime or where daylight is minimal)
    - Persons in water (thermal imaging cameras to help identify persons)
    - Persons injured in rural areas (able to cover areas and thermal imaging cameras to assist)

    We will also have the ability to live stream to incident command rooms through a dedicated and secure server.

5. HART will have 7 pilots (1 per team/watch), along with a Chief Pilot (HART Training Manager) trained to standards in line with the Civil Aviation Authority (CAA). Pilots will receive training in drone operation, pre-flight checks, safety critical process (including pre-flight risk assessments) and how to operate the drone for the incidents listed above.

6. Training was completed week commencing 31.03.2025 and all operatives successfully passed the course. Plans are in place with the IT Project Management Team to set up some live streaming on an exercise to showcase the capability.

NEPTS Roster Review

7. In 2021, ORH reviewed NEPTS demand and capacity across Wales, recommending changes to roster keys based on projected demand, service delivery changes, and operational parameters. WAST confirmed the need for re-rostering after reviewing the ORH report.

    The 2021 report was updated with the latest 12-month data, reflecting current patient numbers and operations. The simulation model was updated to test original shifts against new parameters.

8. Current rosters lack sufficient relief, causing inefficiencies due to long-term absences and daily instances where demand exceeds capacity, preventing WAST from providing transport to all patients. Changes in Health Board treatment centres and centralisation of services, along with increased patient support needs, have further impacted vehicle loading efficiency.

9. Remodelling has identified opportunities to convey more patients per week and improve relief capacity within the current full-time establishment. Two NEPTS roster Working Parties have taken place, gathering feedback from stakeholders and Trade Union engagement. The service management team has committed to reviewing this feedback and considering alternative proposals in balance of operational need and well-being of our people.

FINANCE AND CORPORATE RESOURCES

Finance

10. The outturn revenue financial position for the financial year ending 31st March 2025 reported a small surplus of £70k *(subject to audit)*.

11. The finance team supported the production of a balanced revenue financial plan for 2025/26 year as detailed in the submitted version of WASTs IMTP and MDS (Minimum Data Sets), following Trust Board approval in March 2025. Delegated budgets have now been set in core finance systems and formal budget delegation meetings between the Executive Director of Finance & Corporate Resources, Chief Executive and each Executive Director have been diarised for Quarter 1 of the 2025/26 financial year.

12. The finance team played a key part in the over-delivery of the 2024/25 savings target and in setting the organisation increased savings plan / target of £8.5m for the 2025/26 financial year, to which all have been allocated to schemes / themes and directorates to ensure robust monitoring and delivery will commence as early as possible in the financial year. The finance team will continue to support the Financial Sustainability Programme (FSP) and the further identification of schemes / themes for this and future financial years.

13. The Finance Team continues to participate in the NHS Wales Finance Academy programme (Finance Operating Model) to review all job families to ensure future proofing of services and delivery. Programme for the job families of Finance Business Partnering and Management Accounts and

Financial Accounting both have concluded and the next family of DoF and Deputy DoF's is planned to commence in Quarter 1 of the 2025/26 financial year.

14. The finance team also supported in the production of the 2024/25 draft financial accounts of the Trust which were submitted to WG on 2nd May 2025. The audit of the accounts commenced on 6th May 2025, with the audit certification deadline once again being brought forward to 30th June 2025 as opposed to 15th July 2024.

15. The finance team will continue to work with Audit Wales to deliver the impending audit of the draft financial accounts. The audited accounts are due to be presented to ARAC on 24th June, approved by Trust Board on 27th June and signed by the Audit General for Wales on 27th June prior to submission to WG on 30th June 2025.

16. The 2024/25 capital programme delivered to plan despite small number of in year movements with the Trust achieving it's CEL with a small underspend of £26.73 against a budget of £20.449m *(subject to audit)*.

17. Work continues to progress well with the development of the PLIC system, and local modelling being undertaken with comparison to the NHS England model, work will continue around the development of costing other elements outside the NHS England model including 111 and Ambulance Care.

18. The Finance Department, following successfully becoming an approved ACCA Professional Development organisation a few years ago, has recently been awarded ACCA Trainee Development – Gold accreditation, this recognises that the Trust has a clear learning direction for its trainee's and invests both time and resources in them to ensure they achieve ACCA qualification. Not only is this great for existing students going through their studies but also ensures the Trust attracts staff to future roles within Finance.

Capital Development, Estates, Environmental and Facilities

19. New Dolgellau Ambulance Station – Confirmation has now been received from the landlord chain to approve the proposed works on the site. Therefore, the lease can now be finalised for approval, and the contract award document is ready for approval by the Trust Board. The team continues to liaise with the NWSSP Legal Team regarding timescales for

this and are keen to bring this to a conclusion as quickly as possible, so that the contractor can mobilise on site.

20. Llangunnor CCC enhancements – the estate works on the site have now been completed, and the teams will be consolidated within the newly expanded and refurbished space.

21. North Wales CCC estate – The full programme of works for the fit out of the space has been completed and operational teams have relocated to the new facility.

22. Monmouth Ambulance Station – Pre-planning application advice has now been received, and the Project Board will meet in mid-May to consider the impacts on the options available.

23. Bangor Fleet Workshop – Exploration of alternative solutions continue, as the previously preferred option could not be delivered within the project budget envelope. The team continues to liaise with NWSSP Specialist Estates Services regarding options and to consider the scope of works to align with the available funding.

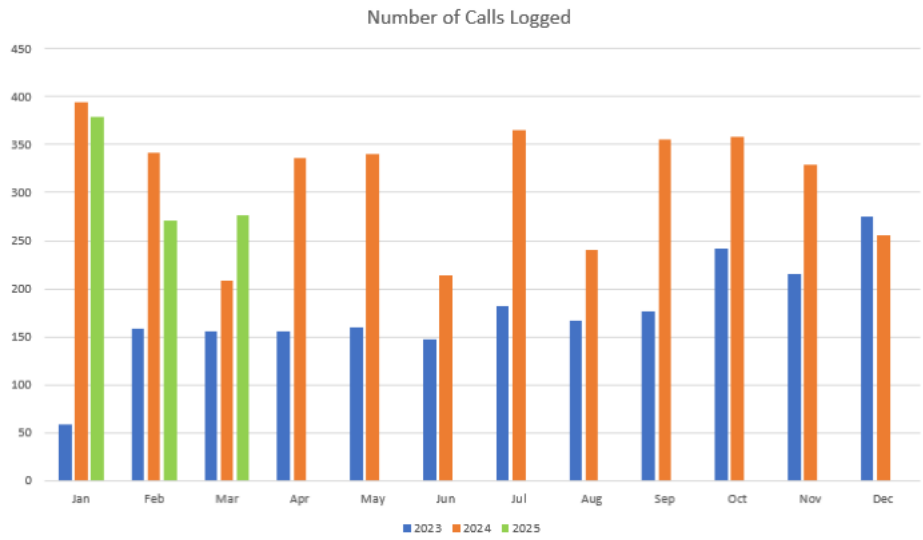
24. Bridgend Ambulance Care Hub (Bennett St) Phase 2 – This scheme has been completed.

25. Decarbonisation/EFAB – all of the projects are complete and have delivered a range of renewable energy systems, heating upgrades, infrastructure and welfare facility improvements.

26. Infrastructure for placement of hybrid and full electric vehicles – rapid charging infrastructure has been installed at Wrexham, Beacon House, Cwmbran and Cardiff.

27. Feedback on the recently undertaken all Wales Capital Prioritisation work with Welsh Government has now been received and the Trust will need to consider how it progresses some of the estates and other schemes within this outlook that are unable to be supported at this stage for capital funding. As an initial response to this, the Trust has been successful in obtaining Targeted Estates Funding for 2025/26 – 2026/27 for three schemes – Abergavenny and HART in 2025/26 and Rhyl in 2026/27.

28. Estate Help desk logged calls are shown as follows up to March 2025.



February 2025 Summary

Total Number of Helpdesk Calls Logged – 271

Top 4 Categories: -

- Access Cards 71
- Plumbing 24
- Electrical 24
- Vehicle Chargers 19

March 2025 Summary

Total Number of Helpdesk Calls Logged – 277

Top 4 Categories: -

- Access Cards 102
- Electrical 28
- General Building 20
- Plumbing 19

Fleet

The 2024/25 Trust Board approved Fleet replacement programme and BJC was submitted to Welsh Government on 23/11/2023 requesting funding for the replacement of a number of vehicles including an element of catch up from 2023/24.

CORPORATE GOVERNANCE

37. In support of our commitment to promoting the Welsh language and ensuring compliance with the Welsh Language Standards, the Trust will be participating in the 2025 National Eisteddfod of Wales in Wrexham (2–9 August). Coordinated by the Trust's Welsh Language Services Manager, this cross-directorate initiative brings together colleagues from Operations (Volunteer Service), People and Culture (Recruitment), Clinical (Save a Life Cymru), Quality and Nursing (Patient Experience and Community Involvement), and Communications. Together, they will ensure an engaging presence that promotes our services and career opportunities

through the medium of Welsh, while contributing to a memorable and inclusive experience for all visitors.

38. Effectiveness reviews have concluded for all seven committees of the board, and the advisory group. The Audit, Risk and Assurance Committee (ARAC) has received the output of those reviews, and their AAA is before the board today, as is a comprehensive report on the reviews. Whilst it was concluded that the committees were effective with respect to all areas of their remits, ARAC challenged the team to go further and to look at other measures to streamline governance at committee level. That work has commenced and will be overseen by ARAC.

39. The Trust's 2024/25 annual report was submitted to Welsh Government and Audit Wales on Friday 09 May 2025 which includes the performance report and the accountability report. The certification deadline proposed by Audit Wales is 30 June 2025. ARAC will receive the Annual Report & Accounts on 24 June 2025 after which this will be approved by the Trust Board at an extraordinary meeting on the 26 June 2025. It is not anticipated that there will be any adjustments required to the dates for these meetings given the planning approach taken.

40. We continue to make strong progress in addressing Internal Audit recommendations. Of the 83 recommendations due for completion during Quarter 4 of 2024/25, 58 (70%) were confirmed as closed within the quarter. The Internal Audit Plan for 2025/26 has now been finalised and includes 20 audits across all directorates, ensuring continued focus on priority areas and system-wide improvement.

41. Following a structured, risk-based planning process, in April 2025 Audit Wales issued the Trust's Draft Detailed Audit Plan 2025. Covering audit year 2024/25, the plan includes a comprehensive suite of financial audit work (including financial statements, materiality, fraud, and asset valuations) and performance audit work (covering strategic planning, financial sustainability, workforce planning, governance, and the Well-being of Future Generations). The programme is expected to be substantially completed by March 2026 and will provide valuable external assurance on our key systems and processes.

42. A policy re-prioritisation exercise, undertaken by the Corporate Governance Team in collaboration with the Assistant Directors Leadership Team, has confirmed that 60 Trust-owned policies require review or development in 2025/26. The resulting Policy Work Programme has been aligned with assessed risk levels and directorate priorities, enabling more

effective tracking and reporting of progress throughout the year. Our aim remains to achieve 95% compliance with review dates across all Trust-owned policies by March 2026. A Policy Transformation Programme will kick off in 2026/27 once this has been achieved.

STRATEGY, PLANNING AND TRANSFORMATION

Strategy Development

43. Work has commenced to build relationships with Health Board strategy teams to consider opportunities for strategic alignment and share best practice regarding strategic development and horizon scanning processes. Initial meetings have taken place with C&VUHB and meetings planned with ABUHB strategy leads in May. Recruitment is underway to fill the vacant Strategy Development Manager position and following confirmation of permanent funding recruitment is also underway for the Strategy & Transformation Engagement Manager position. Both posts are expected to be filled in Q2.

Integrated Strategic Planning & Transformation

44. The IMTP was submitted to Welsh Government following Board approval at the end of March. We have yet to receive feedback on the plan but will have a chance to discuss some of the key areas set out within the plan at our year end JET meeting with WG executives in June. Following its approval, the Welsh translation of the IMTP, and summary versions for the public and our people are being finalised along with a short video which will be hosted on our website along with the narrative IMTP documents.

45. Work has been underway to finalise Directorate level plans that underpin the delivery of the IMTP, following the prioritisation processes and approval of the IMTP by the Board. Moving to digital platforms for our plans has commenced with significant progress on developing and implementing an initial structure with further development of the digital capabilities that will support planning and assurance ongoing throughout Q1. This is a significant step to support streamlining, efficiency, management of interdependencies and assurance processes across the organisation.

46. The directorate has invested in membership of the Healthcare Project and Change Association, which has given access to a wealth of resources, training and competency frameworks for project & programme management and change. It has also paved the way for networking across

the UK ambulance sector, UK NHS and an opportunity also exists to develop a Welsh project and change network. SP&P and People & Culture colleagues will be taking a lead role in developing the Welsh network, working closely with colleagues in the NHS Executive and Public Health Wales to establish its purpose and scope, so that it adds value to the role that project, programme and change plays across the Trust and across Wales.

Clinical Model Transformation

47. Significant progress has also been made in digitising the programme management of the Clinical Model Transformation (CMT) programme. Core programme controls, including risks, issues, and decisions, have been migrated to a central MS365 solution. An interactive Programme Portal is now live, and workstream plans for FY2025/26 are being built in MS Project, aligned with IMTP deliverables. Efforts are ongoing to refine this solution and develop automated Power BI reporting, starting with risk and issue management.

48. Key deliverables such as the Clinical Services Model Information Pack and the updated Service Model Blueprint are nearing completion, with final revisions underway. The development of patient personas is also advancing well, with final edits pending approval from the CMT Board. In the area of benefits realisation, logic-benefits mapping for each workstream has been completed, providing a technical foundation to define meaningful and measurable benefits. Draft scorecards have been developed for CMT Board endorsement. Subject to approval, a consultation period will refine the scorecards further with input from workstream SROs and key stakeholders, with final development managed by the Insights & Data Services team.

49. Quality, and Equality Impact Assessments (QIAs) remain integral to programme assurance. QIAs for the Digital Front-End and Urgent Community Response workstreams have been approved, and the programme-level EQIA was approved by the CMT Board on 6 May. To support audit readiness, a programme health check has been initiated, and any gaps in documentation or areas for improvement will be addressed to ensure robust governance.

Significant progress has been made across the CMT workstreams:

50. In Digital Front-End, the implementation of a Virtual Assistant for the NHS 111 Wales website is advancing well, with live deployment preparations underway. Following strong staff engagement during the CEO Roadshow,

over sixty name suggestions were received for the Virtual Assistant and a shortlist of names will soon be available on Siren for a staff vote. Additionally, the Capital Funding Group is expected to approve funding for the Online Symptom Checker, paving the way for a significant development in our digital front-end strategy. This initiative includes the forthcoming proposal to the Trust Board for authorisation to procure a web-based Call Prioritisation Streaming System (CPSS), which will enhance the integration of our 111.Wales website with our telephony service.

51. Currently, the Emergency Response workstream is focused on the forthcoming implementation of newly defined call categories, including Purple (Arrest), Red (Emergency), and Maroon (RCS0), and we are pleased to confirm that we are on track to meet Welsh Government expectations of the 1 July 2025 for official implementation.

52. The UCR Service Specification is now complete and has been formally approved, marking a key milestone in defining the framework for future service advancements. The Mental Health Response Vehicle remains operational, with an evaluation now underway to assess its impact using available data. ITV Wales recently featured the service on the 6 o'clock news (22 April 2025), providing the public with an insightful look at how WAST develops personalised services to meet population needs.

53. Within Remote Integrated Care, building on the positive evaluation of the Winter Desk Initiative, a proposal is now in development to outline next steps. The initiative demonstrated the successful application of the Call Prioritisation Streaming System (CPSS) for 999-originating calls and strengthening these findings, and building on this success, remains a key priority. Following the well-received evaluation of Remote Monitoring Solutions within the community, work is progressing to establish clear metrics for measuring the operationalisation of the new Care Planning function and a series of workshops are planned to evaluate the full impact of remote care planners, ensuring informed decision-making and service optimisation.

54. Finally, a Health Transport workshop was convened during April to determine patient criteria and journey processes, ensuring clarity on planned journey outcomes based on a Remote Integrated Care (RICS) assessment. The patient suitability criteria and process flows have now been established, shaping several key initiatives that will now be taken forward under the leadership of the Health Transport Board, including the development of transport pathways across health boards, ensuring alignment with RICS assessment outcomes.

55. Priority clinical engagement has continued into Q1 with key clinical stakeholders on the changes to the Clinical Services Model. Plans are underway to commence engagement with wider system stakeholders and the public from Q1 onwards. This engagement has been dovetailed with the urgent planning for external communications to support the implementation of the new Ambulance Performance Framework, A bespoke communications strategy has been developed, stakeholders mapped, and a detailed delivery plan developed. Work is now continuing with the team to develop the key products and collateral to support the communications approach in readiness for the 1st of July go-live. The team has developed a detailed paper to provide assurance to the Trust Board on the changes and preparatory work for the extraordinary board meeting which took place on 7th May.

Service Review

56. Work is concluding on the Service Review as part of the Financial Sustainability Programme (FSP). Over 330 ideas were generated during the review, some of which can be delivered at team and department level where there is evidence of benefit, others will be taken forward at directorate and cross-directorate level following agreements on 'big ticket' items at ELT. The review also presented directorates with SWOT analyses to support their directorate planning and generated an overarching view of the organisation and how it operates. Key outcomes include efficiencies in how Make Ready Depots will be managed by Fleet department going forward, the right sizing of engagement resources within the Partnerships and Engagement directorate and agreement on the governance framework for FSP and how recommendations from the review will be taken forward and monitored.

Adaptation Planning

57. A working group has been established, led by SP&P, to take forward Adaptation Planning.

58. Adaptation Planning is the planning required to adapt to the impact of climate change on our activity, estates and healthcare delivery (where Decarbonisation is the planning to mitigate the impact of our activity on the environment). Welsh Government is expecting climate impact risk assessments to be undertaken to understand gaps in our current plans, so that Adaptation Plans can be developed by Q3. SP&P and Estates colleagues will join a WG led Adaptation acceleration project and are

building networks with colleagues in Health Boards. A lot of planning for adaptation is undertaken at Public Service Board level. Therefore, key to this work will be how WAST is able to forge links with others were adapting to the impact of climate change requires support from other agencies.

Health Board Strategic Service Planning

59. Nationally, the National Stroke Programme is a significant focus, with plans to develop Hyper Acute Stroke Units (HASUs) across Wales, which will affect travel times and ambulance services. In South Wales, the Adult Thoracic Surgery programme at Morriston has been paused, and a new thrombectomy service is being developed at University Hospital of Wales. North Wales is seeing the refurbishment of the Royal Alexander Hospital, which will increase transport requirements for day-case surgeries and rehabilitation patients.

60. In Mid & West Wales, there are developments in urology and ophthalmology pathways, as well as the establishment of a chemotherapy unit at Bronglais General Hospital. South-East Wales is focusing on the development of a Radiotherapy Satellite Centre at Nevill Hall Hospital and the reconfiguration of stroke services. These changes will have implications for emergency response and ambulance care, requiring adjustments in workforce planning and coordination with health boards to ensure appropriate non-emergency transport provision.

61. In the Southeast, work is progressing at pace to develop the investment case for a diagnostic and surgical centre in Cwm Taf Morgannwg (CTM). The Planning Team is working closely with CTM colleagues to understand the impact on non-emergency patient transport.

CLINICAL DIRECTORATE

62. Colleagues in the Clinical Development Team, led by Jonathan Chippendale, have been conducting risk stratification work related to breathing difficulties that present as Red calls, applying the insights gained from the significant pressure we experienced during the Winter of 2024/25. This work will be used to mitigate what will inevitably be a repeat of the activity as we approach this Winter, particularly in the 0-4 age group.

63. Work continues on developing call flow and categorisation, aligned with the new response measures. This initiative is chaired by Greg Lloyd, Assistant Director for Clinical Delivery. While there is significant work to be done, progress remains on track for the 1st of July.

64. Interviews for the Head of Research and Innovation position took place on the 16th of May, resulting in the successful appointment of an experienced researcher. Onboarding for the role is underway, with an agreement on the start date imminent. The position will provide essential support to the Assistant Director of Research and Innovation and the broader research team.

65. WAST hosted a 'Stroke Study Day' for Paramedic pre-registration students at Swansea University last month. Speakers included our own Director of Paramedicine, Consultant Paramedic Mike Jenkins, service users, and several stroke consultants. Following the day's success, planning is underway to replicate this event at Wrexham Glyndwr University.

66. The Clinical Team has been delivering CPR and AED training to members of the Senedd and their associated staff following the announcements made regarding the measurement of red performance and out-of-hospital cardiac arrest response earlier this year. These eight events have demonstrated significant interest from the parties involved and have been a positive experience for both recipients and trainers alike.

DIGITAL SERVICES

Mobile Data Vehicle Solution (ESN Phase 2) Outline Business Case

67. Significant effort has been given, over the past few months, on refreshing the Mobile Data Vehicle Solution Outline Business Case, the case focuses on the next stage seeking to set out the strategic options and financial requirements needed to allow the Trust to exit the Airwave service, once operationally and technically acceptable. The OBC has begun its journey through Trust governance and is anticipated to be presented to Trust Board at the end of May 2025.

ePCR

68. Work continues to progress positively on the next update to the ePCR application, scheduled for release in May. This will be an in-app store update, with enhancements across the user interface and portal, designed to ensure full compatibility with iOS 18. It will also address known issues with the Corpuls SDK and introduce a range of new features and interface improvements aimed at enhancing overall usability and performance.

69. Work is progressing well on the ongoing redesign of the application. Clinical users are actively involved to ensure the new design reflects the needs of frontline staff and delivers a more intuitive, efficient experience. This close collaboration is a key part of our commitment to continuously improving the application and ensuring it truly supports those who use it.

ICT

70. The ICT team has developed and implemented a system to integrate Mobile Data into vehicle infotainment screens, providing a safer and clearer experience for crews. Between March and April, this system was deployed to 20 vehicles and will continue to be rolled out to dual-crew ambulances, ambulance care vehicles, and other suitable vehicles in the coming months.

71. The North ICT team has been working over the past few months, preparing for the migration of the North CCC from Llanfairfechan to Ty Elwy. This resulted in a successful and seamless transition of the Llanfairfechan-based departments to the new location. During the transition, a particular emphasis was placed on maintaining the operations of two call centres simultaneously. This, according to the Ambulance Radio Programme (ARP) team, who assisted with the migration, was a first for them. It also provided valuable insights and learnings for future transitions at other trusts. This moved followed-on from work carried out by the South ICT team to support the re-development of the CCC at Llangunnor.

72. ICT has developed and deployed a system that enables the Hazardous Area Response Team (HART) to securely view and record live drone footage during incidents. This allows remote decision-makers to view the incident area and gain a better understanding of the situation.

73. ICT continues to advance a project enabling RFID scanning of removable devices (such as defibrillators, wheelchairs, etc.) within ambulances. This system provides staff with confirmation that all necessary devices are present in the vehicle. By utilising Radio Frequency Identification (RFID) tags, it allows for tracking devices between vehicles and monitoring the location of devices sent for repair.

74. Work is ongoing to replace the 999 MIS C3 CAD servers, which have reached the end of their serviceable life. Recently, the core servers managing the central databases and reporting elements of the system were successfully replaced.

75. Following the 999 MIS C3 server replacement, the Paramount replacement project commenced in April to update the 999 Paramount and AQUA environments across both data centres. The most significant step in this process is the introduction of a SQL cluster to host Paramount, AQUA, and all archive databases. This development will enhance the ongoing system management and disaster recovery (DR) capabilities of the environment. Additionally, it will open up future possibilities for improved data access, such as SQL-linked reporting for the MPDS/IDS teams, which are currently unavailable.

Insight & Data Services

76. The Insight & Data Services function is now at full establishment (bar one role in the Information Governance team), including 8 new roles following Digital investment in 2024. We now have a Data Quality team in place, with a breadth of expertise, to build assurance in our organisation's data – this is important as this underpins WAST's reporting, analytics and decision making, and is particularly pertinent as we move to a new operational and clinical performance model as part of the Clinical Model Transformation (CMT).

77. In support of the CMT, the Data & Analytics team have produced three metric definition documents – for Arrest, Emergency and RSC0 call categories – which have been co-developed with Clinicians, Operational leaders, and Commissioners. These have been put forward for approval, and once agreed, development will begin on the data and reporting layers ahead of the proposed 1st July go-live for the new model.

78. The Trust made a submission under the Welsh Government's Information Governance Toolkit in March 2025. Having completed all actions in our internal Information Governance Toolkit Improvement Plan through the course of the year, all categories of the submission met or exceeded expectations, except for the Training & Awareness category. This category refers to the Trust's compliance with Statutory IG Training, which although had improved from <75% in March 2024 to 79% in March 2025, is still below the 85% target. The compliance rate does continue to increase and in mid-May 2025 had reached ~83%. The IG team continue to support awareness with presentations and communications across the Trust, and input directly to projects with expert advice and action.

79. The Records Services team has doubled in size with recent investment (to ~4 FTE Records Officers), and is now better positioned to manage inbound requests which have been increasing in volume and complexity for several

years. In turn the additional capacity means focus can return to Records Management and improvement, and the completion of a recent improvement project has seen all HR leavers files for North Wales and VPH be assessed to update retention schedules and understand the volume ready for destruction or long-term storage.

111 Digital Front end

There has been significant development of the overarching plans and aspiration for running NHS 111 Wales Online as a service. Conversations continue to progress to secure investment for this. In the meantime, our Virtual Assistant (previously referred to as ChatBot) is about to start Beta testing with the public. This will enable us to iteratively develop the Virtual Assistant ahead of a formal launch.

Digital Transformation and Innovation

80. A pilot is currently underway, offering a small cohort of corporate and operational staff a licence for Microsoft Copilot - a secure Generative-AI tool approved for use within NHS Wales. This pilot will run until the end of June 2025, with the aim of understanding use cases and the effectiveness of the tool, as well as testing the helpfulness of bespoke guidance developed to support users. Supporting materials include a dedicated intranet site, a communications channel to encourage peer-to-peer conversations, and official Digital Notices. Two engagement sessions on Generative-AI more broadly were delivered to interested staff earlier in the year, and since the commencement of the pilot, two "promptathon" sessions have also been held. Continuous feedback on Copilot is being collected from pilot members via electronic forms; these findings, along with a more structured pilot evaluation after June, will inform the next steps and support the development of a broader AI Policy for WAST.

HSJ Awards

81. A project led by the Trust's Digital Team and supported by EDI colleagues has been shortlisted for a HSJ Digital Award for promoting digital equality, diversity, and inclusion.
The HSJ Digital Awards shine a light on teams and organisations driving meaningful change through technology, improving patient outcomes, streamlining processes, and enhancing the overall quality of care.
The team presented to a panel on 29th April and the winners will be revealed at the HSJ Digital Awards ceremony on 26 June 2025, a night

dedicated to celebrating the brightest minds and most impactful projects in digital health.

PARTNERSHIPS AND ENGAGEMENT

82. In preparation for the pilot changes to Welsh Government's Ambulance Performance Framework from 01 July 2025, the team has been developing internal and external communications strategies which set out how we will articulate the rationale for the changes and what they mean for our people, partners and the wider public. Engagement on the broader transformation of the Trust's clinical model continues in the meantime. Priority clinical engagement with key clinical stakeholders has now largely concluded, and work is underway to engage with wider system stakeholders and the public. An ITV Wales feature about how the Mental Health Response Vehicle is helping to deliver safer care for patients and protect ambulance capacity for those who need it most was valuable in this regard. The piece can be viewed here https://www.itv.com/watch/news/on-patrol-with-the-ambulance-crew-created-to-respond-to-mental-health-crises/f4h5hdk

83. The Trust published its first set of wellbeing objectives in March as part of its duties under the Wellbeing of Future Generations (Wales) Act 2015, designed to ensure that public bodies across Wales are working together to improve the social, economic, environmental and cultural wellbeing of Wales. These objectives will guide the Trust's decision-making, helping to shape policies and initiatives that prioritise sustainability, inclusivity and wellbeing. Work is now underway to bring these objectives to life, including embedding them throughout the Trust's work, as well as assessing the organisation's maturity as a WBFGA body and looking at our approach to adaptation planning. The Trust has been invited to submit written and oral evidence at a forthcoming meeting of the Senedd's Equalities and Social Justice Committee as it undertakes post legislative scrutiny of the Well-being of Future Generations (Wales) Act.

84. Two of the Trust's long-running campaigns had a boost over spring. The Trust collaborated with the NHS Wales Joint Commissioning Committee to promote the NHS 111 Wales offer across a broad range of platforms, including TV advertising, while the Chief Executive appeared on ITV's Good Morning Britain to talk about the rising number of assaults on UK ambulance workers, amplifying the With Us, Not Against Us campaign.

85. Significant progress continues on this year's Long Service Awards, with a record number of colleagues invited to attend. This increase is the result of revised eligibility criteria, which now include EMSC staff for the King's Long

Service and Good Conduct Medal. Efforts are also underway to enhance our internal communication. We will be introducing updates to our communication platforms, enabling us to tailor content more effectively based on colleagues' job roles. Additionally, we are collaborating with DHCW to improve the accessibility of documents on our website. We aim to launch a new template by the autumn to support this initiative.

86. The Welsh Ambulance Service Charity continues to engage with staff from across directorates on the Charity's future strategy – including through meeting with staff during the April CEO roadshows, and through informal station visits at Bryncethin and Cardiff East. A final draft of the Charity's Theory of Change and Strategic Objectives, along with fundraising projections for 2025-28, have been endorsed by Charity Committee and have been presented to Corporate Trustee for approval. The Charity continues to encourage and support staff who wish to fundraise. James Mailer, an ICT Technical Engineer based at Ty Elwy, raised more than £1,000 for the Charity through a sponsored haircut. Amy Richmond, an EMS Call Taker, and Kerry Llywarch, a Paramedic, both ran the Wrexham 10K in April in aid of the Charity and raised a total of more than £300.

QUALITY SAFETY AND PATIENT EXPERIENCE DIRECTORATE

HEALTH & SAFETY

87. With the increase in delays at hospital Emergency Departments (EDs), considerable work had been undertaken prior to 2023/24 to quantify the exposure of staff and patients to diesel engine exhaust emissions (DEEE).

88. During 2024/25 in order to mitigate the need to run the vehicle engines and diesel heaters during the winter period, bladeless fans with HEPA filtration were identified as a potential control measure to provide thermal comfort for patients and staff. After successful trials at the Grange University Hospital work further was carried out in conjunction with all Health Boards across Wales to install the infrastructure needed at 7 EDs across Wales.

89. A Safe Operating Procedure and Risk Assessment were completed in conjunction with the Health and Safety Team, Infection Prevention and Control (IPC) Team and Operational Teams to ensure the concerns of the Health Board IPC and Estate Teams were addressed. By the end of March 2025 all 7 EDs across Wales that have vehicles delayed under canopy areas have had the required infrastructure installed to all for the use of the bladeless fans. To date, 10 storage units have been installed, 45 bladeless

fans purchased and distributed to the required EDs and crews from across Wales have been trained in how to clean, set up and adjust the fans to provide optimal comfort for our patients.

90. Public Health Wales have provided the Trust with an Evaluation Tool that is being used to assess the potential benefits of the use of the fans in terms of thermal comfort, patient experience, staff implementation and microbial analysis. The outcome of this Evaluation will inform the next phase of the implementation of the bladeless fans at the remaining EDs in Wales.

MENTAL HEALTH AND DEMENTIA

91. The National Suicide and Self Harm Strategy was published on 1 April 2025. This Strategy outlines measures and initiatives to prevent suicide and self-harm for the population in Wales, providing a Framework for support and intervention.

92. The Mental Health and Wellbeing Strategy was published by the Welsh Government (WG) on 30 April 2025. This Strategy focuses on promoting mental health and wellbeing across various sectors, aiming to improve Mental Health Services and support systems. It emphasises an early intervention approach and wants everyone to have the same day open access to mental health care at the point of need using a one at a time approach and ensuring there will be no waiting lists.

93. The Welsh Ambulance Services University NHS Trust (WAST) Mental Health Service has been a key stakeholder in supporting the implementation of both the National Strategies.

QUALITY STRATEGY

94. We have developed a comprehensive and forward-thinking Strategic Plan designed to enhance the quality of healthcare services provided by the Trust. The Plan, which has been developed through extensive collaboration and engagement with our patients, our people and through integration with our Directorates, has now been endorsed by the Quality, Patient Experience and Safety (QuESt) Committee. The Strategic Plan focuses on key areas such as the integration of technology and innovation, population health, value-based healthcare, and person-centred care, creating linkage between Strategic Plans demonstrating 'quality is everyone's responsibility'. The Strategic Plan aims to highlight by leveraging data and insights for evidence-based decision-making and strengthening system partnerships, we aim to ensure our services are efficient, effective,

equitable, and inclusive. The Plan also emphasises continuous improvement, Quality Management Systems, and leadership development, demonstrating our unwavering commitment to delivering compassionate and personalised care.

DOC-WORKS

95. The digital mechanism for submitting WAST Safeguarding Reports has been promoted throughout the Trust since the initial launch of Doc-works Scribe in 2019. WAST colleagues with iPads can use an App and office-based colleagues can utilise the same system on desktop computers.

96. When there are safeguarding concerns, all colleagues complete digital Safeguarding Forms, click submit and the reports are automatically sent to the relevant Local Authority at the time of submission.

97. Since it's introductions the Safeguarding Team have noted an increase annually in the number of Safeguarding Reports submitted. The digitalisation has also had a positive impact on the time and resource as the submission process has been simplified.

98. Prevent Referrals are also submitted via Doc-works Scribe, these are shared with the Counter Terrorism Team.

99. Doc-works Scribe is also the location for alternative Referral Pathways. These include the Live Fear Free Helpline for instances where support is required in relation to domestic abuse or sexual violence, the Fire Risk Referral to Fire & Rescue Service partners who can conduct home safety checks and Dementia Referrals which can be completed and sent to Alzheimer's Society Cymru when there are concerns for an individual's memory or that they may have dementia.

100. Doc-works is currently supporting the Safeguarding Team to develop an innovative, bespoke Digital Platform for recording all safeguarding enquiries (internal & external). The Platform will collect data to assist with the production of Data Reports, which can be analysed to identify themes and trends.

PATIENT EXPERIENCE

101. The WHC/2018/042 requires that 'A range of opportunities should be made available to service users/families/carers to provide feedback at any time. This can include paper and online methods, text and social media'.

The Patient Experience & Community Involvement (PECI) Team currently make a 999 Experience Survey available through the Welsh Ambulance Service website and promote the Survey through social media and when engaging with local communities. However, this results in a very limited response rate and does not enable the Trust to build or report a true reflection of 999 service user experience. More recently, since the implementation of Civica, a request to send SMS Survey links to 999 callers has been made by Welsh Government with the Trust being written to by the Head of Safety & Learning at Welsh Risk Pool, highlighting that we are outliers in not utilising the SMS functionality in comparison to our Health Board colleagues.

102. Due to the nature of calls made to 999, it is not possible to inform 999 callers about the potential receipt of an SMS Survey, to seek their preferred method of receipt (such as postal versus SMS), or an opportunity to opt-out. However, this is also the case for colleagues across NHS Wales, with individual patients attending the Emergency Department or Outpatients for example not informed in advance that they may be contacted for feedback. Instead, this is managed by privacy notices and relevant information displayed on Health Board websites and posters and signage within the hospitals. Our intention would be to do the same, making the possibility of contact by SMS Text to request feedback clearly visible on relevant pages of the Trust's website. In advance of sending any SMS Texts we would also work with colleagues in our Communications Team to conduct a Public Awareness Campaign about the Project.

103. A Data Protection Impact Assessment (DPIA) has been written and submitted to the Information Commissioner's Office (ICO) to enable a wider reach for patient experience reporting. The DPIA submitted has identified assessed and minimised any data protection risks through the issuing and processing of the 999 Surveys, including the methods used to send Survey communications to service users. The DPIA covers:

INFECTION PREVENTION AND CONTROL

104. The Infection Prevention and Control (IPC) Service Improvement Plan is progressing with measurable improvements in governance, reporting, and quality assurance. A significant milestone was the presentation of the first Quarterly Report at the IPC Strategic Group Meeting. This report provided a comprehensive overview of IPC service provision, including performance against key indicators such as the rollout of respiratory protective equipment across WAST, incident and outbreak management, Quality Assurance Audits, education and training delivery, issuance of Directorate

Notices, review of Policies and Guidance documents, and support for the fume mitigation project.

105. Despite these advancements, the report identified several areas requiring further improvement. These included compliance with Hand Hygiene Protocols, as well as the cleaning of equipment and vehicles. In particular, attention must be given to the cleaning of bladeless fans and storage units, which require reviewed Procedures and the development and implementation of targeted Improvement Plans. Additionally, efforts are needed to ensure that all staff are fully compliant with statutory and mandatory training requirements.

106. Recommendations from the report focused on the need to support Locality Managers in engaging with the audit process by developing Action Plans and working with staff to improve service quality. It was also recommended that vehicle and equipment cleaning be prioritised to protect both patients and staff from healthcare-associated infections.

107. Over the past year, the IPC Team has faced several challenges impacting their operational capacity. These included changes in workforce and leadership, staffing shortages, and reduced training opportunities. As a result, the majority of IPC activity was concentrated in Quarters 3 and 4.

108. Workforce capacity is now improving through a Recruitment Programme. A Band 7 IPC Practitioner commenced employment on 1 May 2025. A Band 6 IPC Practitioner and a Band 3 Business Support Officer have been appointed, with their start dates pending. Recruitment for the substantive Head of IPC Service is also underway, with the role scheduled for publication on TRAC in the coming week.

MATERNITY CARE UPDATE

109. The Trust continues to advance the quality and safety of care provided to women, babies, and families during the perinatal period, both in remote and face-to-face settings. Updates to Pregnancy Protocols within the Medical Priority Dispatch System (MPDS) have been implemented to ensure alignment with National Guidance, supporting safe and timely clinical responses to maternity-related 999 calls.

110. Enhancements to the Call Streaming Prioritisation System within NHS 111 Wales now provide more effective signposting for pregnant and postnatal women to the most appropriate Maternity Services, improving patient experience and supporting prudent use of healthcare resources.

111. The Trust's Midwife has provided national leadership in the revision of Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Maternity and Neonatal Clinical Guidelines, strengthening the quality of care delivered in low-frequency, high-impact incidents.

112. The Trust's growing leadership in pre-hospital maternity care was recently recognised at a National Maternity Conference in Northern Ireland, where our work on neonatal thermoregulation was commended as an example of exemplary practice. This external recognition reflects the wider impact we are having across the pre-hospital system, where our evidence-based interventions are helping to set standards, influence practice, and improve outcomes for women and newborns across Wales and beyond.

PEOPLE AND CULTURE DIRECTORATE

Staff Survey

113. Continuing our focus on amplifying colleague voice, Directorate-level data from the Staff Survey has now been shared and Directorate Leads have been tasked with engaging colleagues in discussions about their results and developing local action plans in response. To complement the annual NHS Wales Staff Survey (which will run throughout October and November), we will shortly be launching a series of shorter pulse surveys; these will run in May, August and February and are aligned to the themes of Our WAST Way – Care, Connect and Value Everyone. The pulse surveys will focus on three high-priority areas identified through the 2024 results: burnout and workload (Care), regular meaningful 1:1s with managers (Connect) and involving colleagues in decisions and change (Value Everyone).

Social Partnership Conference

114. A key feature of our People and Culture Plan is to embed partnership working across the organisation. On 31st March 2025, WAST hosted a landmark Social Partnership Conference at Cardiff City Stadium, the first of its kind in Wales. This event was attended by approximately 150 colleagues, including managers and TU partners from across Wales. The conference aimed to highlight the importance of mutual respect, open dialogue, and a shared commitment to common goals in creating thriving work environments for both the organisation and its people.

115. Participants engaged in round table exercises, the outputs of which will be utilised to further develop partnership working and share best practice. Attendees also participated in workshops covering topics such as sexual safety, avoidable employee harm (compassionate practices), and building inclusive cultures through partnership working. Additionally, the Social Partnership team from Welsh Government delivered a session on understanding social partnership and accessing relevant information and learning. Our work in social partnership is recognised as pioneering within and beyond the sector. We are now exploring opportunities to engage with managers and colleagues across the organisation, bringing together line managers to deepen their understanding of working in social partnership.

116. Furthermore, an ELT report is being prepared, detailing key projects and task and finish groups that are in partnership. Progress is being made on all RAG-rated projects, and the report will be shared with ELT shortly.

Capacity

Improving Attendance at Work

117. As part of our People and Culture Plan, we are committed to improving attendance at work by cultivating a healthier and more resilient workforce. Recent sickness absence data shows a reduction from 7.93% in February to 7.35% in March 2025. Notably, all areas across the Operations Directorate recorded reductions in absence percentages, with EMS achieving a significant decrease to 6.66%, the lowest level in over 12 months. Our People Service Team will continue to work with managers to enhance staff wellbeing.

Flexible Working

118. In line with our ambition to be an employer of choice and improve employee experience, we continue to provide Flexible Working coaching sessions across the Operations Directorate. Our ESR data indicates that between August 2024 and April 2025, a total of 321 flexible working requests were received, with 172 accepted, 3 rejected, and 146 currently being processed.

Supporting Organisational Change Programmes

119. There are currently 9 Organisational Change Programmes identified across the Remote Integrated Care workstream, each with varying levels of

complexity and stakeholder involvement. We have commenced the process to realign the senior management structure, with the consultation period closing on 20th May 2025. A detailed plan has been developed, mapping out key dates and timelines to support the smooth delivery of the process. As part of our goal to have an integrated care service, the team is working on aligning and consolidating the 111 and CSD local terms and conditions into a single document.

Health and Wellbeing

120. The health and wellbeing of our people remain a key organisational priority. In line with the Health and Wellbeing Plan 2025-2029, we have delivered suicide risk assessment training to Occupational Health and Wellbeing staff to improve our detection and response to suicide among the people we serve. Suicide risk assessment is now integrated into the clinical record system, ensuring that those we serve are supported in accessing NHS services when needed.

121. Following a period of consultation, we are about to launch a pilot of the new training package to enhance the Trauma Risk Management (TRiM) network. This training includes more psychological education, coping strategies, and suicide risk management. Our objective is to identify and signpost more staff and volunteers to appropriate support at an earlier stage to prevent prolonged sickness.

122. We are recruiting a bank Cognitive-Behavioural Therapist to provide clinical support and mental health expertise to Occupational Health and Wellbeing.

Skills Mix Task and Finish Group

123. To date, we have held three meetings of the Skills Mix Task and Finish Group. These meetings explored options based on various criteria, including cost, people impact, and patient care impact. Recommendations are being presented to ELT for consideration via a business case with the intention to share this before the end of May. We continue to engage with Trade Union Partners to manage this sensitive topic.

Corporate onboarding and induction

124. Continuing our efforts to create a positive onboarding and induction experience for new starters, we have begun work on designing, building, and creating the module content. We have mapped out the full structure

of the induction programme and are actively developing interactive modules. These will cover key areas such as our organisational structure, values and behaviours, wellbeing support, compliance, policies, benefits, and key digital tools. Each section is being designed with consistency, clarity, and engagement in mind to ensure new starters receive a high-quality and supportive induction experience. We are also working closely with key teams to source relevant resources, such as stock photography, directorate overviews, and updated executive team information, to ensure the content is visually engaging and aligned with current organisational branding and messaging.

Capability

Launching Our WAST Way

125. When we lead with care, connection, and by valuing everyone, we build a culture where people feel supported, trusted, and able to thrive — and that's when we deliver our best for patients and communities.

126. On Tuesday 28th May, we will be launching Our WAST Way. This values-based leadership and management framework designed to build a culture where staff feel valued, involved, trusted, and empowered. It builds on three core principles: Care, Connect, and Value Everyone, and has been developed in response to national leadership expectations, internal culture feedback from our staff, and a growing need to provide more consistent support to those in people management roles.

127. The framework is rooted in evidence about effective leadership development: practical, relevant, grounded in day-to-day work, and accessible to managers working in time-pressured, 24/7 environments. It reflects adult learning best practice and emphasises that real culture transformation happens through small, everyday actions and especially through better conversations.

Sexual Safety

128. As part of our ongoing commitment to promoting sexual safety in the workplace, we have initiated our internally developed sexual safety training sessions. These sessions are designed to raise awareness and address sexual harassment among key staff groups.

129. Recently, our People Services Team, Trade Unions, Inclusion, Culture and Wellbeing Team, and Safeguarding Team participated in a specialised

training session developed by the NWSSP Legal and Risk Team. This session focused on enhancing investigation skills and processes.

130. Additionally, Senior Operations Managers in the South East attended a half-day training session. This session covered managing conversations around professional boundaries, inappropriate behaviour, and sexual harassment. The Head of Service provided positive feedback, and staff have requested further sessions for the DOMs in their areas.

131. This month, we also delivered the first general sexual safety awareness training session to staff. We plan to offer these sessions monthly, making them available to all staff over the next year. Furthermore, we continue to contribute to the development of the All-Wales Sexual Safety Policy, led by NWSSP.

Transgender Awareness

132. The recent Supreme Court ruling on the definitions of 'woman' and 'sex' will have significant implications for the Trust. In response, we have requested an audit of our current toilet and changing room facilities to ensure they meet inclusive standards. Additionally, we have issued a reminder that the Trust is committed to inclusivity for all colleagues.

133. To further support this commitment, Transgender Awareness training has been incorporated into the MIST 2025/26 training program. This training provides practical advice for dealing with transgender patients and supporting transgender colleagues.

Education and Development

134. We have successfully completed the selection process for the Work-Based Learning route to Paramedic registration through the part-time BSc programme at Swansea University. We have confirmed 30 EMTs or EAPs, with a reserve list of 7. This selection aligns with our future workforce needs and projected vacancies across Wales.

135. The Mandatory In-Service Training (MIST) sessions concluded at the end of March, achieving an impressive 91% compliance rate. The 2025/26 programme has been developed and is scheduled to commence on 30th June 2025. We have ensured that all staff requiring MIST will have access to it within a 4-month period. Operations leadership continues to provide valuable support, ensuring the efficient delivery of this crucial training and helping the Education & Development team minimise risk to the Trust.

136. We are excited to introduce a new role and team within Education & Development. Our Essential Skills Tutors specialise in supporting our progression and apprenticeship priorities. Each Tutor brings a unique skill set, collectively offering expertise in literacy, numeracy, digital literacy, mentoring, and coaching. We are also recruiting two additional team members: a Bi-lingual Essential Skills Tutor based in North Wales and a Digital Skills Trainer.

137. Additionally, an increasing selection of topics is now available on Learn365, including a new 'Training Plan' feature. This feature summarises statutory and mandatory content, making it easier to access and enhancing the digital experience across the Trust.

Change Management

138. Aligned with our ambition to continue building organisational change management capacity and capability, we recently welcomed a further 11 colleagues into the Change Community following their completion of accredited change management training. In support of this growing community, we've developed a dedicated SharePoint page that brings together tools, guidance, a directory of Change Community members and a range of development resources. Designed as a one-stop shop, the site supports managers in guiding teams through change and helps colleagues build confidence and capability in change management.

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

AGENDA ITEM No	9
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

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

MEETING	Trust Board
DATE	29th May 2025
EXECUTIVE	Jason Killens, Chief Executive
AUTHOR	Rachel Marsh, Executive Director Strategy, Planning & Performance Hugh Bennett, Assistant Director Commissioning & Performance
CONTACT	Jason.Killens@wales.nhs.uk

EXECUTIVE SUMMARY

1. At its July 2022 meeting Trust Board received and discussed a report relating to avoidable patient harm. The original report was accompanied by a supporting action plan designed to mitigate patient harm. Updates have been provided at every subsequent Board meeting.
2. At its September 2024 meeting Trust Board received a closure report for the patient mitigations action plan and agreed to receive just the patient harm scorecard going forward.
3. The Trust continues to take many actions to mitigate patient harm, at a strategic, tactical and operational level, which are reported through to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report, Monthly Integrated Quality & Performance Report, QuEST committee agendas etc.
4. On the 11 March 2025 the Cabinet Secretary announced a new ambulance performance framework, in particular, splitting the current red category into arrest and emergency with the final stage of the rapid clinical screening process, (RCS0) being introduced for some current red incidents. The go live is planned for 01 July 2025 and preparations are on target.
5. *Appendix 1* contains the patient harm mitigations one page scorecard. This is the second scorecard that contains the impact of clinical model transformation changes switched on through winter 2024/25.
6. Key headline patient harm mitigation metrics for Q4 2024/2025 and April 2025

include:-

- The Trust is responding to more red 8-minute incidents as a result of its focus on CHARU recruitment;
- Patient cancellations are reducing and automatic Clinical Safety Plan "can't sends" have been switched off;
- The Director of Commissioning for 111 & Ambulances has recently approved the revised consult & close metric definition. The resumption of formal reporting will coincide with the move to the new arrest and emergency category, but informal reporting indicate a +20% rate, a material uplift linked to Rapid Clinical Screening;
- Conveyance to emergency departments is reducing;
- However, handover lost hours remain very high at over 20,000 hours per month (less in February 2025, but a shorter month);
- As a result the levels of avoidable patient harm remain unacceptably high in the 999-emergency ambulance care pathway, making further clinical model transformation a strategic imperative.

RECOMMENDATIONS

Trust Board is asked to:

- **NOTE** that the Trust's clinical model transformation is beginning to take effect.
- **NOTE** the continued level of avoidable patient harm in the 999-emergency care pathway.
- **NOTE** the strategic imperative to continue delivering the clinical model transformation programme at pace, supported by early tactical planning for winter 2025/26.

KEY ISSUES/IMPLICATIONS

As outlined in the Executive Summary above.

REPORT APPROVAL ROUTE

Date	**Meeting**
20 May-25	**Executive Director Strategy, Planning & Performance**
29 May-25	**Trust Board**

REPORT APPENDICES

Appendix 1 – Patient Harm Mitigations Dashboard

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	x	Financial Implications	x

Environmental/Sustainability	x	Legal Implications	x
Estate	x	Patient Safety/Safeguarding	x
Ethical Matters	x	Risks (Inc. Reputational)	x
Health Improvement	x	Socio Economic Duty	x
Health and Safety	x	TU Partner Consultation	x

SITUATION

1. Sustained and extreme pressure across the Welsh NHS urgent and emergency care system is negatively impacting on patient flow leading to avoidable patient harm and death.

2. This report provides Trust Board with a patient harm mitigations dashboard.

BACKGROUND

3. The 28 July 2022 Trust Board received the first iteration of a report and actions to mitigate real time avoidable patient harm which has then been updated for every Board meeting.

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

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

6. On the 11 March 2025 the Cabinet Secretary announced a new ambulance performance framework, in particular, splitting the current red category into arrest and emergency with the final stage of the rapid clinical screening process, (RCS0) being introduced for some current red incidents. The go live is planned for 01 July 2025 and preparations are on target

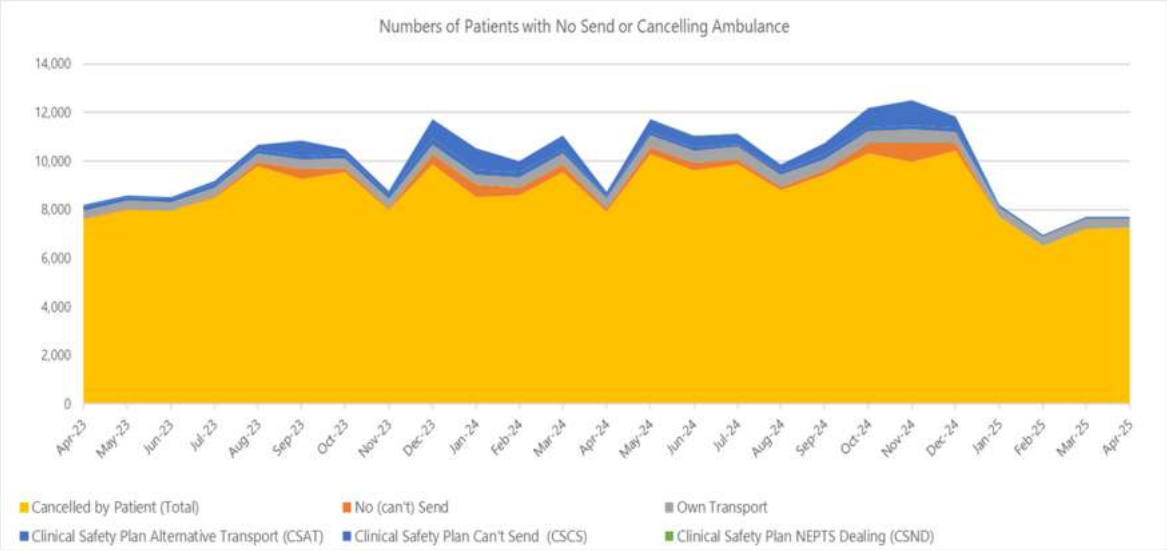
ASSESSMENT

7. *Appendix 1* contains a simplified patient harm mitigations dashboard. These metrics indicate continuing levels of unacceptable patient harm, for example:

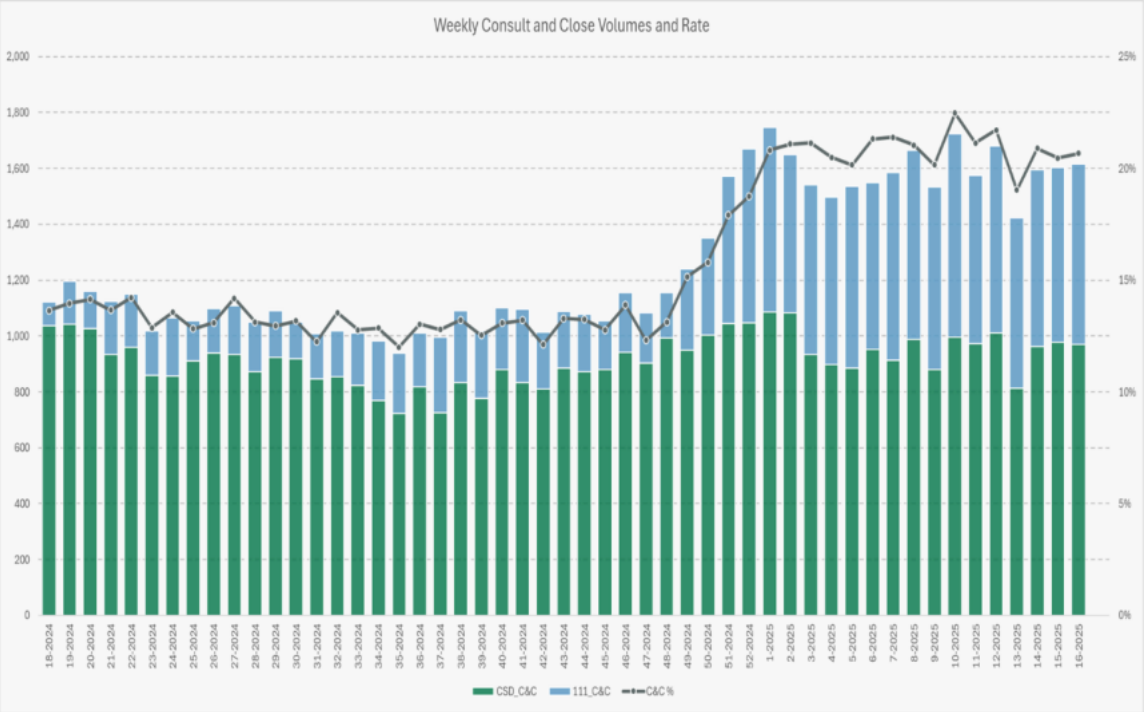
    - 463, 531 and 542 patients were estimated to have come to severe harm outside EDs in February, March and April 2025 respectively due to extended handover times;

8. However, there are a number of positives connected to the Clinical Model Transformation Programme-

    - There were zero Clinical Safety Plan "can't sends" in the last three months, as a result of the introduction of RCS and a change in the plan from the automatic deployment of "can't sends" at higher levels of the plan to a last resort at the discretion of the strategic commander.
    - Similarly, there was a 22% reduction in patient cancellations (pre-arrival) (see graph overleaf), which the Trust believes is attributable to the implementation of Rapid Clinical Screening; and
    - A 14% lower conveyance to EDs in Q4 24/25, compared to Q4 23/24.



9. As previously reported the switching on of Rapid Clinical Screening has driven more patient flow into Integrated Care i.e. remote telephony triage. Early data suggests that 75% of Amber 2 and Green demand is Integrated Care suitable and 66% of Amber 1 demand. More patient flow into Integrated Care is leading to a higher consult & close rate, as illustrated the following graph:-



10. This is a temporary graph, assured by Insight & Data Services (IDS), which indicates a consult & close rate in excess of 20%, at least five percentage points higher than the highest rate the Trust has previously achieved, and consistent with the 2023 EMS Demand & Capacity Review modelling. The Director of Commissioning for 111 & Ambulances has recently approved the new definition for consult & close (used in the above graph) with formal reporting via the Ambulance Services Indicators (ASIs) due to resume in August 2025, which will be the first month the Trust will report the new arrest and emergency categories. The switching on of Rapid Clinical Screening and the increased patient flow into

Integrated Care marks a "cultural shift" for the Trust away from traditional dispatch to remote care and community care.

11. Rapid clinical screening for green and amber calls was implemented over the winter period. The final stage will be the introduction of rapid clinical screening for a proportion of existing red calls (RCS0), which will be switched on from the 01 July 2025, as part of the response to the 11 March 2025 Cabinet Secretary announcement on the new ambulance performance framework e.g. arrest and emergency. This announcement is a major part of the Trust's Clinical Model Transformation programme and will see a move away from a blunt hit/miss metric for the current red (immediately life threatening category) to a much more sophisticated set of metrics based on the chain of survival and clinical outcomes. The Welsh Government letter requested the supply of the proposed definitions by 31 May 2025 and the Trust's proposed monitoring and assurance arrangement. Both were supplied on 13 May 2025, with overall preparations on target.
12. The continuing high levels of Red demand, hospital handover lost hours and avoidable patient harm make it an imperative to continue at pace with the Clinical Model Transformation Programme
13. Clinical Model Transformation Programme priorities in advance of next winter include:-
    - As above, implementing the new performance framework by the 01 July 2025 which will include introduction of arrest, emergency and RCS0 categories;
    - Further collaboration with Welsh Government on the second phase of the new ambulance performance framework, in particular, Amber and Green;
    - The development of more clinical outcome measures and general improvements in benefits reporting;
    - Further internal integration between 111 and 999, in particular, the establishment (phase 1) of the Remote Integrated Care Service (RICS); and
    - Further integration of patient flow and shift left activities between the Trust and health boards including introduction of more palliative care paramedics.
14. A key lesson identified from the changes put in during winter 2024/25 is to put the changes in earlier and lock down any further changes, enabling clinicians to familiarise themselves with these change in advance of winter demand pressures.
15. The Trust is continuing to build the supporting architecture around the Clinical Model Transformation Programme, details of which are in the separate Trust Board report on Integrated Medium-Term Plan Q4 Assurance.
16. Finally, whilst the Trust is making significant strides at real pace to mitigate the impact of high red demand and high hospital handover lost hours, handover reduction by health boards remains critical. The Cabinet Secretary has required

the establishment of an Ambulance Handover Improvement Implementation Group to ensure that the priority to eliminate all handovers over 45 minutes by October is achieved (a recommendation from the MAG report). The CEO and the Executive Director of Paramedicine are members of this group which also has strong clinical representation from Health Boards.

RECOMMENDATIONS

Trust Board is asked to: -

- **NOTE** that the Trust's clinical model transformation is beginning to take effect.
- **NOTE** the continued level of avoidable patient harm in the 999-emergency care pathway.
  NOTE the strategic imperative to continue delivering the clinical model transformation programme at pace, supported by early tactical planning for winter 2025/26.

Patient Harm Mitigation Indicators Dashboard

Top Monthly Indicators	Target 2024/25	Feb-25	Mar-25	Apr-25	2 Year Average	RAG
Our Patients						
Volume of Red Responded Incidents in 8 Minutes	↑	2,586	2,677	2,600	2,434	G
Volume of Amber 1 Responded Incidents	↑	8,913	9,844	9,988	11,104	R
Can't Send & Cancelled by Patient Volumes	↓	6,972	7,712	7,712	10,034	G
Our People						
Sickness Absence *(all staff)*	6.0%	7.93%	7.35%	N/A	8.18%	R
Number of Shift Overruns	↓	3,599	3,839	3,773	3,868	R
Total EMS Resource (all types) UHP	95%	95%	94%	97%	96.45%	G
Value						
% of Conveying Production Lost Due to Handover Lost Hours	7.81%	21.1%	22.2%	22.2%	22.6%	R
% of 111 Demand Referred to ED	↓	15.83%	16.48%	15.18%	14.28%	R
% of EMS Demand Conveyed to ED	↓	34.73%	38.18%	N/A	36.30%	G
Average Jobs per Shift (All Vehicles)	↑	2.55	2.56	2.64	2.36	G

Top Monthly Indicators	Target 2024/25	Feb-25	Mar-25	Apr-25	2 Year Average	RAG
Partnerships / System Contribution						
Successful Consult & Close Outcome	17.0%	N/A	N/A	N/A	13.28%	
% of EMS Verified Demand Accessing SDECs	↑	N/A	N/A	N/A	0.16%	
Number of Handover Lost Hours	7,500	18,811	21,852	21,193	21,788	R
Number of Patient Handovers > 1 hour	0	5,144	5,903	6,025	5,960	R
Number of Patient Handovers > 4 hour	0	1,601	1,906	1,800	1,874	R
Immediate Released (Red) Declined	0	1	7	1	7	R
Immediate Released (Amber 1) Declined	0	370	400	369	337	R
Patients Estimated to be coming to Severe Harm (from long ED wait)	0	463	531	542	537	R
Joint Investigation Framework Incidents Referred to Health Boards	0	36	33	17	15	R

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

AGENDA ITEM No	**10**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Trust Board
DATE	29 May 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks.

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

3. The BAF has been included in the new reading room facility in Ibabs, which is a digital space that hosts documents. Access to the reading room is through the documents/shared folder in Ibabs' main menu.

4. This document has been included in the reading room given its significant size and that it has been reviewed by each of the committees during this quarter. Any changes to it have been drawn out within this report. The BAF will be available on the website.

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

6. The Board can take assurance that each of the principal risks have been reviewed in line with the agreed schedule detailed at Annex 3 and that the Executive Leadership Team (ELT) approved the principal risk activity on 21 May 2025 having considered the review of each risk undertaken throughout April and May 2025 by Risk Owners and the Assistant Director Leadership Team (ADLT).

7. This executive summary continues to outline the broader discussions across the senior leadership teams and the Committees on the higher rated risks and signposts the Board accordingly. The Risk Owners have an opportunity to further add to this narrative and detail of any assurances or escalations during the meeting and Committee Chairs will

also contribute to this as appropriate, drawing from the Alert, Advise, Assure reports (AAA).

8. This report and the risk management work programme outline the significant work undertaken, to keep under review, the Trust's principal risks, and the Audit, Risk and Assurance Committee (ARAC) will scrutinise each of the these at its next meeting on 24 June 2025 as well as the progress made against the work programme.

9. There have been no material changes to the principal risks during this period; however, each of the Committee AAAs before the Board describe the discussions against risks within their remit.

10. **Risks 223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) remain at the highest score of 25. The score is not based on the volume of cases of catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.

10. These two risks continue to be dynamically reviewed; however, the scores remain unchanged.
    - 10.1. Handover delays continue to present patient safety risks and extended waits in the community with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service.
    - 10.2. The number of lost hours due to handover delays remained significant reported at 21,854 in March 2025 and 21,193 in April 2025.
    - 10.3. The Trust Board continues to focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm action plan which is presented at each Board meeting. Additionally, scrutiny is undertaken through the papers presented to the Quality, Patient Experience and Safety Committee (QUEST).
    - 10.4. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) and committees and Trust Board in a variety of reports e.g. IMTP Assurance Report and described in the Monthly Integrated Quality & Performance Report to address these risks.
    - 10.5. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. A key one being that a Handover Improvement Group has been established by the NHS Executive. The Terms of Reference and scope of work has yet to be defined; however, it is being led by the Director of Operations at the NHS Executive.
    - 10.6. Most of the Trust's actions in the action plan have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to mitigate the scale of handover lost hours due to

the environment which it is operating in or make improvements in performance because of the continued challenges in the urgent and emergency care system.

10.7. It's important to note that while some of the target dates of the mitigating actions are showing in the past, there has been close scrutiny of these two risks in dedicated workshops; the outcome of which will be presented to the June ARAC meeting for discussion.

11. **Risk 160** (*high absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service*) is rated 20.
    11.1. Whilst there has been a significant reduction in absence levels, the score of 20 (5x4) remains static during this quarter; however, the Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for relevant initiatives to support the mitigation of this risk.
    11.2. The Assistant Directors Leadership Team will undertake a deep dive of the risk on 28 May 2025 as part of a revised approach to risk.

12. **Risk 201** (*A loss of stakeholder confidence that damages the Trust's reputation*) remains static at 20.
    12.1. The risk was discussed at the last People & Culture Committee on 15 May 2025 and the tension in the reputational risk was noted that while the Trust has positive relationships with stakeholders, the patient experience remains poor due to harm in the community.
    12.2. A deep dive will be conducted on the risk over the summer to consider splitting it into a stakeholder risk and a patient experience reputational risk.
    12.3. This approach aims to address the different aspects of reputation and ensure the risk is accurately profiled.

13. **Risk 260** *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems* remains static at a score of 20 (4x5).
    13.1. This is due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations.
    13.2. A review was undertaken by the Closed meeting of the Finance & Performance Committee on 20 May 2025 with several issues also raised in the cyber management report.
    13.3. The discussion was held in closed session due to the sensitive and security based nature of the report.

14. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5).

15. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the Risk Owner to describe the rationale for each

of the risk ratings which is particularly important where ratings have remained static or increased.

16. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4).
    16.1. This risk was discussed in detail at the FPC on 20 May 2025 and it was agreed that a deep dive will be undertaken in readiness for the next meeting on 22 July 2025.

17. **Risk 558** *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures,* **Risk 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* and **Risk 623** *Failure to comply with Data Protection Legislation* all remain unchanged this period and static at a score of 15 (3x5).
    17.1. The Welsh Ambulance Services Partnership Forum (WASPT) will undertake a deep dive on Risk 558 at its July 2025 meeting.

18. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* and **Risk 163** *Maintaining Effective & Strong Trade Union Partnerships* remain unchanged at a score of 12 (3x4). The WASPT will review this risk at its next meeting on 30 May 2025.

19. **Risk 139** *Failure to Deliver our Statutory Financial Duties*. This is due to the reasonable revenue position for 2024/25; however, separate risks may be considered in the future relating to capital funding and vehicle/fleet.

RECOMMENDATION:

20. Members are asked to consider and discuss the contents of the report and:
    a) Receive assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees.
    b) Note the ratings and mitigating actions for each principal risk.

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
Each of the Principal Risks have been or will be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period: • Assistant Directors Leadership Team (28 April 2025) • Executive Leadership Team (21 May 2025) • Trust Board (29 May 2025) • Audit, Risk and Assurance Committee (24 June 2025) • Finance & Performance Committee (22 July 2025) • Quality, Safety & Patient Experience (05 August 2025) • People & Culture Committee (12 August 2025)

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

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death.	**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	**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)** →
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	**20 (5x4)** →
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	Director of Partnerships & Engagement	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny		
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**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 (4x4)** →
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in	Executive Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage		
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	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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.		
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	**IF** the Trust does: • not achieve financial breakeven and/or	Executive Director of Finance &	**8 (2x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	Duties in accordance with legislation.	• 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	Corporate Resources	

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ɔcal 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
OPEN	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – March 2025 / April 2025

MEETING	Trust Board
DATE	29th May 2025
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Georgia Tizzard – Commissioning and Performance Officer Melanie O'Connor - Senior Performance Analyst Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Georgia.Tizzard@wales.nhs.uk Melanie.O'Connor@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

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 **March 2025/ April 2025.**

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

3. Data quality issues have been identified and are being addressed within 111, APPs and throughout the quality indicators, with the result that there are a number of Board approved metrics which are not available at this time.

4. The response times for red 8-minute performance was 50.9% in April 2025, with performance marginally increasing compared to March 2025. The Amber 1 median was 1 hour 48 minutes, which was also a slight improvement on the 1 hour 51 minute 12-month average. The Trust knows these extended times (the ideal is 18 minutes) lead to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining high levels of EA production (93% in April, slightly below the

benchmark) and fully rolling out the CHARU service (91% in April); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.

5. The Trust lost 21,183 hours to handover in April 2025 (30-days). This level of lost capacity is difficult to compensate for, despite all of the actions being taken by the Trust.

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

7. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in April 2025, with performance decreasing to 11.7% from 11.2% in March 2025. There is currently a review of 111 rostering practice – initial report expected in June.

8. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is stable, with both oncology and renal journeys remaining above target in April 2025. The NEPTS transport roster review has now started which is a key efficiency.

9. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 7.04% in April 2025. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions remain minimally above the 30% benchmark figure in April 2025 at 30.26%.

10. The Trust is continuing to deliver its Clinical Model transformation (CMT) programme at pace. Key parts went live in December, in particular, remote clinical screening (RCS), which was a cultural shift in how the Trust manages 999-demand. There are early indications in the data in this report that the clinical model transformation changes implemented over the winter are having an effect. The new Purple Arrest and Red Emergency categories were announced on 11 March 2025 and are due to go live on 01 July 2025.

RECOMMENDATION

Trust Board is asked to: -

i. **Consider** the March 2025/ April 2025 Integrated Quality & Performance Report and actions being taken and determine whether:

a) The report provides sufficient assurance.

b) Whether further information, scrutiny or assurance is required, or

c) Further remedial actions are to be undertaken through Executives.

REPORT APPROVAL ROUTE
28.05.2025 Executive Leadership Team

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

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

SITUATION

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

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



BACKGROUND

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

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

4. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. A Board development session was held in April 2025 at which the annual review was undertaken. It was noted that there will be some changes to metrics in 2025/26, aligned to the new performance framework announced by the Cabinet Secretary. No specific other changes were requested, but the Board did discuss a number of areas where it was felt development and progress could be made in terms of the MIQPR and 'what good likes' reporting. At other levels of the organisation, work continues in terms of developing appropriate metrics which can be used to measure quality and performance against our 4 domains. Appendix 2 to this report sets out the key areas of discussion.

ASSESSMENT

<u>Our Patients – Quality, Safety and Patient Experience</u>

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

6. **999** call answering times decreased in April 2025 with the 95th percentile increasing to 46 seconds, compared to 27 seconds in March 2025. The 65th percentile and median performance remain consistently good; and data quality checks have been undertaken. Work will be undertaken early in Q1 on a demand and capacity analysis of 999 call demand.

7. **111 call answering performance has decreased over recent weeks,** with the call abandonment performance for April 2025 being 11.7%, and still failing to achieve the 5% target. Recruitment has been undertaken to ensure that staff in post reflect the establishment position, and this has seen performance improve, but high abstraction levels are having an effect. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2024/25 compared to last year (-4%).

8. 111 demand in April 2025 was 1.79% higher than during April 2024. The Trust procured a third party in January 2025 to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.

9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 97%. Response times for lower priority calls declined, recording 65.5% and 52% for P2CT and P3CT respectively. This is consistent with previous years but needs to be monitored closely over the coming months.

10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for April 2025 was 50.9%, remaining below the 65% target, but improving slightly compared to March 2025. The Trust is reaching more red patients in 8-minutes, but the denominator (demand) has also grown. The Amber 1 median in March was 1 hour and 48 minutes and the Amber 1 95th percentile was 7 hours 26 minutes. The Clinical Safety Plan and CHARUs will protect red demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on avoidable patient harm. New performance arrangements were announced by the Cabinet Secretary on 11 March 2025 which will come into effect on the 1st of July 2025 and will see the introduction of new purple arrest and red emergency categories alongside an increased emphasis on improving patient outcomes.

11. Traditionally the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. The Trust's main focus is to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme,

elements of which have been implemented over the winter. Areas of focus for 2025/26 include: -

- Data quality issues have been identified with APPs and these are currently being addressed.
- Further investment into remote clinical capacity;
- Further investment in APPs;
- Development of the remote integrated care service (111 clinicians and CSD clinicians);
- Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connected Support Cymru, mental health response pilot, Falls response etc. (MH pilot live);
- New Purple Arrest and Red Emergency categories (announced on 11 March 2025) with go live planned for 01 July 2025.

12. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 21,183 hours were lost during April 2025. Cardiff & Vale's handover lost hours continues to remain comparably much lower, due to an organisational focus within the health board. While some small improvements have been seen in other health boards during 2024, Betsi Cadwaladr health board remains significantly high and above its two-year average figure, with 7,251 hours being lost within the health board during April. WG have re-iterated to health boards the critical importance of improvements in this area and the reduction of all over 45 minute waits was a recommendation from the recent Ministerial Advisory Group on Performance and Productivity. The WG pan-Wales target of no handovers of more than one hour, equates to 7,500 lost hours.

13. **Ambulance Care (Patient Experience)**: Oncology performance in April 2025 was 79.6%, achieving the 70% target. Renal performance improved to 72.8% which was also above target. Advanced discharge & transfer journey performance however decreased marginally to 75% and remains below its 95% target. Same day discharge & transfer journey performance also dropped below target for the first time since the performance changes were made in April 2023 to 94%. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive Health Transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is currently re-rostering NEPTS transport (now started) which will better align available capacity with changing demand patterns (on target). This is proving complex and difficult but will be delivered.

14. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported five NRI's to the NHS Executive in April 2025, slightly less than March 2025 (6) and 17 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In April 2025 complaint response times increased

to 68%, compared to the 55% recorded in March 2025, however remaining below the 75% target, with cases remaining complex.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 90.1% in April 2025, decreasing slightly and remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate increased to 21.8% in April 2025 compared to 19.8% in March 2025.

16. The Trust can report on call to door times for Stroke and STEMI patients. For April 2025, these highlight call to hospital door times of two hours and 35 minutes for stroke patients and two hours and nineteen minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, because of the pressures and issues outlined in this report.

17. In April 2025, 6,431 patients **cancelled** their ambulance (this figure excludes patients who refused treatment). This is a significant reduction on previous levels. This reduction is likely to be the impact of switching on RCS through the winter. The Trust believes that 50% (of the pre-RCS switch on figure) of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Anecdotal evidence from health boards suggests that as the Trust has switched on RCS and as the level of patient cancellations has dropped, so has the demand presenting elsewhere in the system. Caution is required at this stage though as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its Clinical Safety Plan in December, removing the "can't send" application, with the option remaining at the strategic commander's discretion in the new plan.

<u>Our People (workforce resourcing, experience, and safety)</u>

18. **Hours Produced**: The Trust produced 126,639 Ambulance Response unit hours during April 2025 and delivered an emergency ambulance unit hours production (UHP) of 93%, remaining below the 95% target.

19. **Response Abstractions:** EMS abstraction levels decreased to 30.26% in April 2025, minimally above the 30% benchmark figure. Response sickness abstractions stood at 6.88% (benchmark 5.99%).

20. **Trust sickness absence:** the Trust's overall sickness percentage was 7.04% in April 2025, an improvement on the 7.38% recorded in March 2025. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 7.04% is above the 2023/24 IMTP ambition of 6%.

21. **Staff training and PADRs:** PADR rates did not achieve the 85% target in March 2025 and decreased slightly to 82.04%. Compliance for Statutory and Mandatory training also decreased slightly to 87.93% but continues to achieve the 85% target.

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

Finance & Value

23. **Financial Balance**: the reported outturn performance at Month 12 is a surplus of £70k and the Trust achieved both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

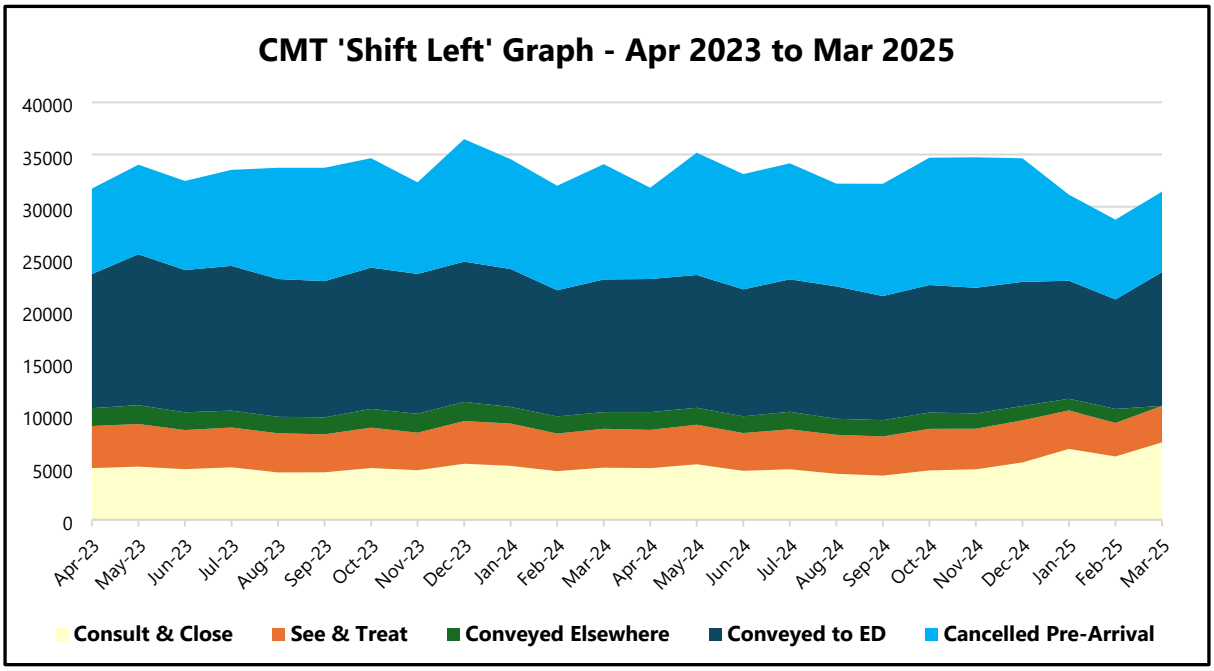
24. We are not able to report on the consult & close rates as the 111 contribution is not available due to issues with system changes within the 111 CAS system. The IMTP ambition (and Welsh Government target) remains 17% at this point in time. The Trust is currently validating new data in this area. A one-off Insight & Data Services consult & close graph indicates that the Trust is now achieving a consult & close rate of +20%. IDS have developed a new consult & close definition which is now approved by ELT and the Commissioner, so reporting can restart.

Summary

25. The indicators used at this high-level highlight that 111 has been resilient during the winter months, more so than in in previous years. However, performance variation and the level of performance for 111 remains a hot topic with the JCC and WG. An initial independent report is expected in June on 111 rostering practices. For the 999-emergency pathway, the Trust produced good metrics on what it can control e.g. production, abstractions etc. and managed to turn on new elements of its clinical model transformation programme, which appears to be having a positive effect; however, hospital handover lost hours remain extreme. These levels give further strategic imperative to continuing with the clinical model transformation and continued work by WG on focusing health boards on reducing handover lost hours. NEPTS performance was stable, with the NEPTS transport re-roster started, but proving complex and difficult.

26. The graph below has been included to show in broad terms what the outcomes (dispositions) are for 999 callers and to track changes. It shows that since

December 2024 there has been a drop in the number of patients conveyed to ED and the number of ambulances being cancelled pre-arrival. It also highlights that there has been an increase in the Consult and Close rate over the same period.



RECOMMENDATIONS

Trust Board is asked to: -

i. **Consider** the March 2025/April 2025 Integrated Quality & Performance Report and actions being taken and determine whether:

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

Appendix 2

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

Board Development MIQPR Session

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

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

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

March 2025 /April 2025

Annex 1 – Top Indicator Dashboard



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

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2024/25	Mar-25	Apr-25	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	11.2%	11.7%	8.5%	R
111 Clinical Triage Call Back Time (P1)	90%	97.5%	97.0%	97.8%	G
999 Call Answer Times 95th Percentile	00:06	00:27	00:46	00:21	R
999 Red Response within 8 minutes	65%	50.3%	50.9%	49.6%	R
999 Amber 1 Median	00:18	01:53	01:48	01:32	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	74.8%	79.6%	73.0%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	78.2%	75.1%	79.7%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	19.8%	21.8%	19.9%	A
Stroke Patients with Appropriate Care	95%	91.6%	90.1%	82.4%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:41	02:35	10.1%	A
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	70.0%	60.3%	54.1%	R
National Reportable Incidents reports (NRI)		6	5	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	6,431	6,433	8,686	G
Concerns Response within 30 Days	75%	55%	68%	54%	R
Enactment of the Duty of Candour Total		6	5	5	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	91%	93%	90%	A

Top Monthly Indicators	Target 2024/25	Mar-25	Apr-25	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	7.38%	7.04%	7.79%	R
Mental Health Absence Rates	Reduction Trend	2.31%	2.22%	2.32%	R
Staff Turnover Rate	Reduction Trend	8.42%	8.28%	8.42%	G
Statutory & Mandatory Training	>85%	87.96%	87.93%	78.29%	G
PADR/Medical Appraisal	>85%	82.38%	82.04%	73.33%	A
Number of Shift Overruns	Reduction Trend	3,839	3,773	3,681	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.90%	2.30%	1.8%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	N/A	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	30.7%	29.4%	28%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.56	2.64	2.35	A
NEPTS on the Day Cancellations	Reduction Trend	12.9%	12.9%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	N/A	N/A	13.1%	
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	10.48%	10.19%	11.3%	R
Number of Handover Lost Hours	7,500	21,852	21,183	21,785	R
NHS111					
NHS111 Dental Calls	Increasing Trend	N/A	N/A	7,137	
Consult & Close Volumes by NHS111	Increasing Trend	N/A	N/A	962	

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

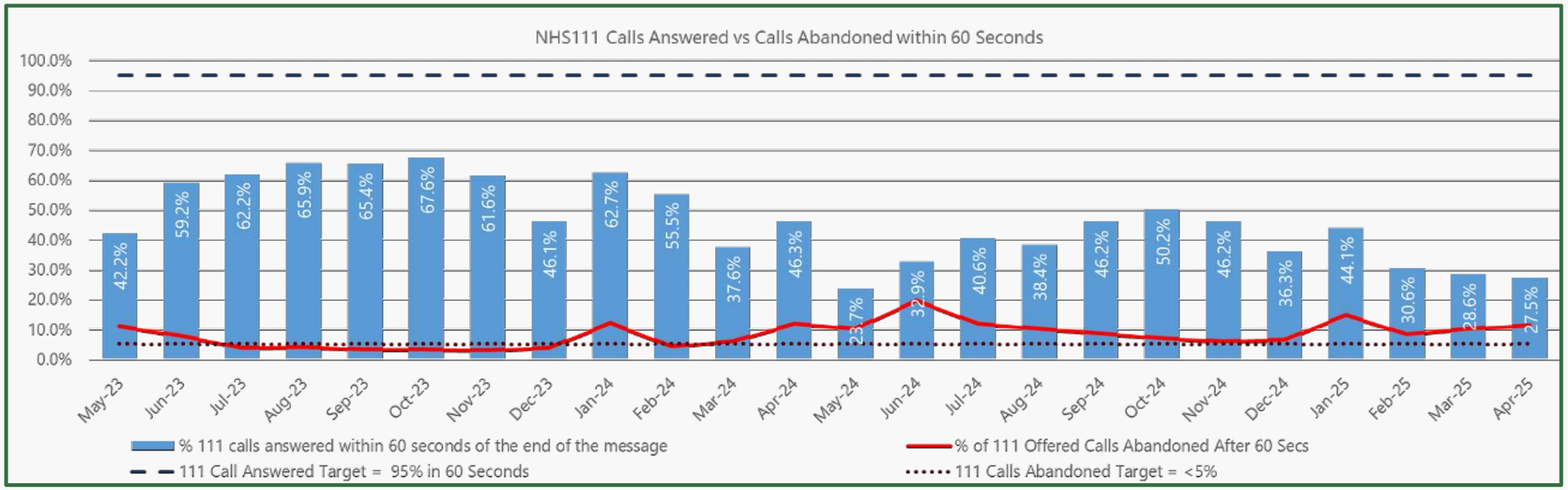
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

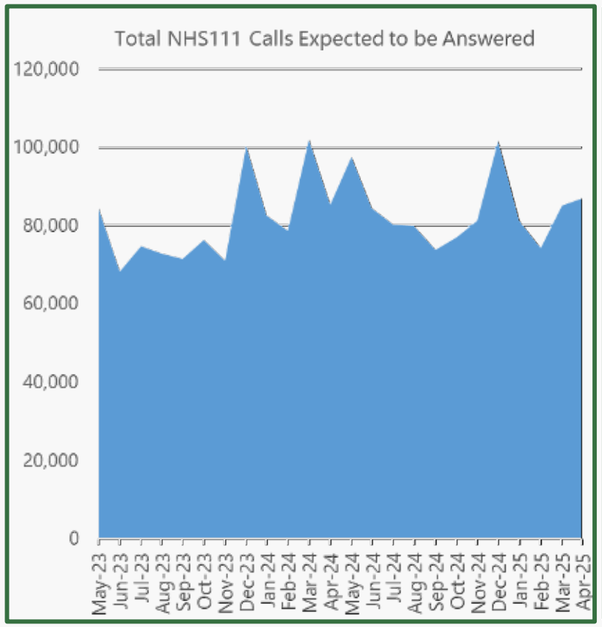
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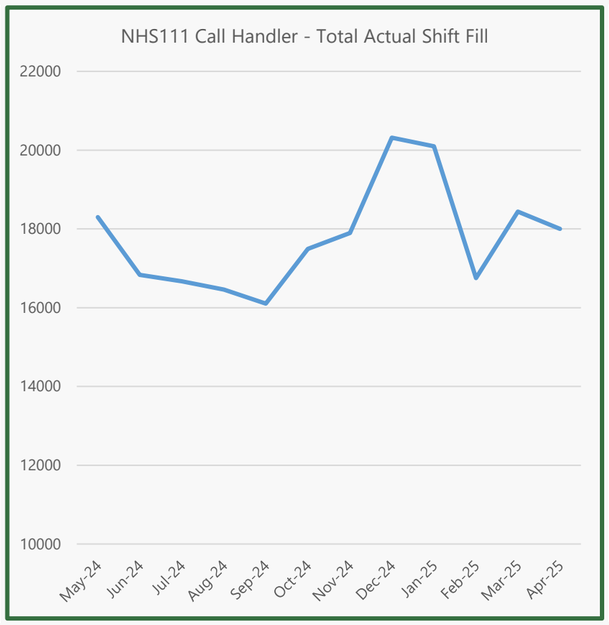
Abandonment Rate: R

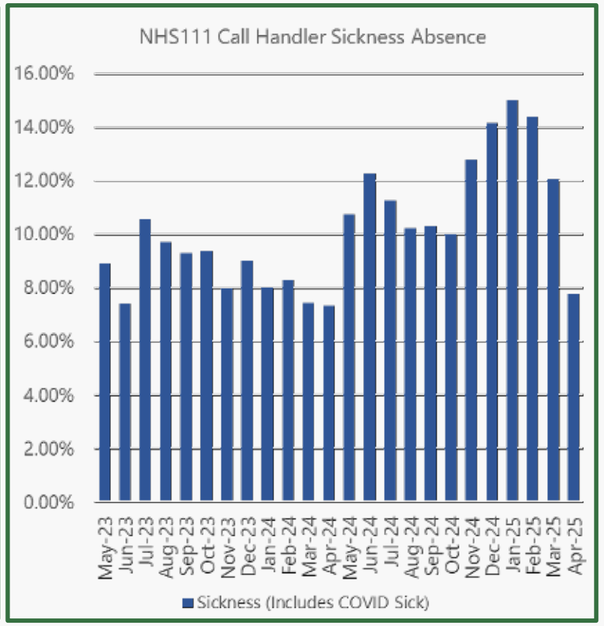
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Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate increased slightly to 11.7% in April 2025 from 11.2% in March 2025. The percentage of 111 calls answered within 60 seconds decreased, from 28.6% in March 2025 to 27.5% in April 2025 and continues to remain significantly below the 95% target.

Following a decline in performance during the middle part of 2024, due mainly to the introduction of the new 111CAS system, which went live on 30th April 2024, performance did improve during the latter months of 2024, however March and April 2025 have seen a further dip in performance levels. This follows a similar pattern to the last few years, which has seen demand increase during April. This is at a time when UHP capacity for call handlers has reduced slightly, compared to January 2025 and abstraction levels have decreased slightly to 34.55% with an increase in inductions, maternity and special leave in April.

Remedial Plans and Actions

Key actions include:

- Actions have been undertaken to try and improve the call handling position across the Winter and Spring months with record levels of resourcing seen in December 2024 as well as opportunities for further bolstering including overtime, bank and managers/supervisors also re-aligned to call handling.
- A focus on realising the benefits of the new 111CAS;
- A 111-re-roster pre-work review (underway) that takes account of the increased demand the Trust is seeing; what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.
- The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.

Expected Performance Trajectory

We might expect to see an improvement in performance in the spring, traditionally a period with lower demand and sickness.

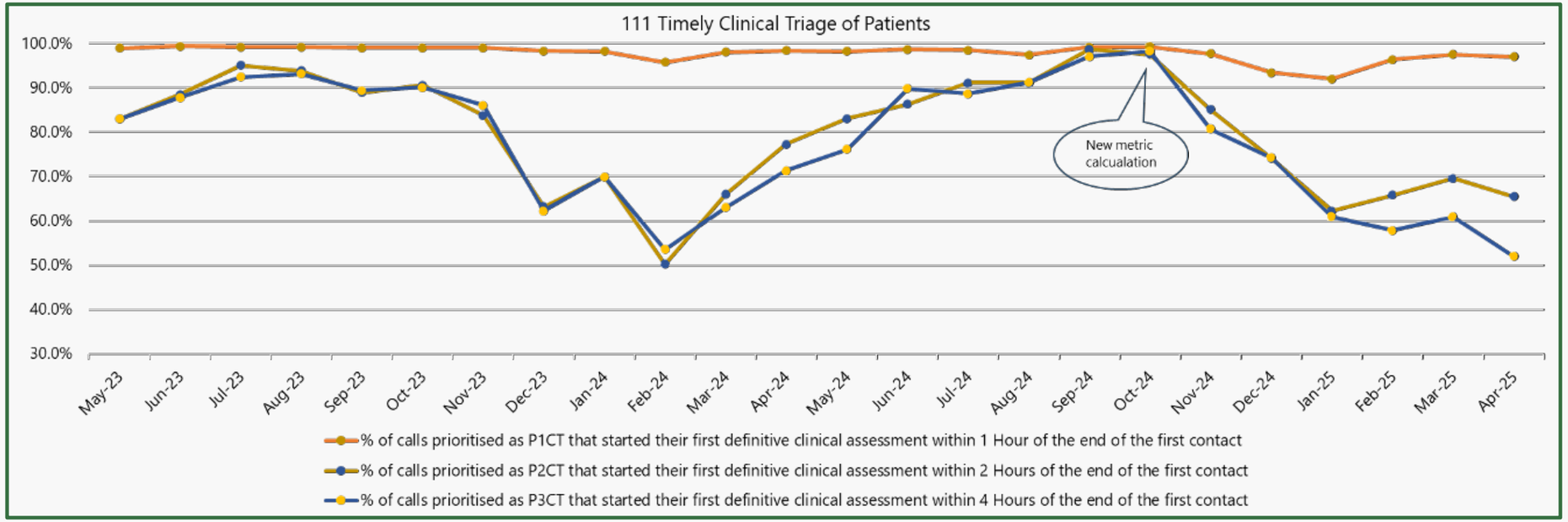
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

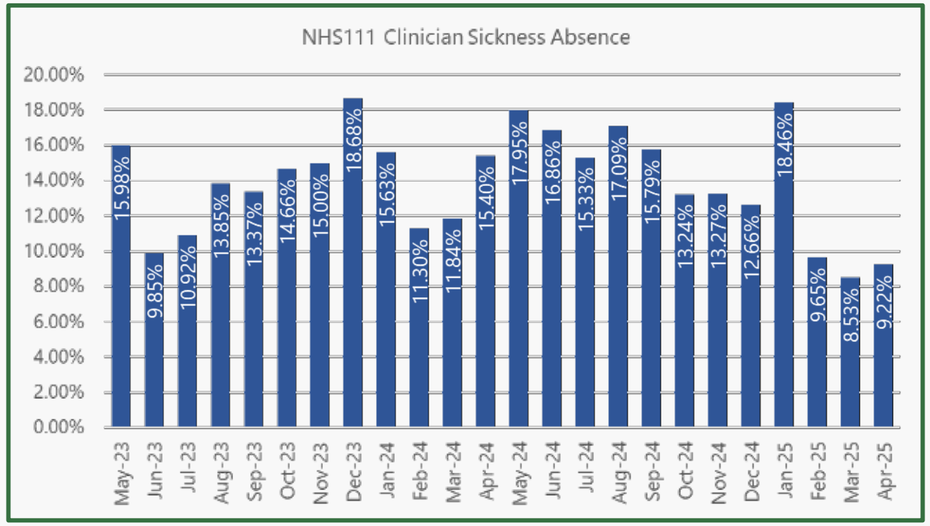
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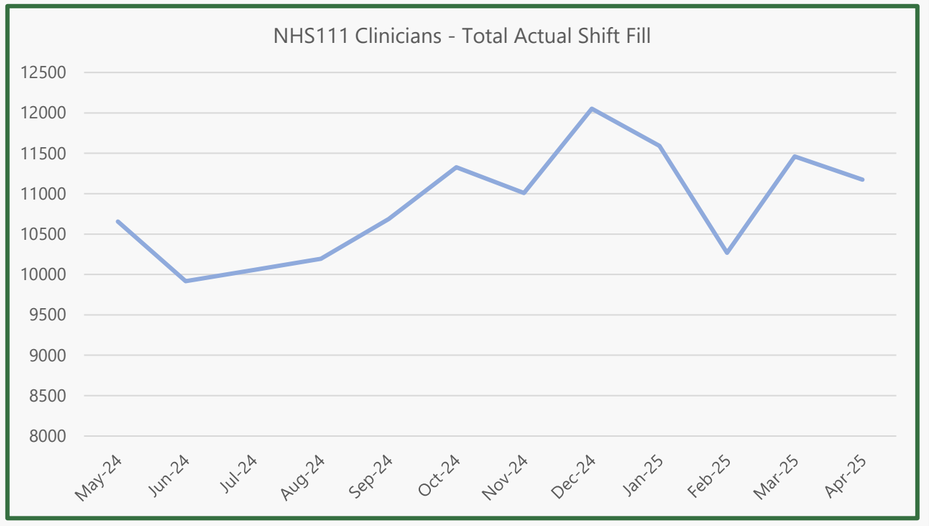
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NB: Data quality issues have been identified in 111. These are currently being addressed.







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 97% in April 2025.

Ring back times for lower category calls did decline during April 2025, with P2CT calls falling to 65.5% and P3CT to 52%.

Numbers of clinician hours produced decreased slightly last month, reducing from 11,460 hours in March 2025 (31 days) to 11,172 hours in April 2025 (30 days). This was a 14.65% increase on April 2024. Clinician sickness absence rose slightly during April 2025 was 9.22%.

Remedial Plans and Actions

The key actions include:

- A focus on delivering the benefits of the new 111CAS.
- Recruitment up to commissioned levels of clinicians (forecasts reported to WG, which are stable and increasing to/at target).
- A review to determine appropriate levels of capacity to meet increasing demand, including rostering practice (review now live, initial report in June).
- 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

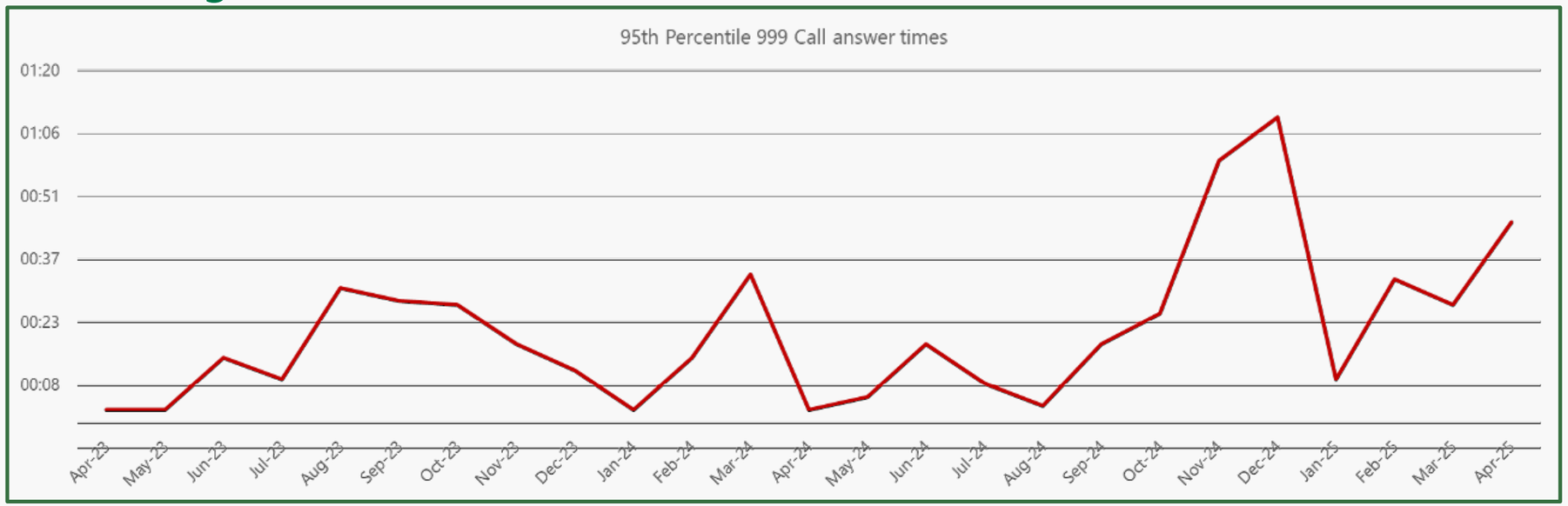
The new 111CAS will bring performance benefits. Initial approach to performance prediction developed, but further work being undertaken to refine the accuracy of the predicter.

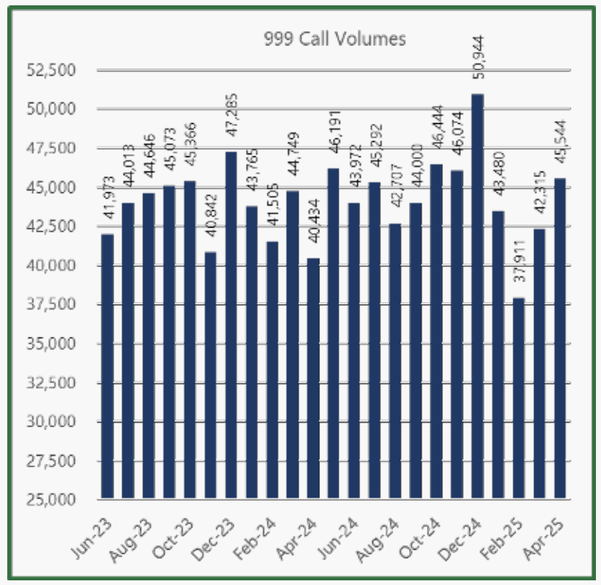
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

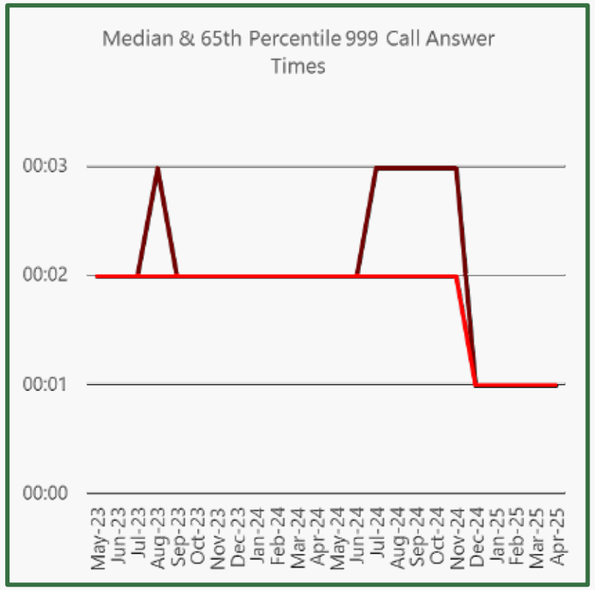
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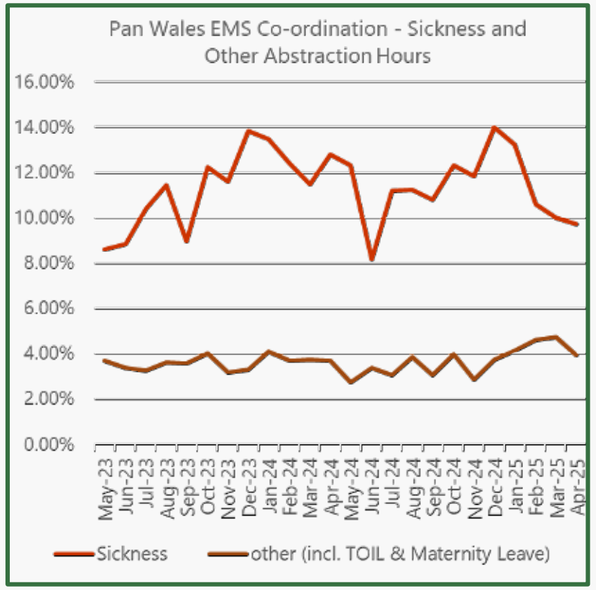
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Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance increased to 46 seconds in April 2025 and failed to achieve the 6 second target; however, the median call answer time for the 999-service has been consistently good at 1 second. The new system is now aligned with reporting and is signed off.

There was an increase in demand in April 2025 to 45,544 calls from 42,315 in March 2025. this was a 12.6% increase when compared to April 2024.

Sickness levels saw a slight improvement, reducing from 9.99% in March 2025 to 9.73% in April 2025. This was also a 24.04% decrease from April 2024.

Remedial Plans and Actions

- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) which will also support potential losses from the Bryn Tirion move to Ty Elwy.
- Further recruitment is underway in North, and 3 cohorts started by the end of the fiscal year.
- Work is ongoing to identify what is contributing to high sickness via the Managing attendance at work and attrition via the recruitment and selection processes.

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

- There is feedback from EMS that the new dispatch boundaries are adversely affecting performance. Further information being sought, with possible re-modelling.
- The Executive Director of Operations has asked for some additional modelling on EMD capacity. Capacity was not increased through the transformation programme but is an area of interest.
- We need to keep under review the consequences on allocators of changing/increasing resources e.g. APPs, Falls Resource etc.

Expected Performance Trajectory

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

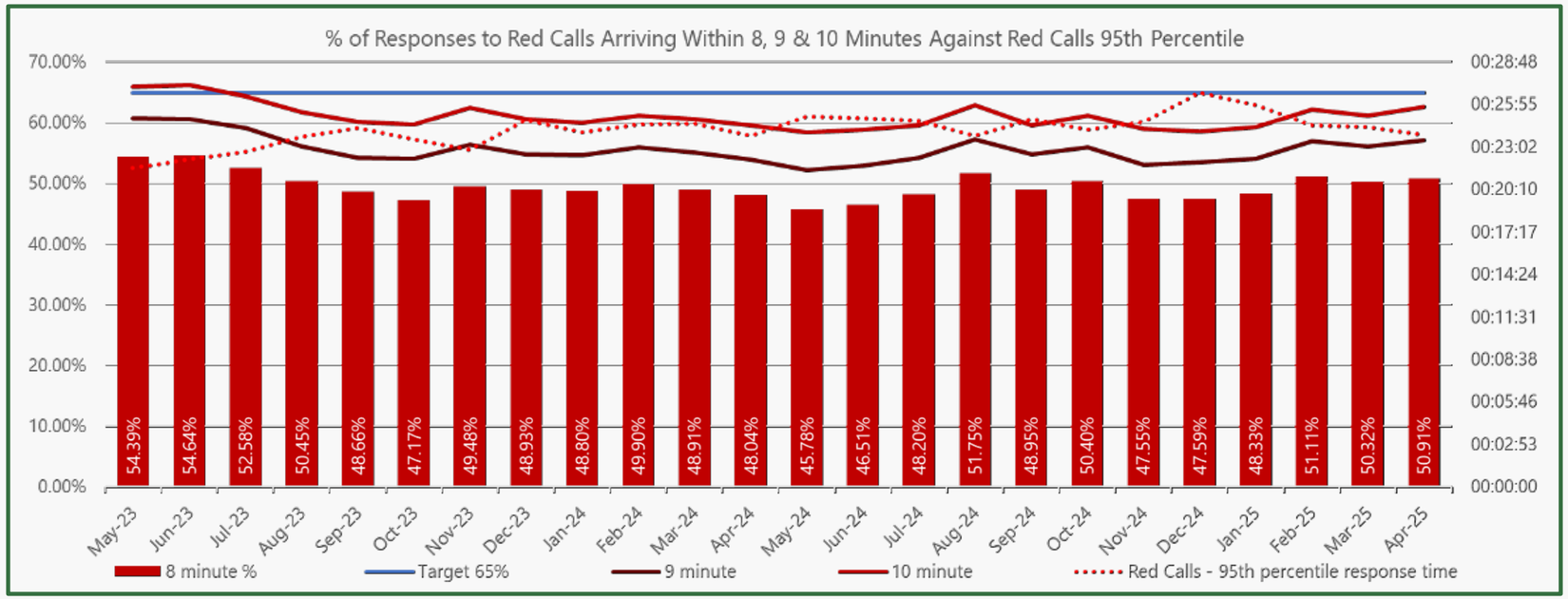
Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

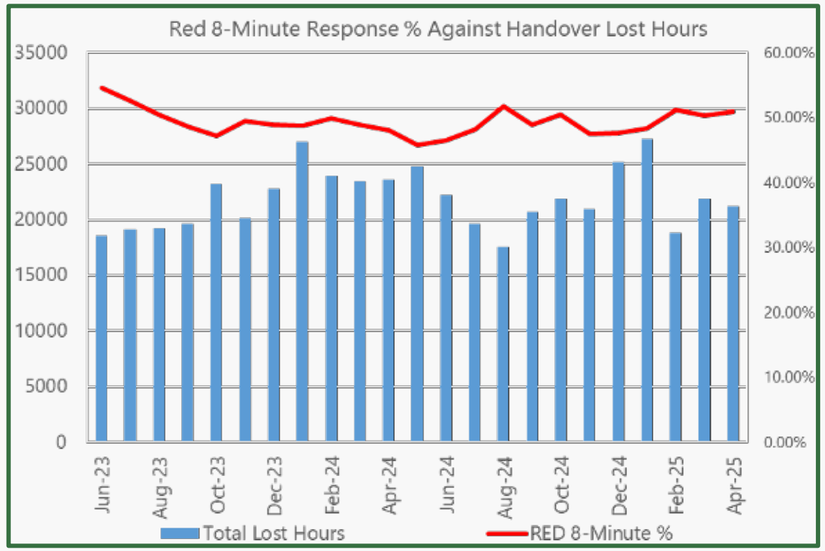
Influencing Factors – Demand, Hours Produced and Hours Lost

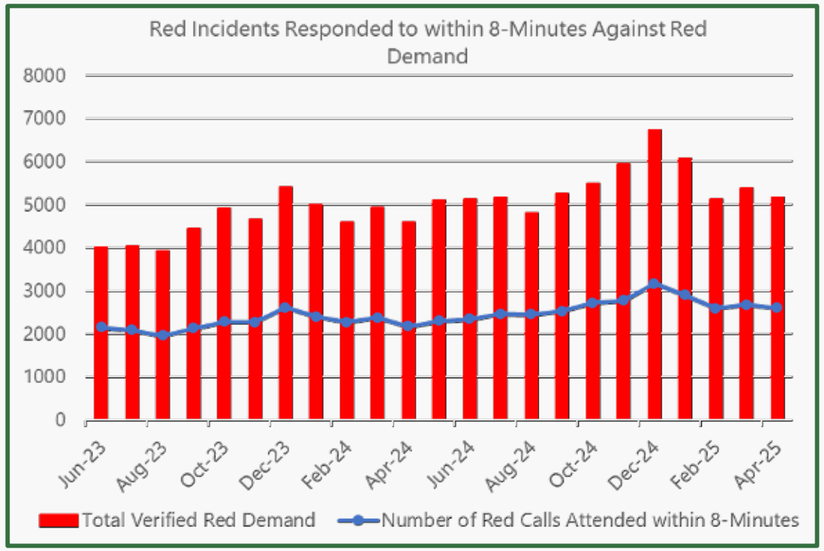
(Responsible Officer: Lee Brooks)

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Analysis

Red 8-minute performance improved slightly in April 2025 to 50.9% from 50.3% in March 2025, but remained below the 65% target.

Red 10-minute performance for April 2025 was 62.6%, which is marginally above the 2-year average (61.1%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in April 2025 being 12.5% higher than that seen in April 2024. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for April 2025 of 2,600, being 19.5% higher than the figure for April 2024, i.e. the Trust is reaching more red calls in 8-minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and **hospital handover lost hours**, which shows that as handover rates decrease, so red performance improves. There were 21,183 lost hours during April 2025.

Remedial Plans and Actions

The main improvement actions in the Trust's gift are:

- To maintain commissioned establishment in post levels overall: the Trust remains close to achieving its 95% UHP benchmark in March with 91% UHP (all resources);
- Full roll out of the Cymru High Acuity Response Unit (CHARU): the Trust achieved its highest ever CHARU UHP in January;
- The deployment of rapid clinical screening, as outlined in our IMTP (the Trust achieved this); and

Expected Performance Trajectory

On the 11th March 2025 the Cabinet Secretary for Health & Social Care announced that the current Red category will be replaced with a new arrest category and emergency category from 01 July 2025, with the focus moving to measures of the chain of survival and patient outcomes i.e. saving lives, rather than a hit/miss time target.

Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

(Responsible Officer: Lee Brooks)

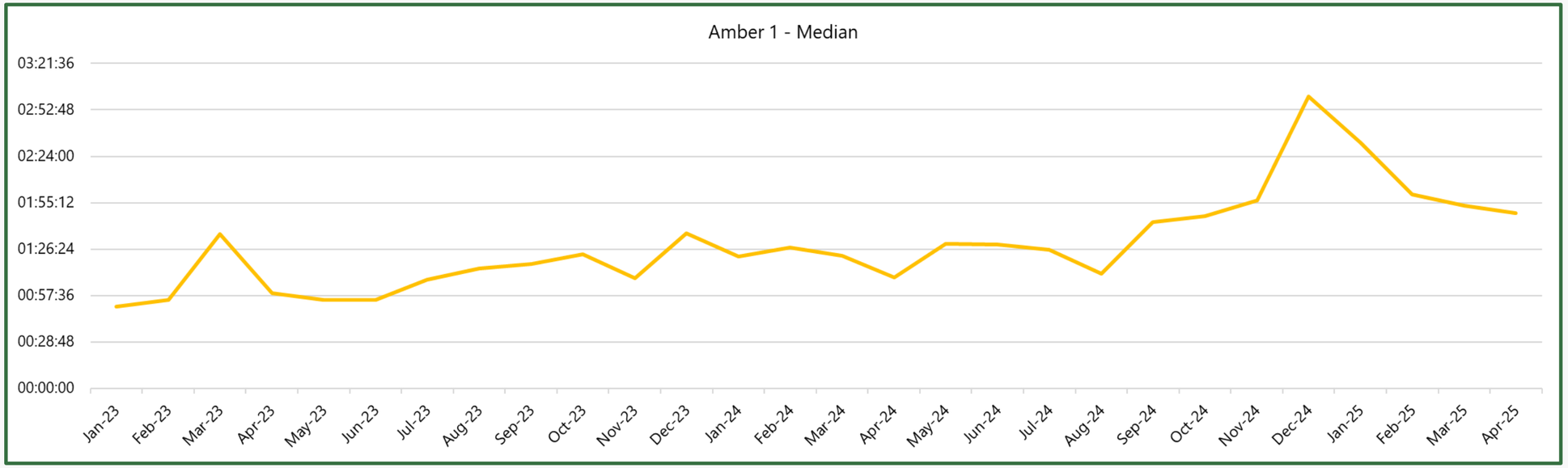
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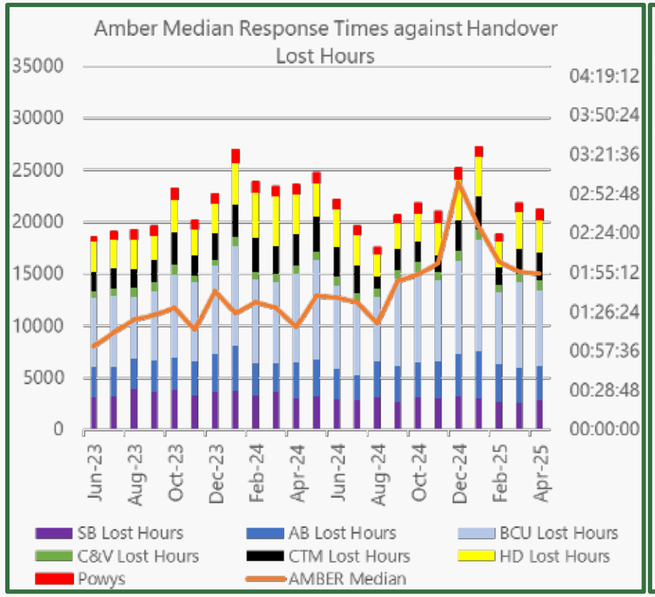
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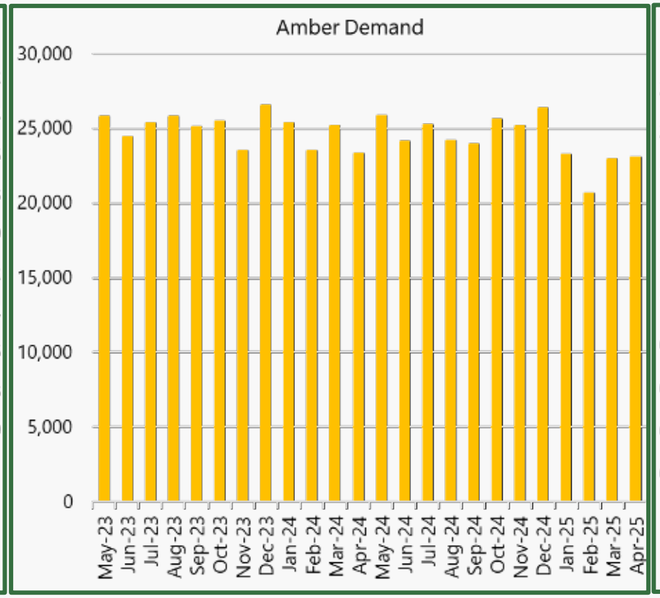
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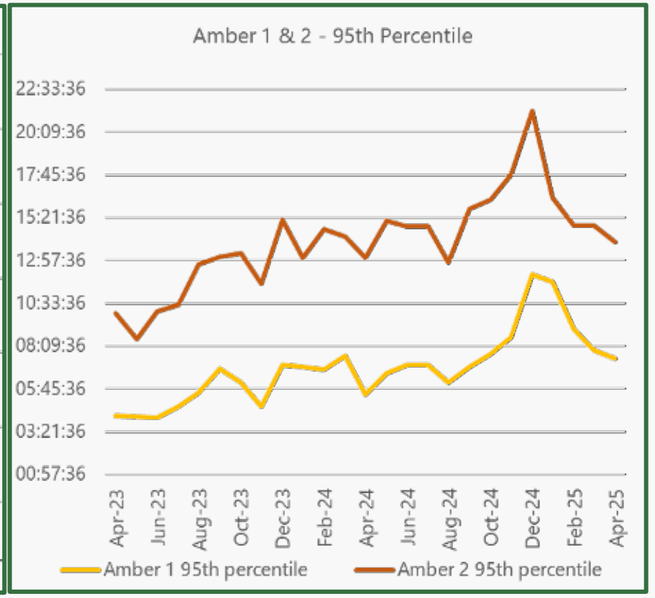
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Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time decreased during April 2025 to 1 hour and 48 minutes compared to 1 hour 53 minutes in March 2025. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also decreased during April 2025 to 7 hours 26 minutes, down from 7 hours 53 minutes in March 2025. This time remains far too long and remains above the 2-year average figure of 7 hours 02 minutes.

As with Red, there is a strong correlation between Amber performance and lost hours due to handover delays.

Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide. A Welsh Government review of Amber response times is due to start imminently.

Expected Performance Trajectory

The Trust's commissioned level of production (its rosters) is designed to cope with 6,000 hours of handover lost hours. Unless there is a material reduction in handover lost hours and a transformation of the 999-emergency ambulance pathway, the Trust will continue to see long amber waits and avoidable patient harm. The Trust is now part o a WG led meeting on how handover can be reduced.

Our Patients: Quality, Safety & Patient Experience

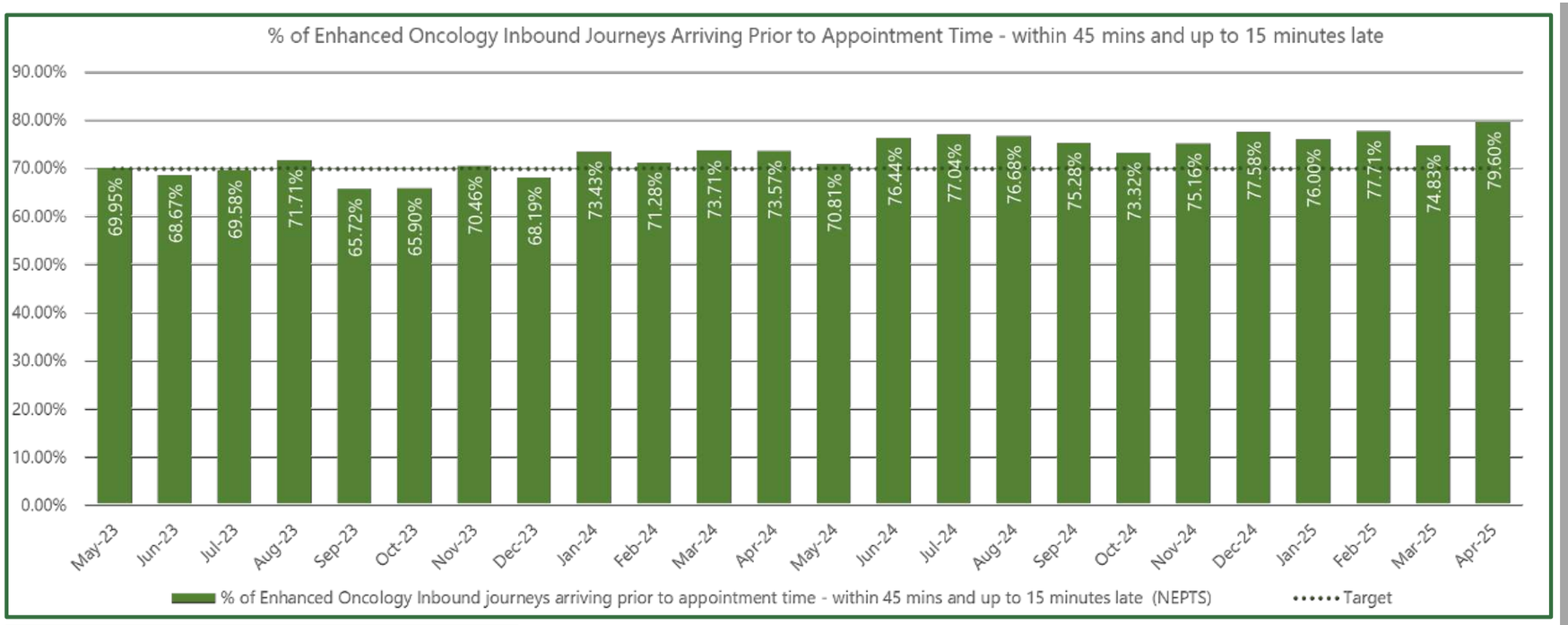
Patient Experience – Influencing Ambulance Care Indicators

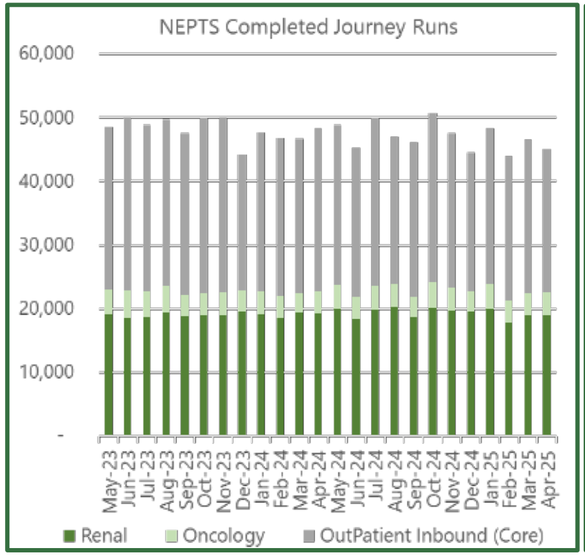
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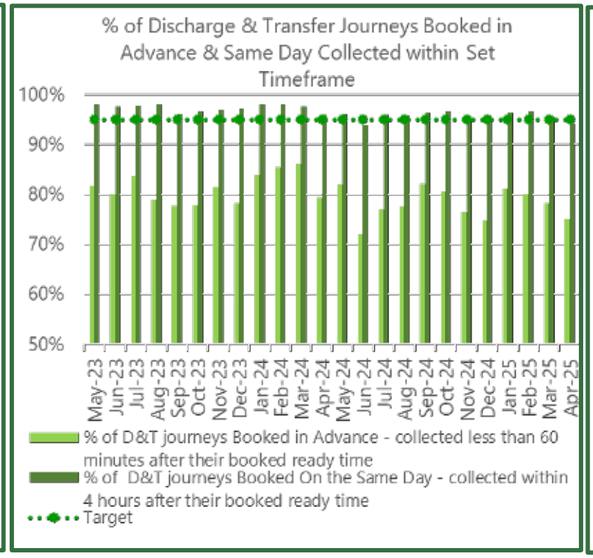
D&T	Oncology	Welsh Calls
R	G	G

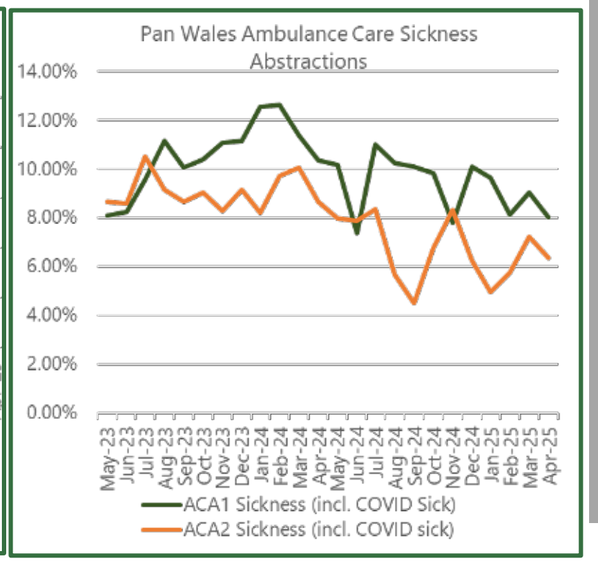
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Analysis

79.60% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in April 2025, once again achieving the 70% target. Oncology performance continues to be an area of focus for the service, and we continue to invest both time and resources on these journeys.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment decreased in April 2025 to 75% and remains below the 95% target. Discharge and Transfer journeys booked on the same day also failed to reach the 95% target in April 2025, achieving 94%. The lowest percentage since before the performance targets changed in April 2023.

Enhanced Renal journeys minimally decreased from 73.74% in March 2025 to 72.81%, however therefore achieving the agreed performance standard of 70% for only the fourth time since September 2024.

Call volumes answered decreased to 14,469 calls during April 2025, down from 16,389 in March 2025; however, the average speed of call answering increased from 7 minutes 52 seconds to 11 minutes 7 seconds.

ACA1 sickness remains above the 5.99% target, at 8.03% in April 2025. ACA2 sickness also remains above the 5.99% target at 6.36% in April 2025.

Remedial Plans and Actions

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

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

Expected Performance Trajectory

The re-roster, which will take six months to deliver will enable the Trust to reach more patients within the current resource envelope

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

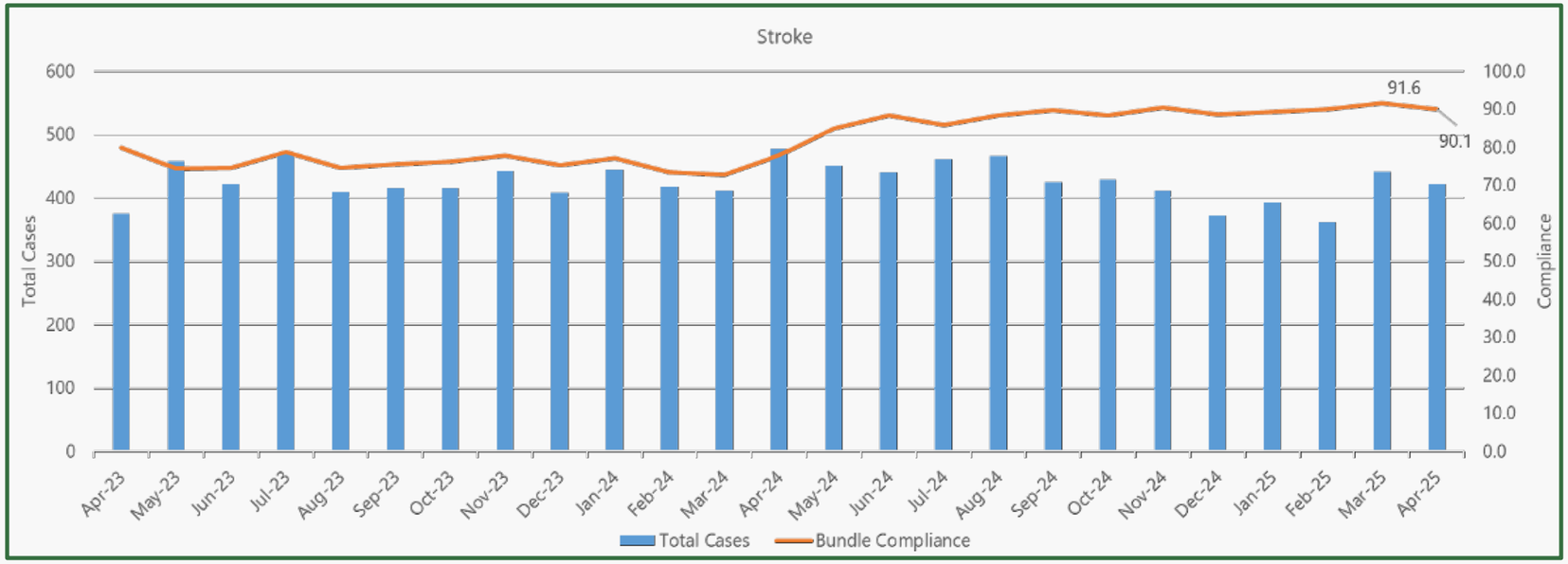
Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care

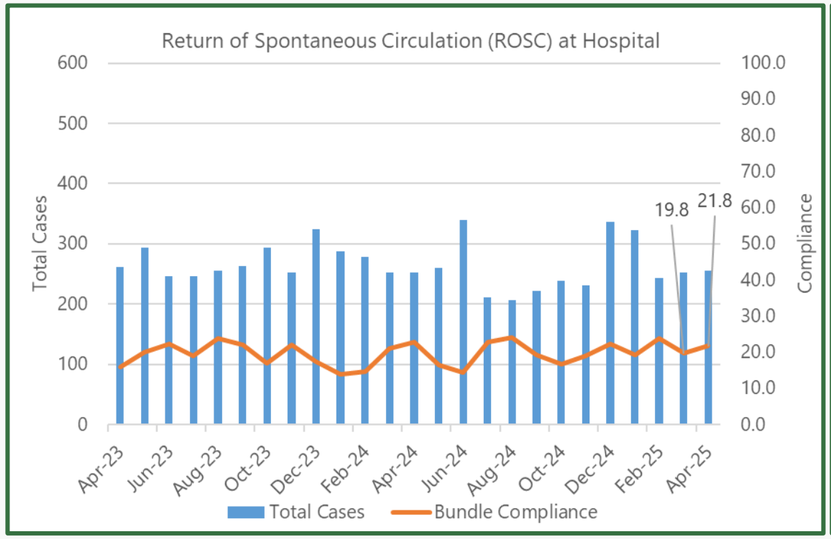
Stroke	ROSC	STEMI
A	A	R

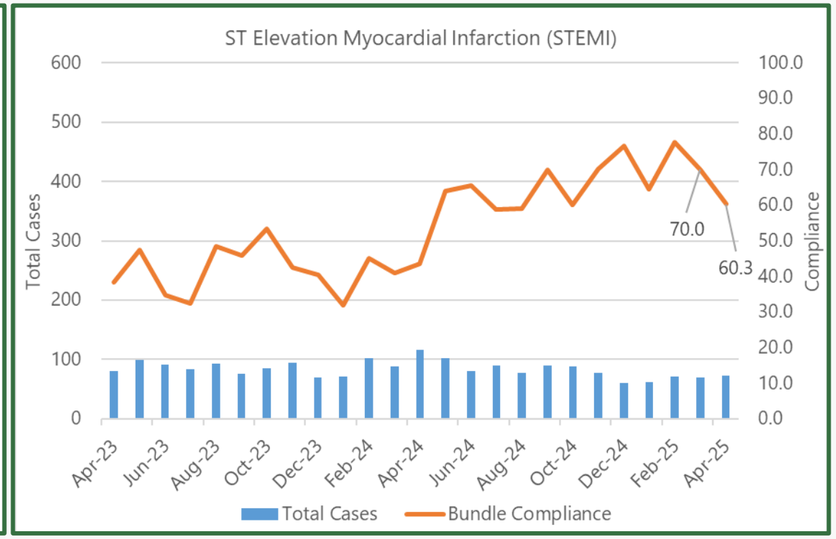
Self-Assessment: Strength of Internal Control: Moderate

QUEST

(Responsible Officer: Andy Swinburn)







Analysis

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

Stroke – 91.1%, a slight decrease from 90.6% in March 2025. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

STEMI (heart attack) – 60.3%, a decrease from 70% in March 2025. There has been a decrease in documenting all criteria in Q1, particularly in the pain score and analgesia components. The number of cases remained low (73) therefore, increasing the volatility of the compliance data so this could be natural variance.

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 21.8%, an increase from 19.8% in March 2025. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024. Both December and January continued to see higher numbers of cases in this indicator.

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

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

Design of the electronic Patient Clinical Record User Interface

Clinician interaction with the electronic Patient Clinical Record

Accuracy of the scripting to extract the data from the data warehouse to create the reports.

Further electronic Patient Clinical Record User Interface changes are planned for the next update scheduled for Autumn 2025, the impact will be monitored by the Clinical Intelligence & Assurance Group.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

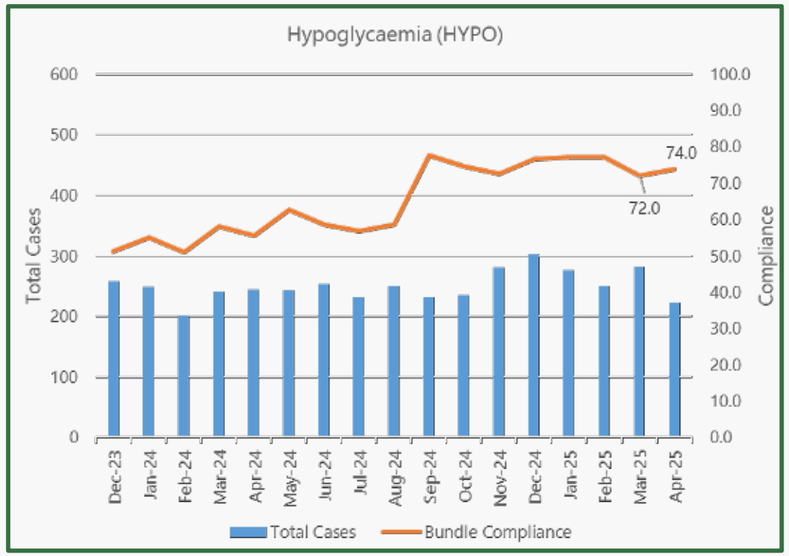
Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)

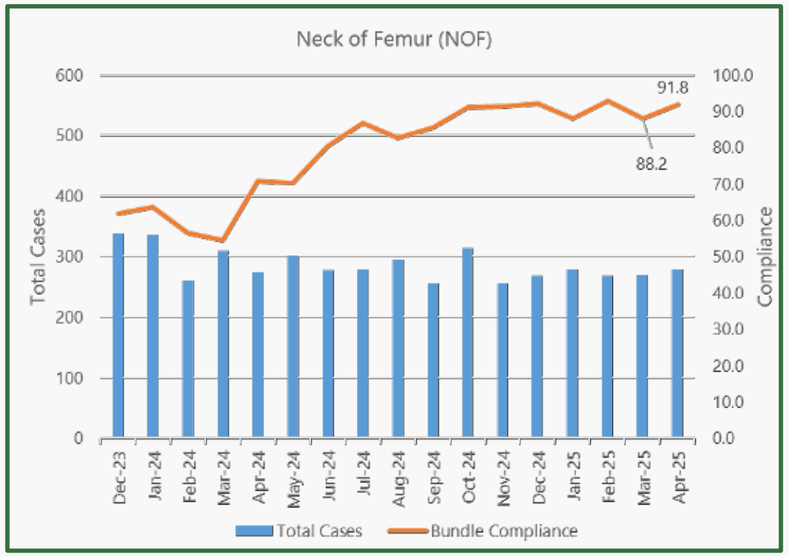
(Responsible Officer: Andy Swinburn)

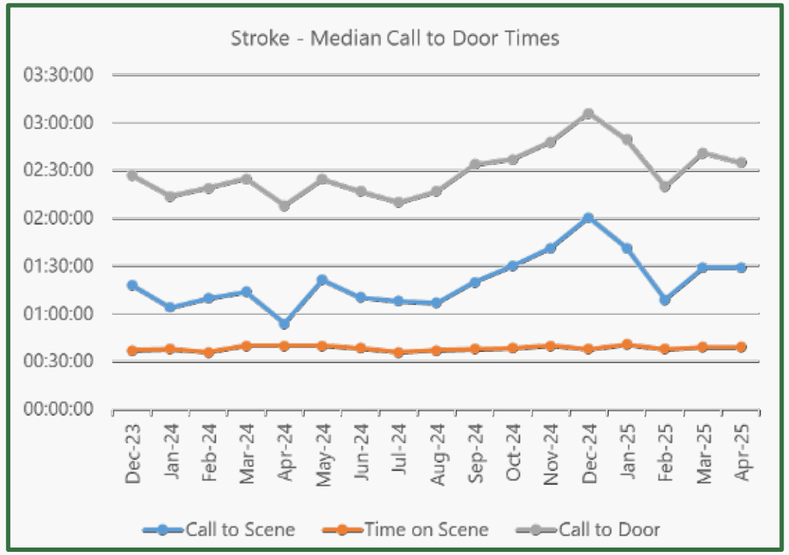
Call to Door
A

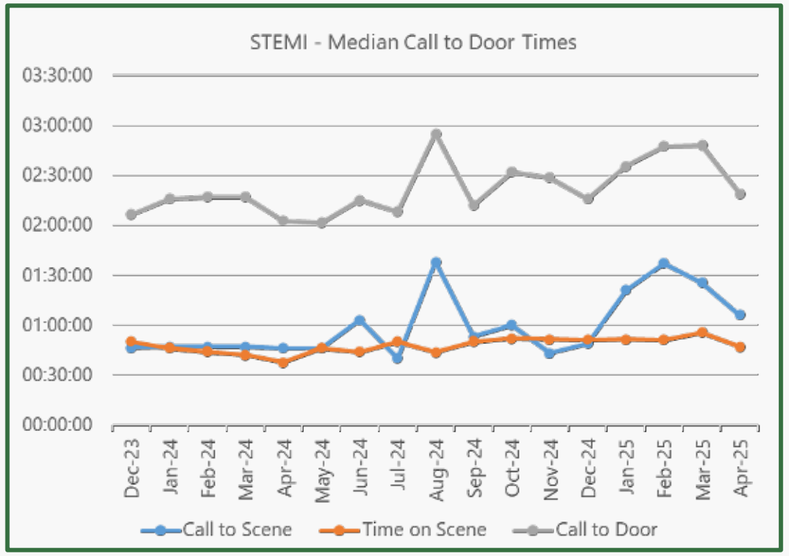
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

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

Hypoglycaemia (diabetic patients with low blood glucose) – 74%, an increase from 72% % in March. Compliance has remained quite static through Q1, although with a slight decrease in the number of cases from 276 (Jan 25) to 223 for April. This is likely to be within the natural variation.

Fractured Neck of Femur (hip fracture) – 91.8%, an increase from 88.2% in March. Only a slight increase in compliance this can be attributed to a decrease in the documenting analgesia.

Call to door times for Stroke and STEMI – Call to door times have reduced for STEMI during Q1, the corresponding report for stroke improved with the changes both being attributed to the call to door element of the call cycle.

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.

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience
Patient National Reportable Incidents & Duty of Candour

(Responsible Officer: Liam Williams)

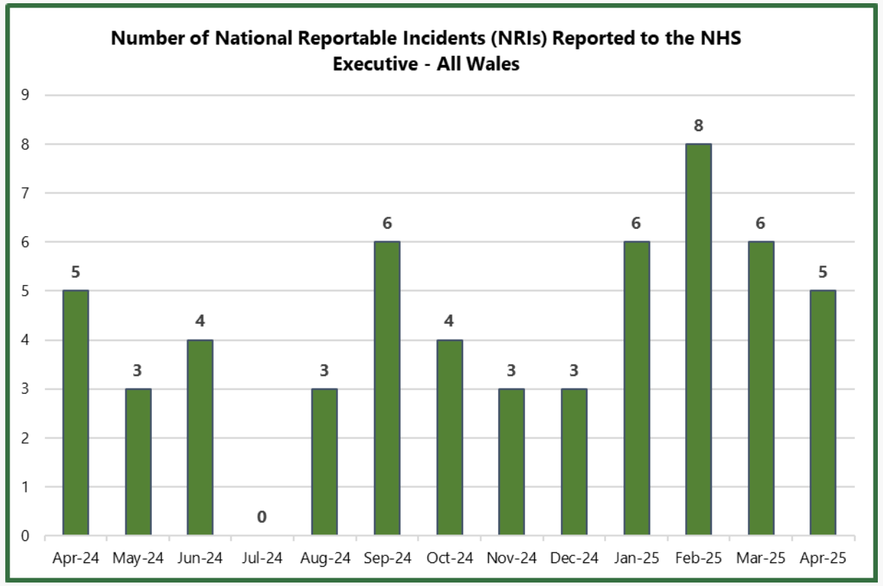
Concerns.
R

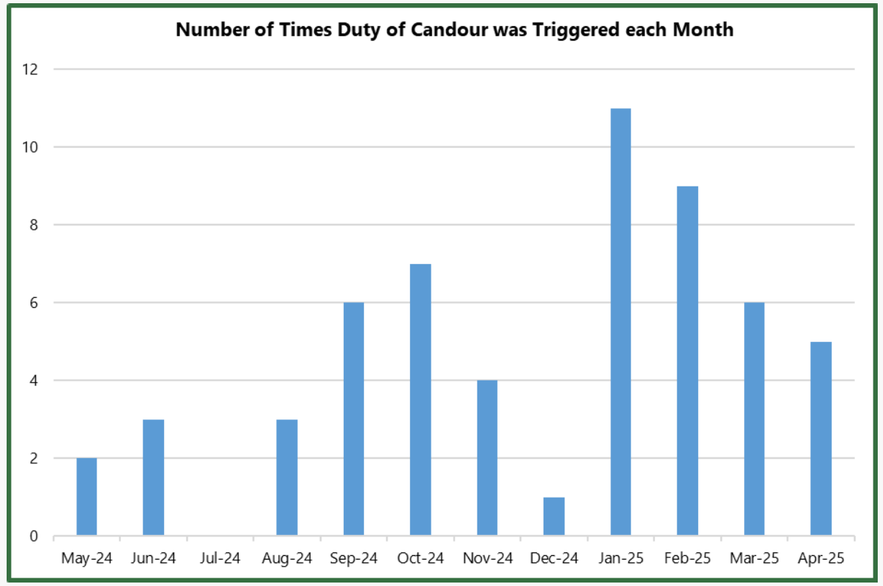
Self-Assessment: Strength of Internal Control: Moderate

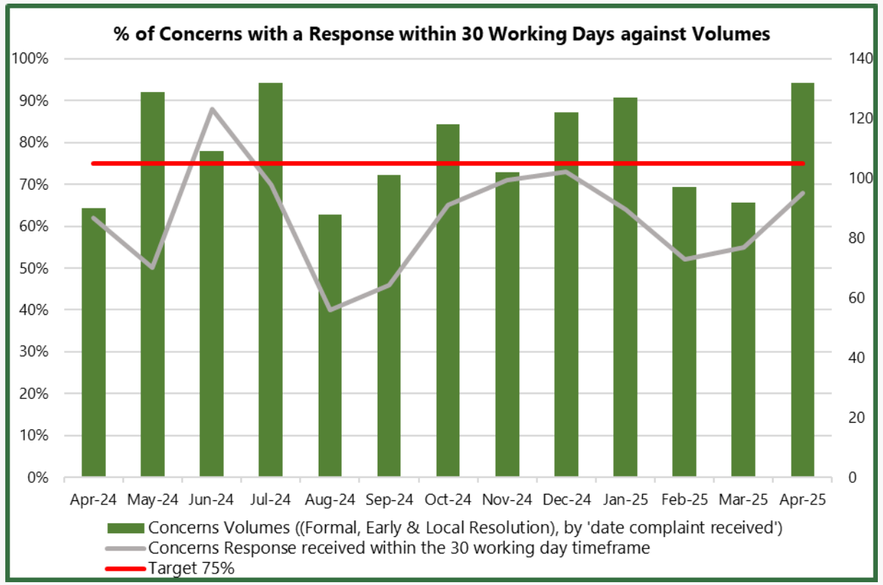
QUEST

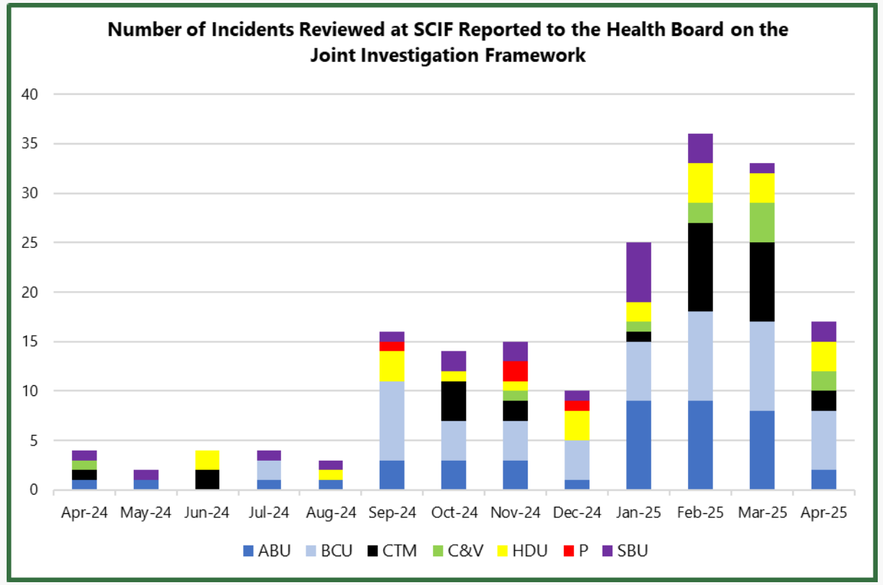
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis

Compliance with the 30 working day complaints target is not achieved but remains at a reasonable level. The performance for closed complaints however masks a concerning picture of growing open and overdue complaints. This is due to increased complexity of investigations within the Trust and an increased volume of incidents. These may have arisen from changes in the Clinical Safety Plan that increased the Trust risk on behalf of the wider NHS system, plus the need to recruit additional staff to support audit of the different interventions now in place.

NRI reporting has returned to a more average level following a spike during the winter months.

Remedial Plans and Actions

Ongoing monitoring of national incident reporting, enactment of the Duty of Candour and Complaints performance is monitored by team leads on a regular basis and all teams are working to achieve national timescales and a benchmarking position comparative to other NHS Wales organisations as visible in the national Quality and Safety dashboard, Beacon.

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

Expected Performance Trajectory

The increasing number of open complaints and the proportion of which are overdue presents a challenging picture of future performance. The complaints management process itself is well-assured, with families continuing to receive regular contact from the Trust. However, delays in completing investigations mean there is the potential of future PSOW findings against the Trust for cases where our response timescale is unreasonably lengthy

*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*

NRI & Concerns Data source: Datix / Longest Waits Data Source: Report Manager

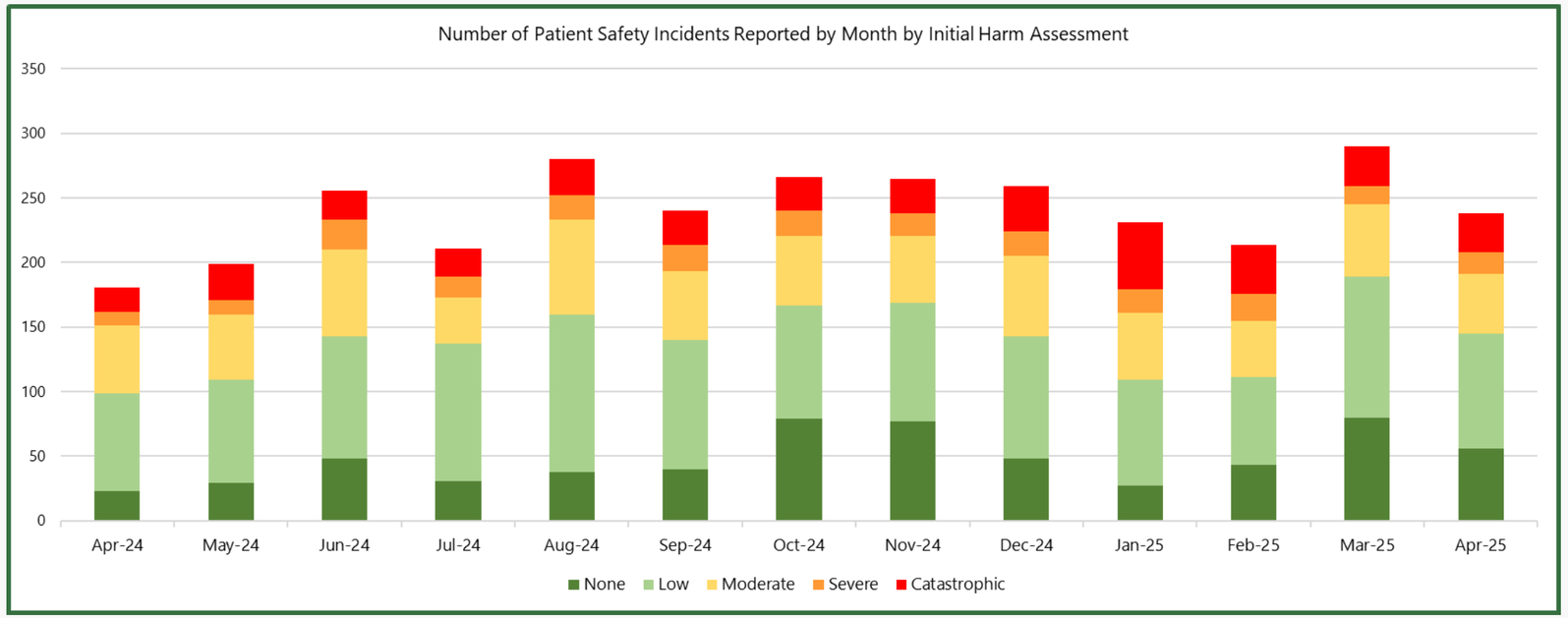
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

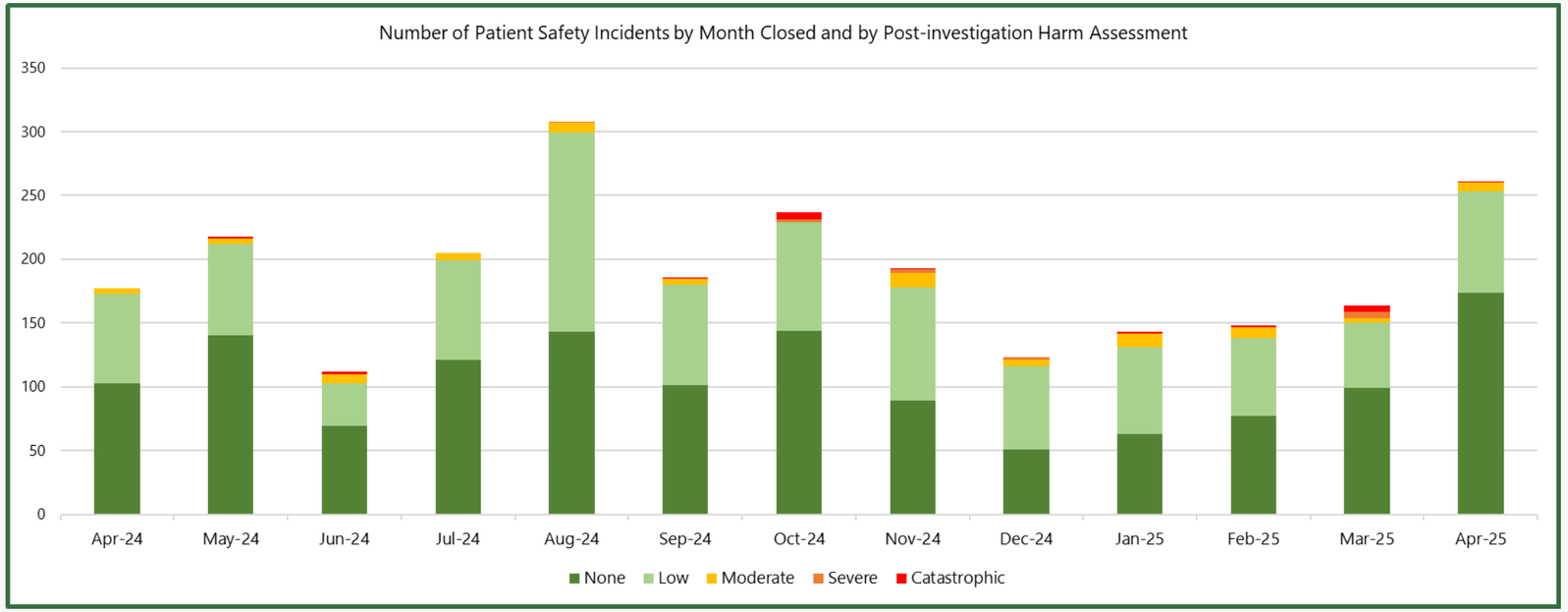
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care





Analysis
Incident reporting volumes have decreased back towards the organisational baseline. Incident closure rate has shown a marked improvement in the number of investigations being completed and closed down. This follows significant focus within service areas and improvement work of account permissions as part of the Datix Recovery & Improvement Plan. Near miss reporting is being encouraged during daily operational meetings to ensure we learn from all opportunities. Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low. NRI's that have been closed with the NHS Executive Wales have improved during the last month

Remedial Plans and Actions

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

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

Data source: Datix

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

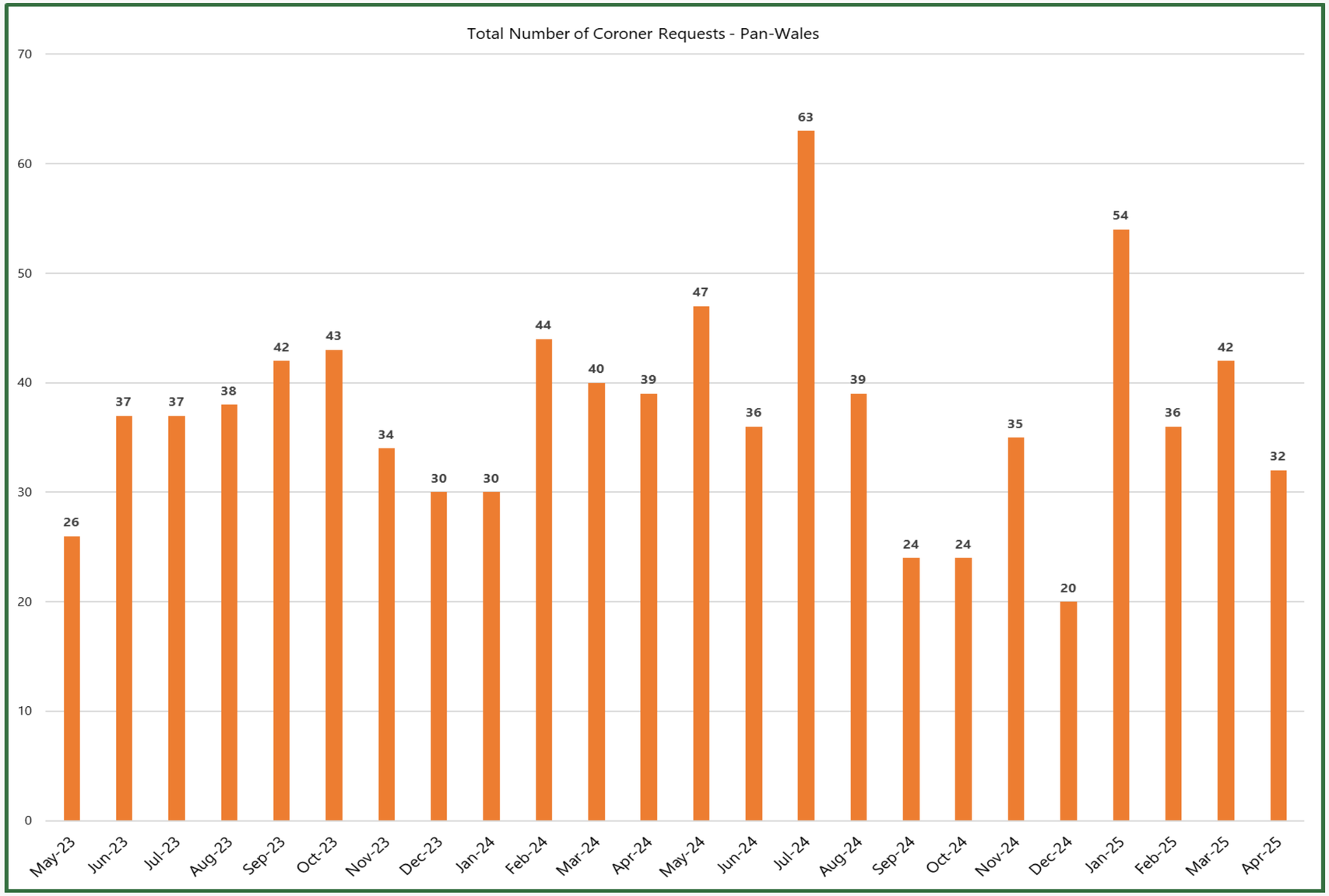
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



Analysis

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

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

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

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

Remedial Plans and Actions

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

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

Mortality Reviews Data source: Internal Web Application

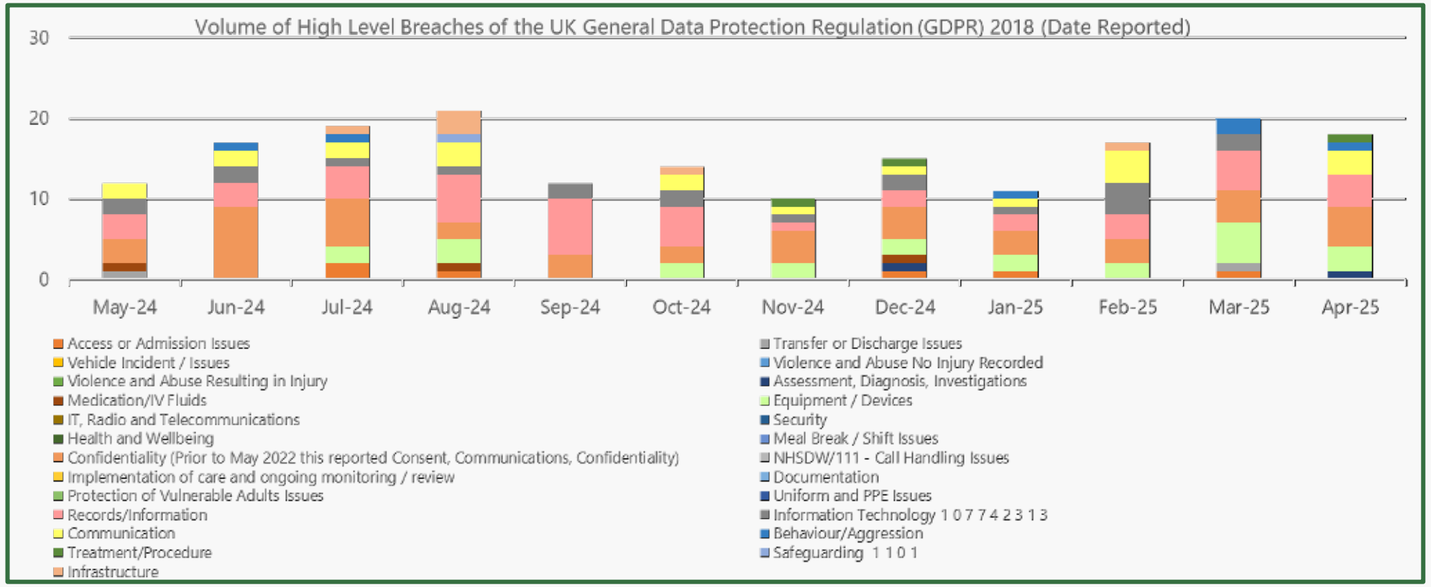
Our Patients: Quality, Safety & Patient Experience Safeguarding, Data Governance & Public Engagement Indicators

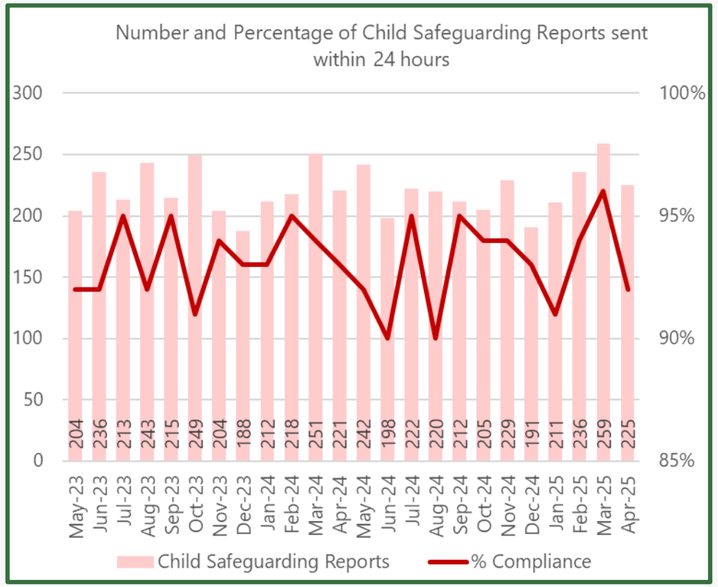
(Responsible Officers: Jonny Sammut & Liam Williams)

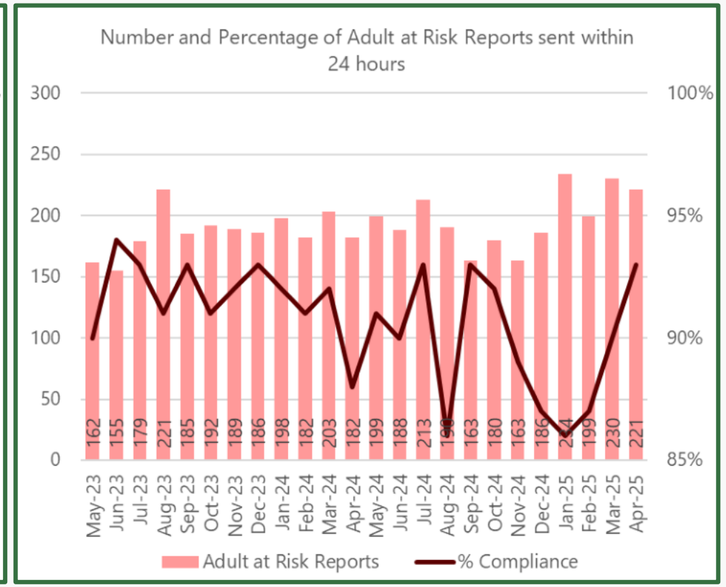
Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong

PCC







Analysis

Safeguarding: In April 2025 WAST colleagues submitted a total of 221 Adult at Risk Reports, 93% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 767 reports were shared with local authorities across Wales during this reporting period. There have been 225 Child Safeguarding Reports submitted in April 2025, 92% of these were processed within 24 hours.

Data Governance: In April 2025, there were 18 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 18 breaches, 5 related to IG/Confidentiality, 4 Records/Information, 3 Communication, 3 Equipment, 1 Behaviour, 1 Assessment Investigation, and 1 Treatment/Procedure.

Public Engagement: During April, PECI attended 23 community engagement opportunities, engaging with approx. 298 people. This included attending Whitchurch Memory Cafe for people with Dementia and their carers, Coleg Gwent Annual Health & Wellbeing Fair, Barry Over 50's Coffee Morning and Monmouth Parkinson's Support Group.

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.

Data Governance: During the reporting period, of the 18-information governance related incidents reported on Datix, no incidents were reported to the Information Commissioner's Office (ICO). The IG Team continues to monitor, and review reported incidents where applicable.

Public Engagement: As a result of The Service Review, CMT and other influencing factors, during April the PECI Team were informed of an upcoming OCP which will see the Team restructured and re-aligned to meet the Trust's ongoing strategic objectives. The PECI Team will continue to engage in an ongoing dialogue with the public about their experiences and expectations of our services, though it is unclear how this will change and what Team will be responsible for public engagement in the future.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission was completed on 31st March 2025. The next iteration of the IG Toolkit is waiting to be opened for submissions.

Public Engagement: The Team is about to lose three members of staff to retirement or moving onto new positions elsewhere. The impending OCP means we are unable to back fill these posts. This will impact on our ability to support/attend community engagement opportunities.

**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

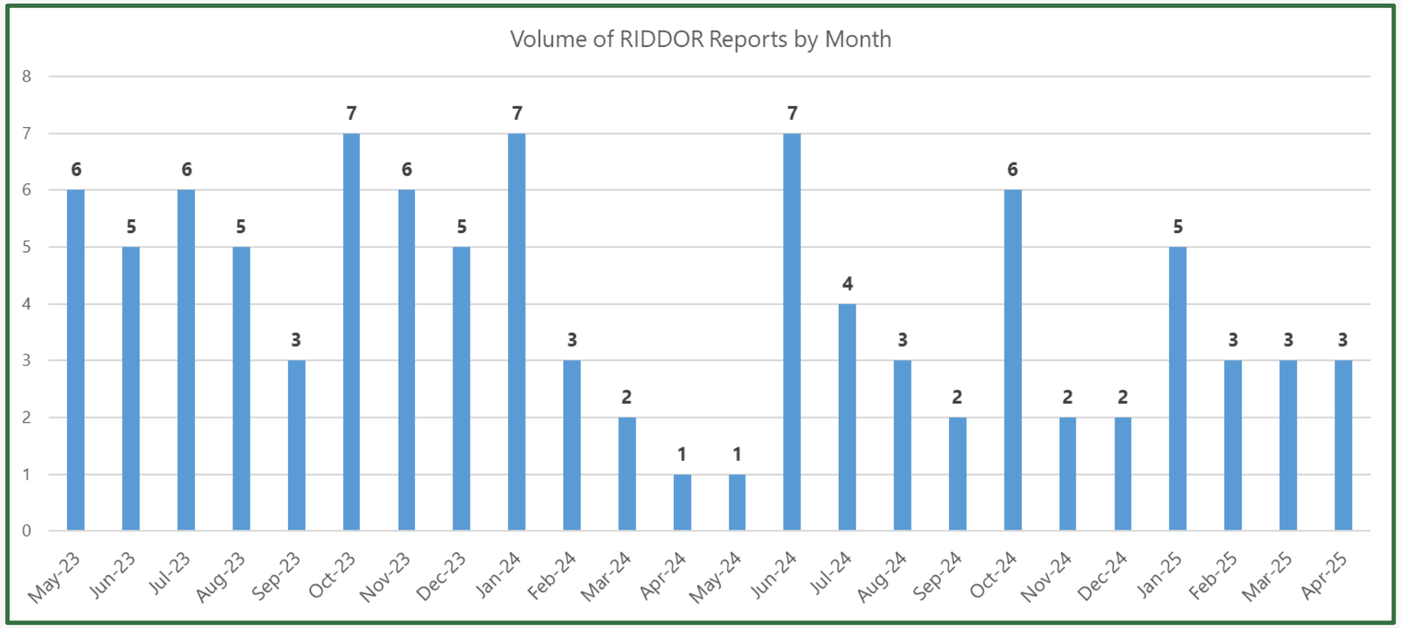
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

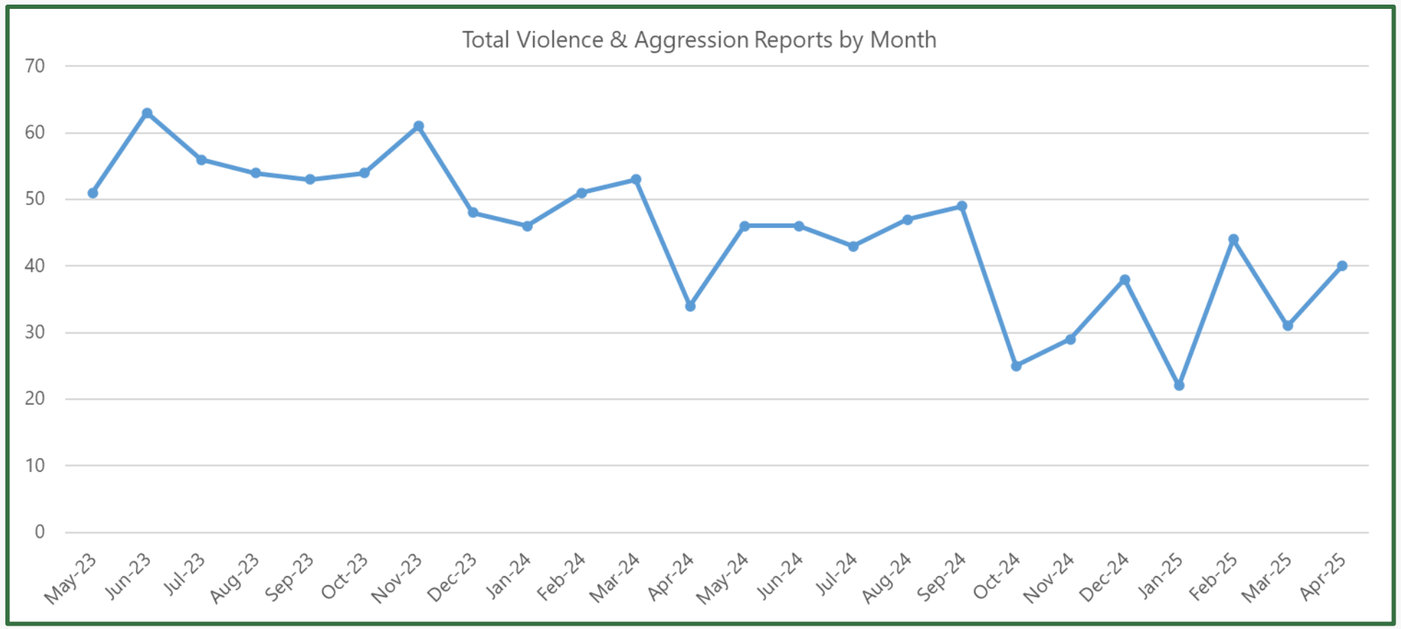
(Responsible Officer: Liam Williams)

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 April 2025 all 3 were for an injury requiring over 7 days of work.

67% of the RIDDOR's were submitted within the HSE reporting timelines, late identification of a RIDDOR reportable incident prevented 100% compliance with HSEW timescales.

Two RIDDOR's reported during the month were a result of manual handling patients and one whilst moving equipment from the vehicle.

Violence and Aggression:
A total of 40 incidents have been reported of V&A in April, an increase from the 31 in March 2025.

- 6 Physical Assault on staff was reported during the month with 3 incidents of verbal abuse
- 6 incidents were reported as Moderate in harm and 23 noted as low harm with 1 case being noted as causing severe harm.
- The number of verbal assault incidents remained during the month with aggressive and threatening behaviour accounting for 23 of the 34 incidents.

Remedial Plans and Actions
RIDDOR:
The weekly Datix incident meeting is being used to identify RIDDOR reportable incidents. A Safety Advisor is designated to assist with the investigation to find root cause and reporting to the Health and Safety Executive (HSE).

Violence and Aggression:
V&A Team continue to support staff with pursuing remedial action for V&A cases with 2 cases going to Magistrate court during the month and custodial sentences given for both.
The team continue working with the Clinical Support Desk to explore mechanisms to better protect staff by use of Community Behavioural Orders via the Patient Care Plans.

Expected Performance Trajectory
RIDDOR:
It is apparent the Trust is experiencing a lower number of slip and trip incidents reported due to improvement in ground conditions at patient properties.

Violence and Aggression:
The number of verbal assaults has been on the increase as staff become more confident in the support provided by the V&A team.

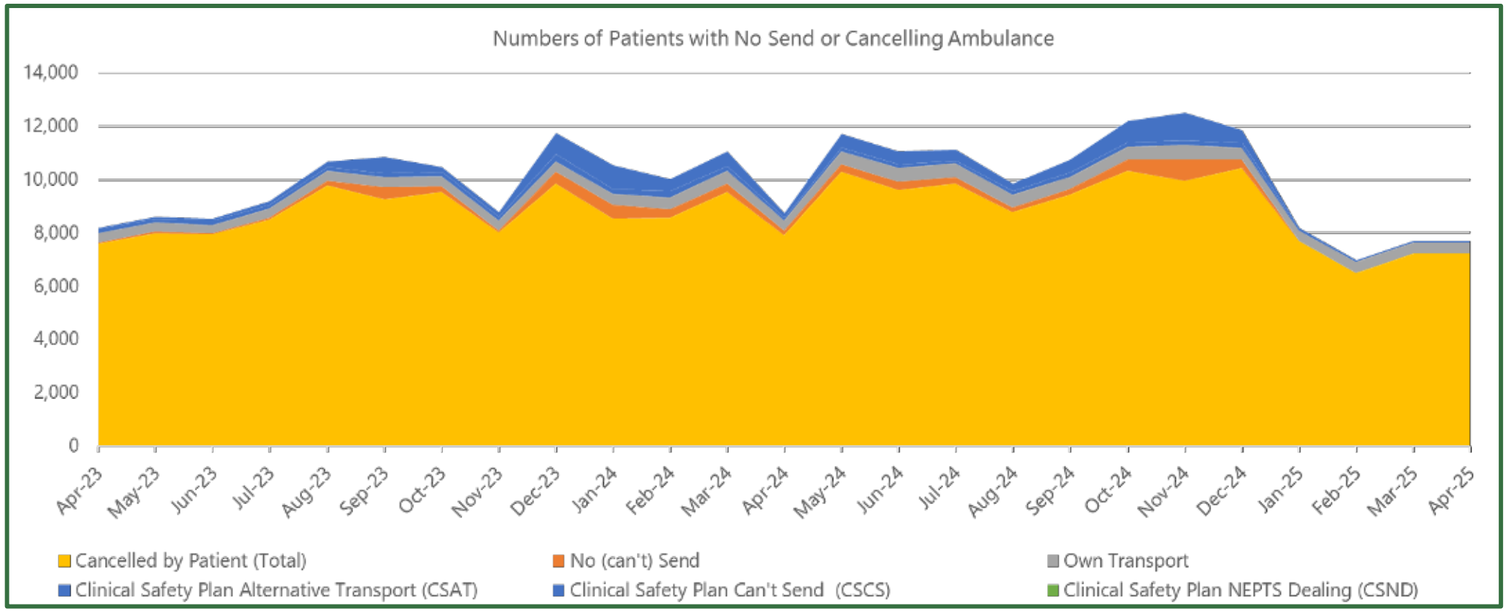
Data source: Datix

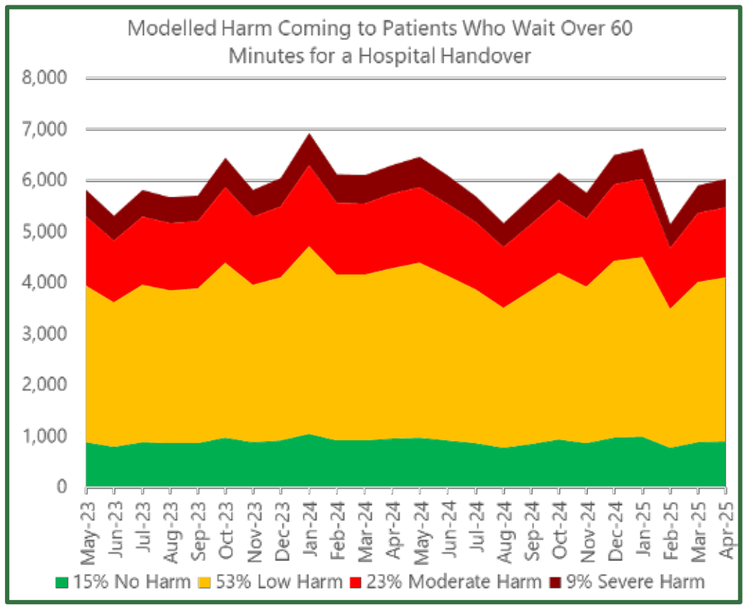
Our Patients: Quality, Safety & Patient Experience
Potential Patient Harm Indicators

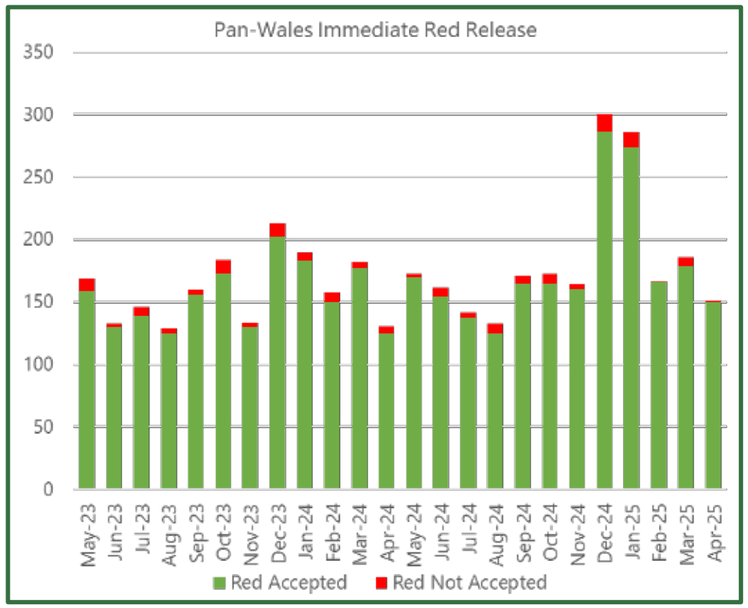
(Responsible Officer: Andy Swinburn)

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QUEST







Analysis

In April 2025, 71 ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 6,431 ambulances were cancelled by patients (including patients refusing treatment at scene) a minimal decrease from the 6,433 in March 2025. There has been a downward trend in patient cancellations since December 2024 which the Trust believes is connected to the implementation of Rapid Clinical Screening.

There were 712 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in April 2025. Of these 150 were accepted and released in the Red category, with 1 not being accepted and 192 ambulances were released to respond to Amber 1 calls, but 369 were not.

The graph in the bottom left shows the estimated level of patient harm during April 2025. Of the 6,025 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (903 patients) would experience no harm, 53% (3,193 patients) would experience low harm, 23% (1,385 patients) would experience moderate harm and 9% (542 patients) would experience severe harm.

In April 2025 CSP levels for the Trust were:



Remedial Plans and Actions

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

Expected Performance Trajectory

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

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

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

April 2024		
NEPTS (233 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	79
Were you happy with the transport you received?	85	95
999 (18 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	93
The 999-call taker who answered your call explained what was going to happen next.	85	100
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	94
The length of time I waited for an ambulance to arrive was acceptable.	85	50
111 (25 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	50
Did you follow the advice given to you by NHS 111 Wales?	85	100
Would you consider using NHS 111 Wales again?	85	50
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
○ Ambulance care	88.59% Good	7.07% Poor
○ Integrated Care (NHS 111 Wales Telephone line only)	50.00% Good	50.00% Poor
○ EMS (including CSD)	62.5% Good	18.75% Poor
○ NHS 111 Wales Online	46.15% Good	30.77% 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
Within the NEPTs survey the response provided did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment, while the question 'Were you happy with the transport your received', came out above the 85-benchmark figure (n=95).

In the 999 survey 'The length of time waited for an ambulance to arrive was acceptable' question failed to meets its target. Whilst within 111 survey the only question to achieve its 85-benchmark was 'Did you follow the advice given by NHS 111 Wales?'

Response rates to the 999 and 111 surveys remain low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes.

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

Remedial Plans and Actions
We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:
999 EMS Response (incorporating CSD)
Ambulance Care (NEPTS)
NHS 111 Wales Telephony
NHS 111 Wales Online
Response rates to some of our PREM's surveys continues to be disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. A DPIA has now been submitted to the ICO for consideration, which would allow us to contact certain 999 callers by SMS Text to ask them to provide feedback. We hope to receive a response within eight to ten weeks.
We continue to work closely with the Trust's Falls Improvement Lead to deliver a targeted survey looking at the experiences of people who are responded to by either a Level 1 or Level 2 falls responder. Plans are in place to duplicate this method of survey delivery with patients attended to by a CWR Volunteer.
We continue to engage with the Once for Wales Programme Board who have updated the 'All Wales Patient Experience Question Set' and 'People's Experience Framework'. The Framework and new questions have now been formally released by Welsh Government alongside an updated Welsh Health Circular.

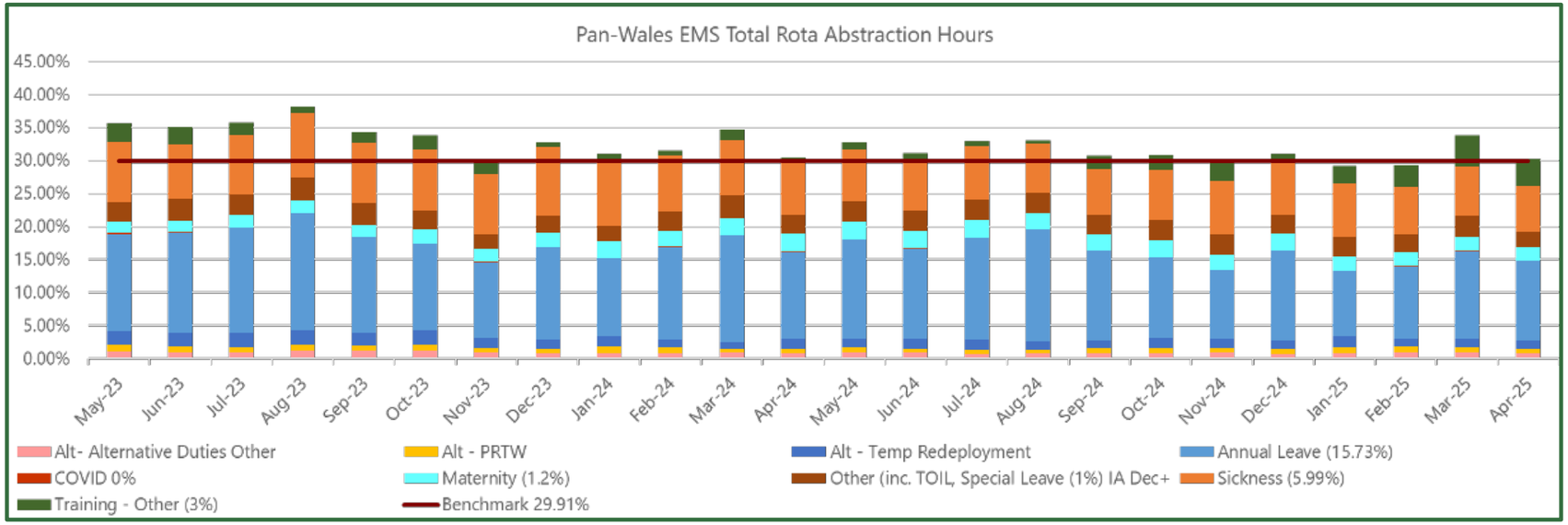
Expected Performance Trajectory
An overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data.

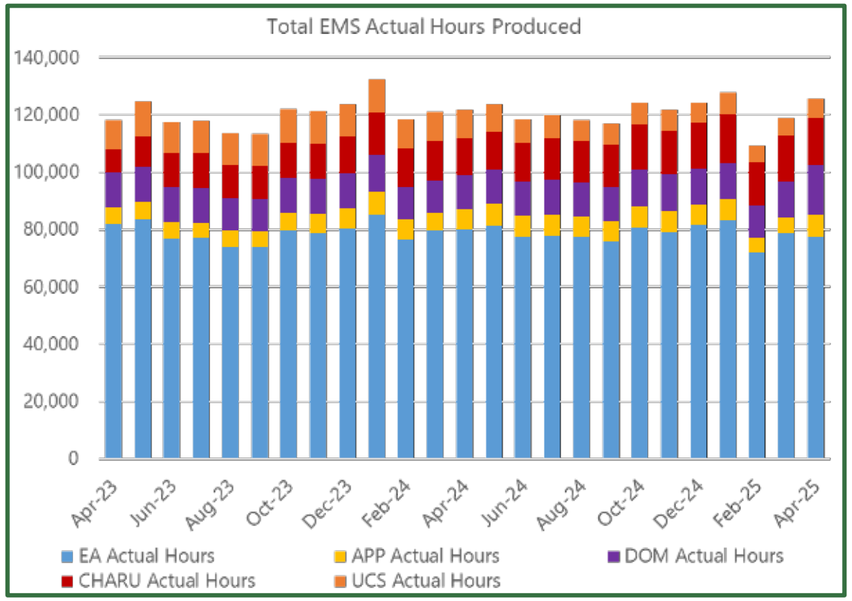
Our People
Capacity - Ambulance Abstractions and Production Indicators

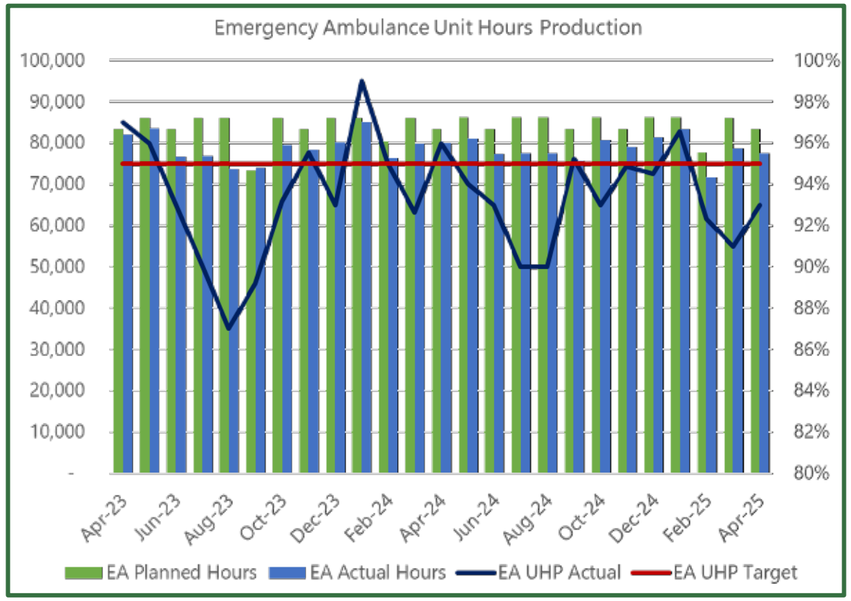
(Responsible Officer: Lee Brooks)

EA Production	Abstractions
A	R

CI PCC FPC







Analysis

As shown in the top graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. April 2025, saw a total EMS abstractions (excluding Induction Training) of 30.26%. This was a decrease on the 33.86% recorded in March 2025 and is minimally above the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 12.08% followed by sickness at 6.88%.

The total EMS hours produced is a key metric for patient safety. The Trust produced 125,639 hours during April 2025, an increase compared to the 121,578 hours produced during April 2024. The Trust is delivering good levels of production.

Emergency Ambulance Unit Hours Production (UHP) achieved 93% in April 2025 which equated to 77,470 Actual Hours.

In April 2025 CHARU UHP was 91% against the full roll out requirement. The second highest UHP in the last four months.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

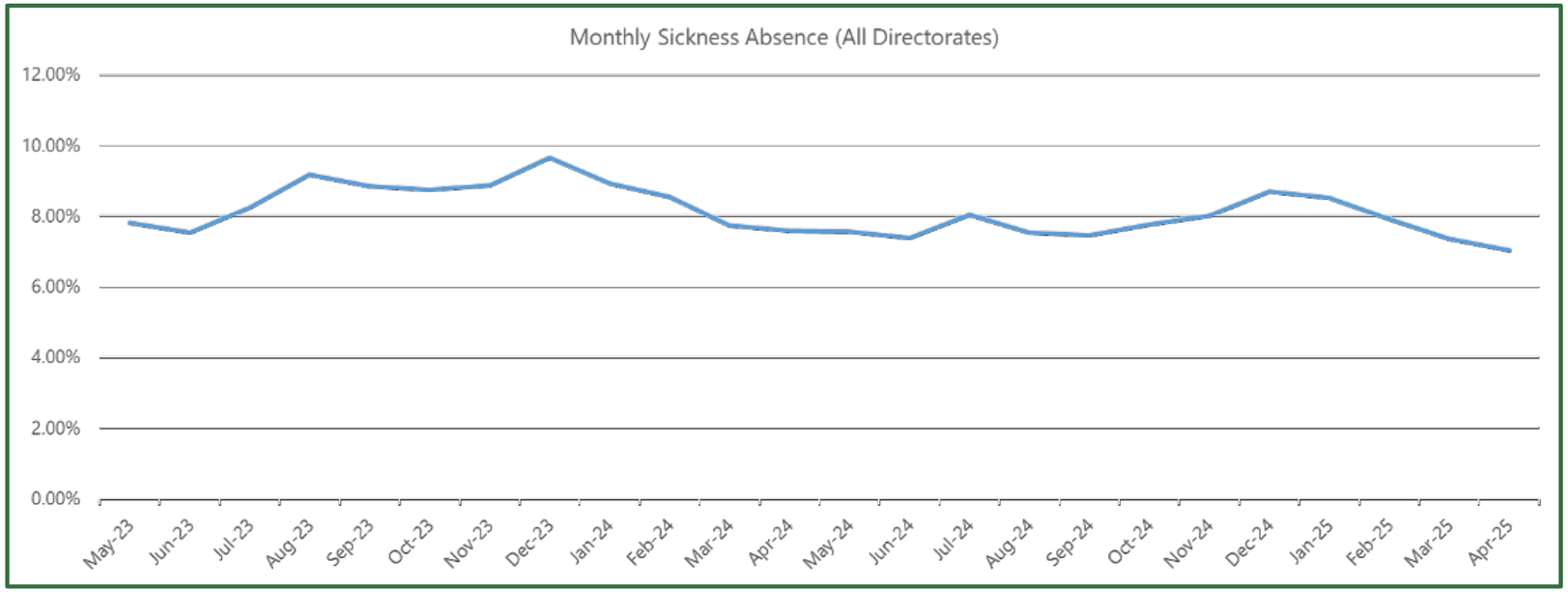
Our People
Capacity - Sickness Absence Indicators

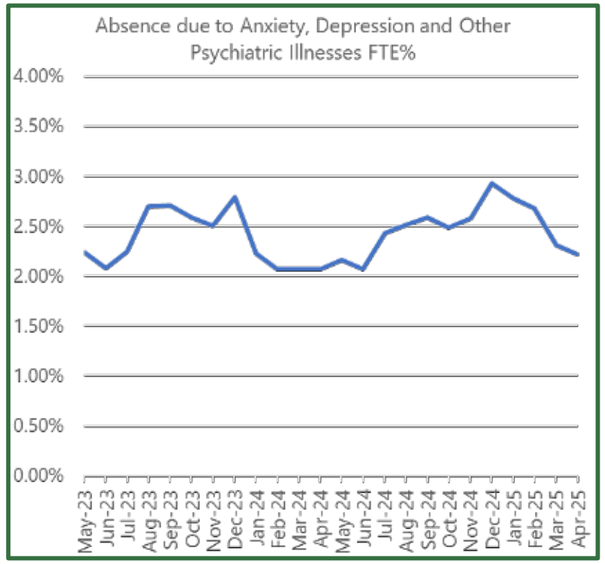
(Responsible Officer: Angela Lewis)

Mental Health: R

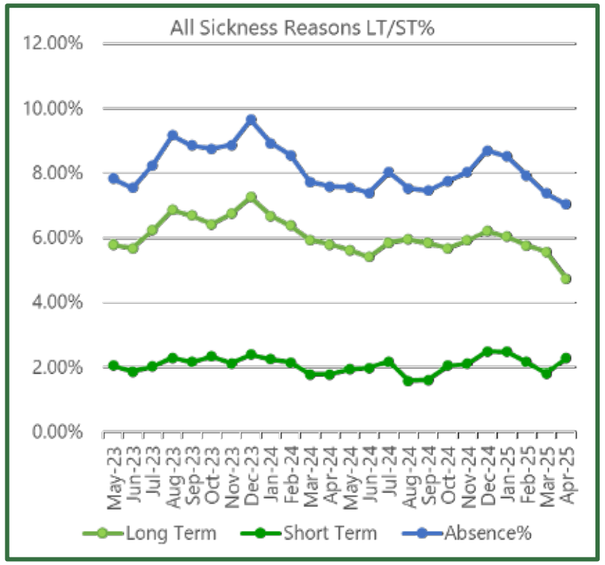
PCC

CI





Average working days lost per FTE (Annual)	
17.76	days
Single month Absence %	
7.04%	
Long Term	**Short Term**
4.75%	2.28%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.22%	0.72%



Analysis

There was a slight decrease in overall sickness absence rates between March 2025 and April 2025, dropping from 7.38% to 7.04%. Long term absence decreased from 5.57% in March 2025 to 4.75 % in April 2025, while short-term absence increased slightly to 2.28% in April 2025 from March 2025 (1.81%).

The highest reasons for absence in April 2025 were Anxiety/ Stress/ Depression, Gastrointestinal problems, other musculoskeletal problems, and injury fracture.

Absence due to Mental Health decreased slightly for the fifth consecutive month from 2.31% in March 2025 to 2.22% in April 2025.

In April 2025, WAST Occupational Health continue to meet national KPIs set by the All-Wales Occupational Health standards and scope of practice, i.e., regarding turnaround times for referrals the national KPI states: The 1st offered appointment date will be within 29 calendar days of the date referral received. KPI that this is achieved 80% of the time. 140 management referrals and 22 self-referrals were made in April. The current average waiting time for an offered appointment date, from point of referral is 5.13 days.

The Employee Assistance Programme service received a total of 65 calls, including 55 calls for counselling support and 10 call for advice, covering employment, divorce & separation, childcare and bereavement.

Remedial Plans and Actions

- The Health and Wellbeing Plan for 2025-29 has been approved by the WAST Board and a delivery plan has been developed and implemented. The focus of the plan is to improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges increasingly on a systemic level, in addition to providing support on an individual level.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits and drop-in clinics. We regularly give presentations to newly recruited staff to highlight and promote the Occupational Health & Wellbeing service.
- Continuous review of the Occupational Health and Wellbeing provision, so that we ensure that services/interventions offered are relevant, appropriate, and up to date, our focus remains on continuous improvement.
- The programme plan for the pilot Health Check Programme, Health Diagnostics, (HD), has now started. The programme was promoted and discussed with staff members at each of the Spring roadshows, the team are scheduling clinics inviting staff to book screening appointments.

Expected Performance Trajectory

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

April 2025

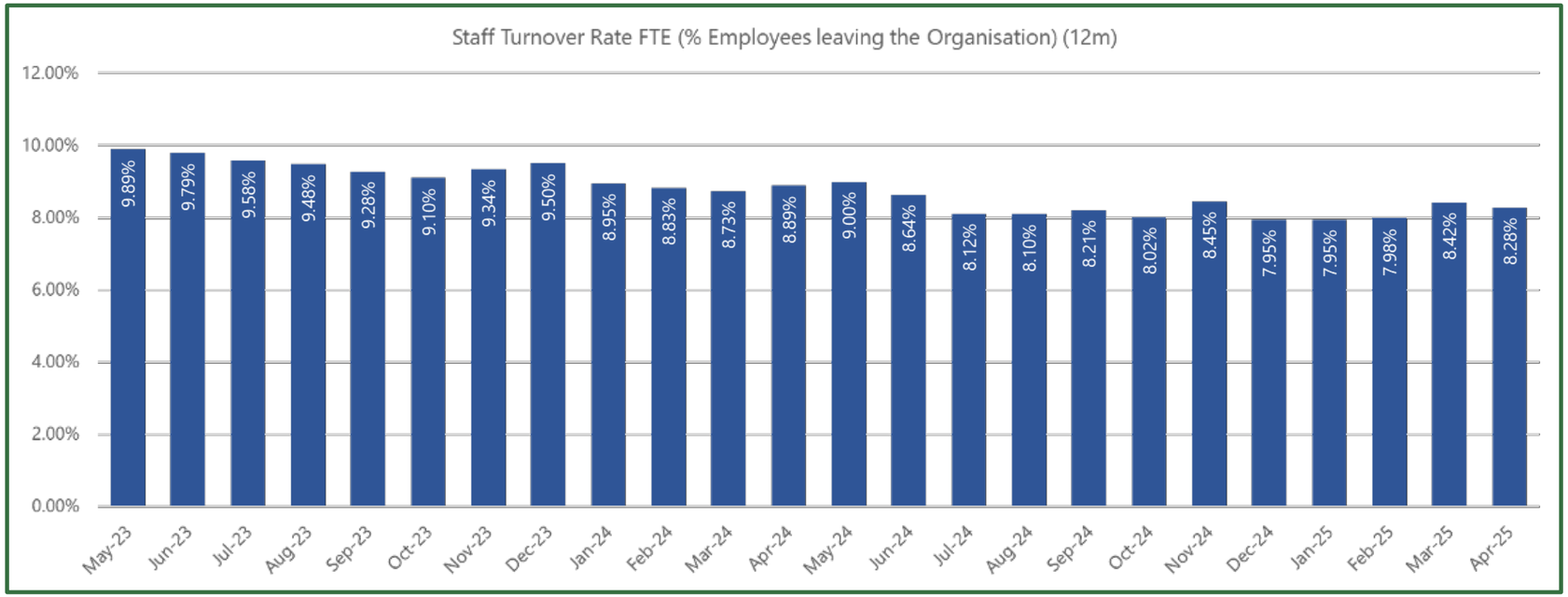
**NB:* Sickness data will always be reported one month in arrears

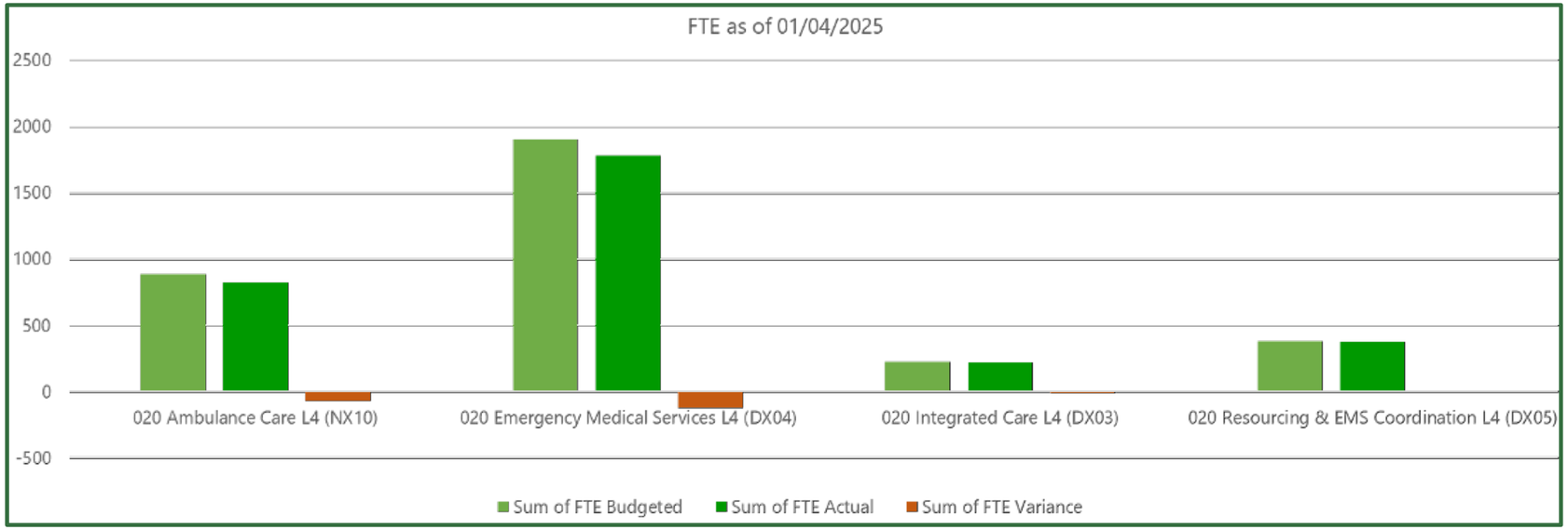
Our People
Capacity – Staff Turnover

(Responsible Officer: Angela Lewis)

G

PCC





Analysis

Staff turnover rates in April 2025 were 8.28%, decreasing from 8.42% in March 2025. April saw 22 leavers (18.34 FTE). Of those leaving, the group with the greatest number were.

- Ambulance Care Assistants or Patient Transport Drivers (4 people),
- Technicians (4 people), and
- Paramedic (4 people).

In April, this was compensated by 45 joiners (41.74 FTE). A headcount of 9 people into Corporate roles and 36 people into Operational roles including:

- Ambulance Care Assistants or Patient Transport Drivers (11 people),
- Staff Nurse (8 people)
- Emergency Call Handler (5 people)

Currently it has been noted that in early months of the year and start of the financial year sees a peak occurs, predominately due to retirements.

Remedial Plans and Actions

- The Trust is looking at longer term models to grow our APP cohort to support our future ambitions, which will include the recruitment of additional NQPs to support our B6 paramedics movement into APP roles.
- Discussions around the future skill mix of our EMS workforce are ongoing, this could have considerable impact on the EMS workforce going forward. However, sufficient training capacity has been planned during 2025-26 to enable the trust to recruit any staff into the organisation, regardless of what grade that may be.

Expected Performance Trajectory

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

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR: A

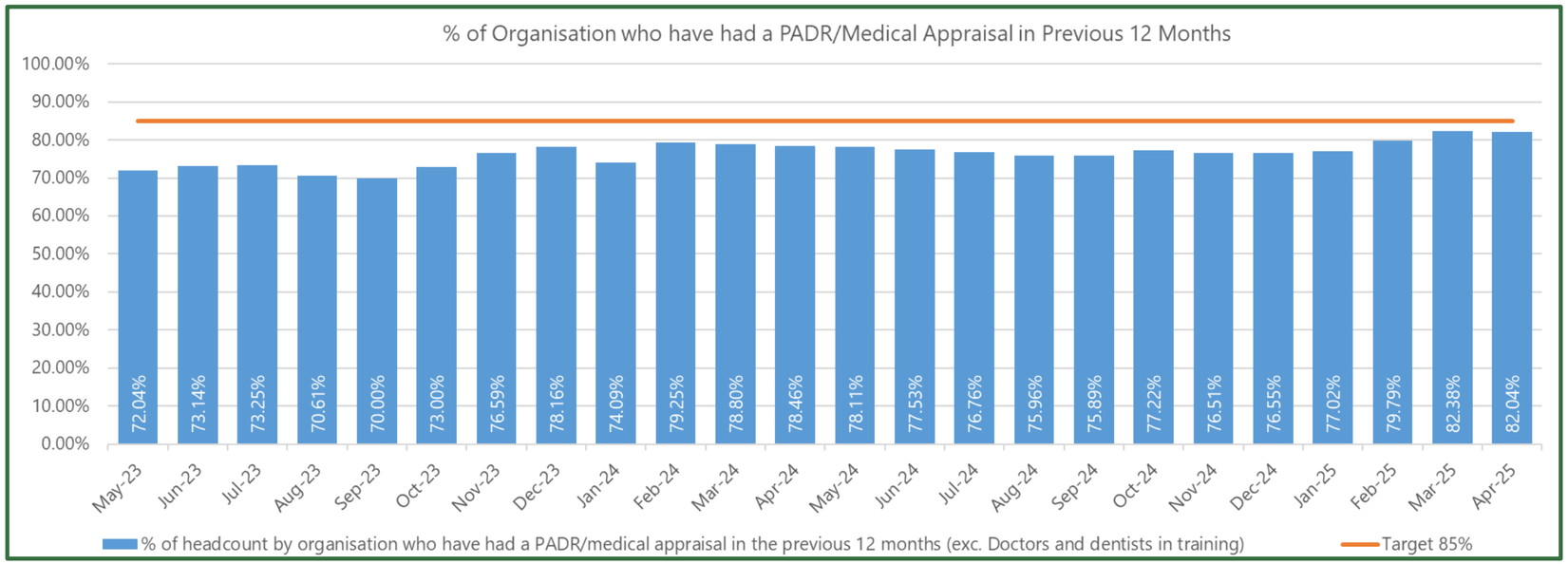
Stat & Mand: G

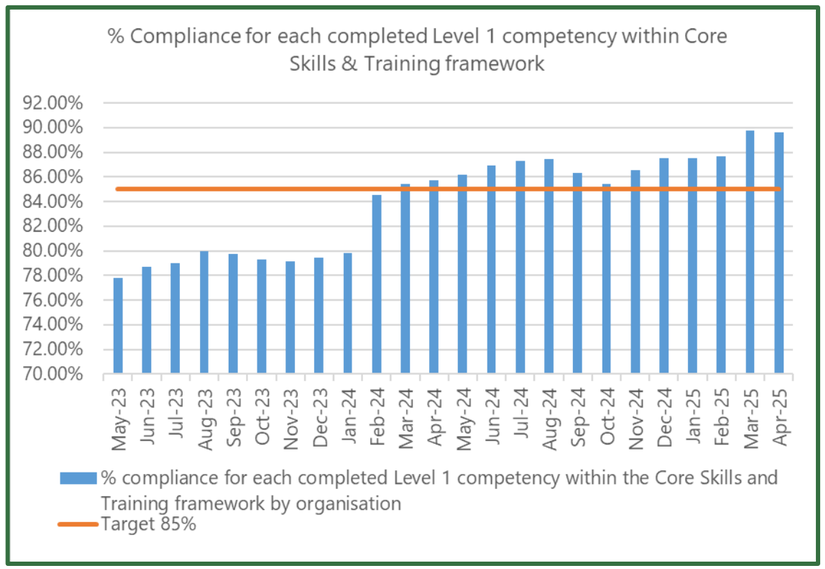
CI

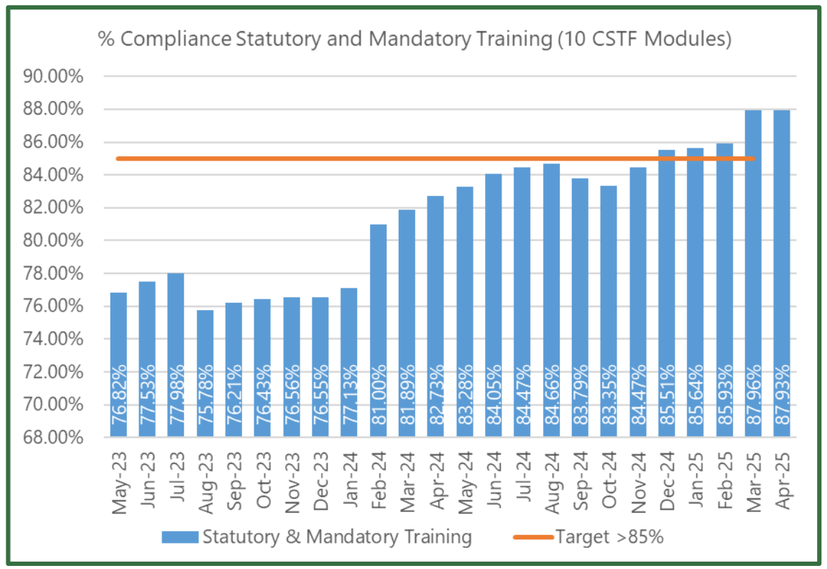
PCC

Health & Care Standard
Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates minimally decreased minimally from 82.38% in March 2025 to 82.04% in April 2025 and remains close the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In April 2025 Statutory & Mandatory Training rates reported a combined compliance of 87.93% exceeding the 85% target for the fifth consecutive month. However, only Dementia Awareness (98.19%), Moving & Handling (95.47%) and Safeguarding Adults (95.16%), achieved the 85% target. Equality & Diversity (82.59%), Information Governance (82.13%), Fire Safety (77.91%), Paul Ridd (76.60%), Fraud Awareness (76.76%), Violence Against Women, Domestic Abuse & Sexual Violence (73.38%) and Welsh Language Awareness (71.34%) all remain below this target.

There are currently 19 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table:

Skills & Training Framework	NHS Wales Minimum Renewal Standard
Equality, Diversity & Human Rights (Treat me Fairly)	3 years
Fire Safety	2 years
Health, Safety & Welfare	3 years
Infection, Prevention & Control Level 1	3 years
Information Governance (Wales)	2 years
Moving & Handling (Level1)	2 years
Resuscitation	Annually
Safeguarding Adults (Level 1)	3 years
Safeguarding Children (Level 1)	3 years
Violence & Aggression (Wales) Module A	No Renewal
Mandatory Courses	
Violence Against Women, Domestic Abuse and Sexual Violence	3 years
Dementia Awareness	No Renewal
Welsh Language Awareness	3 years
Paul Ridd (Learning Disability Awareness)	No Renewal
Enviroment, Waste & Energy (Admin & Clerical Staff Only)	Annually
Duty of Quality	3 years
Fraud Awareness	3 years
Prevent Course 1 - Awareness	No Renewal
Duty of Candour	3 years

Remedial Plans and Actions

Engagement in the PADR process serves as a Key metric for evaluating team cultural health. By increasing engagement with the PADR process, our goal is to enhance employee development, support better Communication between managers and employees and develop a culture of accountability and continual improvement.

There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly environment enabling easier access to these reportable competencies.

Expected Performance Trajectory

Performance is improving as compliance has risen.

Data source: ESR

Our People
Health and Well-being – Shift Overruns

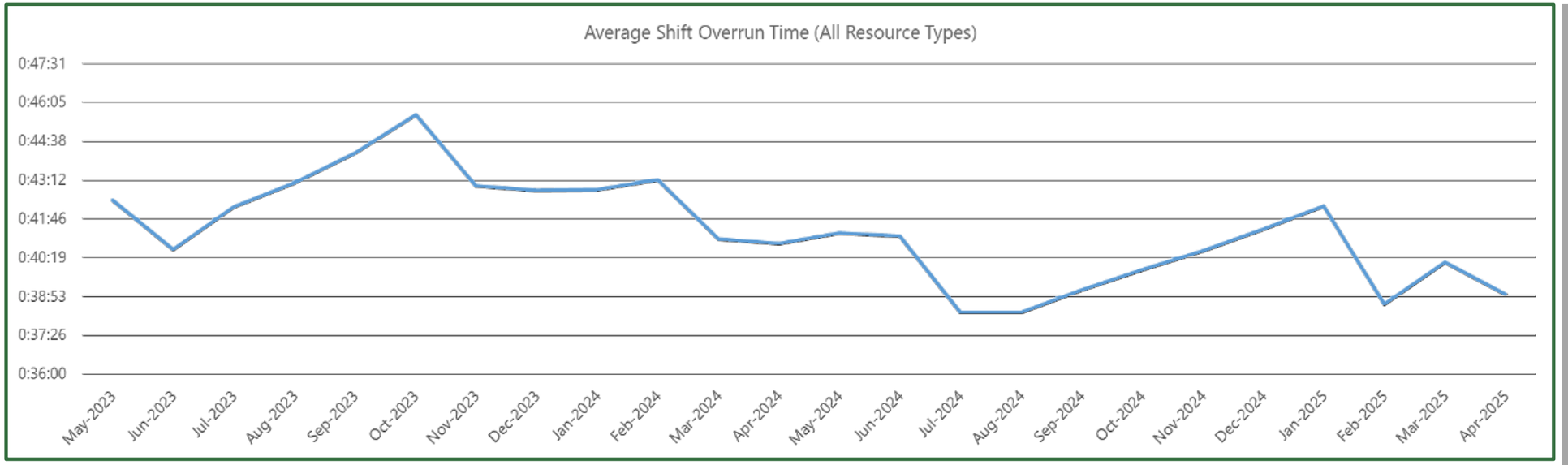
(Responsible Officer: Angela Lewis)

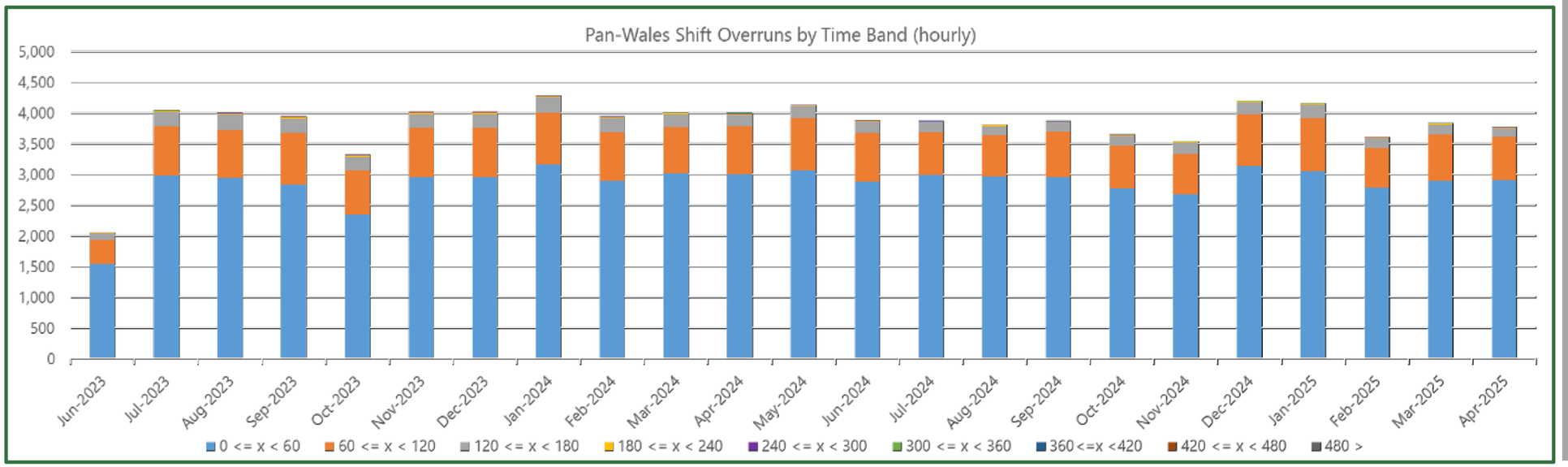
Overruns R

CI

PCC

FPC





Analysis

There were 3,773 shift overruns during April 2025.

The average overrun figure for April 2025 was 38 minutes and 58 seconds, a minimal decrease from March 2025 (00:40:08). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 75.8% of the total. 19.3% fall within the 61 to 120-minute category, 4.4% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.2% in the 241 minutes and over category.

Remedial Plans and Actions

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

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

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

Expected Performance Trajectory

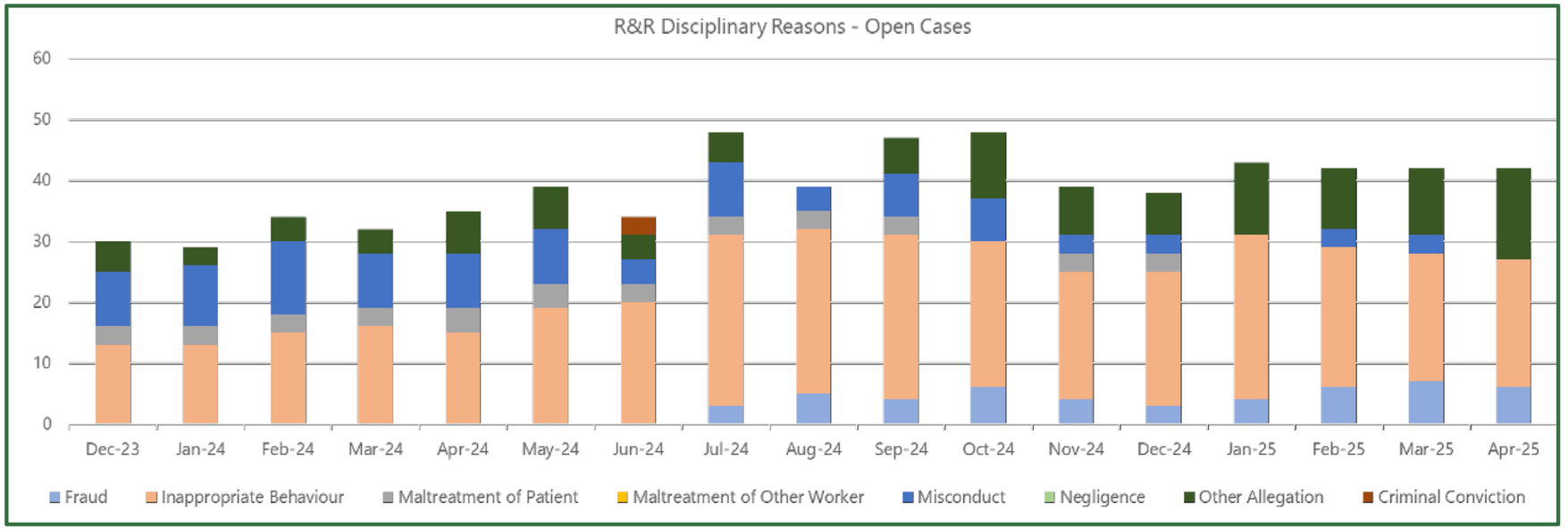
Overruns correlate with handover lost hours and may continue to increase.

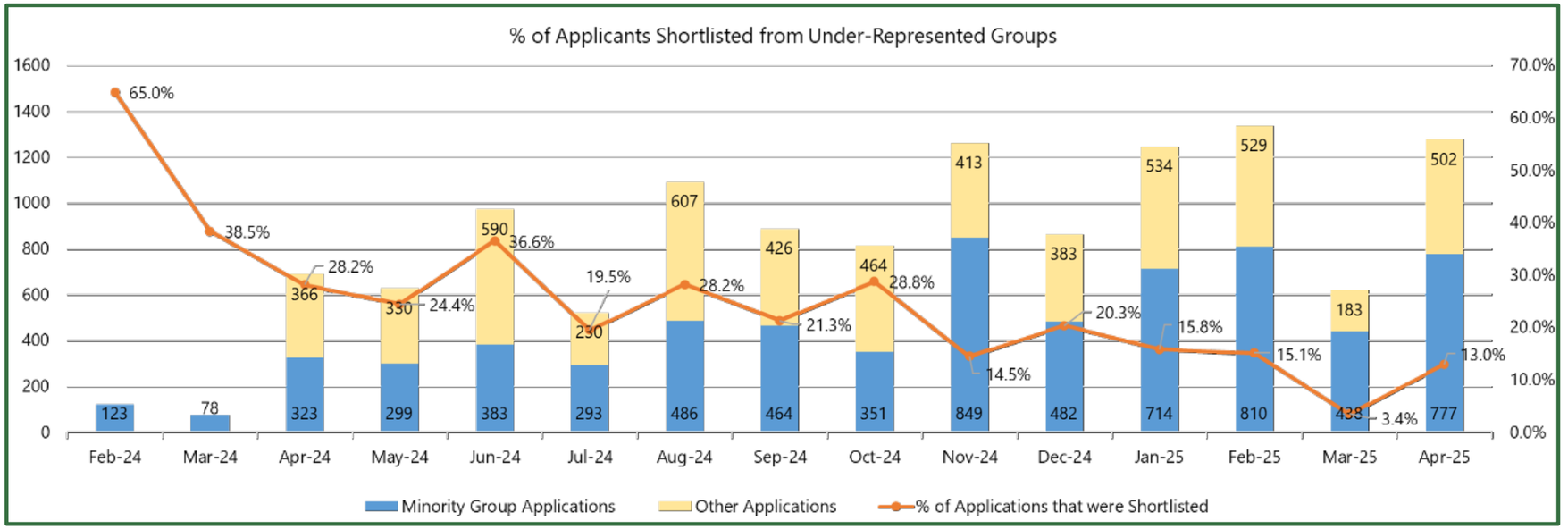
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 42 open formal disciplinary cases recorded at the end of April 2025, which remains consistent with the previous month. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by fraud.

There were 11 open formal Respect and Resolution cases submitted by employees in April 2025, three more than the 14 recorded in March 2025. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in April 2025, 1,279 job applications were processed, and 265 interviews planned.

Of the 1,279 applications, a total of 777 were from under-represented groups with 580 in the category of Ethnicity, 115 within Disability and 82 identifying within Sexual Orientation.

In April 2025, 13% (n=101) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was an increase from the 3.4% in March 2025.

Remedial Plans and Actions

R&R Formal Disciplinary Cases: Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events. Work continues with recruitment workshops for Black, Asian and Ethnically diverse applicants into our digital roles. These workshops have expended to applicants with protected characteristics who have been invited to interview as Graduate Paramedics. Unconscious bias training for the managers that will be involved in their recruitment is underway.

Expected Performance Trajectory

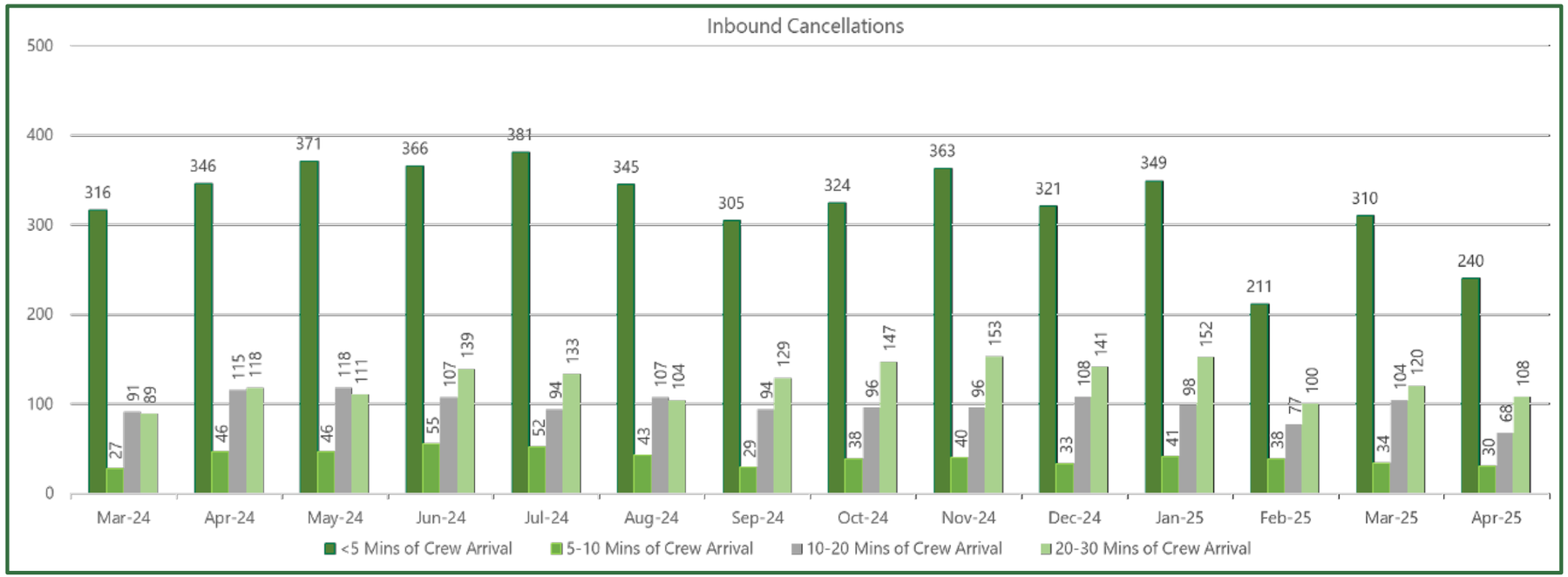
Continue to monitor levels, no trajectory for this measure.

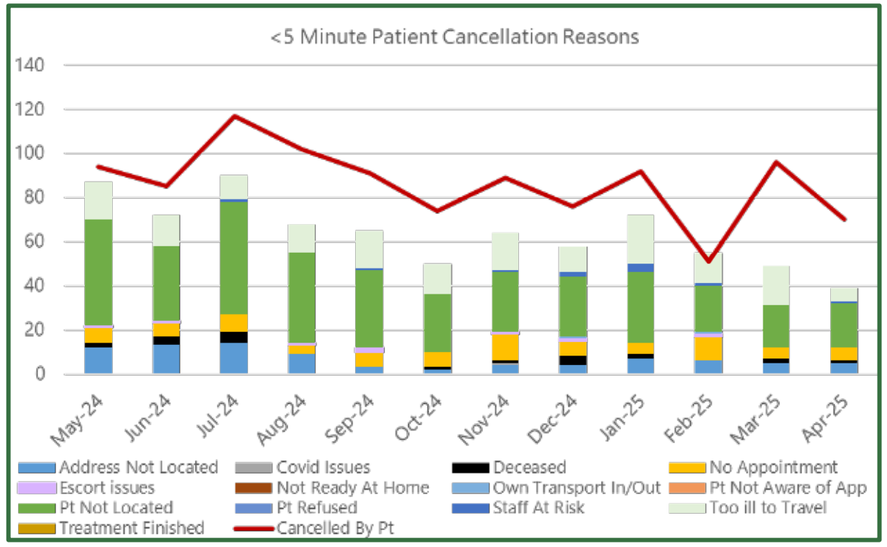
Finance, Resources and Value
Value: Ambulance Care Indicators

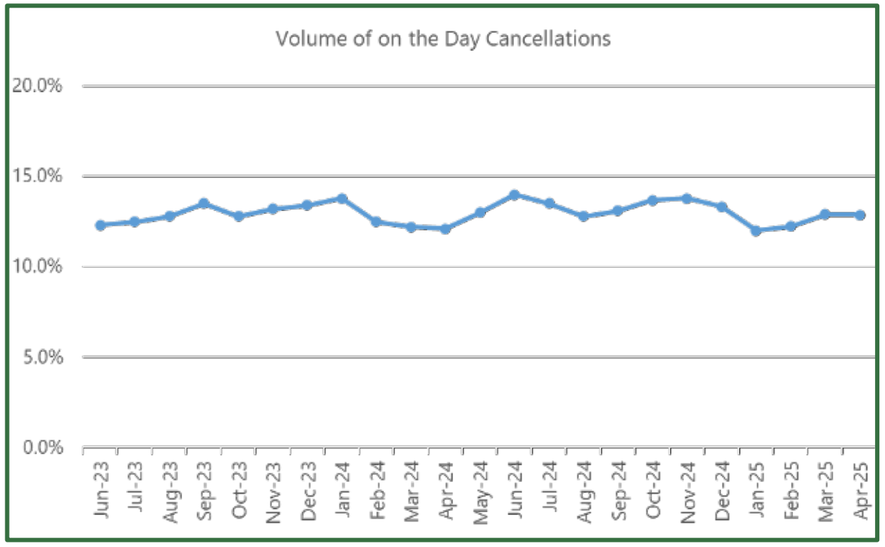
(Responsible Officer: Lee Brooks)

Cancellations
R

FPC







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a decrease in April 2025 to 240, compared to 310 in March 2025. The total number of cancellations within 30 minutes also decreased from 568 in March 2025 to 446 in April 2025.

In April 2025 there were 70 travel bookings cancelled by patients (including via SMS), decreasing from 96 in March 2025.

The other top reasons for less than 5-minute cancellations included: 20 patients not located, 6 unwell/too ill to travel, 6 no appointment and 5 address not located.

Same day cancellations remained consistent in April with March at 12.9%.

Remedial Plans and Actions

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

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

Expected Performance Trajectory

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

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

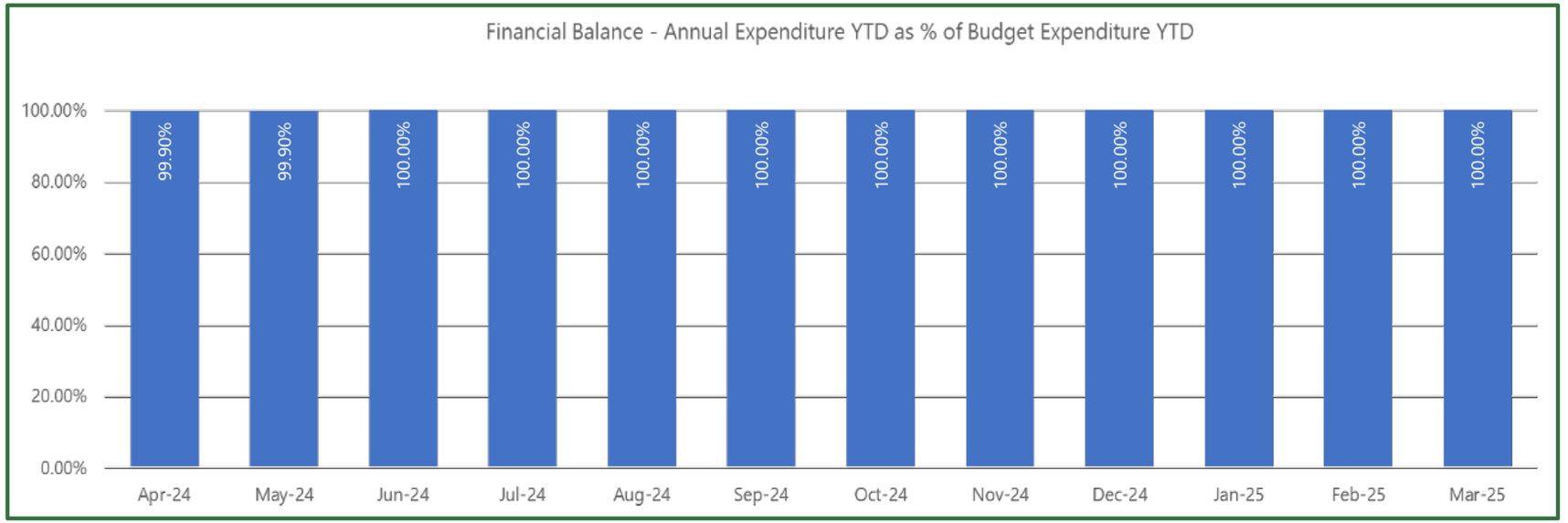
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

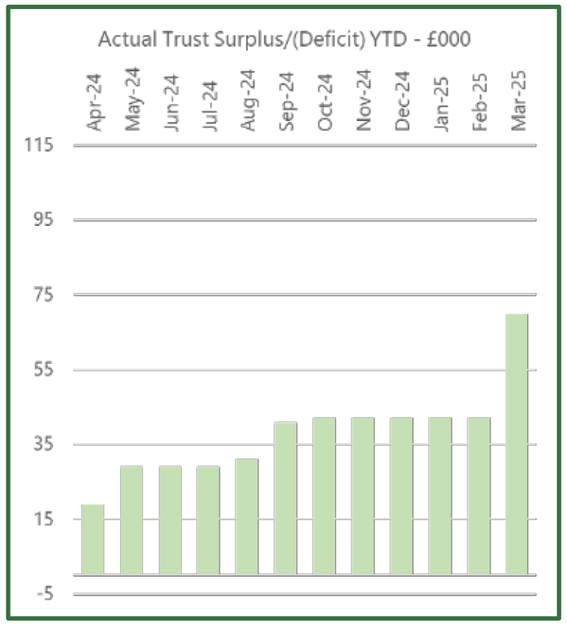
Finance, Resources and Value
Value - Finance Indicators

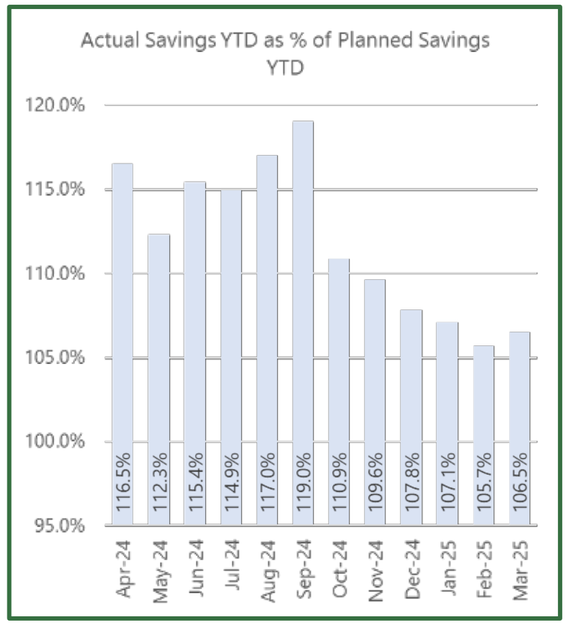
(Responsible Officer: Chris Turley)

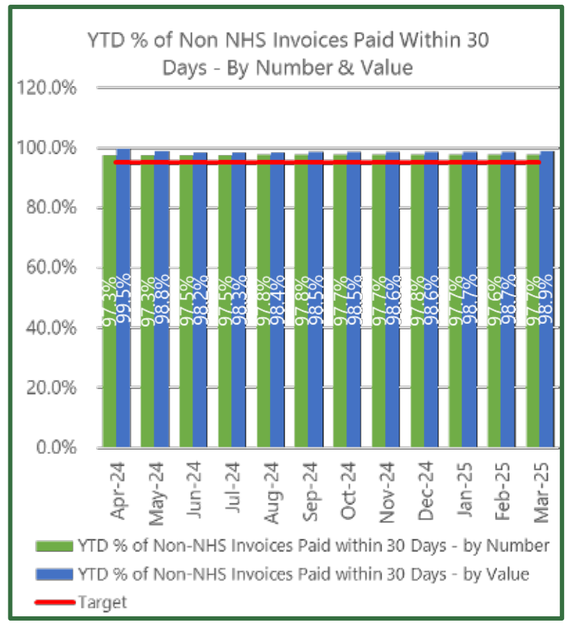
G

FPC









Analysis

The reported outturn performance at Month 12 is a surplus of £70k.

For Month 12 the Trust is reporting planned savings of £6.421m and actual savings of £6.838m (an achievement rate of 106.5%).

The Trust's cumulative performance against PSPP as at Month 12 is 97.7% against a target of 95%.

At Month 12 the Trust achieved both its External Financing Limit and its Capital Expenditure Limit.

Remedial Plans and Actions

There is no remedial plan required given the Trust closed the year with a small surplus of £70k (subject to audit); however, key areas of focus in future years include:-

- Undertaking a review of commercial opportunities for income generation (Report being considered by FSP group).
- A continued focus on the Trust's financial sustainability programme.
- Improved governance for Value Based Health Care, with a particular focus on benchmarking; and
- An improved approach to benefits realisation

Expected Performance Trajectory

The month 12 / year end position was a small surplus of £70k (subject to audit)

Finance, Resources and Value
EMS Utilisation & Average Job/Shift Times

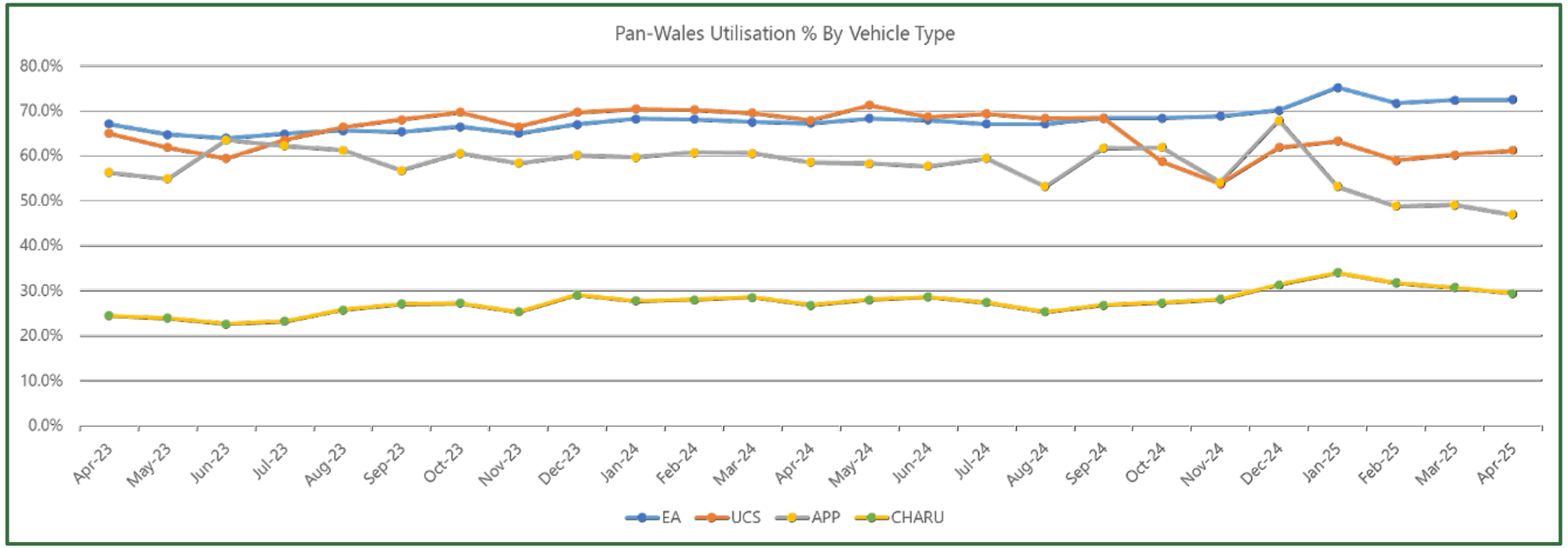
(Responsible Officer: Lee Brooks)

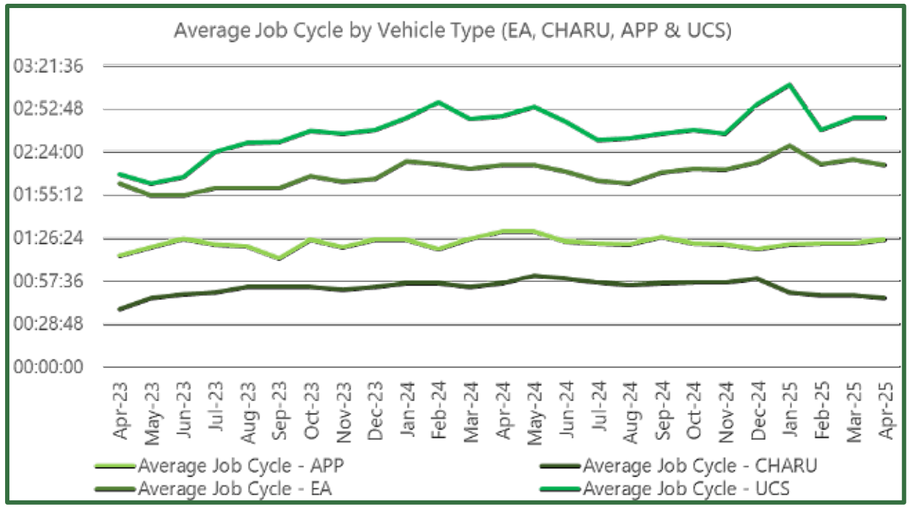
Jobs Per Shift: A

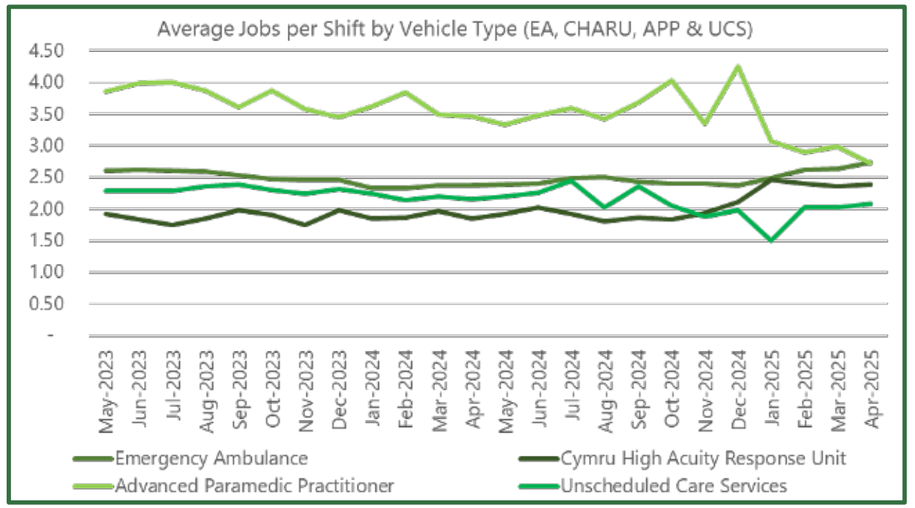
CHARU Utilisation: G

FPC

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







Analysis

Pan Wales Utilisation metrics in April 2025 were 63.7% for all vehicles types, a decrease from 64.4% in March 2025. EA saw the highest rate during the month at 72.5%, returning to the upward trend seen over the past year. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle increased in April 2025 for EAs (2 hours 15 minutes) and APPs (1 hour 25 minutes). UCS (2 hours 47 minutes) remained the same as the previous month: however, CHARU minimally increased (46 minutes).

Overall average jobs per shift was 2.64 in April 2025, a minimal increase from March 2025 (2.56). EAs averaged 2.74 jobs per shift and UCS crews 2.08. This is lower than what would be ideal and a product of handover delays.

APPs attended on average 2.73 jobs per shift and CHARU's 2.39. However, both sets of data are under review.

Remedial Plans and Actions

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

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

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

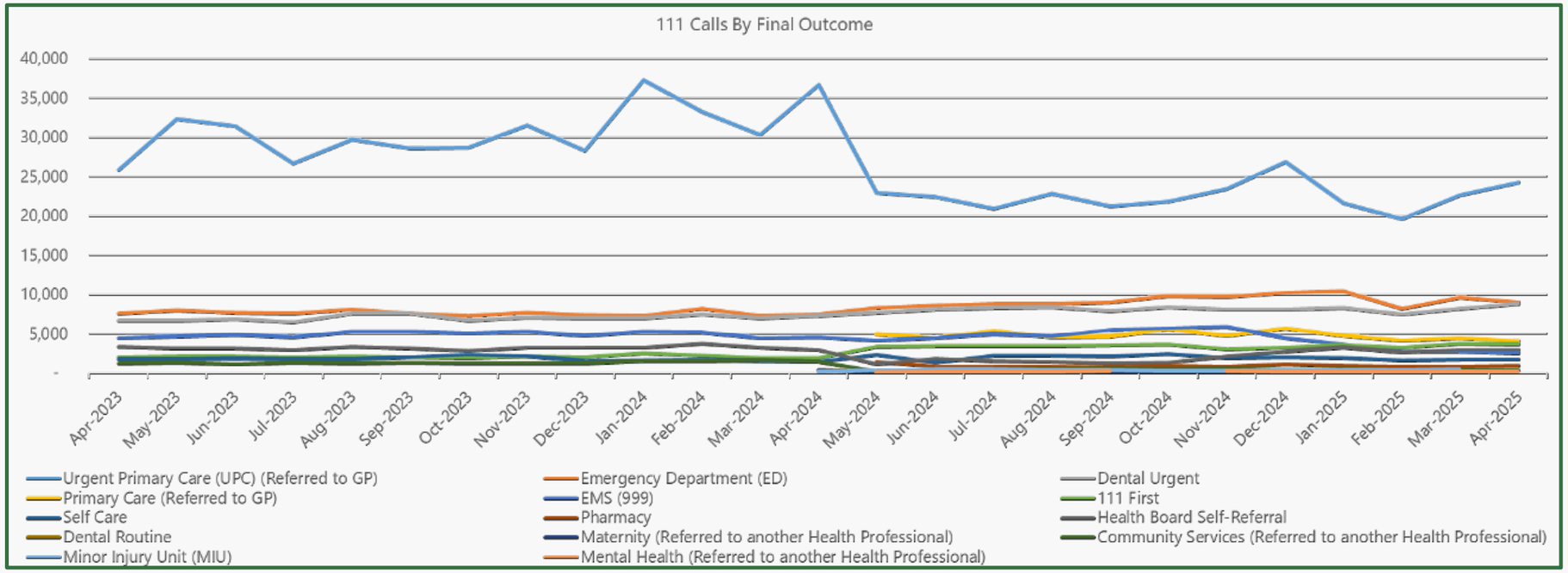
Expected Performance Trajectory

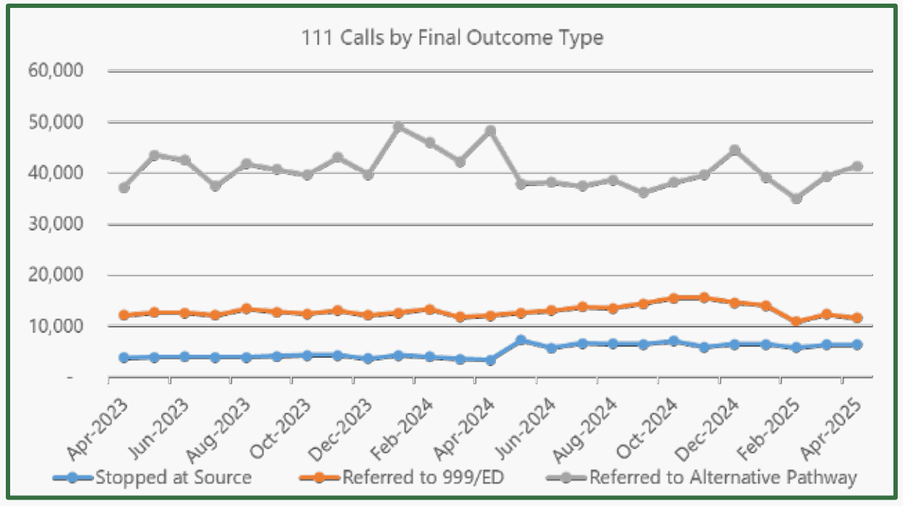
The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in CHARU utilisation and a decrease in EA utilisation during 2025/26 linked to the remedial actions identified above.

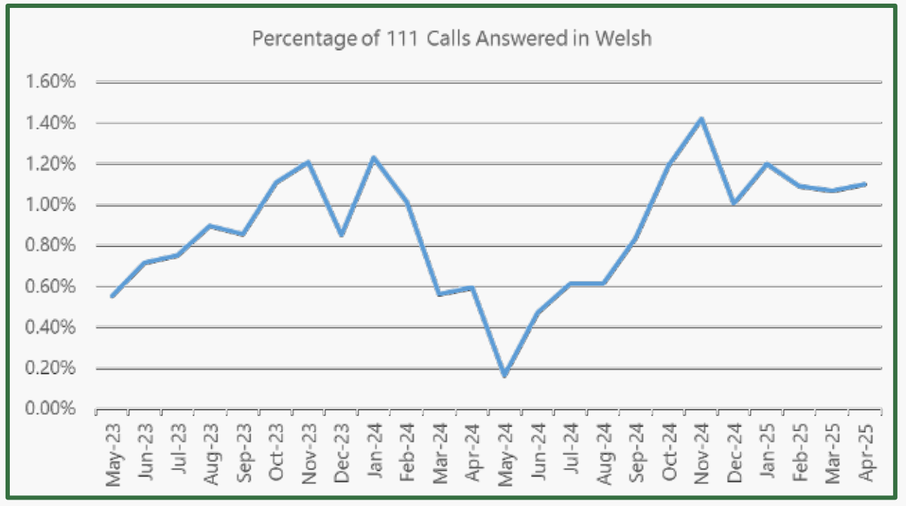
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

(Responsible Officer: Lee Brooks)

Influencing Factors – Demand and Clinical Hours Produced







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

Analysis

During April 2025, 59,345 calls were allocated into the 14 categories displayed in the graph opposite; an increase compared to the 58,114 seen during March 2025. However, data quality issues continue within 111 reporting which are currently being addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 35.24% of all calls during April 2025, but there has been a material drop since the implementation of the new 111CAS system.

As the bottom left graph highlights, in April 2025, 6,344 calls were 'Stopped at Source', with no onward referral, a slight decrease from 6,363 in March 2025. 11,615 calls were referred to 999/ED in April 2025.

The percentage of 111 calls answered in Welsh increased slightly from 1.07% in March 2025 to 1.10% in April 2025. This equated to 55.4% 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.

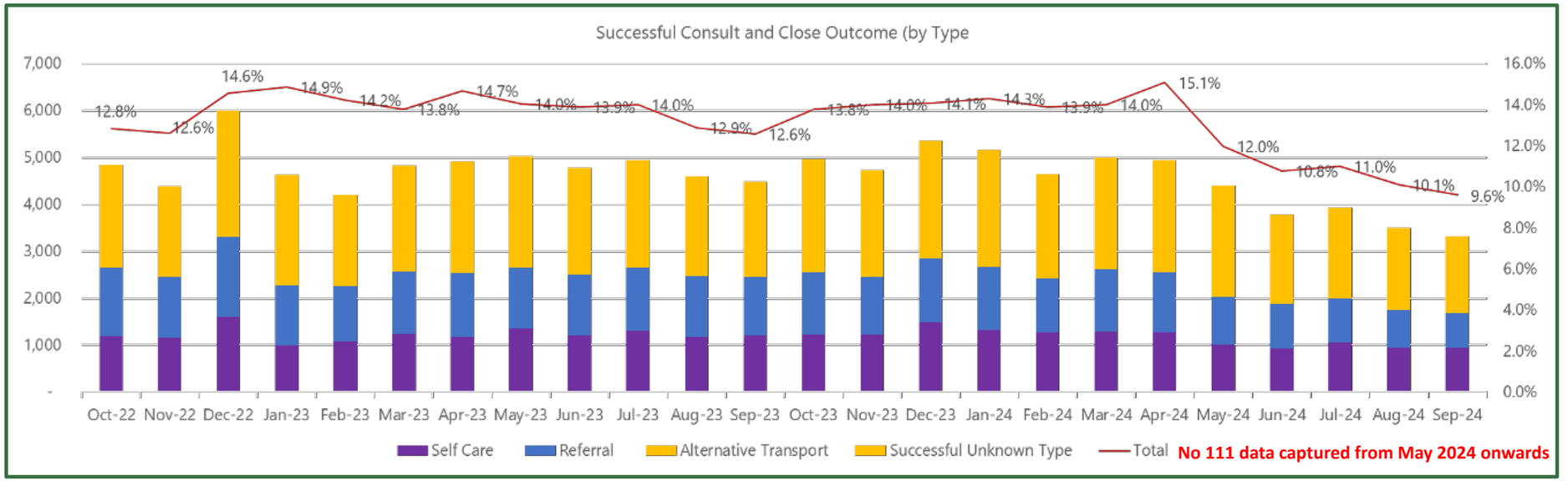
Partnerships / System Contribution
Consult & Close Indicators

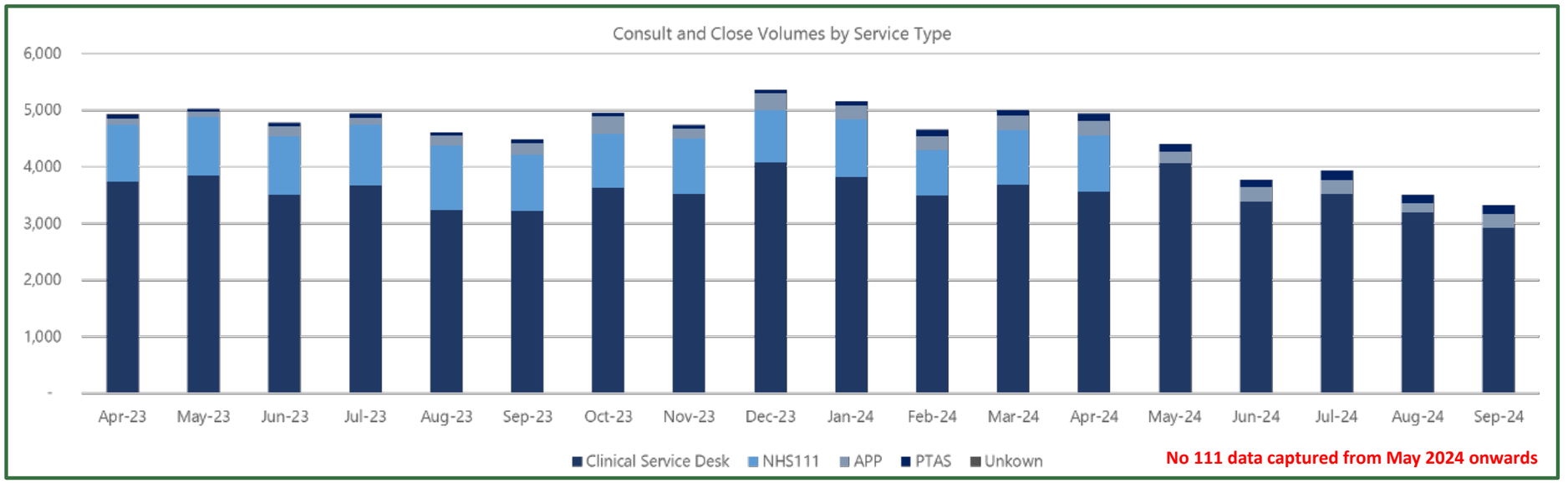
(Responsible Officer: Lee Brooks)

C&C Outcomes

FPC

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





No additional analysis possible given no 111 data is currently available on these metrics.

A revised metric is under development.

See separate patient harm mitigations report to Trust Board.

New metric definition agreed. With commissioners for approval.

A one-off IDS assured graph indicates that the Trust is achieving a +20% consult & close rate.

The definition is now approved by the Commissioner (w/e 16/05/25), so reporting of this metric can recommence.

Partnerships / System Contribution
Conveyance to ED Indicators

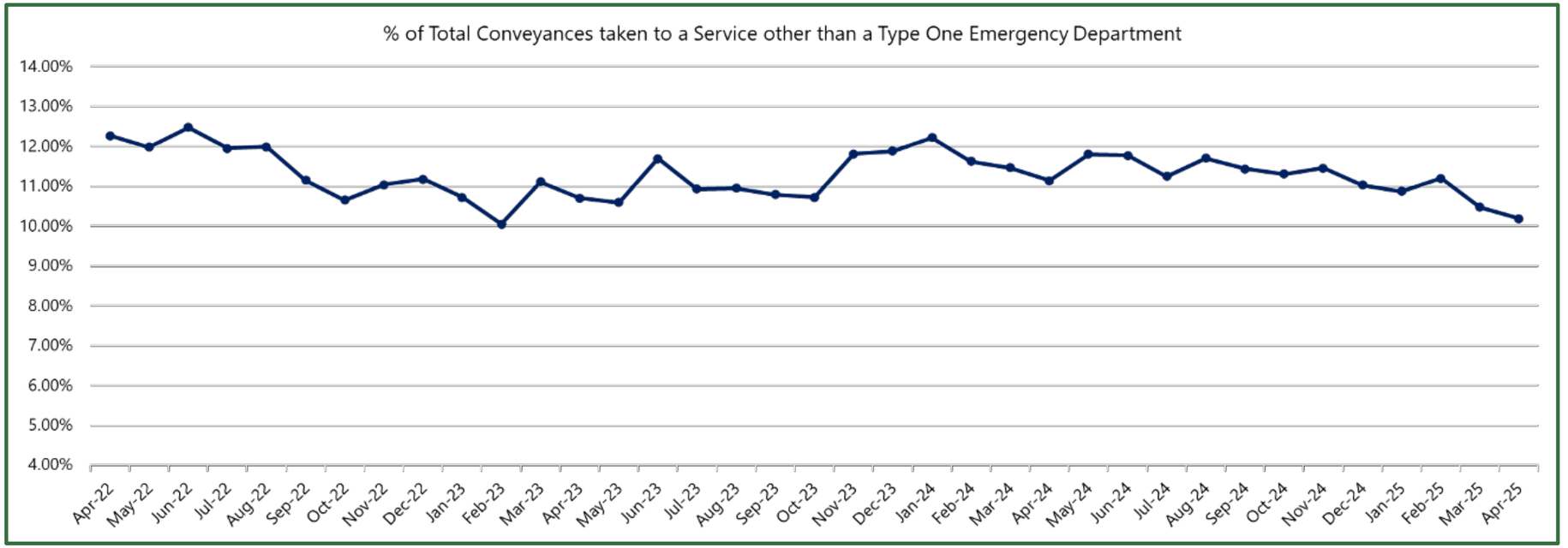
(Responsible Officer: Andy Swinburn)

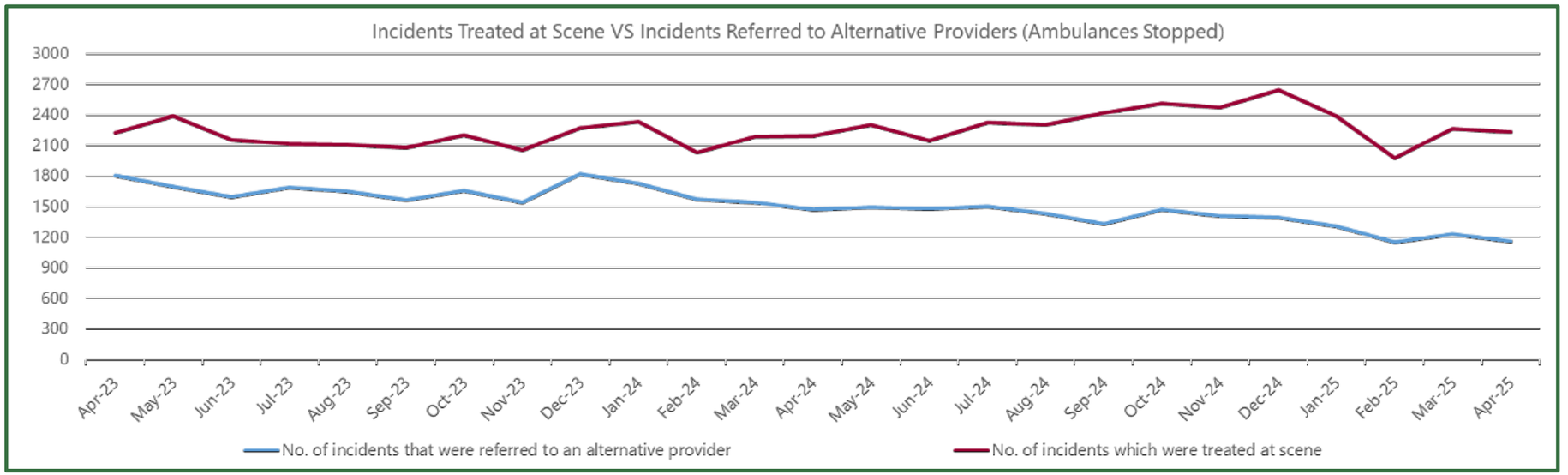
Conveyances
G

FPC

Ministerial Measure

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





Analysis

In April 2025 10.19% of patients (1,321) were conveyed to a service other than a Type One ED, while 34.81% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers decreased, from 3,494 in March 2025 to 3,395 in April 2025.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

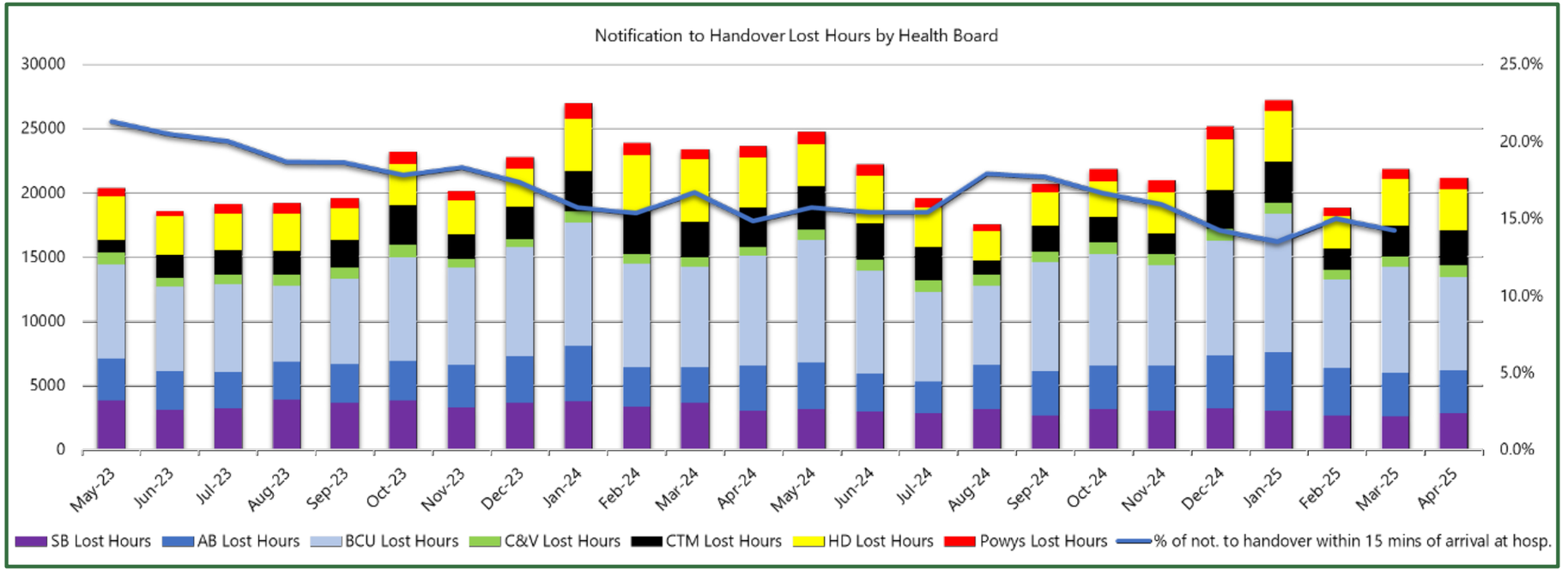
Partnerships / System Contribution
Handover Indicators

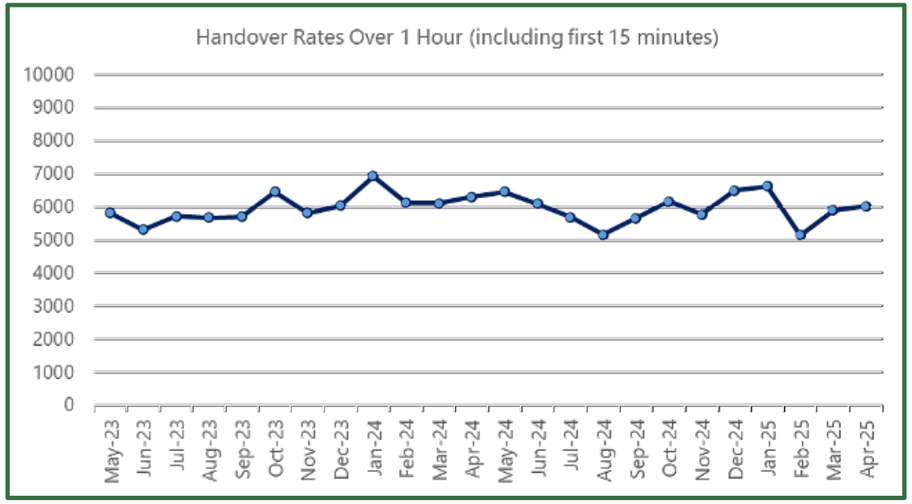
(Responsible Officer: Health Boards)

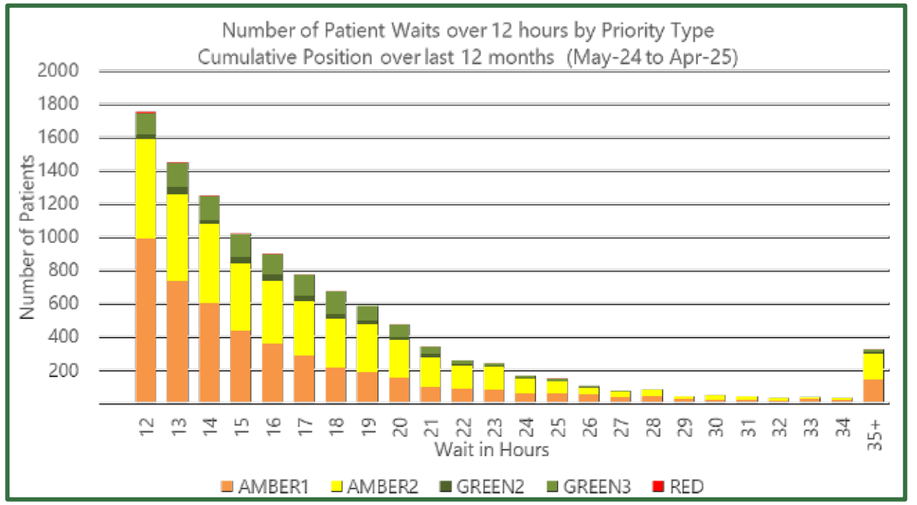
Lost Hours R

CI

QUEST







Analysis

261,945 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (May-24 to Apr-25), compared to 260,947 hours over the same timeframe the previous year. There were 21,183 hours lost in April 2025, which is 10.3% lower than the 23,631 hours lost during April 2024.

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

- Grange University Hospital (ABUHB) at 3,169 lost hours
- Morriston Hospital (SBUHB) at 2,791 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 2,578 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,265 lost hours
- Glan Clwyd Hospital (BCUHB) at 2,246 lost hours

Notification to handover lost hours averaged 706 hours per day during April 2025 (30 days) compared to 705 hours per day (31 days) in March 2025.

In April 2025, the Trust could have responded to approximately 6,682 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

In April 2025, 776 patients waited over 12 hours for an ambulance response.

Remedial Plans and Actions

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

Expected Performance Trajectory

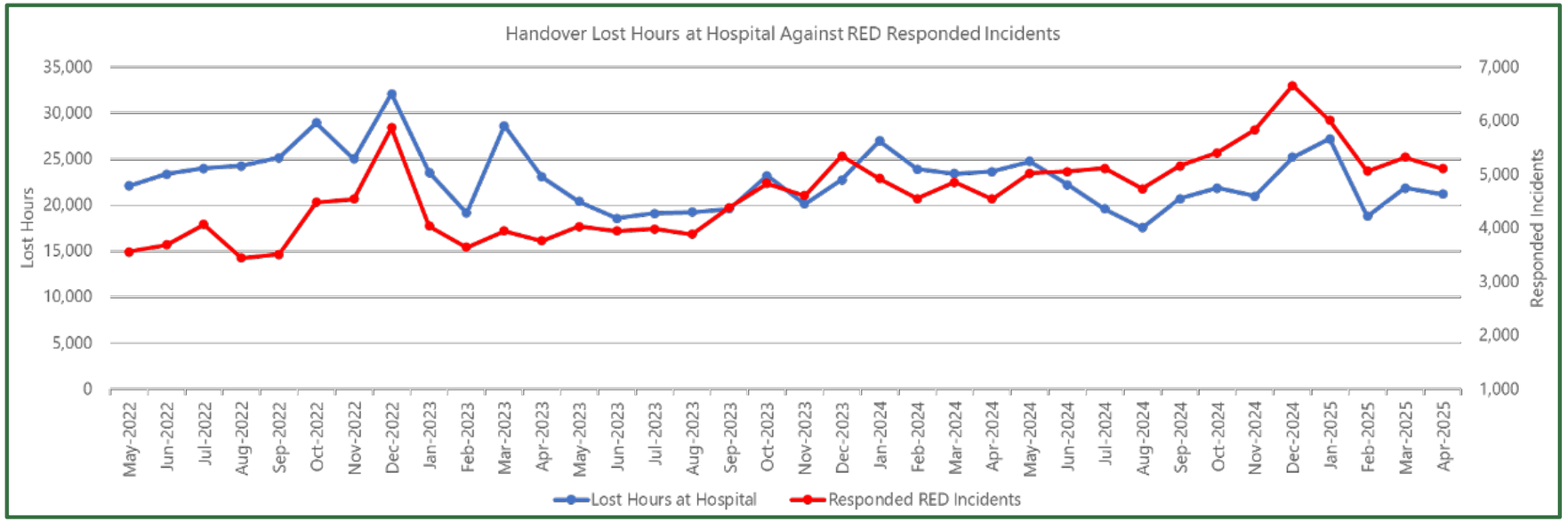
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.

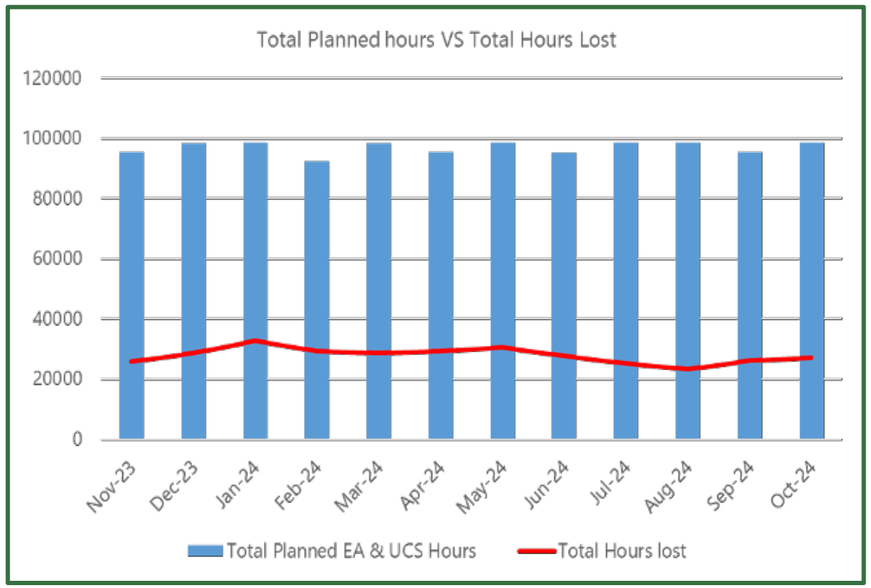
Partnerships / System Contribution

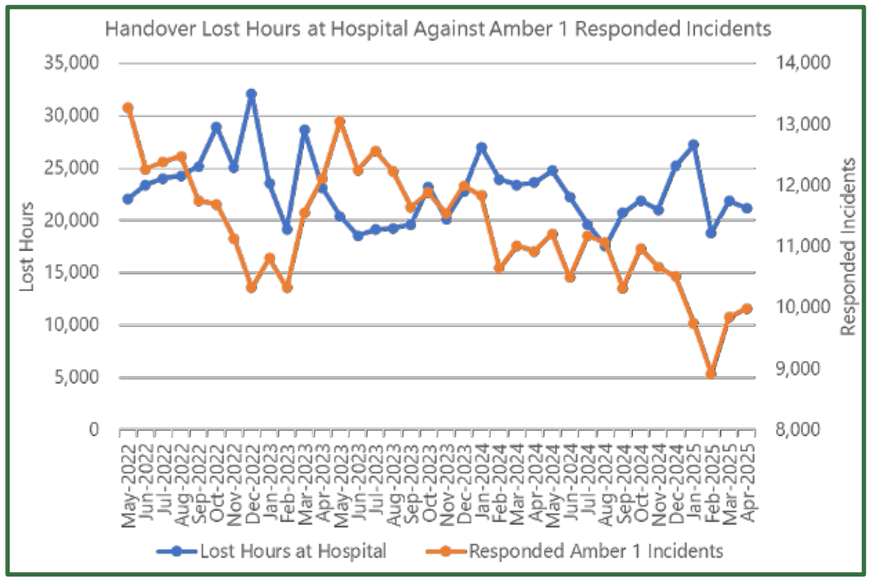
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

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

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

Remedial Plans and Actions

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

Expected Performance Trajectory

The Welsh Government target is no patient handovers of more than one hour, which equates to 7,500 lost hours a month. The Welsh Government target was to see a 30% reduction in this metric by December 2024. However, this has not been achieved, with the 21,183 hours lost in April 2025.

**NB: Data correct at time of abstraction*

Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	CTM / CTMHB	Cwm Taf Morgannwg Health Board	HIW	Health Inspectorate Wales	NHSDW	National Health Service Direct Wales	ROSC	Return Of Spontaneous Circulation
AOM	Area Operations Manager	C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	HI	Health Informatics	NPUC	National Programme for Unscheduled Care	RRV	Rapid Response Vehicle
APP	Advanced Paramedic Practitioner	DAG	Delivery & Assurance Group	H&W	Health & Wellbeing	NQPs	Newly Qualified Paramedic	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
AQI	Ambulance Quality Indicator	D&T	Discharge & Transfer	HR	Human resources	NRI	Nationally Reportable Incident	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	DU	Delivery Unit	HSE	Health and Safety Executive	OBC	Outline Business Case	STEMI	ST segment Evaluation Myocardial Infarction
CASC	Chief Ambulance Services Commissioner	EAP	Emergency Ambulance Practitioner	IG	Information Governance	OD	Organisational Development	TPT	Tactical Pandemic Team
CCC	Clinical Contact Centre	ED	Emergency Department	IMTP	Integrated Medium Term Plan	ODU	Operational Delivery Unit	TU	Trade Union
CCP	Complex Case Panel	ELT	Executive Leadership Team	IPR	Integrated Performance Report	OH	Occupational Health	UCA	Unscheduled Care Assistant
CEO	Chief Executive Officer	EMD	Emergency Medical Department	JCC	Joint Commissioning Committee	P / PHB	Powys / Powys Health Board	UCS	Unscheduled Care System
CFR	Community First Responder	EMS	Emergency Medical services	KPI	Key Performance Indicator	PCR / PCRs	Patient Care Record(s)	UHP	Unit Hours Production
CI	Clinical Indicator	ePCR	Electronic Patient Care Record	LTS	Long Term Strategy	JRCALC	Joint Royal Colleges Ambulances Liaison Committee	U/A RTB	Unavailable – return to Base
CHARU	Cymru High Acuity Response Unit	FTE	Full Time Equivalent	MACA	Military Aid to the Civil Authority	PECI	Patient Engagement & community Involvement	VPH	Vantage Point House (Cwmbran)
COOs	Chief Operating Officers	GDPR	General Data Protection Regulations	MIU	Minor Injury Unit	POD	Patient Offload department	WAST	Welsh Ambulance Services University NHS Trust
COPD	Chronic Obstructive Pulmonary Disease	GPOOH	General Practitioner Out of Hours	MPDS	Medical Priority Dispatch System	PPLH	Post Production Lost Hours	WG	Welsh Government
COVID-19	Corona Virus Disease (2019)	GTN	Glyceryl Trinitrate	NCCU	National Collaborative Commissioning Unit	PSPP	Public Sector Purchase Programme	WIIN	WAST Improvement & Innovation Network
CMT	Clinical Model Transformation	HB	Health Board	NEPTS	Non-Emergency Patient Transport Services	QPSE	Quality, Patient Safety & Experience		
CSD	Clinical Service Desk	HCP	Health Care Professional	NEWS	National Early Warning Score	RCS	Rapid Clinical Screening		
CSP	Clinical Safety Plan	HD / HDHB	Hywel Dda / Hywel Dda Health Board	NHS	National Health Service	RICS	Remote Integrated Care Service		

Definition of Indicators

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

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

Integrated Medium Term Plan (IMTP) Delivery/Assurance End of year report

MEETING	Trust Board
DATE	29 May 2025
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Planning & Transformation Heather Holden, Head of Transformation Deborah Kingsbury, Senior Planning & Performance Business Partner
CONTACT	alexander.crawford2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide the Board with an end of year position for IMTP delivery and assurance for 2024/25 (year 1 of the 2024-27 IMTP).

This paper provides a position for the Clinical Model Transformation (CMT) programme Directorate-led IMTP portfolio, and Ministerial (now Cabinet Secretary) Priorities set by Welsh Government.

It also provides an assessment against the 'what good looks like' outcomes statements set out in the 2024-27 IMTP.

This paper has been reviewed by Finance & Performance Committee (FPC) who were assured by the report although have asked for future reports to include a RAG status against the cabinet secretary's priorities.

RECOMMENDED:

That the Board

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

KEY ISSUES/IMPLICATIONS

The WAST IMTP for 2024-27 was approved by Trust Board on 28 March 2024 and submitted to Welsh Government the same day. Welsh Government approved the IMTP subject to accountability conditions on 9 August 2024. The accountability conditions set out the following:

- Continue with the development of the clinical model, liaising with wider services including health boards, to provide the evidence base and impact expected;
- Continue to derisk the financial assumptions in the plan to secure the organisation's position; and
- Ensure delivery is maintained against the commitments within the plan, including ensuring the availability of the detail behind the plan is available if needed.

This report will set out in detail how the Clinical Model Transformation programme delivered on our commitment to refreshing the current clinical model and how the wider IMTP is has been through a directorate led approach. The IMTP set out a break-even position with a savings target in excess of £6m which was achieved by year end.

Clinical Model Transformation (CMT) Programme

The Clinical Model Transformation (CMT) programme continues to progress, with notable advancements in digitising programme management. A centralised MS365 solution now houses all core controls, supported by a new interactive Programme Portal and the development of workstream-specific gateways. FY25/26 plans are being built in MS Project, aligned to IMTP deliverables, and initial work is underway to automate reporting through Power BI.

Key deliverables are nearing completion, including the Clinical Services Model Information Pack, updated Service Model Blueprint, and patient personas, which are being finalised ahead of CMT Board submission. Benefits realisation activities have also advanced, with logic-benefits mapping completed and draft scorecards prepared for Board endorsement, prior to wider consultation and refinement.

Impact assessments remain a core assurance function, with QIAs for several workstreams already approved and others progressing through governance. The programme-level EQIA is ready for CMT Board review, and the final workstream QIA is currently in development. A recent health check has also been initiated to assess audit readiness, with findings to inform updates to the programme management plan.

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

Directorate-led IMTP Portfolio

The Planning Team continues to work with Directorates to ensure assurance through directorate plans to the CEO and Strategic Transformation Board (STB), enabling a structured approach to

planning through the Integrated Strategic Planning and Development Group (ISPD). Work has progressed to digitise Directorate plans with the aim to commence reporting through MS365 applications by Q2 2025/26.

The assurance report in Appendix 1 sets out the end of Q4 position. A number of deliverables at directorate level remain **AMBER** (in progress, off track) with some deliverables having rolled over into the 2025-28 IMTP. However, there are a number of key pieces of work **COMPLETE** and progress on track (**GREEN**) in a number of areas where delivery is across multiple years of the plan.

Appendix 2 sets out how we are progressing against ministerial priorities set out in the last NHS Planning Framework.

Outcomes measures

This report has drawn on available data from the MIQPR and through directorate level monitoring where available. Detailed information for each area of the IMTP that has 'what good looks like' statements is contained within appendix 1. The following visual gives an overview of progress of the plan in terms of the outcomes set out in the IMTP 2024/25.

What Good Looks Like Direction of Travel (2024/25)

Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
NHS 111 Wales				
111 Abandonment Rate	70.3%	6.6%		5%
111 Patient Satisfaction Rate		55.9%	12.5%	90%
Consultations Closed with No Further Follow Up		47,843	54.9%	95,686
111 Website Hits		5,255,996	54.1%	5,781,596
111 Completed Symptom Checkers		152,321	34%	167,553
Emergency Medical Services (999)				
Red 8-Minute Target	10.9%	50.3%		65%
Reduce Unmet Demand/Cancellations	6.7%	118,631		59,316
Consult & Close		13.8%	28.1%	17%
See & Treat	2.9%	45,969		91,938
Rosc Rates		19.2%	15.5%	25%
Ambulance Care				
Renal Journey Times		74.4%	100%	70%
Oncology Journey Times		70.4%	100%	70%
Discharge & Transfer Journey Times	33.1%	82.3%		95%
On the Day Cancellations	3.9%	12.7%		5%
Patient Satisfaction Rate		88.7%	7.3%	95%
Our People				
Sickness Absence		8.54%	28.4%	6%
Staff Turnover Rate		8.73%	17.9%	7%
Staff Engagement Scores		65.8%	13.1%	75%

The graphic focuses on 'What Good Looks Like' for 2024/25, based on data up to the end of February 2025, and then 'What will be Different' (noting that this has been changed mid-year). It concentrates not only on new initiatives or processes that are yet to be implemented, but also on how we are progressing against existing targets and ambitions.

NB this differs in format from the previous quarterly report and the version in the IMTP. We aim to bring through a more visually accessible version in reporting for 2025/26.

The 2025/26 IMTP includes updated 'what good looks like' statements and associated metrics.

Commitments to our people

It has been a commitment within our IMTP to address three key issues based on feedback we have received through engagement with staff and volunteers, surveys and TU relationships. By year end we had made the following progress:

- **Shift overruns:** a task and finish group has been set up collaboratively with trade union partners, with workshops in Q4 focussed on what further actions are within WAST's gift to address overruns. Two key initiatives were identified and are being further explored. Additionally, there is a list of other identified issues that need to be addressed, as this remains a commitment into 2025/26.
- **Digital Experience:** this year, we have laid key foundations to improve the digital experience for staff and align with our People & Culture and Digital Plans. Infrastructure work is underway with DHCW to enable Microsoft Hello and begin to deliver a simplified single sign-on experience. We have launched a 150-person pilot of Microsoft Copilot to explore the benefits of Artificial Intelligence (AI), and begun mapping opportunities to automate manual processes across the organisation. Early exploratory work on our Smart Station concept has progressed and will move to a business case stage. We have also completed the migration of our reporting into Power BI, in order to deliver more accessible and actionable insights. These efforts are supported by a growing Digital Skills plan to build confidence and capability across our workforce.
- **Flexible working:** following extensive work and the implementation of legislation, we see flexible working as a commitment we are now delivering on and will undertake a review of All Wales policy and its impact on WAST.

Given that we have delivered on flexible working, a commitment was added to the 2025-28 IMTP, **1:1 conversations.** Through Our WAST Way, regular 1:1 conversations will be embedded to address staff challenges, enhance motivation and wellbeing, and build a supportive work environment through open dialogue and joint problem-solving.

Forward assurance plan in 2025/26

Cycles of business for Strategic Transformation Board through CMT programme and ISPD have been developed for reporting into the FPC and Trust Board. Both CMT and ISPD are developing digitised mechanisms to support programme and directorate-led IMTP delivery using Microsoft suite of applications available to the Trust. This may result in a change in format of reporting. However, the general approach will remain as in 2024/25 with updates against the CMT programme, directorate-led updates and against ministerial templates. This year we will be reporting against new ministerial priorities:

- Prevention
- Timely access to care – this incorporates urgent & emergency as well as planned care
- Mental health access
- Community capacity
- Women's health

At the recommendation of Finance & Performance Committee, these updates on priorities will be RAG rated.

Strategy Planning & Performance directorate is continuing to develop outcomes monitoring of the 'what good looks like' statements and working with directorate leads to ensure data is available against each statement to demonstrate progress in terms of the outcomes set out in the plan.

REPORT APPROVAL ROUTE
Strategic Transformation Board (STB) 24 February 2025

REPORT APPENDICES
Appendix 1 – IMTP Delivery Assurance Report **Appendix 2 - Assurance against the Cabinet Secretary's priorities 2024/25**

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

Appendix 1 - IMTP Delivery Assurance Report

SITUATION

1. The purpose of this paper is to provide the Board with an end of year position for IMTP delivery and assurance for 2024/25 (year 1 of the 2024-27 IMTP).

2. This paper provides a position for the Clinical Model Transformation (CMT) programme Directorate-led IMTP portfolio, and Ministerial (now Cabinet Secretary) Priorities set by Welsh Government.

3. It also provides an assessment against the 'what good looks like' outcomes statements set out in the 2024-27 IMTP.

BACKGROUND

Clinical Model Transformation (CMT) Programme Management Progress Update and Next Steps

4. The programme continues to mature in its approach, with further progress made in digitising our programme management approach. All core programme controls – including risks, issues, and decisions – have been migrated to a centralised MS365 solution. An interactive Programme Portal has been launched, with workstream-specific gateways currently in development. FY25/26 workstream plans are also being built in MS Project, aligned to IMTP deliverables, providing a digitised and transparent foundation for delivery. Work is ongoing to test and refine this solution, including the development of standard operating procedures for project managers. The team is also exploring the use of Power BI to automate elements of programme reporting, beginning with risk and issue management as the first use case.

5. Key deliverables such as the Clinical Services Model Information Pack and an updated Service Model Blueprint are nearing completion, with final revisions underway ahead of wider circulation. The development of patient personas is also progressing well, with final edits being agreed with SROs before submission to the CMT Board for approval.

6. Significant progress has been made in the area of benefits realisation. Logic-benefits mapping for each workstream has been completed, providing a technical foundation to define meaningful, measurable benefits at the workstream level. Version one of the scorecards has been developed and is on the agenda for endorsement by the CMT Board. Subject to approval, a consultation period will commence to refine the scorecards further with input from workstream SROs and key stakeholders, prior to final approval and development by the Insights & Data Services (IDS) team.

7. Quality and equality impact assessments remain integral to programme assurance. QIAs for the Digital Front-End and Urgent Community Response workstreams have been approved, while assessments for Remote Integrated Care and revisions to Emergency Response (v9) are progressing through governance. The programme-level EQIA is also ready and scheduled for CMT Board approval. The Health Transport QIA is the final assessment under development, following the recent April workshop.

8. In support of audit readiness, a programme health check has been initiated. The findings, including any gaps in documentation or areas for improvement, will be addressed through updates to the programme management plan to ensure robust governance and oversight are maintained.

9. From a management perspective, the overall status of the programme remains **YELLOW** (cautionary) due to ongoing challenges related to documentation and workload pressures arising from the pace of change.

ASSESSMENT

Clinical Model Transformation (CMT) Workstream and Enabling Working Group Updates

CORE CLINICAL MODEL TRANFORMATION (CMT) WORKSTREAMS	
DIGITAL FRONT-END	**↔ Green**
On Track: The implementation of a Virtual Assistant for the NHS 111 Wales website is progressing well, with preparations underway to ensure readiness for live deployment. Security Assessment and Data Protection Impact Assessment (DPIA) approvals are scheduled for the upcoming Project Group Meeting in May. Following strong staff engagement during the CEO Roadshow, over sixty name suggestions were received for the Virtual Assistant. A shortlist will be published on Siren, allowing staff to vote for their preferred options before a final decision is made by the Project Group. The Capital Funding Group is set to review funding for the Online Symptom Checker on 14th May 2025, with expectations of approval. Funding pathways continue to be explored within the Project Group to ensure alignment and readiness. Pending funding approval, the proposal will move to the Trust Board on 29th May 2025 for authorisation to procure a web-based Call Prioritisation Streaming Service (CPSS). This will mark a significant progress point in the transformation of our digital front-end, enabling us to better integrate the 111.Wales website through alignment with our 111-telephony service. In early April, a meeting between WAST and Welsh Government explored Digital Front-End opportunities. A phased approach was proposed with Phase 1 focusing on foundational infrastructure, followed by Phase 2 unlocking new capabilities to support the six goals strategy and collaborate on urgent and emergency care policy developments. Project documentation continues to evolve, with digitalisation of the Digital Front-End Workstream SharePoint Site complete and recent approval of the Quality Impact Assessment (QIA) by the Clinical Quality Governance Group (CQGG) on 14th April 2025.	

EMERGENCY RESPONSE	↔ Green

On Track: As we continue advancing the Rapid Clinical Screening and Call Flow Prioritisation programme, key milestones are being achieved to enhance emergency response accuracy, data transparency, and operational efficiency.

The integration of Telephony Power BI reporting is now fully embedded as business as usual, supporting improved oversight and decision-making. Alongside this, AQM Reporting is progressing in collaboration with the Insights & Data Team and will further our ability to evaluate the impact of Rapid Clinical Screening.

Currently, the team is focused on the forthcoming implementation of newly defined call categories, including Purple (Arrest), Red (Emergency), and Maroon (RCS0), and we are pleased to confirm that we are on track to meet Welsh Government expectations of the 1st July 2025 for official implementation.

The project group has done considerable work to define quality and performance measures aligned to the newly defined categories and the formal Data Definition documents are undergoing final governance review before being submitted to the CMT Board in May for formal endorsement. Project governance continues to strengthen with updates to the Quality Impact Assessment (QIA) progressing, and ongoing development of the overall project plan to ensure alignment with safety and quality standards.

URGENT COMMUNITY RESPONSE	↔ Green

On Track: Considerable progress has been made across the Urgent Community Response (UCR) workstream, with a focus on enhancing operational efficiency and strengthening service delivery. The UCR Service Specification is now complete and has been formally approved, marking a key milestone in defining the framework for future service advancements.

The Mental Health Response Vehicle (MHRV) remains operational, with an evaluation now underway to assess its impact using available data. ITV Wales recently featured the service on the 6 o'clock news (22nd April 2025), providing the public with an insightful look at how WAST develops personalised services to meet population needs. An SBAR will be considered by the CMT Board in May to request a recruitment of a third Mental Health Practitioner to resolve some staffing challenges related to the MHRV.

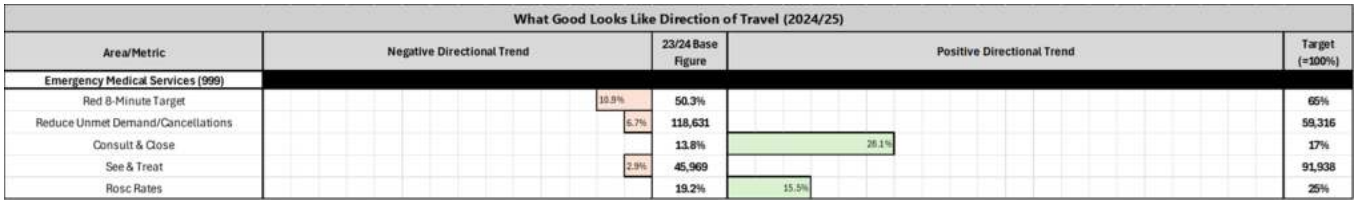
In Cardiff and Vale, the APPNAV service is now operating extended hours, providing coverage until 02:30. Meanwhile, the APPNAV for Aneurin Bevan is set to go live in early May, marking a significant milestone—with all seven Health Board areas soon having an operational APPNAV resource.

APP recruitment remains a priority, with an active advert for Advanced Paramedic Practitioners (APPs) within Palliative Care in Cardiff and Vale, supporting continued expansion. However, the Advanced Clinical Practice Delivery Group has reported its status as **'Yellow' (cautionary)** as a decision is required on the proposed increase in APP FTE for FY26/27. This is currently being considered, but is impacting recruitment timelines, placements, and location planning.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for 999 callers over the next 3 years. These workstreams within the Clinical Model Transformation more or less cover what is currently the traditional 999 response, and the IMTP set out that the following metrics would determine the positive impacts of our plan:

- 65% red target
- Reducing unmet demand by half
- Doubling the number of patients safely managed at home or in the community
- An increase in ROSC rates



What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
Emergency Medical Services (999)				
Red 8-Minute Target	10.8%	50.3%		65%
Reduce Unmet Demand/Cancellations	6.7%	118,631		59,316
Consult & Close		13.8%	28.1%	17%
See & Treat	2.9%	45,969		91,938
Rosc Rates		19.2%	15.5%	25%

The Board is able to scrutinise this data in more depth in the MIQPR.

REMOTE INTEGRATED CARE — ↑ Green

On Track: Building on the positive evaluation of the Winter Desk Initiative, a proposal is now in development to outline next steps. The initiative, presented at various CMT Project Groups, Clinical and Quality Governance Group, and Operational Forum, demonstrated the successful application of the Call Prioritisation Streaming System (CPSS) for 999-originating calls and strengthening these findings, and building on this success, remains a key priority.

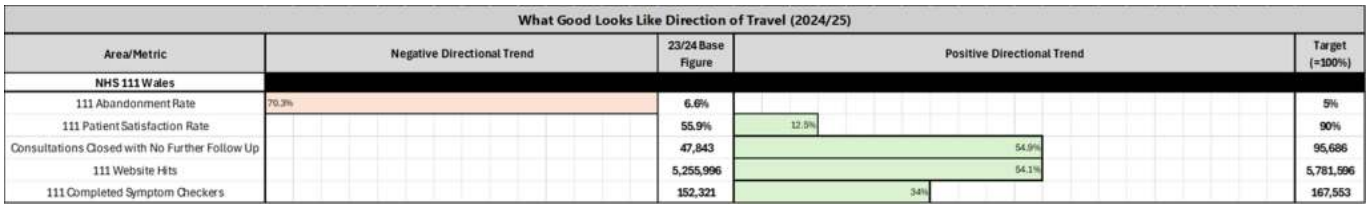
Following the well-received evaluation of Remote Monitoring Solutions within the community, work is progressing to establish clear metrics for measuring the operationalisation of the new Care Planning function. A series of workshops are planned to evaluate the full impact of remote care planners, ensuring informed decision-making and service optimisation.

Additionally, Remote Integrated Care Plans have now been developed and approved, backed by a structured delivery framework and a robust reporting system. These enhancements will drive continuous improvement and oversight, reinforcing the commitment to responsive, data-driven care solutions.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for 111 callers over the next 3 years. The RICS workstream within the Clinical Model Transformation more or less cover what is currently the 111 response (noting that the CSD element of Integrated Care is covered above), and the IMTP set out that the following metrics would determine the positive impacts of our plan:

- 111 Call Abandonment Rate
- Improved patient satisfaction
- Increase in calls closed with no follow up required
- Increased proportion of next steps booked for the patient



What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
NHS 111 Wales				
111 Abandonment Rate	70.3%	6.6%		5%
111 Patient Satisfaction Rate		55.9%	12.5%	90%
Consultations Closed with No Further Follow Up		47,843	54.9%	95,686
111 Website Hits		5,255,996	54.1%	5,781,596
111 Completed Symptom Checkers		152,321	34%	167,553

The Board is able to scrutinise this data in more depth in the MIQPR.

HEALTH TRANSPORT — ↑ Green

On Track: Following the agreement of the Health Transport definition, a workshop was held on 11th April to determine patient criteria and journey processes, ensuring clarity on planned journey outcomes based on a Remote Integrated Care (RICS) assessment.

The patient suitability criteria and process flows have now been established, shaping the following key initiatives:

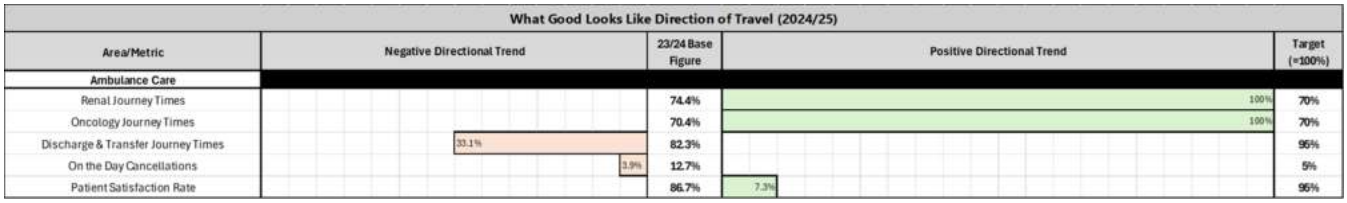
- A proof of concept will explore transport options for patients who meet Clinical Support Desk (CSD) Taxi Standard Operating Procedure (SOP) criteria but are currently unsuitable due to mobility concerns. The scope may be expanded to include all taxi-suitable patients, subject to data review.
- The development of transport pathways across health boards, ensuring alignment with RICS assessment outcomes.
- An assessment of the feasibility of patient transport to planned care following a face-to-face assessment, mirroring GP referral processes.

These initiatives, alongside the Transfer & Discharge Project, will be taken forward under the leadership of the Health Transport Workstream Board. Next steps will include establishment of relevant Task & Finish groups to begin data analysis and inform future developments.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for users of Ambulance Care services. Whilst the programme for Health Transport continues to develop and whilst commissioners and WAST work to develop a new vision for non-emergency transport and Ambulance Care services, operational improvements and some of the IMTP delivery actions have contirbuted to the following metrics:

- Timeliness
- Fewer on the day cancellations
- Inter-site transfers provided within the time required
- Increased patient satisfaction



What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
Ambulance Care				
Renal Journey Times		74.4%	100%	70%
Oncology Journey Times		70.4%	100%	70%
Discharge & Transfer Journey Times	33.1%	82.3%		95%
On the Day Cancellations	3.9%	12.7%		5%
Patient Satisfaction Rate		86.7%	7.3%	95%

The Board is able to scrutinise this data in more depth in the MIQPR.

CHANGE ENABLING WORKING GROUPS	
QUALITY & PERFORMANCE METRICS	**↓ Yellow**

Yellow (cautionary status) overall: The CMT Metrics Workstream has made significant progress in several key areas while also identifying and addressing various challenges. The definitions for Purple (Arrest), Red (Emergency), and Maroon (RCS0) have been approved with minor clarifications, and further work on monitoring and assurance metrics is underway, with expectations for approval by CQGG on 12th May.

Draft workstream scorecards have also been developed and are central to our approach to benefits management across the programme. The scorecards have been informed by the development of technical 'Logic Benefits Maps' and will be shared with the CMT Board in May for consideration. Following CMT Board endorsement we will commence more detailed work with workstream SROs to finalise benefit measures and will commence dashboard development.

To manage capacity challenges, the workstream continues to collaboratively prioritise incoming IDS requests, with several meetings during April to review and agree priorities with Executive Leadership. However, the ability to manage competing and changing priorities and the capacity to deliver these continues to present the greatest risk. It is expected that this will be addressed through the additional IDS investment agreed via the IMTP 25/28, however continued collaborative prioritisation of the IDS workplan will provide some mitigation whilst additional resource is recruited.

The CMT independent evaluation procurement was out to tender during April, with shortlisting taking place in early May.

CHANGE MANAGEMENT	**↔ Yellow**

Yellow (cautionary status) overall: The Board was alerted to ongoing challenges regarding the availability of Senior Responsible Officers (SROs) to attend workstream meetings. Alternative approaches are being explored to identify barriers and improve engagement. A proposal to repurpose the Transformation Delivery Network (TDN) has been shared, aiming to broaden participation to include all those with an interest in the transformation agenda. This revised model would be chaired by Strategy, Planning and Performance (SP&P), with updates provided by SROs. Feedback from workstream members is currently being gathered.

The development of the next internal communications output is underway, featuring talking head videos with workstream SROs. In addition, the CMT prioritised Change Management on the agenda for May.

PARTNERSHIPS & ENGAGEMENT	**↔ Green**

On Track: Engagement with priority clinical stakeholders has continued throughout Q4, including targeted sessions with All Wales Medical Directors, Associate Medical Directors, and National Clinical Leads for Urgent Care. Preparations are underway to engage with National Clinical Directors and Directors of Primary Care, while thematic analysis of stakeholder feedback has

commenced, with outputs to be shared in due course. Planning has also begun for the next phase of broader system stakeholder engagement, as outlined in the Programme Engagement Plan.

The Board was assured that regular contact is being maintained with key leaders at Llais. The Chief Operating Officer of Llais continues to attend Trust Board meetings, and feedback to date remains positive. While no concerns have been raised, active dialogue is ongoing to ensure continued confidence in the Trust's engagement approach.

Directorate-led IMTP Delivery & Assurance Approach

10. IMTP deliverables outside the scope of the Clinical Model Transformation programme are managed through Directorate Plans or bespoke programmes noting that some actions may still require cross-directorate working.

11. Existing Directorate Business Meetings are utilised, and assurance provided to the STB and onward to FPC and Board.

12. This process is facilitated by the Integrated Strategic Planning & Development Group (ISPD), with summary updates from Directorates to the group. This will also support with the cycle of strategic planning. Updates by exception will subsequently be incorporated into quarterly reports to STB, providing status updates on the IMTP deliverables and escalating any key risks/issues or achievements.

13. The current update in this paper is the end of quarter 4, year end position.

14. Directorate led IMTP deliverables below are set out against each of our strategic objectives.

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

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
High quality, immediate or timely on scene assessment, care and conveyance where needed	Fully roll out CHARU	**Complete**	**Transition to core business**	• UHP at 94% nationally, 1% off 95% target • External recruitment completed; secondment opportunities being considered for remaining gaps
Excellent clinical leadership	New remote clinical assessment service clinical leadership team	**Yellow**	**Will roll over to 25/26**	• In process of recruiting clinical navigators and locality manager
Rapid call answering, initial triage and onward referral	Demand & capacity review for activity originating in 111	**Green**	**Review to be completed**	• Demand and capacity review, tender process completed, contract award being made • Further re-roster deliverables in 25/26 IMTP following completion of the review
A flexible, user centred Non Emergency Patient Transport Service with the right capacity in place to meet demand	Complete NEPTS roster review and commence benefits realisation	**Yellow**	**Will roll over into 25/26**	• Significant progress but longer timescale to implement, project established, engagement underway • To be delivered by end of Q2 25/26
	Develop and implement an enhanced oncology joint plan with partners	**Green**	**Will roll over into Q1 25/26**	• Will roll over into Q1 25/26 • Significant work with cancer centre liaison to develop national checklist to maximise service delivery
	Reduce cancellations through system redesign with health boards	**Green**	**Further phases in 25/26**	• Text messaging options developed, two-way messaging gone live Mid Feb. • Further phases to SMS messaging in 25/26 which will contribute to reduction in cancellations
	Implement a revised Liaison Service Model	**Green**	**Completed**	• Engagement sessions in February/March

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	Plan for 24/7 major trauma desk & transfer clinical hub (subject to funding)	**Yellow**	**Will roll over to 25/26**	• Business case being developed • Consideration as part of future model development
A high quality, safe service with improved patient experience	Quality assurance mechanism for external providers further enhanced	**Complete**	**Transition to core business**	• Annual inspections now programmed in with quarterly reporting in place.

SO2 Enabling our people to be the best they can be

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Capability	Ongoing work; People Development Plan, People Management Essentials and PADR check ins	**Green**	**Continual development and implementation**	• Further focus on PADRs in 25/26 plan. • Continual development and implementation of people development plan, embedding into organisation
Capacity	Delivery of Strategic Workforce Plan	**Complete**	**Action plan will roll over into 25/26**	• Plan was presented at People and Culture Committee where it was endorsed • Action plan for implementing is included within 25/26 IMTP
	Ongoing work; Health & Wellbeing Plan, Retention Work Plan, e Timesheets	**Green**	**Delivery in 25/26**	• Ongoing work progressing towards Q4 deadlines, albeit there may be some delay on e timesheets due to sickness of key staff working on delivery

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Culture	Expand Culture Champions and Change Network	**Green**	**Ongoing into 25/26**	• Ongoing work continuous into IMTP for 25/25 • Development of a culture toolkit currently on hold whilst developing Our WAST Way
	Ongoing work; Allyship & Bystander training, Employee offer, Culture Champions & Change Network, impact of culture toolkit	**Complete**	**Transition to core business**	

In the IMTP we set out what good would look like for Our People, by monitoring the following metrics:

- Sickness absence below 6%
- Turnover rates falling
- Engagement rates (measured for example by NHS Staff Survey completion)

What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
Our People				
Sickness Absence		8.54%	28.4%	6%
Staff Turnover Rate		8.73%	17.9%	7%
Staff Engagement Scores		65.8%	13.1%	75%

The Board is able to scrutinise this data in more depth in the MIQPR.

SO3 Being at the forefront of innovation & technology - Digital

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Patient access	Video triage calls, deployment and adoption of video triage technology for our CSD & 111 services	**Green**	**Will roll over to 25/26**	• Trialling in Swansea Bay and Hywel Dda, plan for Wrexham • Roll out in plan for 25/26
Rapid progress of technology	Telephony upgrade for 999	**Complete**		• Successfully delivered November 24
	MDVS project conclusion EMS & NEPTS replacement of mobile data terminals & associated hardware/software	**Complete**	**Phase 2 in 25/26**	• Completed Phase 1, closure report completed. • Plan for MDVS Phase 2 Outline Business Case 25/26
Developing & implementing our plans for Environmental Sustainability and Adaption	Delivery of EFAB funded schemes throughout the year	**Green**		• Newtown due for completion mid-March • Tredegar complete • HART premises complete • Pontardawe complete • Fire alams & medical gas storage work complete

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Right buildings in the right place, enabling our staff to provide the best and safest care across Wales	Prioritised estates capital schemes delivered through year and across IMTP years	**Green**	**Schemes across IMTP years**	• Further consideration required on planning for Swansea, Llanelli, Newport and Llandrindod Wells in 2024/25 due to AWC funding • Bangor Fleet Workshop – delivery included in 2025-28 IMTP • Llangunnor due for completion by end of March 2025 • Ruthin remains 'urgent attention required' as alternative solutions required • Dolgellau - delivery expected in 2025/26 • Monmouth delivery included 2025-28 IMTP • North Wales CCC relocation works are on track to be completed by end of March 2025 • Thanet House on hold and included in 2025/26 prioritisation
The right fleet in the right place, enabling our staff to provide the best & safest care across Wales	Prioritised fleet capital schemes delivered through year and across IMTP years	**Green**	**Schemes across IMTP years**	• 35x EA vehicles due for conversion and completion in year • 5x HART responder vehicles due for delivery in February 2025 with completion slipping into 2025/26 • 30 x SRVs on track for commissioning into April

The digital plan is key to turning the dial on the following metrics:

- No successful cyber breaches
- Reduced numbers of helpdesk calls and better rate of first call resolution
- Increase in the number of scaled up technology projects
- Increased confidence in using data
- Increased levels of patient and staff satisfaction with digital solutions

Whilst some of this data is available there is further work to update metrics for the 2025/26 IMTP delivery. Some indicators above will be available through committee/Board reports and/or the MIQPR.

SO4 Developing our services in collaboration - Partnerships & Engagement

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Meet the requirements of the Wellbeing of Future Generations Act	Delivery of wellbeing objectives published by end of Q4	**Complete**	**Deliverables in 25/26**	• Wellbeing objectives approved and work commenced to identify initiatives supporting delivery.
University Trust Status in collaboration with WG, embracing democratised culture of learning, research and innovation	Academic Partnership priorities updated and published	**Complete**		• Priorities agreed and included in 25 – 28 IMTP
Well place to influence system thinking/ strategy development	Structured engagement commenced with stakeholders & public	**Green**	**Will continue into 25/26**	• Continued ongoing work being worked up alongside CMT development - working in collaboration with strategy and transformation teams

The Engagement Framework and CMT Engagement plan are key to turning the dial on the following metrics:

- Improved reputation scores
- Stakeholder support for our strategic plans
- Increasing number of research projects
- Increased levels of alternative (to core commissioning) funding streams

Whilst some of this data is available there is further work to update metrics for the 2025/26 IMTP delivery.

SO5 Being quality driven and clinically led

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Systems that meet the requirements of the Duty of Quality and Duty of Candour	Establish a Quality Improvement Hub	**Amber**	**Will be completed early 25/26**	• Life QI purchased and implemented • Meetings held with Transformation Team to identify opportunities to utilise software for transformation tracking of PDSA test of change data
A culture of quality improvement with robust quality management systems	WAST Quality Plan	**Green**	**Will roll over into early 25/26**	• Quality T&F Group established to support draft content • Governance approval routes identified • Implementation plan in draft
Meaningful engagement and co-production with communities	CIVICA enhancement	**Amber**	**Will roll over into 25/26**	• Report completed • Launched SMS text service • Continue to expand the wider patient experience capture, DPIA being progressed for Information Commissioner approval

We are currently refreshing both the Clinical Plan and the Quality Plan for the Trust. We will seek to turn the dial on the following metrics:

- Duty of Candour compliance
- Increased number of patient outcomes reported
- Increased evidence of meaningful public and patient engagement
- Increased opportunities for out people to progress their clinical practice and career

Whilst some of this data is available there is further work to update metrics for the 2025/26 IMTP delivery. Some indicators above will be available through committee/Board reports and/or the MIQPR.

SO6 Delivering exceptional value

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Rapid call answering, initial triage and onward referral	Undertake demand & capacity review	**Green**	**Re-roster in 25/26**	• Been brought back on track to enable re-roster in 25/26
Sustainable savings & efficiencies	Service Review across the Trust completed with recommendations	**Amber**	**Will roll over into 25/26**	• Final report agreed • ELT session in Feb 25 with key areas of work to be delivered in 3 phases in next IMTP 25 -28
Generate income alongside our core commissioned functions	Develop commercial strategy based on outcome of market analysis exercise	**Amber**	**Will roll over into 25/26**	• Recruitment of Head of Commercial unsuccessful, JD being reviewed to re-advertise with commitments to continue to focus on commercial opportunities in 25/26

Well governed

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
A risk management framework as a key enabler of our long-term strategy & decision making	Implementation of strategic BAF by end of Q3	**Complete**	**Transition to core business**	• Finalised for roll out in 25/26 for transition to core business
	Suite of risk appetite statements implemented and issued	**Complete**	**Transition to core business**	• Sessions in Board Development delivered; transition to core business

	Risk training rolled out & Level 1 training package on ESR	**Complete**	**Transition to core business**	• Design ready to be published on LM365
Strengthen Welsh Language compliance	Toolkit for senior leaders & board developed	**Complete**	**Complete**	• Toolkit included into Welsh Language Policy • Suite of documents included in Board Development Days

RECOMMENDATION

15. That the Board:

- **Notes** the progress in identifying 'what good looks like' through the continuing development of high-level outcomes measures;
- **Notes** the CMT programme end of year position;
- **Notes** the Directorate-led IMTP end of year position;

Appendix 2

Assurance against the Cabinet Secretary's priorities 2024/25

BACKGROUND

WAST submitted eight templates covering plans against four of the Cabinet Secretary's priorities for NHS Wales. These covered how we engage across community services, provide support to planned care and cancer, but also how we aligned to the Six Goals programme for Urgent and Emergency Care and how we approached our response to patients with mental health needs. In 2024/25 we were to develop a 'Six Goals' delivery plan. Whilst we set out in the templates submitted to WG many areas across the six goals where we can implement change, these are already factored into the scope of the work to develop a future clinical services model, therefore we have tried not to duplicate reporting in the table below.

ASSESSMENT

The following table sets out the key areas for WAST against the priorities, and the milestones to be achieved by the end of Q4. Bold font indicates new progress update. The end of year position does not differ from the interim position reported at the last Board meeting. Future reports will include a RAG rating (noting that there are new priorities set by the Cabinet Secretary through both the NHS Wales Planning Framework and in response to the Ministerial Advisory Group recommendations for NHS Performance and Productivity).

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
Primary and Community Care, with a focus on improving access and shifting resources into primary	111 Skill Mix	• Group established to consider and develop scope for 111 MDT skill mix	• Scoping paper to commissioners	• (Subject to commissioner support) Project initiation & Business Case Developed	• Business case submitted for introducing new roles	• Off track. The paper has not yet been presented to commissioners. • Multi professional skill mix features within 2025-28 IMTP
	111 Pathways	• Dental access improved in 4x health boards by end of Q4 • Strengthened links into primary care / Out of Hours in. Urgent Primary Care Centre access by end of Q4 • Medicines management pathways in place by end of Q4				• Modelling being undertaken for 3 remaining Health Boards to take on dental access pathways

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
and community care						• Currently piloting in BCU and C&V direct booking into Urgent Primary Care Centres
	999 Pathways: Falls & Frailty	• Level 1 falls - Assessment of the demand & capacity modelling undertaken • Level 2 falls - Undertake evaluation of our existing services	• Presentation of L1 options and benefits • Present evaluation and options for sustainability of L2 services going forward	• Implement new L1 model • Develop and Implement L2 Plan	• Monitor & evaluate impact on delivery • Y2/3 Milestones for expansion of services across Wales	• **Deliverables for falls have been included in 2025-28 IMTP aligned to the National Community Falls framework** • WAST engaged closely with NHS Executive on the National Community Falls Framework, and is attending a National Task Force group of falls leads across NHS Wales. • Health boards are completing baseline assessments and gap analysis; mapping what current community falls response services exist and how these can be accessed. • We have undertaken 24hr level 1 response modelling nationally (on the basis that all falls can be supported at level 1 where clinically appropriate) and we are supporting health boards on understanding demand and where scaling up is required to provide a response across all geographical areas 7/7.
	999 Pathways: Digitised pathways	• Evaluate the effectiveness of the new digital solutions to make referrals to existing pathways and usage	• Develop further opportunity for digital notifications with Welsh portal	• Implementation and roll out	• No milestone for Q4	• A new digital transformation and innovation programme has been set up to manage and prioritise digital workstreams that fall outside the clinical transformation programme – this is progressing
	999 Pathways: Connected Support Cymru (CSC)	• Recruitment of key roles to support CSC delivery (dependent on	• Engaging with key stakeholders and evaluating overall project	• Development of secondary business case to support sustainable	• Submission of business case • Y2/3 Milestones for	• **CSC is now part of the work to develop remote integrated care in the 2025-28 IMTP**

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
		outcome of business case) • Commenced recruitment of internal volunteers • Testing 'ambulance in a box' in Care Homes in AB & BCU, evaluate and conclude forward plan	data to determine resource requirements moving forward • Commencement of recruitment and on-boarding on external partner organisations and ongoing recruitment and onboarding of internal volunteers • Developing technology enabled care community pathways up until end of Nov; testing in Care Homes in AB & BCU and in patients homes • Evaluate and conclude forward plan	implementation • Develop business case for procurement of technology (subject to funding)	expansion of services across Wales	• No further progress on funding requirement to support ongoing CSC development. • Project continues in BCU and remains part of the WAST IMTP and Clinical model transformation programme as part of the wider remote clinical service development.
Urgent and Emergency Care, with	Goal 2: New 111 System	• Full implementation of new CAS	• Realise benefits in line with business case	• Formal benefits realisation report shared	• No milestone in Q4	• 111 metrics report being developed for JCC

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
a focus on delivery of the 6 goals programme		system 30th April • Decommission old system		with commissioners		
	Goal 2: 111 website & symptom checkers	• Scoping exercise to review requirements of a 111 website – and develop options appraisal accordingly	• Development of business case • Review and develop requirements to improve symptom checkers, with potential requirement for procurement.	• Finalise business case in readiness to Seek approval through organisational BC governance process • Identify approach to improvement of symptom checkers	• Secure funding and commence recruitment of website team as determined within business case process.	• **No additional funding for website team at this stage** • **The procurement process for RoboticsAI's Virtual Assistant is complete, with contracts signed and development in progress.** • A meeting with the current CPSS supplier in December where the high level Symptom Checker Specification was discusses. A high level specification was approved in the DFE Project. The current corporate risk regarding the symptom checkers has been reviewed by ADLT and will now be presented to ELT • The Business Case for the NHS 111 Wales website is at first draft which will be reviewed by the CMT Board. • To ensure clarity on technical requirements, a collaborative meeting between the Digital and Health Informatics teams facilitated the initial drafting of the technical specification for the Content Management System procurement. • Our WAST Network members (made up from the public) and Llais public contacts and members have been invited to take part in a review of the NHS 111 Wales website. This will provide vital feedback on the current website content and usability to inform planned improvements

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
	Goal 2: 111 re-roster	• No Q1 milestone	• Agreement with commissioners to proceed	• Complete procurement process to undertake Demand and capacity review	• Undertake demand and capacity review • Re-roster takes place in year 2	• **Contract live and work being undertaken with strong expectation that we will re-roster in 25/26** • Review of rostering practices. Agreement from commissioners to commence Review of rostering practices. Procurement process ongoing
	Goal 3: • Develop the remote clinical assessment speciality • Develop a fully remote working clinician offer (operations/training/digital) • Develop Pre-Dispatch Outcome Risk Stratification Tools linking CAD & ePCR data • Roll out of new integrated (111/clinical support desk) care model • Connected support Cymru • Extend use of video/ phone consultation • Urgent On-Scene Community Response	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• These are key deliverables in the Clinical Model Transformation Programme. See assurance report in appendix 1
	SDEC Pathways	• Re-establish ICAPs with Health Boards (subject to JCC commissioning arrangements) • Complete data quality assurance of end destination in CAD to	• Implementation of SDEC criteria across WAST	• Implementation of SDEC criteria across WAST	• Implementation of SDEC criteria across WAST	• This is now under goal 4. WAST is now part of the Goal 4 delivery group and will develop its own 6 goals delivery plan reflecting actions to improve referrals into SDEC from clinicians on scene. However, actions around SDEC activity currently sit with Health Boards within their 6 goals delivery. WAST will continue to engage and respond to requests to work collaboratively to improve uptake of direct referrals

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
		ensure SDEC direct referrals fully captured				
	Goal 4: CHARU	• Complete CHARU recruitment by end Q2 • Improve utilisation rate to modelled benchmark by end Q2 • (work ongoing during Q1)		• Improved staff in post to establishment		• **CHARU UHP in Q4 up to 94% (1% off target) nationally** • **123.7 FTE staff in post against target of 141.4 FTE (91% SIP to establishment)**
	Goal 4: Rural variation	• Complete CHARU recruitment by end Q2 • Continue process of targeted recruitment and process of smoothing i.e. aligning SIP to establishment by end Q2 • Build rurality results from 2023 EMS Demand & Capacity Review by end Q2 • Agree Implementation Plan with commissioners by end Q2		• Continued targeted recruitment in rural areas		• **SIP to establishment in Powys is 90.19% with only 0.8FTE vacancy and 80.37% in Hywel Dda equating to 8.3 FTE vacancies** • Recruitment in rural areas remains challenging, but is monitored regularly and is a focus within WAST. • The Clinical Model Transformation Programme constitutes WASTS's implementation plan for the D&C. The D&C will need to be formally reported to JCC at some point.
	Goal 4: Sickness reduction in EMS and EMSC	• Ongoing continuation of managing attendance and implementation of the health and wellbeing plan throughout year				• **(NB figures are organisation wide) There was a slight increase in overall sickness absence rates between November 2024 and December 2024, rising from 8.06% to 8.69%. Long term absence decreased from 5.95% in November 2024 to 5.56 % in December 2024, while short-term absence increased slightly to 3.14% in December from November 2024 (2.11%).** • Work on managing attendance continues and engagement is ongoing to develop the next iteration of the Trust's Health & Wellbeing Plan
	Goals 5 & 6: Transfer and Discharge model	• Engagement on modelled options for transfer	• Development of reporting against new protocols	• Develop implementation plans dependent on	• Integration of long term developmental plans into	• **Revised plan being developed for inclusion in 2025-28 IMTP, aligned to updated commissioning intentions for**

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
		services with health boards commenced • Implementation of new MTPS protocols within the Computer Aided Dispatch (CAD) system designed to allocate transfer resources more effectively	within the CAD post MTPS implementation • Agree outline service model for further engagement with Health Boards. • Develop business case/principles for All Wales service. • Develop business case for 24/7 Major Trauma Desk following outcome of Gateway 5 review.	outcome of commissioning discussions.	ambulance care service vision. • Develop implementation plans for major trauma desk.	**transfers in EMS and NEPTS commissioning intentions.** • **Project to be reframed in line with commissioning intentions in 2025-28 IMTP** • Final modelling shared with JCC colleagues shows high levels of staffing requirement for a ring fenced all Wales service. • Further options to improve timely access to transfer services and discharge capacity now being considered with JCC in line with its future vision for transport and through the Health Transport workstream of the Clinical Model Transformation Programme.
Planned Care and Cancer, with a focus on reducing the longest waits	Roster review of NEPTS Ambulance Care Assistants	• Continue with NEPTS Demand & Capacity work, in particular, undertake NEPTS transport roster review by end Q3		• Complete NEPTS roster review and start to review benefits.		• **Working parties for re-roster have commenced with full implementation expected Q3 2025/26** • Contract let with third party providers. • Project manager being appointed to lead the work internally, timescales slipped into Q4.
	Enhanced hub for oncology patients	• Establish expected outcomes & principles to develop enhanced oncology service	• Develop action plan to deliver the required change	• Action plan for oncology implemented	• Enhanced hub live	• Significant work with cancer centre liaison to develop national processes to maximise service delivery, continued joint working

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
	Quality assurance of external providers	• No specific milestone in Q1	• Welsh Ambulance Quality Standard award implemented	• No specific milestone in Q3	• Review award and update as required	• Ongoing
Mental Health, including CAMHS, with a focus on delivery of the national programme	Develop and implement a referral pathway for 111 Press 2 teams	• Completion of 111 CAS system implementation to aid improvement in 111 press 2	• New CAS system will provide resolution to Press 2 pathway	• No specific milestone in Q3	•	• CAS implementation complete • Review with health boards effectiveness of press two and where there is opportunity to improve
	Mental Health Response Vehicles	• Collating and presenting evidence from pilot within AB, discussing outcomes and options for further pilots	• Undertake further pilot (pending agreement) • Continuing to engage with national evidence across UK	• Prepare business case dependent on outcomes	•	• See assurance report in appendix 1 – this forms part of the Clinical Transformation Programme
	Right Care Right Person	• Engaging with Police Services in Wales, NHS partners, Local Authorities and third sector providers on changes affecting response to people in crisis	• Assess impact to WAST • Possible update to 2023 EMS Demand & Capacity Review results.	• Develop Business case	•	• Modelling can be undertaken, but requires further clarity on the likely level of activity • No progress on Business Case
	Mental Health Practitioners in CSD	• Assess demand and capacity plan outlining future needs for the team and training	• Share plan with commissioners for further discussion	• Training implemented (subject to cost and funding)	•	• See assurance report in appendix 1 – this forms part of the Clinical Transformation Programme

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
		requirements (as part of overall demand and capacity work for the future clinical service model)				

RECOMMENDATION

That the Board:

- **Notes** the end of year position for the Cabinet Secretary's priorities set out in the 2024-27 planning framework.

AGENDA ITEM No	**13**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

Financial Performance as at Month 1 – 2025/26

MEETING	Trust Board
DATE	29th May 2025
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Interim Assistant Director of Finance) Steph Taylor (Assistant Head of Capital Planning)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

This paper presents to the Board the first Financial Performance Report of the 2025/26 financial year, the reported position as at Month 1 (April 2025). A summarised presentation of the month 1 position was presented to Finance & Performance Committee on 20th May 2025.

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.

KEY ISSUES/IMPLICATIONS

Key highlights from the report for the Board to note are:

- The Trust is reporting a small revenue surplus (£4k) for month 1 2025/26;
- In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust is currently forecasting to breakeven for the 2025/26 financial year;
- Capital expenditure plans are being finalised with plans to fully achieve in year;
- In line with the financial plans that support the IMTP, gross savings of £0.718m have been achieved in month 1 against a target of £0.663m;
- Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.8% for the number, and 99.5% of the value of non NHS invoices paid within 30 days

REPORT APPROVAL ROUTE
• FP&C – 20th May 2025 – via presentation • Trust Board – 29th May 2025

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

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

TRUST BOARD

FINANCIAL PERFORMANCE AS AT MONTH 1 2025/26

INTRODUCTION

1. This report provides the Board with a summary of the revenue financial performance of the Trust as at 30th April 2025 (Month 1 2025/26), along with an update on the initial 2025/26 capital programme. A summarised presentation of the month 1 position was presented to Finance & Performance Committee on 20th May 2025.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2025/26** (1st April 2025 – 30th April 2025) are that:

   - The cumulative revenue financial position reported is a small **underspend against budget of £0.004m**, 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 **£0.718m** have been achieved against a target of **£0.663m**;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 98.8% for the number, and 99.5% of the value** of non-NHS invoices paid within 30 days.

3. Whilst continuing to be broadly balanced at the outset of the financial year, which is clearly encouraging, it is key to also note the following assumptions that have been made in reporting this current and forecast position:

   - The ability to deliver a minimum of c£8.500m in savings and efficiencies in year. This equates to c2.7% of the Trusts discretionary income;

   - No other developments, enhancements or cost increases not currently funded within budgets will be able to be progressed until a confirmed funding source for them is found, or an agreed equivalent value of cost is stopped or reduced elsewhere. These includes any costs, capital or revenue, emerging from the recommendations of the Manchester Arena Inquiry.

- Despite an element of additional funding provided, some cost elements are still hard to predict through the 2025/26 financial year (and beyond) and may remain volatile;

- The ability to manage in year cost pressures as they arrive, within the small contingency the Trust continues to hold, as per the IMTP / 2025/26 financial plan.

- Income assumptions in opening financial plan are fully funded via commissioners and Welsh Government (i.e pay awards / Employers National Insurance increases)

4. 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 1 are set in line with the submitted IMTP and summarised later in this report. Accepting that it is early in the new financial year, as we go through the next few months these will continue to be scrutinised and amended accordingly, with mitigations and management plans in place.

REVENUE FINANCIAL PERFORMANCE – MONTH 1 2025/26

5. The table below presents an overview of the financial position for the period 1st April 2025 to 30th April 2025.

Revenue Financial Position for the period 1st April - 30th April				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-312,370	-25,482	-25,527	-45
Expenditure				
Pay	234,033	19,388	19,195	-193
Non-pay	62,835	4,803	5,048	245
Total pay & non-pay expenditure	296,867	24,191	24,243	52
Depreciation & Impairments / interest payable & receivable	15,502	1,292	1,281	-11
Total	**-0**	**0**	**-4**	**-4**

Income

6. Reported Income against the initial budget set to Month 1 shows an overachievement of **£0.045m**.

Pay Costs

7. Overall, the total pay variance at Month 1 is an underspend of **£0.193m**.

Non-pay Costs

8. The overall non-pay position at Month 1 is an overspend of **£0.245m**. In addition, for reporting purposes Depreciation, Impairment and interest is excluded from the above figure, underspend of **£0.011m,** hence the total underspend to budget of **£0.004m**.

Savings

9. 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.

10. Month 1 in month performance was, plan of £0.663m and £0.718m achieved, therefore an overachievement of £0.054m (recurrent overachievement of £0.012m and non recurrent overachievement of £0.042m), as per the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Themes	6,225	474	486	12	474	486	12	6,281	6,281	0
Non Recurrent Schemes / Themes	2,275	190	232	42	190	232	42	2,219	2,219	0
Overall Total	**8,500**	**663**	**718**	**54**	**663**	**718**	**54**	**8,500**	**8,500**	**0**

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

11. ***Appendix 3*** provides the overall detail for Month 1 by theme. This is now further split over recurring and non-recurring schemes.

Financial Performance by Directorate

12. Whilst there is a small surplus reported at Month 1, there are some small variances between Directorates, as shown in the table below, when compared to the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature, given we are so early in the financial year, but they will be continued to be closely monitored.

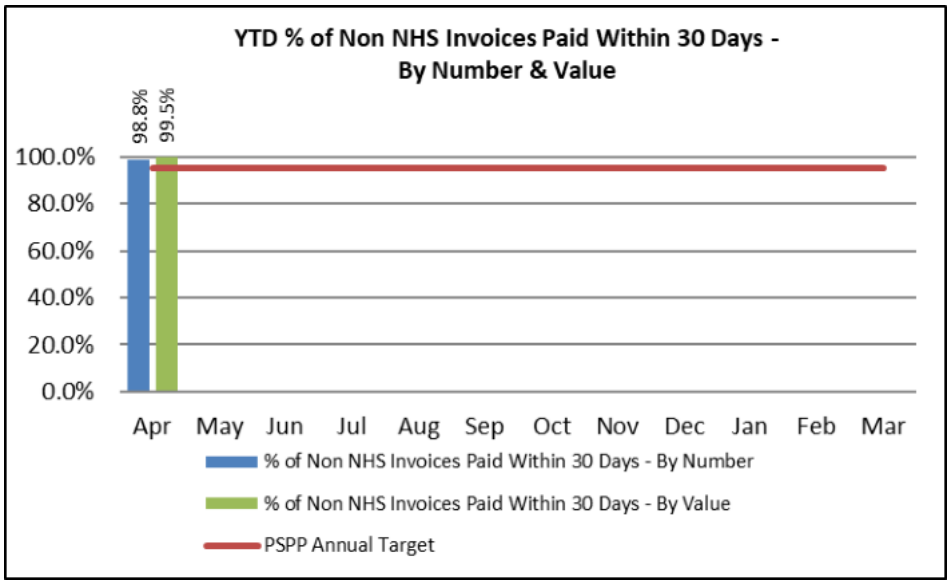
Financial position by Directorate @ 30th April	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	216,408	18,103	18,044	-59	-0.3%
Chief Executive Directorate	2,132	182	182	0	0.1%
Board Secretary	671	51	51	-0	-0.1%
Partnerships & Engagement Directorate	563	41	42	0	0.7%
Finance and Corporate Resources Directorate	36,432	3,086	3,108	22	0.7%
Planning and Performance Directorate	3,005	212	212	-1	-0.4%
Quality, Safety and Patient Experience Directorate	7,070	578	567	-11	-1.9%
Digital Directorate	16,542	1,098	1,070	-28	-2.5%
People and Culture	6,286	517	503	-14	-2.7%
Medical & Clinical Services Directorate	5,853	392	408	16	4.1%
Trust Reserves	1,217	35	106	71	203.7%
Trust Income (mainly JCC)	-296,178	-24,295	-24,295	-0	0.0%
Overall Trust Position	**0**	**0**	**-4**	**-4**	

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

- Most directorates broadly in line with budget plan for Month 1 with the exception of Trust reserves where this includes a carry-over of spend for Ambulance Care provision agreed with JCC.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

14. Public Sector Payment Policy (PSPP) compliance to Month 1 was **98.8%** against the **95%** WG target set for non-NHS invoices by number and **99.5%** by value.



2025-26 INITIAL CAPITAL PROGRAMME

15. As we are in the early stages of the financial year the discretionary capital programme and resulting budgets are only now being finalised.

16. At Month 1, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2025/26 is **£32.216m**. This includes **£26.268m** of All Wales Approved schemes and **£5.948m** for Discretionary schemes.

RISKS AND ASSUMPTIONS

17. Understandably this early in the financial year, the risks reported are still being fully assessed, however at present it is considered that there are no medium or high likelihood risks, but as we move through the next few months we will continue to review the risks to ensure that the level of likelihood is assessed along with the financial value. Alongside ensuring that Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.

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

19. A low risk has been included around the JCC additional saving request, whilst nothing further has been raised in relation to this risk, it remains but with a zero value.

20. Given the increased requirement again in our savings target that has been required this financial year, to cover increasing cost pressures the Trust has included a risk around the identified savings (**£3.000m** low risk) and as we move through the financial year the aim will be to reduce these risks down once savings are achieved.

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

22. A low-level risk is included re PIBS (Permanent Injury Benefit Scheme) of **£1.000m**. Matched funding for this highly volatile area is provided by WG on an annual basis.

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

24. As noted above, whilst there are therefore no current individually assessed high or medium financial risks as we enter the financial year, however when this is then considered alongside continuing significant service pressure and the likely balancing of this risk against patient safety, quality and experience, it is clear that, as expressed withing the IMTP, this will likely be another challenging financial year, despite the initially reported good financial performance in M01.

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.

RECOMMENDED that the Board:

a) **Notes** and gains **assurance** in relation to the Month 1 revenue financial position and performance of the Trust as at 30th April 2025;

b) **Notes** the delivery of the 2025/26 savings plan, and the context of this within the overall financial position of the Trust;

c) **Notes** the initial capital programme for 2025/26, and

d) **Notes** the Month 1 Welsh Government monitoring returns submission included within ***Appendices 1 – 2*** (as required by WG).

Appendix 1

This Item is I the Ibabs reading room

Appendix 2

This Item is in the Ibabs reading room

Appendix 3

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

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 25-26

Reporting Month 1

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprentice Income	50	4	4	0	4	4	0	50	50	0
Balance Sheet Flexibility	200	0	0	0	0	0	0	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	100	0
Disposals	250	0	0	0	0	0	0	250	250	0
End of Shift Overrun	100	9	8	-1	9	8	-1	99	99	0
Fuel	230	19	42	23	19	42	23	296	296	0
Interest Receivable	516	43	54	11	43	54	11	527	527	0
Non Pay Local Schemes - Corporate	914	64	47	-17	64	47	-17	898	898	0
Non Pay Local Schemes - Operations	650	50	46	-4	50	46	-4	646	646	0
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	284	284	0	284	284	0	3,140	3,140	0
Pay Vacancy Management - Corporate	2,275	190	232	42	190	232	42	2,219	2,219	0
Pay Vacancy Management - Corporate 25-26	75	0	0	0	0	0	0	75	75	0
Totals	**8,500**	**663**	**718**	**54**	**663**	**718**	**54**	**8,500**	**8,500**	**0**

Savings Performance by Theme 25-26 - Recurrent

Reporting Month 1

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprentice Income	50	4	4	0	4	4	0	50	50	0
Balance Sheet Flexibility	200	0	0	0	0	0	0	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	100	0
Disposals	250	0	0	0	0	0	0	250	250	0
End of Shift Overrun	100	9	8	-1	9	8	-1	99	99	0
Fuel	230	19	42	23	19	42	23	296	296	0
Interest Receivable	516	43	54	11	43	54	11	527	527	0
Non Pay Local Schemes - Corporate	914	64	47	-17	64	47	-17	898	898	0
Non Pay Local Schemes - Operations	650	50	46	-4	50	46	-4	646	646	0
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	284	284	0	284	284	0	3,140	3,140	0
Pay Vacancy Management - Corporate	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate 25-26	75	0	0	0	0	0	0	75	75	0
Totals	**6,225**	**474**	**486**	**12**	**474**	**486**	**12**	**6,281**	**6,281**	**0**

Savings Performance by Theme 25-26 - Non Recurrent

Reporting Month 1

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprentice Income	0	0	0	0	0	0	0	0	0	0
Balance Sheet Flexibility	0	0	0	0	0	0	0	0	0	0
Commercialisation Opportunities	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
End of Shift Overrun	0	0	0	0	0	0	0	0	0	0
Fuel	0	0	0	0	0	0	0	0	0	0
Interest Receivable	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Corporate	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Operations	0	0	0	0	0	0	0	0	0	0
Pay Cost Management (Variable / Net Vacancies) - Operations	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,275	190	232	42	190	232	42	2,219	2,219	0
Pay Vacancy Management - Corporate 25-26	0	0	0	0	0	0	0	0	0	0
Totals	**2,275**	**190**	**232**	**42**	**190**	**232**	**42**	**2,219**	**2,219**	**0**

Please note figures are rounded to the nearest whole number

AGENDA ITEM No	**13.1**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

Financial Performance as at Month 12 – 2024/25

MEETING	Trust Board
DATE	29th May 2025
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Interim Assistant Director of Finance) Steph Taylor (Assistant Head of Capital Planning)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

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

The Committee is asked to review, comment, note and receive assurance on the financial outturn position for 2024/25, ***subject to audit*** and ahead of the Trust Board presentation of the 2024/25 accounts in June 2025.

KEY ISSUES/IMPLICATIONS

Key highlights from the report for the Board to note are:

- The Trust is reporting a small revenue surplus (£70k) as at month 12, and which will be the basis for the draft accounts for the 2024/25 financial year (*subject to audit*);
- Capital expenditure is fully spent;
- In line with the financial plans that support the IMTP, gross savings of £6.838m have been achieved against a target of £6.421m;
- Public Sector Payment Policy is on track with performance, against a target of 95%, of 97.7% for the number, and 98.9% of the value of non-NHS invoices paid within 30 days.

REPORT APPROVAL ROUTE
• ELT – 16th April 2025 – verbal update on draft m12 / year end position • F&PC – 20th May 2025 – to note • Trust Board – 29th May 2025 – to note

REPORT APPENDICES
Appendices 1 – 2 *– Monitoring returns submitted to Welsh Government for month 12 – as required by WG* ***Appendix 3*** *– Savings performance*

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

TRUST BOARD

FINANCIAL PERFORMANCE AS AT MONTH 12 / YEAR END 2024/25

INTRODUCTION

1. This report provides the Board with a summary of the revenue financial performance of the Trust as at 31st March 2025 (Month 12 2024/25 and therefore the draft 2024/25 year end position), along with an update on the final 2024/25 capital programme spend, both of which are now part of the draft 2024/25 accounts and therefore ***subject to audit***.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2024/25** (1st April 2024 – 31st March 2025) are that:

   - The cumulative revenue financial position reported is a small **underspend against budget of £0.070m** (*subject to audit*);

   - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of **£6.838m** have been achieved against a target of **£6.421m**. Now included within this paper is a more detailed analysis of savings including the recurring / non-recurring nature of their delivery;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 97.7% for the number, and 98.9% of the value** of non-NHS invoices paid within 30 days.

3. Any risks previously reported were continued to be reviewed and fully assessed right up to the year end, however there are now no reported financial risks included in the draft year-end position, subject to audit.

4. As Committee members will be aware, the Trust did escalate one financial risk in its reporting to Welsh Government early in the financial year (in month 2) – that in relation to EMT / technician level posts re-banding. Following detailed work over the past few months and the net impact of the Trust previously holding circa 100 WTE positions and thus the reduction in potential backpay for these elements, along with mitigation associated with the roll out of the training wrap around, this risk had been reduced in stages through the financial year, including when it became clear from WG / commissioners that no additional in year funding would

be made available for these additional costs. Discussions continue with commissioners around this issue, along with the more significant impact of future year's cost increases and resulting funding pressure previously highlighted through the submitted business case. It is pleasing to report that we have been able to update the residual risk in relation to this issue, which has now been reduced to zero, this was done by managing other variable spends. As detailed in the 2025/26 financial plan, this is likely to continue to be a significant pressure for 2025/26 onwards though, not least because the costs significantly increase in future years.

REVENUE FINANCIAL PERFORMANCE – MONTH 12 2024/25

5. The table below presents an overview of the financial position for the period 1st April 2024 to 31st March 2025.

Revenue Financial Position for the period 1st April - 31st March				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-323,197	-323,197	-323,727	-529
Expenditure				
Pay	238,513	238,513	236,138	-2,375
Non-pay	64,126	64,126	67,629	3,503
Total pay & non-pay expenditure	302,638	302,639	303,767	1,128
Depreciation & Impairments / interest payable & receivable	20,559	20,559	19,890	-669
Total	**0**	**0**	**-70**	**-70**

Income

6. Reported Income against the initial budget set to Month 12 shows an overachievement of **£0.529m**.

Pay Costs

7. Overall, the total pay variance at Month 12 is an underspend of **£2.375m**.

Non-pay Costs

8. The overall non-pay position at Month 12 is an overspend of **£3.503m**. In addition, for reporting purposes Depreciation, Impairment and interest is excluded from the above figure, underspend of **£0.669m** hence the total underspend to budget of **£0.070m** *(subject to Audit)*

Savings

9. As above, the 2024/25 financial plan identifies that a minimum of **£6.421m** of planned savings (including Income generation) are required to achieve financial

balance in 2024/25, this equates to c2.2% of the Trusts discretionary income. Of this, **£3.646m** is recurrent and **£2.775m** is currently deemed non recurrent.

10. Month 12 in month performance was, plan of £0.446m and £0.521m achieved, therefore an overachievement of £0.075m (recurrent overachievement of £0.072m and non recurrent overachievement of £0.003m). Cumulative performance was plan of £6.421m and £6.838m achieved, therefore an over achievement of £0.417m* (£0.497m recurrent and -£0.079m non recurrent), as per the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Themes	3,646	238	310	72	3,646	4,143	497	3,646	4,143	497
Non Recurrent Schemes / Themes	2,775	208	211	3	2,775	2,696	-79	2,775	2,696	-79
Overall Total	**6,421**	**446**	**521**	**75**	**6,421**	**6,838**	**417**	**6,421**	**6,838**	**417**

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

11. ***Appendix 3*** provides the overall detail for Month 12 by theme. This is now further split over recurring and non-recurring schemes.

12. Main variances by scheme in Month 12 are as follows.

- Interest receivable overachieved in M12 by £0.020m, FYF is an over achievement of £0.471m.
- Over achievement on corporate vacancies in M12 was £0.013m, FYF is an overachievement of £0.157m.
- Fuel forecourt prices continue to be lower than budgeted and hence has overachieved target by £0.056m for M12, FYF is an overachievement of £0.445m.
- For the planned apprenticeship programmes, income in M12 equalled budget, FYF is an over achievement of £0.064m.
- Workforce efficiencies in M12 was an under recovery £0.010m, FYF is an underachievement of £0.091m.
- Non pay local schemes in Corporate and Operations overachieved in M12 by £0.013m, FYF is an underachievement of £0.276m.
- MS office VAT rebate is now not being achieved this financial year, so this is reporting a FYF underachievement of £0.300m.
- Fleet repair position continues to be challenging and hence has underachieved target by £0.007m for M12, FYF is an underachievement of £0.053m.

Financial Performance by Directorate

13. Whilst there is a small surplus reported at Month 12 there are some small variances between Directorates as shown in the table below, when compared to

the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature.

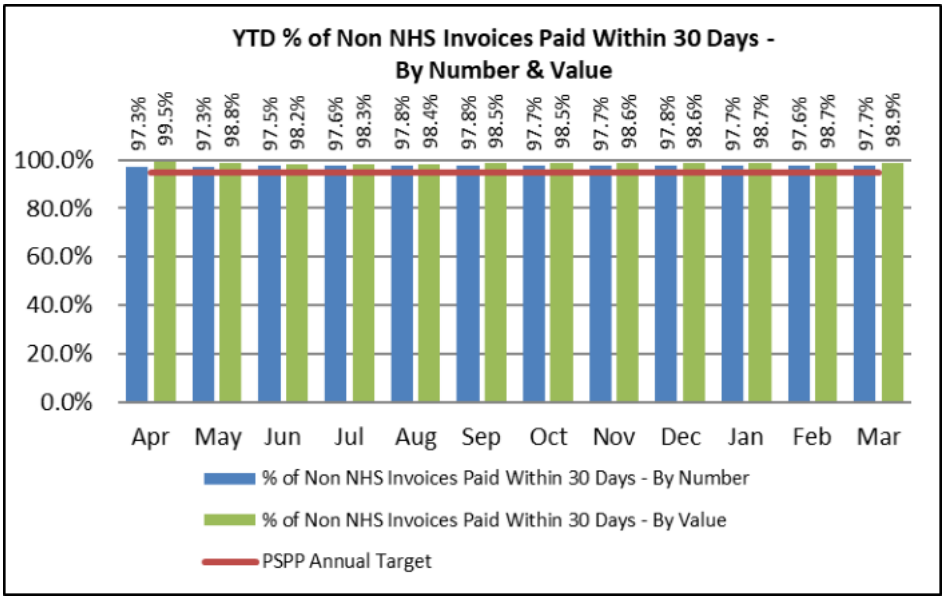
Financial position by Directorate @ 31st March	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	212,566	212,566	211,335	-1,231	-0.6%
Chief Executive Directorate	1,970	1,970	2,112	142	7.2%
Board Secretary	672	672	653	-19	-2.8%
Partnerships & Engagement Directorate	522	522	526	4	0.7%
Finance and Corporate Resources Directorate	35,691	35,691	36,732	1,041	2.9%
Planning and Performance Directorate	3,093	3,093	2,953	-140	-4.5%
Quality, Safety and Patient Experience Directorate	6,716	6,716	6,826	110	1.6%
Digital Directorate	15,101	15,101	15,127	26	0.2%
People and Culture	5,686	5,686	5,337	-349	-6.1%
Medical & Clinical Services Directorate	3,860	3,860	3,962	102	2.6%
Trust Reserves	922	922	1,258	336	36.5%
Trust Income (mainly JCC)	-286,799	-286,799	-286,892	-93	0.0%
Overall Trust Position	**0**	**0**	**-70**	**-70**	

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

- Most directorates broadly in line with budget plan for Month 12;
- Operations (EMS Response) - mainly due to pay savings across most ADO areas;
- Chief Executive – pay underachieved on savings delivery due to mainly full establishment (some NED vacancies) and non-pay due to increased membership / subscriptions;
- People & Culture – overachieved on apprenticeship income (large receipt in March 25), large vacancies on pay establishment;
- Finance & Corporate Resources - main areas of overspend were fleet maintenance, losses and savings under achievement on MS office rebate offset by interest receivable over recovery;
- Reserves – underachievement on savings target plus impact of some technical / balance sheet adjustments at year end (e.g. increase in TOIL / Annual leave).

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

15. Public Sector Payment Policy (PSPP) compliance to Month 12 was **97.7%** against the **95%** WG target set for non-NHS invoices by number and **98.9%** by value.



2024-25 CAPITAL PROGRAMME

16. At Month 12, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2024/25 is **£20.449m**. This includes **£14.994m** of All Wales Approved schemes and **£5.455m** for Discretionary schemes.

17. The Trust achieved the CEL target of **£20.449m**, with a very small underspend against plan of **£26.73** *(subject to audit)*. Below is a summary of the year end capital spend across the main headings of the capital plan. Committee members had previously received a more detailed update on how any in year slippage or underspend against previously set capital budgets were to be cash managed over the year end period.

	Actual £'000
All Wales Capital Programme: Schemes:	
ESMCP - Control Room Solutions	164
Efab - Infrastructure	303
Efab - Fire	333
Efab - Decarbonisation	596
MDVS	46
2024-25 Ambulance Vehicle Replacement Programme	12,487
Maintenance Backlog 2024-25	635
Special Operational Response Teams (SORT) Enhancement Equipment	430
Sub Total	**14,994**
Discretionary:	
I.T.	1,357
Equipment	1,584
Statutory Compliance	0
Estates	2,413
Other	102
Unallocated Discretionary Capital	0
Sub Total	**5,455**
Total	**20,449**
Less NBV reinvested	
Total Funding from WG	**20,449**

RISKS AND ASSUMPTIONS

18. There are currently no remaining or expected financial risks to the reported draft year end position (*subject to audit*). Inevitably any audit period has an element of inherent risk and based on the detailed audit plan received from Audit Wales there are some areas of greater focus that will be scrutinised through the accounts audit work, but at this stage there is no expectation that any of this should result in any material changes to the draft year end position, or the detailed notes that accompany this as part of the draft accounts.

2024/25 YEAR END ACCOUNTS AND AUDIT

19. Finalisation of the Accounts and audit work continues in respect of the 2024/25 Trust Annual Accounts. The draft accounts were submitted to WG and Audit Wales, as per the issued guidance, on 2nd May 2025, with the audited accounts to be presented to Audit Committee on 24th June 2025 ahead of seeking final approval of these at Trust Board on 26th June 2025.

20. The 2024/25 year-end audit will again be conducted virtually, maximising the use of technology and building on the experiences of the previous 5 years' audits.

RECOMMENDED that the Board:

a) **Notes** and gains **assurance** in relation to the Month 12 (and therefore draft 2024/25 year end) revenue and capital financial position and performance of the Trust as at 31st March 2025;

b) **Notes** the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust;

c) **Notes** the Month 12 Welsh Government monitoring returns submission included within ***Appendices 1 – 2*** (as required by WG).

Appendix 1

This Item is in the Ibabs reading room

Appendix 2

This Item is in the Ibabs reading room

Appendix 3

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

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 24-25

Reporting Month 12

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprenticeships	200	17	17	0	200	264	64	200	264	64
Fleet Repair	80	7	0	-7	80	27	-53	80	27	-53
Fuel Efficiencies	249	22	78	56	249	694	445	249	694	445
HEIW CPD Provision	140	12	12	0	140	140	0	140	140	0
Interest Receivable	300	25	45	20	300	771	471	300	771	471
MS Office VAT Rebate	300	10	0	-10	300	0	-300	300	0	-300
Non-pay Local Schemes - Corporate	600	59	73	15	600	397	-203	600	397	-203
Non-pay Local Schemes - Operations	515	41	39	-2	515	442	-73	515	442	-73
Vacancy Management Corporate Teams	2,275	181	194	13	2,275	2,432	157	2,275	2,432	157
Workforce Efficiencies & Transformation	1,062	16	16	0	1,062	1,038	-24	1,062	1,038	-24
Workforce Efficiencies & Transformation Variable	700	57	47	-10	700	633	-67	700	633	-67
Totals	**6,421**	**446**	**521**	**75**	**6,421**	**6,838**	**417**	**6,421**	**6,838**	**417**

Savings Performance by Theme 24-25 - Recurrent

Reporting Month 12

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprenticeships	0	0	0	0	0	0	0	0	0	0
Fleet Repair	80	7	0	-7	80	27	-53	80	27	-53
Fuel Efficiencies	249	22	78	56	249	694	445	249	694	445
HEIW CPD Provision	140	12	12	0	140	140	0	140	140	0
Interest Receivable	300	25	45	20	300	771	471	300	771	471
MS Office VAT Rebate	0	0	0	0	0	0	0	0	0	0
Non-pay Local Schemes - Corporate	600	59	73	15	600	397	-203	600	397	-203
Non-pay Local Schemes - Operations	515	41	39	-2	515	442	-73	515	442	-73
Vacancy Management Corporate Teams	0	0	0	0	0	0	0	0	0	0
Workforce Efficiencies & Transformation	1,062	16	16	0	1,062	1,038	-24	1,062	1,038	-24
Workforce Efficiencies & Transformation Variable	700	57	47	-10	700	633	-67	700	633	-67
Totals	**3,646**	**238**	**310**	**72**	**3,646**	**4,143**	**497**	**3,646**	**4,143**	**497**

Savings Performance by Theme 24-25 - Non Recurrent

Reporting Month 12

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprenticeships	200	17	17	0	200	264	64	200	264	64
Fleet Repair	0	0	0	0	0	0	0	0	0	0
Fuel Efficiencies	0	0	0	0	0	0	0	0	0	0
HEIW CPD Provision	0	0	0	0	0	0	0	0	0	0
Interest Receivable	0	0	0	0	0	0	0	0	0	0
MS Office VAT Rebate	300	10	0	-10	300	0	-300	300	0	-300
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
Vacancy Management Corporate Teams	2,275	181	194	13	2,275	2,432	157	2,275	2,432	157
Workforce Efficiencies & Transformation	0	0	0	0	0	0	0	0	0	0
Workforce Efficiencies & Transformation Variable	0	0	0	0	0	0	0	0	0	0
Totals	**2,775**	**208**	**211**	**3**	**2,775**	**2,696**	**-79**	**2,775**	**2,696**	**-79**

Please note figures are rounded to the nearest whole number

AGENDA ITEM No	**14**
OPEN or CLOSED	**N/A**
No of ANNEXES ATTACHED	**15**

BOARD COMMITTEE EFFECTIVENESS REVIEWS 2024/25

MEETING	Trust Board
DATE	29 May 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. **Part I** of this paper provides an overview of the effectiveness of the Trust Board, with **Part II** focusing on the effectiveness of the seven committees of the board. The board is requested to focus on Part 1 – their own effectiveness – and take assurance from the Audit, Risk and Assurance Committee (ARAC) with respect to Part II. Of note, this report is accompanied by a significant pack of papers for approval, however much of it will have been reviewed by members through their attendance at relevant committees and ARAC.

2. With respect to Part I, the Board's effectiveness in 2024/25 was evaluated through member feedback and an assessment of how well it fulfilled its responsibilities. All scheduled meetings were held, quorate, and characterised by strong attendance, active participation, and constructive debate. Board development sessions throughout the year were varied, well-attended, and engaging. Members, particularly those newly appointed, have made a concerted effort to meet staff and patients, deepening their understanding of WAST's work. Although the effectiveness survey had a 50% response rate, it yielded valuable insights, highlighting that:

    - Board leadership is seen as increasingly strategic, though more time is needed for long-term planning.
    - Committees are generally effective but face occasional duplication of effort.
    - Board meetings are well-chaired with high-quality papers, but the digital board software could be more user-friendly, and patient and staff stories could have a clearer focus.

- There is a strong recognition of the need to improve diversity at board level, particularly in terms of ethnicity, as the board does not yet fully reflect the communities it serves. This lack of representation limits the board's ability to bring diverse lived experiences into strategic decision-making

3. With respect to Part II, ARAC is required to *advise and assure the Board and the Accountable Officer on whether effective arrangements are in place to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales*. Annually it receives the results of the effectiveness reviews of all committees and provides assurance to the board on their arrangements. This occurred on 1 May 2025 and the link to the ARAC papers is here at agenda item 5 for further details. The ARAC Chair's AAA report before this board meeting also sets out the conclusion of that committee.

4. ARAC reviewed the terms of reference and assurance reporting arrangements, and where appropriate these were benchmarking against committee structures and remits in other UK ambulance services. Following this comprehensive review it has been concluded that the areas of oversight and scrutiny delegated by the board (see Annex 1) are appropriate for an organisation of WAST's size and complexity.

5. However, while new tools and guidance will be introduced in 2025/26 (see Annex 8), it is proposed that further work is undertaken in Q1 and Q2 (and overseen by ARAC) in an attempt to streamline the board committee structure to address a number of recurring themes raised during these reviews. Drivers for this include a number of issues raised relating to length and frequency of meetings, committee quoracy requirements, and the opportunities posed in reviewing the remit of the Academic Partnerships Committee.

6. Whilst transformational change to committee structures may potentially lead to rationalising meeting time and frequency, this must be coupled with a reduction in the volume of papers and an improvement in the clarity of information presented. Delivering more efficient and impactful governance ultimately depends on the collective responsibility of report writers and committee members to do this. This includes encouraging constructive input from Non-Executive Directors (NEDs) and other members, responding openly to feedback, and considering how each individual can contribute to more focused, streamlined, and purposeful governance.

7. Notwithstanding the further work to be carried out above, **ARAC was assured that all committees are effective in the way in which they operate**, noting that they all met as scheduled, were quorate for each meeting, kept the board updated in a timely way on deliberations via their AAA reports, delivered extensively and diligently on their delegated responsibilities, and have reflected on changes that would make them more effective and add value.

8. The board will note that the annual report and amended terms of reference for the Charity Committee will be presented to the Corporate Trustee at its 29 May 2025 meeting.

RECOMMENDATION

9. The board is requested to:

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

REPORT APPROVAL ROUTE

ARAC received the annual reports and terms of reference and discussed overall effectiveness at their 1 May 2025 meeting.

ARAC and board paper circulated to ELT 15 May 2025

All committees have received their annual reports and terms of reference where appropriate and, other than for the Welsh Ambulance Service Partnership Team (WASPT) they have approved the relevant documents. For all except ARAC and

Charity Committee, this was done by way of Chair's Action as the timing of meetings did not allow for another approach.

REPORT APPENDICES

1. Annex 1 – Committee remits delegated by Board
2. Annex 2 – Academic Partnership Committee 2024/25 annual report
3. Annex 3a and 3b – ARAC annual report 2024/25 and amended terms of reference
4. Annex 4a and 4b – Finance and Performance Committee 2024/25 annual report and amended terms of reference
5. Annex 5a and 5b – People and Culture Committee 2024/25 annual report and amended terms of reference
6. Annex 6a and 6b – Quality, Patient Experience and Safety Committee 2024/25 annual report and amended terms of reference
7. Annex 7a and 7b – Remuneration Committee 2024/25 annual report and amended terms of reference
8. Annex 8 – Proposed changes to operating arrangements in 2025/26
9. Annex 9 – Progress report on changes to operating arrangements completed in 2024/25
10. Annex 10 – Board SOP heatmap
11. Annex 11 – Board survey results (in Ibabs reading room)

REPORT CHECKLIST

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

COMMITTEE EFFECTIVENESS 2024/25

SITUATION

1. The board is required to undertake an annual self-assessment of its effectiveness. The purpose of this report is to bring together the sources of assurance that support this assessment process.

2. Part I of this report looks at the effectiveness of the Trust Board itself, and Part II provides and overview of the effectiveness and operating arrangements for the other six committees of the board.

3. The advisory group of the board, Welsh Ambulance Service Partnership Team (WASPT) reports to the People and Culture Committee. WASPT conducted their effectiveness review on 29 March and their annual report and terms of reference will be approved at their 30 May meeting and presented thereafter to the People and Culture Committee and onward to the board. The review was positive with minimal changes made to the terms of reference and operating arrangements.

BACKGROUND

4. WAST's corporate governance framework creates a supportive environment where decisions are made transparently, resources are used wisely, and responsibilities and accountabilities are clearly defined. It involves providing strong leadership, guiding the service with a clear vision, maintaining high standards of care and ethics, and fostering a positive and inclusive culture that builds trust among our people, our patients, and our stakeholders. Additionally, it includes having robust controls and processes in place to ensure everything runs smoothly and safely, from our preparedness to respond to change, to our day-to-day operations.

5. An effective board and committee structure is vital to ensure our corporate governance framework is operating effectively, ethically, and responsibly. Whilst we adopt a continuous improvement methodology throughout the year, annual effectiveness reviews conducted in Q4 are an opportunity to formally review committee membership, look back at the work of the board and committees during the year, celebrate strengths, identify improvements and, where appropriate, set priorities for the coming year. This process checks our governance remains fit for purpose and demonstrates our commitment to the Duty of Quality.

6. The Audit, Risk and Assurance Committee (ARAC) received the results of these reviews and now endorse the committee annual reports and amended terms of reference amendments (set out annexes 2 to 7) to the board for approval.

7. The annual report and terms of reference for the Charity Committee are not included in this paper and will be presented separately to the Corporate Trustee following this board meeting.

ASSESSMENT

Part I: Trust Board Effectiveness

Role of the board

8. The Trust Board is accountable for governance, risk management and internal controls at WAST. Its focus is on the following key areas:

   - The Board is responsible for setting the Trust's long term **strategy**, identifying priorities, establishing goals, and allocating resources to support strategic planning and delivery. A key part of this responsibility is understanding the **risks** that may impact the achievement of objectives and ensuring that robust systems of risk management and internal controls are in place.

   - Shaping the **culture** of the Trust through multiple avenues: how it engages with staff, patients, and stakeholders; how it sets and manages its agenda; the tone and focus of its discussions; the visibility and accessibility of its members across the organisation; and its decisions on where to invest time and resources. Board and committee members are expected to uphold the highest ethical standards, demonstrating integrity, probity, and a commitment to the Nolan Principles.

   - Setting clear, organisation-wide expectations for high performance and for ensuring compliance with the Duty of Quality and the Duty of Candour. It must foster a culture where all staff understand their role in delivering safe, effective, and high-quality care within a governance framework that values trust, openness, constructive debate, and effective challenge. **Accountability** is twofold: the board must hold others to account and remain open to being held to account itself, demonstrating leadership by example in delivering the strategy within the strategic and performance frameworks it has established.

10. The board has established several committees to support in discharging these responsibilities effectively. The committees are designed to undertake the detailed work required to provide robust assurance, explore risks and performance issues, and examine key matters within their specific remits. By doing this 'heavy lifting,' they have the capacity to delve deeper into issues, identify assurance gaps, and set the necessary context for informed decision-making.

11. A strong committee structure is in place and is essential to supporting the board in fulfilling its responsibilities. However current board agendas still contain some duplication and could more effectively reflect the board's role in setting direction, monitoring risk and performance, and leading cultural change. The ongoing work on defining 'what good looks like' and refining the Strategic Board Assurance Framework (BAF) will help realign the agenda and provide greater clarity of focus over the next 12-18 months.

Transparency and Accessibility of Meetings

12. In accordance with the Public Bodies (Admissions to Meetings) Act 1960, the Trust is required to meet in public and has done so for the seven scheduled meetings held in person in Cardiff in 2024/25. To ensure business is conducted in as open and transparent a manner as possible, members of the public, staff and stakeholders are able to join the public board and committee meetings virtually and have the opportunity to send questions to the board prior to those meetings. Board meetings were livestreamed on the Trust's Facebook page until they were switched to Teams Townhall in March 2025. Recordings are retained on YouTube and the Trust website for future reference. All meetings, save for the July 2024 meeting of the Trust Board, had British Sign Language interpretation.

13. In addition to the public meetings, the board met seven times in private session in 2024/25, where matters of confidentiality and/or commercial sensitivity were discussed. Decisions made in private session are reported in the public session as soon as possible.

14. The Trust held its Annual General Meeting virtually on 26 September 2024 and this too was livestreamed.

15. A lived experience, either of a staff or patient, was heard at each board meeting other than the January meeting where there were technical difficulties. A thank

you letter is sent to those sharing their experience from the Chair, and Trust staff are signposted to the story and the discussion that ensued via Siren.

16. There were six Chairs Actions taken in 2024/25. All were conducted in line with the Standing Orders and Governance Practice Note and were ratified by the board at the next opportunity.

17. Board and committee meetings in 2024/25 were appropriately constituted and quorate with excellent attendance. The Trust did not stand down any of the scheduled board or committee meetings.

18. Agendas and papers for public sessions of the board and committees are published on the Trust's website seven days before a meeting. Board members are provided with detailed briefs on the agenda to support the cross-over of substantive items and AAAs for Chairs in particular.

Member Visibility

19. The Board Visibility and Engagement Standard Operating Procedure (SOP) supports the Chair and Chief Executive in their responsibility to provide strong, effective, and visible leadership in the Trust. It aims to provide a range of ways in which the board can be accessible, hear from our people, our patients, and our stakeholders and to triangulate the information received through more formal routes.

20. The SOP dashboard can be accessed by board members and staff via this link and manipulated and filtered for date ranges and to enable the user to move between the sub-dashboards of 'Board Member Visits', 'Roadshows and Awards', and 'Hospital Visits'. The dashboard heatmap, a snapshot of which is at Annex 10, illustrates a good number of visits (68 in year) however there is a notable concentration of visits in the southern and northern regions of Wales, particularly around our headquarters in Cardiff, Cwmbran, Swansea, and St Asaph.

21. There are a number of opportunities for Directors to visit our people and our patients due to the nature of their work, however the time commitments of the Non-Executive Directors (NEDs) mean that this can be a challenge. Other than the Chair and Vice Chair who have minimum commitments of 14.5 and 8 days per

month respectively, NEDs are engaged for up to four days per month. It is recognised that this time commitment is often consumed by committee and board meetings and preparation for those meetings, leaving limited time for visits.

22. Recognising the need for broader geographic engagement, members are encouraged to utilise this heatmap strategically to promote a more equitable distribution of visits across Wales in the coming year.

23. In 2024/25, we had committed to exploring opportunities for the Board to 'roam' - holding meetings in different locations across Wales - to reflect our status as a national organisation and to strengthen our connection with staff, patients, and local communities. While this was not progressed during the year, we intend to revisit this commitment as we plan the next board calendar and corporate events. Going forward, we will look to align board meetings or board development days with key events such as the CEO roadshows and long service awards, and to host them at venues including Cardiff Ambulance Station, Ty Elwy in St Asaph, Matrix House in Swansea, and Vantage Point House in Cwmbran. This approach will be supported by planned opportunities for NEDs and Directors to visit local stations, make ready depots, office based staff, call centres, and Emergency Departments, ensuring meaningful engagement with teams across the organisation. While most board and committee meetings (except ARAC, Remuneration, and Finance and Performance) already include a patient or staff story, the ability to better coordinate meeting locations with engagement activities will further enhance the visibility and reach of board members across Wales.

Feedback from Board Members via Survey

24. This was the first year that the board used a longer effectiveness review survey. A summary of the responses to the questions are set out below, and in attempt to reduce volume the full survey results appear at Annex 11 in the reading room on Ibabs.

25. The survey was conducted via MS Forms, with responses anonymised, and achieved a 50% return rate. This was lower than hoped as it was the only online survey issued to board and committee members this year. This followed changes to the methodology in response to feedback about survey length in previous years.

26. Notwithstanding this, there was a richness of feedback which will enable further refinements to be made. The summarised feedback and proposed action where appropriate is below:

- *Composition*: There is a strong recognition of the need to improve visible diversity at board level, particularly in terms of ethnicity. While non-visible diversity and gender balance are present to some degree, the Board does not yet fully reflect the communities it serves. This lack of representation limits the board's ability to bring diverse lived experiences into strategic decision-making.
    - NED appointments are made by Welsh Government; however, all efforts are made in that process to attract a wide range of candidates.
    - The board is participating in the Aspiring Board Members Programme with Welsh Government, and it is anticipated that this will open up further discussions and impetus for a more diverse range of thinking and membership.
    - The Strategic Equality Plan has a number of initiatives for the board under the Anti-racist Wales Action Plan.
    - The board skills mix is being updated as part of the work being overseen by ARAC (see below) to highlight ongoing gaps in skills.

- *Leadership:* Board leadership is seen as increasingly effective, with a more strategic focus developing over time. However, more time could be dedicated to longer-term planning and public visibility of key challenges, particularly around workforce and financial sustainability.
    - Board development in October 2025 will be dedicated to long term strategic horizon scanning.
    - The work overseen by ARAC on the board agenda and duplication of issues from committee to the board is aimed at refocusing the board on these concerns.

- *Board Committees:* Committees are generally effective and supported by strong governance frameworks, although some are more mature than others. Capacity constraints and occasional duplication of effort between committees and the Board were noted.
    - The changes to operating arrangements below will strengthen committee effectiveness, and the benefits of the OCP in the

Governance Directorate will have an impact from Q2. This coupled with more effective and timely minutes, and the work overseen by ARAC on streamlining in Q2 is also aimed at refocusing the board on these concerns.

- *Board Meetings:* Board meetings are well-chaired, with high-quality papers and strong governance practices. However, some areas receive less consistent attention, and the board paper software could be more user-friendly. Patient and staff stories could be more focused to ensure clarity of purpose.
    - Alternative digital board packs are being investigated, particularly where they offer artificial intelligence gains. In the meantime, however members are encouraged to raise questions ahead of meetings where appropriate, either through Ibabs or via email or Teams.
    - The new patient and staff story pro-forma provides for an objective and any next steps, which should provide more clarity of purpose.

- *Board Culture:* Board culture has improved, with a greater focus on openness and speaking up. However, subtle cues such as non-verbal behaviour and digital distractions can unintentionally undermine inclusivity and engagement. End-of-meeting reflections are valued but may not always be the best forum for deep insight
    - The use of a digital platform for accessing Board papers can sometimes give the impression of disengagement, particularly when members are navigating documents during discussions. While this is often a practical necessity, all members are encouraged to remain fully present, minimise digital distractions unrelated to the meeting, and bring their authentic and focused selves to the table.
    - Maintaining eye contact and active participation helps reinforce the inclusive, open culture we are continuing to build.

- *What is working well:* The Board benefits from a strong foundation: open relationships, clear agendas, excellent support; good timekeeping, and well-structured meetings. The mix of operational and strategic discussion is broadly well balanced, and there is increasing confidence in the quality of debate and challenge.

- *Areas for further improvement*: Opportunities exist to further improve Board impact through stronger regional visibility, increased focus on patient experience, better use of time for long-term planning, and deeper relationships beyond the boardroom. Duplication in some Board materials and papers could be reduced.
    - Much of this has been drawn out above.

Board Development

27. The Board Development Programme continued in 2024/25 with a focus on understanding, learning and reflection. The six scheduled sessions were well attended and designed to stimulate discussion on strategic initiatives; shape culture and behaviours; strengthen system and partnership working; enhance knowledge of the regulatory environment and allow for more detailed briefing of complex issues ahead of formal meetings. Sessions included:
    - Strategy
    - Evolving clinical model (two session)
    - Reputation (two sessions)
    - Commercialisation
    - Wellbeing of Future Generations Act
    - Manchester Arena Inquiry Recommendations
    - International ambulance practice (Australia, Canada and USA)
    - Integrated Medium Term Plan 2025-28 (two sessions)
    - Duty of Quality and Duty of Candour
    - Risk Management and Risk Appetite (two sessions)
    - Remote Clinical Care
    - Cyber security
    - Welsh language

28. Each development session includes a CEO update and feedback from NEDs on recent visits and meetings of note.

Part II: Committee Effectiveness

Methodology

29. Effectiveness reviews took place in Q4. There was a change in methodology this year for some committees. QUEST, People and Culture, Finance and Performance, Academic Partnerships, Remuneration and the Charity Committees reviewed their

terms of reference and reporting arrangements - most of which are focused on providing assurance - in detail during their meetings. This provided an opportunity to confirm that their remits remain appropriate, to realign terms of reference where necessary, and to identify opportunities to streamline reporting by reducing the volume of papers.

30. These committees also utilised Mentimeter to gather feedback. This is contained in their annual reports, and is also themed in the ARAC paper of 1 May which can be found here and include:

    - Enhanced report writing and assurance - issues raised include the requirement for clarity and structure; brevity and alternative formats; improving assurance processes; and enhanced engagement discussion

    - Strengths of committees - including chairing and governance; engagement and discussion; and that use of data and lived experiences

    - Areas for improvement - issues raised include refining focus and scope; agenda and meeting efficiency; enhancing assurance and impact; membership and representation; and use of reports and presentations.

31. ARAC retained use of the National Audit Office Effectiveness Toolkit as part of its annual self-assessment. This comprehensive toolkit includes 180 questions, which were initially reviewed and completed by a small working group of ARAC members during the year. The outputs were then brought back to the full Committee, where members were invited to confirm or challenge the responses. The Committee focused its discussion on a selection of key questions to enable a more in-depth and reflective assessment of its effectiveness.

32. The final annual report and amended terms of reference were then approved either in the next committee meeting or, where timing did not allow for this, by Chairs Action.

Board Delegated Responsibilities

33. Following a comprehensive review of the terms of reference, assurance reporting and operating arrangements, alongside benchmarking against committee structures in other UK ambulance services, ARAC was assured that **the areas of oversight and scrutiny delegated by the board in Annex 1 are appropriate for an organisation of WAST's size and complexity**.

34. Having said that, it is proposed that further work is undertaken in Q1 and Q2 (overseen by ARAC) in an attempt to streamline the committee structure to address a number of concerns raised during reviews. Drivers for this include:

NED Committee Membership and Quorum

(a) The Trust's Standing Order provides that NEDs are designated as 'members' of committees. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum and - where necessary - for voting. Notwithstanding this, the 'members' and 'prescribed attendees' are often referred to collectively as members or membership[1].

(b) Board committees (other than People and Culture Committee) were set at three NEDs members in 2024/25 with a quorum of two. The rationale for this included:

- NEDs (excluding the Chair and Vice Chair) are contracted for no more than four days per month.
- WAST's meeting schedule includes at least seven board meetings, six board development sessions, and at least 27 committee meetings with membership of those divided amongst the Vice Chair and six NEDs[2]. Many of those meetings are held over a full day.
- In addition to meetings and development sessions, NEDs also have preparation time, and attend site visits, roadshows, and long service award events where possible.
- In 2024 four new NEDs were appointed to the Board, two of whom were given responsibility for chairing high profile committees. There was a desire to avoid overloading new NEDs with too many commitments because of this.

(c) Whilst the rationale for setting the quorum was sound, there were occasions during 2024/25 when only two NEDs were available to attend committee meetings. Feedback following such meetings highlighted the significant burden placed on those two NEDs, particularly as one was also chairing.

(d) An increase in the quorum to three NEDs was considered for 2025/26, along with a proposal to raise committee membership to four NEDs to provide resilience. However, due to the number and frequency of meetings, and the contractual

[1] Terms of reference of board committees have been amended this year to clarify this position.
[2] Other than the Remuneration Committee, the Trust Board Chair has a standing invitation to committee meetings but is not a member.

availability of NEDs, this was not considered practical based on the current committee structure and commitments.

(e) Consideration was also given to maintaining a membership of three NEDs whilst increasing the quorum to three, but this carries the risk that meetings will be cancelled at short notice due to a lack of quorum.

(f) Instead, terms of reference for 2025/26 have been updated to reflect the expectation that three NEDs will attend wherever possible. The quorum will remain at two for the time being, to minimise the risk of having to cancel meetings due to insufficient attendance.

(g) The People and Culture Committee has a membership of four NEDs, but this is a historical position other than the need for increased membership and will be reviewed in the next phase set out below.

Academic Partnership Committee

(h) Following the successful achievement of University Trust Status, this committee (originally established to support that ambition) has naturally reached a point where its purpose requires refocus and revitalisation. While the committee has continued to provide oversight of research, its broader direction has lacked clarity.

(i) This provides an opportunity to consider whether oversight of the Trust's strategic objective to "be at the forefront of innovation and technology" justifies retaining this committee - with a revised name and focus - or whether this work, along with research and our University Trust ambitions, can be pursued through alternative opportunities elsewhere.

(j) To allow time for this to be considered the committee reduced its meeting schedule to three meetings in 2025/26, with a further discussion planned for July 2025. Accordingly, the terms of reference and cycle of business of this committee have not been amended or refreshed for 2025/26 as yet.

Frequency of Meetings

(k) Discussions took place during effectiveness reviews on the merits of changing the frequency of the quarterly meetings in particular. This included moving some to bi-monthly, or to be held over two half days. Most felt however that given the breadth of delegated responsibility for some of the committees, meeting for what is often a

full day a quarter – particularly for QUEST and the People and Culture Committee – is not onerous and is often appropriate.

(l) In addition to the time considerations for NEDs outlined above, the time commitment required from Directors and their teams must also be considered. While preparation for and attendance at committee meetings is a key part of a Director's role, it can place considerable demands on their time if meetings are not run efficiently and effectively.

(m) There is an opportunity to consider meeting frequency as we take a more detailed look at the delegated responsibilities. The Trust Standing Orders requires that the board holds at least six ordinary meetings a year, therefore coordinating committees around these will be key

35. **Further considerations will be brought to ARAC in Q2, with the aim of reflecting the factors outlined above and ensuring that delegated responsibilities are distributed across the committees in an equitable and manageable way.**

Changes to Operating Arrangements

36. Following the feedback received in committee reviews and the board effectiveness survey a number of changes to operating arrangements are proposed, and they are set out at Annex 8. These changes will be incorporated into the Corporate Governance Local Directorate Plan, and ARAC will monitor the progress bi-annually.

37. A progress report on the changes ARAC and the board agreed to following the 2023/24 effectiveness reviews is attached at Annex 9 for completeness. One area which has not been progressed as expected in 2024/25 is the board holding meetings in other locations through the year. Whilst there have been other opportunities for board members to undertake visits and triangulate assurance such as CEO roadshows and long service awards, the physical board meetings have remained static in Cardiff this year. As stated above, further work will be done in Q1 for consideration by the board taking account of opportunities to combine meetings with other events and structured visit schedules.

Changes to Terms of Reference

38. Committees reviewed their terms of reference and proposing changes are summarised below:

Theme	Summarised Comments
Changes made to all terms of reference	• Inclusion of a strategic development and delivery section where appropriate, intended to foster a focus on 'what good looks like' for the strategic objectives within the remit of the committee • Consideration of our duties under the Wellbeing of Future Generations (Wales) Act 2015 and in particular the WAST wellbeing objectives • Further explanation of the membership requirements under Standing Orders as set out above and some changes to how this is reflected in the membership section • Changes to placement and slight adjustment of wording of standard elements • Retention of a quorum of two NEDs, but inclusion of the recommendation that all meetings are attended by three NEDs for robust discussion and effective oversight
Finance and Performance Committee	• Inclusion of the commercial development plan and framework, and wellbeing objectives • Introduction of an infrastructure section and movement of some of the elements of estates and fleet • Movement in the document of some of the digital systems and strategy section to avoid duplication • Clarity on the endorsement of business cases and contract awards over the delegated limit of £500K, and consideration of post-implementation reviews of those for key learning. This will be factored in as a prompt at agenda setting where appropriate • No changes to membership proposed, other than the Head of Commercial to be a prescribed attendee on appointment
People and Culture Committee	• Re-ordered to reflect the three Cs of the People and Culture Plan – culture, capability and capacity • Specific reference to assurance on: - Volunteers - Right resources and skills mix - Leadership development and succession planning - Commissioning intentions for training and education • No changes to membership proposed
QUEST	• Re-ordered to reflect the Health and Care Quality Standards • Assurance on the Trust's quality management system • Clarification on a number of areas • Specific authority to approve the annual clinical audit plan • No changes to membership proposed
Remuneration Committee	• Clarity on the consideration of the CEO's objectives and cascading to the Executive Leadership Team

Theme	Summarised Comments
	• No changes to membership proposed
WASPT (not yet approved but discussed in the March 2025 meeting)	• Inclusion of duties under the Social Partnership and Procurement (Wales) Act 2023 • Inclusion of the authority to use Chair's Action where appropriate • Clarity on publication of papers for the meeting and pre-meet for Trade Union Partners • No change to membership proposed

39. Progress against committee priorities for 2024/25 has been good as set out in the annual reports. Where appropriate, committees have now set priorities for 2025/26 and progress against these will be monitored at each meeting. Priorities are not intended to be additional work/papers for members to produce or review but are a particular focus during the year on a part of their remit, including any new areas.

40. The cycles of business for all committees have been amended in line with adjusted terms of reference and have been approved. These, together with committee meeting and deadline dates will support writers and enable the year's work to be planned within their directorates.

41. ARAC reflected on the positive findings in the Audit Wales Structured Assessment 2024 related to the board and its committees and reviewed the self-assessment against the Code of Governance 2017, noting that there were no areas of non-compliance.

Conclusion

42. Good governance consists of mechanics (structures and processes) and dynamics (strategy, behaviours, and culture). Effectiveness reviews seek to reflect on both these elements and ensure that the Duty of Quality applies to everything we do as a Trust Board.

43. With respect to mechanics:

- The board has a well-established committee structure, with regular scheduled and quorate meetings. All committees have performed well during the year, covered a significant portfolio of work and reported/escalated regularly to the board. Whilst volume of papers and length of the agenda remains a concern, ARAC was assured that committees are broadly working effectively and fulfilling their roles. However,

further work is needed to ensure responsibilities are distributed equitably and remain manageable as demands evolve.

- Committee terms of reference are regularly refreshed, and they each have a cycle of business which provides for the appropriate frequency of reporting. Agendas are set well ahead of meetings and are built around the highest rated risks. Timeliness of papers improved in 2024/25 however there is work to do to support report writers, board members, presenters and the secretariat with guidance and new templates.

- Board and committees oversee key performance indicators at each meeting and regularly take deep dives into areas of concern. The board maintains a risk management framework and there is evidence of a strong risk culture at board and organisational level.

44. With respect to dynamics:

- Meetings are conducted respectfully and in line with the Nolan Principles. Presenters are well prepared, and attendance is excellent.

- Meetings are open to the public and decisions made in private session are reported openly and in a timely way. The lived experience heard at the board and many of the committees, together with new ways of conducting board visits allows members to triangulate assurance and connect with our people and our patients.

- Committee Chairs escalate issues to the board transparently and provide timely assurance to the Board on matters within their committee's remit. There is good engagement with NEDs and Directors. The Trust Board Chair and the Chief Executive meet regularly, as does the Trust Board Chair and the Director of Corporate Governance/Board Secretary. The Chair and Vice Chair meet regularly with the Trade Union Representatives and NEDs meet separately on a monthly basis.

- Each meeting seeks clarity on conflicts of interest in line with the Standards of Business Conduct policy, and the publicly available register of interests is linked to each agenda.

- Board members are appointed based on a skill matrix, with campaigns for NEDs tailored where possible to meet any gaps in the matrix. This will be updated as part of the work overseen by ARAC in Q1 and Q2.

- Board development embeds the ethos that we are a learning board, continuously improving and striving for quality in the delivery of our long term strategy.

- This year, the Board has continued its emphasis on long-term strategic planning, a focus that extends across Board and committee meetings as well as board development sessions. This strategic shift is evidenced in the Integrated Medium-Term Plan (IMTP) for 2025-28, which elaborates on our long-term strategy in greater detail.

45. The board and its committees are operating effectively, with clear responsibilities and strong engagement. Governance processes are well-established, and there is a positive culture of openness and constructive challenge. Further refinement is planned for Q1 and Q2 to enhance strategic focus, reduce duplication, streamline further and ensure the Duty of Quality is consistently embedded across all governance activity.

46. Finally, while the changes set out in Annex 8 will have an impact, delivering meaningful improvement on the recurring themes identified in effectiveness reviews ultimately relies on the collective efforts of report writers, board and committee members. Everyone involved has a role to play particularly in welcoming constructive input from NEDs and committee members where reports may not fully meet expectations. This is a shared endeavour, and colleagues are encouraged to reflect on how they can contribute to more efficient and impactful governance.

RECOMMENDATION

47. The recommendation is set out above in the executive summary.

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

WAST BOARD COMMITTEE REMITS – 2025/26

Quality, Patient Experience and Safety Committee

- Duty of Quality and Duty of Candour
- KPIs in remit
- Clinical & quality plans
- Health and Care Quality Standards
- Quality Impact Assessment
- Mental health and dementia standards
- Infection prevention and control
- Safeguarding
- Continual quality improvements
- Learning
- Mortality reviews
- Putting Things Right
- Clinical negligence & personal injury
- Clinical effectiveness
- Clinical audit
- Citizens voice & patient experience
- Clinical and quality governance
- Risks, audits, policies in remit

People and Culture Committee

- People & Culture plan and metrics
- KPIs in remit
- Trust Behaviours
- Health and wellbeing
- Staff & volunteer experience
- Speaking up safely
- Equality, diversity, and inclusion
- Recruitment and retention
- Trade Union relationships and partnership agreements
- Leadership & development
- Commissioning intentions for training and education through HEIW
- Succession plans
- Welsh language
- Health and safety
- Health and Care Standards in remit
- Registration and revalidation
- Partnerships and engagement
- Risks, audits, policies in remit

Advisory Group (WASPT) reports to this Committee

Finance and Performance Committee

- Long term strategic direction
- Long term financial direction
- Capital and revenue monitoring
- Financial sustainability
- Commercial development
- Wellbeing objectives
- Business cases and PIRs
- Compliance with statutory duties
- IMTP endorsement and delivery
- Value based healthcare
- Performance against targets set by Commissioners and Welsh Gov.
- Quality &Performance Management Framework
- Trust wide KPIs (MIQPR)
- Recovery plans for performance
- Demand and capacity
- Estates
- Fleet
- Environment and sustainability
- Digital systems
- Digital plan direction
- Information governance
- Information security
- Major Incident Plan and Business Continuity Plan
- Cyber resilience & security

Audit, Risk and Assurance Committee

- Governance and assurance
- Effective systems of good governance, risk management and internal control (including the Integrated Governance Programme)
- Board Assurance Framework
- Annual Report
- Audited financial accounts
- Standing Orders and SFIs
- Accounting policies
- Assurance processes
- Policies for reg. compliance
- Schedule of losses & special payments
- Single tender actions
- Internal audit (inc annual plan; reports; HOIA Opinion)
- Audit Wales (inc annual plan; ISA260; structured assessment; reports;
- QPMF implementation
- Audit management responses tracking and scrutiny
- Local Counter Fraud Service
- Standards of business conduct

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

- Strategic collaboration with education providers and commercial partners
- Collaboration with partners in health, social care, local authority and third sector
- University Trust Status
- Research governance framework
- Risks, audits, policies in remit

Charity Committee (Corporate Trustees)

- Charity strategic direction and development, for approval by the Corporate Trustee
- Charitable funds monitoring including systems and processes
- Review by Audit Wales of accounts
- Fundraising
- Promote the charity
- Annual Report and Financial Accounts
- Approve expenditure over £5,000
- Bids Panel

OVERSEE | **SUPPORT** | **CHALLENGE** | **ESCALATE**

ACADEMIC PARTNERSHIP COMMITTEE ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which the board's committees form an integral part.

4. The committee met on 23 January 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The purpose of the Committee set out in its terms of reference reflects the maturing University Trust Status (UTS) journey. The committee that 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).

MEMBERSHIP AND ATTENDANCE

6. The committee met four times as scheduled in 2024/25 and was quorate on each occasion. The Committee met in private session on three occasions in July and November 2024.

7. The committee has been supported by the Chair and three Non-Executive Directors as members, and a number of prescribed attendees. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2024/25.

COMMITTEE ATTENDANCE				
Name	**23 April 2024**	**July 2024**	**18 November 2024**	**23 January 2025**
Hannah Rowan				
Prof Kevin Davies				
Ceri Jackson				
Prof Hayley Hutchings				
Jayne Beeslee				
Estelle Hitchon				
Angela Lewis				
Carl Kneeshaw				
Andy Swinburn				
Jonny Sammut	Aled Williams			Aasha Cowey
Jonathan Turnbull-Ross				
Duncan Robertson				
Jonathan Chippendale			Kerry Robertshaw	
Prof Nigel Rees				
James Houston				Alex Crawford
Jo Kelso				
Trish Mills		Julie Boalch		
Mark Marsden				
Keith Rogers				

	Attended
	Deputy attended
	Apologies received
	No longer member

8. The membership of the committee was revised effective quarter four of 2024/25 in response to changes to the Non-Executive Director membership of the Trust Board. This includes the academic Non-Executive Director Hayley Hutchings, appointed in November 2024. Hayley attended the meeting of the committee in November 2024.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

9. The Committee's effectiveness was assessed through a facilitated discussion held at the meeting on the 23 January 2025, which included a review of its terms of reference and cycle of business.

Enhancing Report Writing and Assurance

- A common theme is the desire for greater use of presentations - including visuals and even short videos - as alternatives to written papers. This approach is seen as more engaging, interactive, and less burdensome for report authors, especially given current workload pressures.
- Respondents also called for brevity and clarity, with succinct summaries that clearly outline what is required from the committee. Enhancements could include a clearer purpose for each paper, better alignment with strategic frameworks (e.g., HCRW and other plans), and focused, action-oriented content.
- Other suggestions included:
  - Making the cycle of business more predictable to aid planning
  - Reassessing the SBAR format, which some find repetitive
  - Including key metrics or statistics (e.g. research participation numbers) to support decision-making.
  - Clarifying the expected breadth and depth of content, so authors can better meet the committee's needs.

Strengths of the Committee

- Feedback highlights the committee's strong and inclusive leadership, with particular praise for the Chair's ability to encourage open, respectful, and productive discussions. The Chair is commended for creating space for all voices, especially new members and observers, and for maintaining focus while allowing conversations to flow naturally.
- The committee is described as a welcoming and safe space, fostering high engagement, open dialogue, and creative thinking. Members feel motivated to attend and contribute, with the use of chat features further supporting inclusive participation.

Areas for Improvement

- Suggestions for improvement reflect a desire to refine the committee's remit, focus, and ways of working as it continues to mature. Several comments highlight the need to reassess the scope, particularly regarding innovation, digital, and cyber assurance - areas that align with strategic priorities but may not be fully embedded in other committees.
- With a refocus on the remit, key issues to consider include revisiting membership to ensure appropriate representation; enhance education and training discussions and alignment with academic partners (particularly around undergraduate and postgraduate development); name change of the committee to follow.

10. Following the successful achievement of University Trust Status, the committee originally established to support that ambition has naturally reached a point where its purpose requires refocus and revitalisation. While the committee has continued to provide oversight of research, its broader direction has lacked clarity. Looking ahead, it is proposed to align the committee more explicitly with the Trust's strategic objective to "be at the forefront of innovation and technology". This would see the committee's remit refocused around three core pillars: research, innovation, and technology/digital.

11. This change reflects a wider board ambition to define "what good looks like" in the delivery of long-term strategic goals. For this particular objective, the emphasis for 2025/26 is expected to be primarily digital. Enabling a more coherent and integrated approach may mean transferring digital, including information governance, information security, and cyber, from the Finance and Performance Committee to this committee. The committee will also play a key role in assuring the Board that relevant frameworks - such as the HCRW research governance framework - are being effectively implemented and meet organisational requirements. Recognising existing resource constraints within the Research and Innovation Team, the potential for developing meaningful KPIs will be explored while remaining mindful of capacity.

12. To support this transitional work, the committee has endorsed a revised meeting schedule of three sessions in 2025/26, allowing time for the Executive Leadership Team to shape the refreshed remit, with a further discussion on effectiveness planned for July 2025. This was agreed by the board in January 2025.

13. Because of the above, the terms of reference and cycle of business of this committee have not been amended or refreshed for 2025/26 as yet but will be once the discussions above take place.

Management of the committee's work programme

14. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the committee. The committee's business in 2024/25 included:

(a) Following the Trust's application for **University Trust Status** (UTS) this was approved effective 01 April 2024. The committee oversaw the introduction of this designation and the change of the Trust's name to the Welsh Ambulance Services University NHS Trust. Throughout the year the Committee discussed the benefits which could be borne from having UTS, and this work will continue into 2025/26. Discussions regarding benefits include how well positioned the Trust is as a learning organisation of excellence, and the importance of realising benefits which relate to quality and evidence-based practices.

(b) The **UTS priorities** for inclusion in the Trust's Integrated Medium-Term Plan (IMTP) 2025-28 were discussed and endorsed. These included a commitment to learning, enhancing academic and industry partnerships, and establishing a centre of excellence (by 2028); all of which align to the Trust's long-term strategy 'Delivering Excellence' and the Trust's commitment to the Duty of Quality.

(c) Hannah Rowan, Committee Chair, provided updates to the Committee in her capacity as the Trust's **Research Champion Non-Executive Director**. Additionally, in January 2025, Jayne Beeslee, Non-Executive Director who joined the Trust Board in August observed the meeting as part of her induction.

(d) In January the committee received a lived experience from **Hayley Stevens, Advanced Paramedic Practitioner**, who attended to share her experience of undertaking the MSc in Advanced Clinical Practice and an overview of the dissertation on comparing independent prescribing to Patient Group Direction use in a general practitioner out-of-hours service: a retrospective cross-sectional service evaluation. Members commended Hayley for the significant work undertaken to translate a dissertation into a published paper.

(e) The Committee received updates from colleagues regarding the implementation of the **Health and Care Research Wales (HCRW) Research and Development Framework**. The way in which WAST implements the ten pillars of this framework has showcased the significant amount of research and innovation underway at the Trust, however the committee recognise there is more to do on this framework to identify further opportunities to strengthen and support it at WAST.

(f) The development of **research and innovation Key Performance Indicators** (KPIs) was discussed, and work will continue on the development of these in 2025/26.

(g) The Trust's approach to **Research and Innovation** was discussed, with the next steps for enhancing our capabilities considered. There was a commitment to support the integration of research strategies and objectives across all areas of the Trust to ensure that they become fully embedded into our culture and operations. The need to prioritise development of the structures and processes to support this approach were acknowledged.

(h) The committee continued to oversee and support the campaign for the recruitment of the **academic Non-Executive Director** on the Trust Board. As indicated above, Hayley Hutchings was appointed in Autumn 2024 effective 11 November 2024. The membership of the committee has changed to reflect this appointment as well as the planned turnover of non-executive directors on the Board.

(i) A spotlight session on the **innovation and the use of drone technology** was received. This discussed how the Trust is exploring the use of drone technology within its operations to enhance emergency response capabilities.

(j) The Committee **cycle of business** was approved.

(k) There are no formal **risks** on the corporate risk register for this committee, however the risks related to capacity to take forward the research and innovation agenda were discussed

(l) The **annual effectiveness review** was conducted in the January 2025 meeting. At this meeting the committee endorsed the proposal to meet three times in 2025/26 as opposed to four, to afford time for the Executive Leadership Team to undertake the necessary work on the remit of the committee, with a further discussion on effectiveness planned for July 2025.

15. The committee is required to promote and support the exploration of opportunities with higher and further education providers, commercial partners, and wider community partners for collaboration. The purpose of these sections 3.1 to 3.3 in the terms of reference and the way in which the committee discharges these were explored in the January meeting. A wider discussion will take place at the July 2025 meeting as part of the continued review of the terms of reference.]. The Chair of the committee, Hannah Rowan, is the Non-Executive Director Research Champion for the Trust. Additionally, Nigel Rees, the Assistant Director of Research and Innovation, is active in the research community. The

promotion of WAST is brought through to committee by the Chair's updates on the champion community and the research governance framework by Nigel Rees.

16. The board received a highlight report from this committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This was also presented to the next public board meeting by the Chair of the committee.

SUB-COMMITTEES AND TASK AND FINISH GROUPS

17. The committee is not currently serviced by a sub-committee.

COMMITTEE PRIORITIES

Priorities for 2024/25

18. The Committee received an update on progress against its 2024/25 priorities at each meeting and as can be seen below progress on agreed priorities has been good: It is noted that the Committee revised its priorities mid-year from those which were agreed by the Trust Board in May 2024, and the revised priorities are included in the below table:

Priority	Progress
Clarity on the purpose and focus of the Committee to be communicated to the wider organisation.	The discussions regarding this priority will continue into 2025/26 now that the academic Non-Executive Director, Hayley Hutchings, is in post. See above regarding changes to the remit of the committee overall.
Articulating the benefits realisation of University Trust Status (UTS).	The Committee discussed the benefits realisation from UTS at its meeting on the 19 July 2024 and a follow up item was received at the Committee meeting on 18 November 2024. An update on the work to date was presented to the Committee in January 2025, and this work will continue into 2025/26.

Priorities for 2025/26

19. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. However, at this stage given the discussions due to take place in Q2 on the overall remit of the committee, it may not be appropriate to do so in 2025/26 given that the main priority will be in ensuring the scope of work, membership and programme is appropriate.

AUDIT, RISK AND ASSURANCE COMMITTEE ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The committee met on 06 March 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The purpose of the committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

MEMBERSHIP AND ATTENDANCE

6. The committee met six times in public and four times in private session as scheduled in 2024/25 and was quorate on each occasion. Pre-meets were held with the Chair and Auditors.

7. In 2024/25 the Committee was supported by the Chair and three Non-Executive Directors (NEDs) as members, and several prescribed attendees with good attendance. In year the NED composition of the committee changed, to reflect the changed composition of the Trust Board. Professor Kevin Davies and Joga Singh left the Trust Board and therefore the committee.

8. Following her appointment in late 2024 as a NED, Rhiannon Beaumont-Wood was appointed to the committee as a member effective 01 January 2025. As at year end of the committee membership is Peter Curran, Ceri Jackson and Rhiannon Beaumont-Wood.

9. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2024/25. Audit Wales and Internal Audit were in attendance and the committee welcomed non prescribed attendees at various meetings. The Chief Executive Officer attended three meetings in 2024/25.

COMMITTEE ATTENDANCE						
Name	**30 April 2024**	**7 June 2024[1]**	**10 July 2024[2]**	**12 Sep 2024[3]**	**21 Nov 2024[4]**	**6 Mar 2025**
Peter Curran						
Kevin Davies						
Joga Singh						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Chris Turley						Ed Roberts
Audit Wales	Fflur Jones[5]	Fflur Jones	Yvonne Thomas	Fflur Jones[6]	Fflur Jones	
Julie Boalch						
Judith Bryce					Jon Sweet	
Christian Fox						
Angie Lewis						
Carl Kneeshaw						
Osian Lloyd					From Item 7	
Trish Mills						
Liam Williams					J Turnball-Ross	Wendy Herbert

[1] Jason Killens and Jonny Sammut joined this meeting
[2] Jason Killens and Rachel Marsh joined this meeting
[3] Jason Killens and Rachel Marsh joined this meeting
[4] Bethan Evans, Non-Executive Director joined this meeting to ensure quoracy as new NED membership is implemented
[5] Darren Griffiths and Amy Lord also attended
[6] Gareth Lucy also attended

COMMITTEE VIEWS ON EFFECTIVENESS

Feedback from membership

10. In previous years, members of the committee were asked to complete the extensive NAO Audit and Risk Assurance Committee Effectiveness Toolkit questionnaire. Recognising the need for a more engaging and efficient process, the committee adopted a new approach for the current effectiveness review, commencing in April 2024.

11. This year, a smaller subgroup of ARAC members met throughout the year to proactively address the 180 questions in the toolkit by identifying and addressing any gaps in advance. This preliminary work aims to streamline the effectiveness review by allowing the committee to focus on key areas of improvement and maintain continuous oversight of their responsibilities.

12. At its 06 March 2025 meeting the responses to that questionnaire were reviewed. Members agreed that the responses to the questions were appropriate and spent time reviewing the three areas below in more detail.

A. Does the length of the meetings – and the volume of papers – feel onerous, or does it feel pitched correctly for the business of ARAC?

Members agreed that the Chair is consistently recognised for enabling inclusive, respectful, and well-engaged discussions, allowing all members and attendees time to raise issues. Meetings are considered appropriately timed, supported by evidence from monitoring reports and annual reviews. There is also a strong focus on scrutiny, particularly around internal audit findings and follow-up on recommended actions.

B. On ARAC specific committee induction for new members, what would you like to see included?

Committee-specific induction for new ARAC members is recognised as a current priority. While NED and Trade Union members have already received general board induction and drop-in governance sessions, there is consensus on the need for a more tailored ARAC induction, and more widely for that to be offered on all committees. It was felt the ARAC induction should focus on:

- Governance and risk, reflecting ARAC's ongoing priorities.
- Insight into audit tracker outcomes and the risk transformation programme, as part of a culture of continuous improvement.
- Use of materials like the Audit Wales update reports, which offer useful NHS-specific horizon scanning and sector insights.

- Opportunities for learning through 1:1s with the Chair and the Executive Director of Finance, both qualified accountants, to deepen understanding of financial and governance matters.

C. Do we have the right mix of skills on ARAC?

Members felt overall that the right mix of skills was present on the committee. The board has a skills matrix for members, but not individual committees. However prescribed attendees who are not part of that skills mix are selected for their skills and experience including that of governance, risk and control. It was felt that more development on the three lines of defence model and how it applies in WAST would be welcomed.

13. Changes to operating arrangements as a result of the above and further discussions as part of this review include:

13.1. Discussions ensured on the timing of internal audit reports coming to committees before ARAC, however it was agreed that this was appropriate given the frequency of meetings. The Corporate Governance Team will ensure that ARAC is aware of the discussion on these internal audit reports from the committee and vice versa when they come to ARAC first.

13.2. Trending on risk scores will be added to the risk management report. ARAC continues its oversight of the risk management transformation programme into 2025/26 and the introduction of risk appetite statements and the strategic BAF.

13.3. The changes overall in committee arrangements (both for ARAC and other committees) would be tracked in ARAC bi-annually, rather than annually to ensure they are on track.

13.4. The committee discussed the length of meetings, noting that while the current length is generally sufficient, it is important to ensure meetings do not become too long, which could impact the quality of discussion.

13.5. A paper setting out a more focused understanding of where the three lines of defence sit within the organisation and their importance will be cycled in to the work programme

13.6. The committee induction programme for ARAC and other committees will be rolled out as new members join.

13.7. Members were encouraged to use Ibabs pre-committee to add comments/feedback.

Management of the committee's work programme

14. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect, it has discharged its responsibilities in providing assurance to the Board aligned to its terms of reference

15. The Committee's business in 2024/25 included the following, full details of which are in the Committee's AAA reports and minutes provided to the Board:

15.1. In July 2024 the Committee **endorsed the 2023/24 Annual Accounts and the Annual Report and Duty of Quality Annual Report** 2023/24 which were shortly after approved by the Board. The Audit Report (ISA 260) was also reviewed at that meeting as was the final Head of Internal Audit Annual Report and Opinion.

15.2. The plan for development of the 2024/25 annual filings was received in March 2025 and endorsed.

15.3. At each meeting other than in April, which is a meeting dedicated to the review of Committee effectiveness, members received an **update from Audit Wales and from Internal Audit** on their programmes of work and performance indicators (Internal Audit only).

15.4. In April 2024 the committee received the **Audit Wales Annual Report** for the 2023/24 financial year. The report summarised the findings from the 2023 audit activity which included the audit of the 2022/23 annual report and accounts, the 2023 Structured Assessment, the national workforce review and the Trust's workforce planning arrangements. The 2024 Audit Wales Audit Plan was received in April as well.

15.5. At its meeting in March the committee received the **Annual Audit Wales Report for 2024/25**, which summarised all of the pieces of work completed during the year, including the accounts audit, the Cost Savings Arrangement report, the Quality Governance Follow Up Review, and the 2024 Structured Assessment.

15.6. The following **Internal Audit Reports** were presented by Internal Auditors and discussed by this committee. They were also reviewed by the committees with specific remits over the subject area. The list below

includes a mix of 2023/24 and 2024/25 Internal Audits, as the 2023/24 internal audit programme reporting was completed in year:

- Risk Management and Assurance
- Seatbelt Action Plan
- ICT Contract Management
- Volunteers Governance
- Disciplinary Case Management: Compassionate Practices
- Follow Up Action Tracker Review
- Clinical Audit
- Resourcing Policy
- Integrated Quality and Performance Management Framework
- Overtime Controls
- Data Quality
- Vehicle Accident Management
- Exposure to Fumes
- Patient Experience and Community Involvement
- Rollout of Penthrox
- 111 Digital Operations
- Energy Management

15.7. The **2025/26 Internal Audit Plan was approved** by the committee in March 2025, as was the Internal Audit Charter and fee.

15.8. In November 2024 the Audit Wales Update presented the **WAST 2024 Structured Assessment**, along with the **Review of Cost Savings** audit report. Both of these reports were positive, and members received significant assurance from the opinions given. The committee commended the Trust on the positive nature of the reports

15.9. In March the committee received the **Audit Wales Follow Review of Quality Governance Arrangements,** completed in year. The management responses to the new recommendations were considered positive and comprehensive, and the approach to revised actions for the previously closed recommendations was commended.

15.10. Two areas of **non-compliance with the standing orders** were discussed and escalated to the Board in Spring 2025. The Committee was assured that both areas were being appropriately addressed in a timely way:

- The first related to the approval of the minutes from the 2023 Annual General Meeting (AGM). Standing Order 7.2.7 requires that "A record of the meeting shall be submitted to the next ordinary meeting of the

Board for agreement". It was identified in Autumn 2024 that this had not been the case for the 2023 AGM minutes (which were taken to the 2024 AGM for approval). This oversight was corrected for the 2024 AGM, and the minutes were approved by the board in November 2024.

- The second related to non-compliance with the standing orders in regard to a procurement contract award having been made without the required sign-off by the board, as the financial limit exceeded the Chief Executive's delegated financial limit. This matter was brought to the attention of the board via the request for Chair's Action in early 2025 and the mitigating actions for strengthening internal processes to ensure future compliance with standing orders were provided.

15.11. Amendments to **Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation** were reviewed and endorsed for the Board.

15.12. The committee has oversight of the **Trust's Policy work plan** and in year received updates on the progress against the work programme to clear the backlog of outdated policies. In November the committee heard that a re-evaluation of the policy priorities has been undertaken with the Executive Leadership Team and a revised work programme will be established or 2025/26. In March the committee heard that 46% of the policies identified as a priority for review were now within their review date; which was a significant improvement on the 14% reported in July 2023.

15.13. The committee approved the **All-Wales Procedure for Recovery of Overpayments** via Chair's Action.

15.14. In April 2024 the committee reviewed the **self-assessment against 2017 Governance Code** and noted that there were no areas where the Trust did not comply. The committee reviewed the self-assessment against the code and were assured that the Trust complies with all elements.

15.15. The committee terms of reference require it to receive assurance on the **arrangements for whistleblowing** at the Trust, and it received an update in September. Assurances were received by way of a report from the Chair of the People and Culture Committee on the Speaking up Safely arrangements at the Trust.

15.16. The committee's terms of reference require it to receive assurance on the **arrangements for near miss reporting** at the Trust. Assurances were

received in November by way of a report from the Chair of the Quality, Patient Experience and Safety Committee on the near miss arrangements which noted that it will committee will continue to monitor this maturing area by way of the Putting Things Right Report.

15.17. At each meeting of the committee a report against the organisational **Audit Tracker** was received – Tracker 2.0. The committee received updates regarding development of Tracker 3.0 and improved reporting, which will continue into 2025/26. Directors whose actions were on the third and final date have appeared at the committee to provide assurances on closure plans.

15.18. In March 2025 the committee received an update regarding the work on the **committee specific induction programme**.

15.19. In November an update was received regarding the **implementation of the Quality and Performance Management Framework** (QPMF), with the related internal audit report. The committee agreed that it was sufficiently assured of the progress of implementation of the Framework to transfer oversight of continual effectiveness to the Finance and Performance Committee.

15.20. Other than in April, the **losses and special payments** report is received at each meeting of the Committee. Likewise, **the Local Counter Fraud** update report and **tender and single tender waiver** reports are taken in private session.

15.21. In March 2025 the committee received assurance from the Chair of the Quality, Experience and Patient Safety Committee that the **2025/26 Clinical Audit Plan** had been approved and was being monitored quarterly by that committee.

15.22. The **Register of Interests and the Register of Gifts and Hospitality** was received in April 2024. The committee noted the next stage for the development of the Trust's register which is for the cohort of decision-makers to be held centrally and published throughout 2024, which has now been completed.

15.23. A **risk management and Board Assurance Framework (BAF)** report was provided to each meeting. In year the committee received detailed reports and presentations on the development of the Risk Transformation Programme, in partnership with BDO. This work is considering the development of a strategic BAF, the development of a series of strategic risks, the development of risk appetite statements, and the options

available to reposition the Trust's highest scoring risks, risks 223 and 224. The final key area of this work is the implementation of a digital solution that is needed to underpin the enterprise risk and strategic risk management arrangements. The committee heard that in December and February 2025 the Board met with partners BDO to further this work.

15.24. In March the committee were introduced to the **Integrated Governance Programme**. The committee heard that the aim is to replicate good governance principles from the board and committee level, throughout the entire organisation, ensuring a flow of assurance from floor to board. The mapping of governance structures was received, and this serves as the 'single source of truth' for the Trust, and a baseline for the Quality and Performance Management Framework. The programme includes tiering principles setting out the rules of establishment and operating arrangements to streamline processes. The programme is a two to three-year initiative, with the next steps including the development of a handbook and further refinement of the governance structures.

15.25. In March the committee received the **Impact Assessment** Signpost document for information. This document will be linked to the new front covers to ensure decisions are made following the appropriate impact assessment process.

15.26. Member **reflections** after each meeting were as follows:

- In June, the committee reflected that despite capacity limitations, the future goals regarding scrutiny and assurance are optimistic and supported. They appreciated the pre-meetings with the Chair and auditors, as well as the display of quality improvement during the pre-meetings involving the committee Chair and Non-Executive Director;
- In July, the committee reflected that the spirit of collaborative with which the Trust, Audit Wales, and Internal Audit work to on the end of year reports, providing additional confidence and assurance for all parties;
- In April, the committee reflected that the reports were succinct and recognised the collective effort of all members of the teams that supported the chairs in their review of the effectiveness of their committees. The hybrid nature of the meeting was not as effective for those in the room given the configuration of the IT, however an action was agreed to review instructions for their use in all meeting rooms. The meeting was well chaired;
- In September, the committee reflected that the partnership working between the Trust and Internal Audit and Audit Wales was

evident. They welcomed the maturing journey with respect to risk and the lens on all areas of audit, of risk and of assurance for this meeting in line with the Committee's name change;

- In November, the committee reflected that the hybrid meeting worked well again, with chat kept to a minimum which was appreciated. Directors attending for assurance on third revised dates and their candid comments was seen as positive, and a good discipline for the committee to receive assurance. Members felt the meeting focused on key areas and that papers and presentations were of good quality. Audit reports were positive; however, members recognise resource and capacity issues will continue to be challenging, particularly over the coming months.
- In February, the committee reflected that extensive ground had been covered during the meeting and the high quality of the reports was commended. There was robust and constructive challenge and support from internal and external audit colleagues, which aids the committee's effectiveness and provides the necessary assurances. The significant contributions and reports prepared from various colleagues were noted. Additionally, members felt that the hybrid format worked well.

15.27. The 2024/25 Committee **cycle of business** was approved.

15.28. In year, the Chair took a different approach to **committee effectiveness** and conducted quarterly discussions regarding committee effectiveness, in line with the structure of the National Audit Office Toolkit, rather than waiting under year end to hold the discussion. The output of these discussions of continual effectiveness reviews were consolidated and received at the March 2025 meeting. At the May 2025 meeting committee also reviewed the **annual reports and endorsed changes to terms of reference** for all Board Committee and Advisory Groups.

15.29. The **Committee's priorities for 2024/25** are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

15.30. The Chair gave regular updates regarding the activity of **the All Wales Audit Committee Chairs Network**. At the September meeting the terms of reference for this group were received.

16. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This AAA report included reporting at a high level of matters taken in private session.

17. The Committee is not serviced by any Sub-Committees or task and finish groups that this time.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

18. The proposed changes to terms of reference for this committee for 2024/25 are marked up in **Annex 1** and include:

    18.1. The purpose section has been amended to include a responsibility to take account of the Trust's wellbeing objectives.

    18.2. The integrated governance programme has been incorporated into the terms of reference.

    18.3. Removal of the need to approve the Annual Quality Report, which will be endorsed by the Quality, Patient Experience and Safety Committee ahead of approval by the board.

    18.4. The ability for the committee to meet in private without management has been clarified.

    18.5. Clarification on membership nomenclature

    18.6. Emphasis on the need for three Non-Executive Directors over and above the quoracy requirements

COMMITTEE PRIORITIES

Priorities for 2024/25

19. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

Priority	Progress
Monitor the development of the Committee specific induction programme.	This priority has been delivered. A substantive update was received on this at the March 2025 meeting of the committee and the approach agreed. Additionally, a joint board and committee Chairs and Trade Union retrospective induction took place on 12 June and a committee

Priority	Progress
	member governance overview drop took place in August and September 2024.
Carry-over from 2023/24: Oversight of the development and implementation of the Quality & Performance Management Framework	This priority has been delivered. At the November 2024 meeting of the committee, it received a position update on the progress against the Quality and Performance Management Framework (QPMF), with the related internal audit report. The committee confirmed its assurance on the implementation of the QPMF and noted that oversight of the ongoing effectiveness of the Framework will be overseen by the Finance and Performance Committee (FPC)

Priorities for 2025/26

20. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. The committee will do so at its May 2025 meeting, and these will be provided to the board at its May meeting.

21. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

AUDIT, RISK AND ASSURANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2025/26

1. INTRODUCTION

1.2 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 **Audit, Risk and Assurance 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. INTRODUCTION

2.2 The purpose of the committee is to advise and assure the board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.3 Where appropriate, the committee will advise the board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

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 RESPONSIBILITIES

3.1 With regard to its role in providing advice to the board, the committee will comment specifically upon:

(a) the adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance process, including the Annual Governance Statement, providing reasonable assurance on:

(i) the organisation's ability to achieve its objectives.

(ii) compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others.

(iii) the efficiency, effectiveness, and economic use of resources; and

(iv) the extent to which the organisation safeguards and protects all its assets, including its people,

and to ensure the provision of high quality, safe healthcare for its citizens:

(b) the board's Standing Orders and Standing Financial Instructions (including associated framework documents, as appropriate) and receive a report from the Director of Corporate Governance/Board Secretary on any non-compliance.

(c) the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements'

letter of representation to the external auditors; the committee shall approve all financial procedures.

(d) the Schedule of Losses and Special Payments.

(e) the register of Single Tender Actions.

(f) the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports).

(g) the adequacy of executive and management's response to issues identified by audit, inspection, and other assurance activity.

(h) proposals for accessing Internal Audit services via Shared Services arrangements (where appropriate).

(i) anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

(j) any particular matter or issue upon which the board or the Accountable Officer may seek advice.

(k) the adequacy of the arrangements for Declarations of Interests, providing an annual report to the board to this effect.

(l) arrangements for the discharge of the Trust's responsibility as bailee for patients' property.

3.2 The committee will support the board with regard to its responsibilities for governance (including risk and control) by reviewing:

(a) all risk and control related disclosure statements (in particular the Annual Governance Statement) together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board.

(b) the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

(c) the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.

(d) the policies and procedures for all work related to fraud and corruption as

set out in the Welsh Government Directions and as required by the Counter Fraud and Security Management Service.

3.3 In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness. The committee will receive assurance on the integration and effectiveness of governance structures that span the entirety of the organisation from floor to board.

3.4 This will be evidenced through the committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the committee to review and form an opinion on:

(a) the comprehensiveness of assurances in meeting the board and the Accountable Officers assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

(b) the reliability and integrity of these assurances.

3.5 To achieve this, the committee's programme of work will be designed to provide assurance that:

(a) there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the board and the Accountable Officer through the committee;

(b) there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the board and the Accountable Officer through the committee and ensure all reported fraud concerns and ongoing investigations are notified to the committee.

(c) there are effective arrangements in place to secure active, ongoing

assurance from management with regard to their responsibilities and accountabilities, whether directly to the board and the Accountable Officer or through the work of the board's committees.

(d) the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity.

(e) the work carried out by the whole range of external review bodies is brought to the attention of the board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply.

(f) the systems for financial reporting to the board, including those of budgetary control, are effective.

(g) the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements.

(h) monitor progress against the requirement of the Auditors' Management Letter.

(i) receive and review key Trust Annual Reports e.g., Trust Annual Report (including the Annual Governance Statement) and make recommendations to the board for their adoption.

(j) review the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.

Risks and Audit

3.6 The committee has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust and that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance

Framework and each recommendation from the audit tracker, will be presented to an appropriate board committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. In addition, these committees will follow due process to escalate any issues to Audit, Risk and Assurance Committee for oversight, scrutiny and assurance. Regular reports will be provided to individual committees on those items for which they have responsibility for oversight and overall Trust-wide progress reports will be presented to each Audit, Risk and Assurance Committee.

3.7 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 DELEGATED RESPONSIBILITIES

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 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 board'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.

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.

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.

Access

4.7 The Head of Internal Audit and the Engagement Leads/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the committee.

4.8 The committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

4.9 The Chair of committee shall have reasonable access to Directors and other relevant senior staff.

Sub Committees

4.10 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 Finance and Corporate Resources (Committee Lead)
- Director of People
- Executive Director of Quality and Nursing
- Assistant Director of Operations, National Operations & Support
- Director of Corporate Governance/Board Secretary

- Assistant Director of Corporate Governance and Risk
- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General
- Trade Union Partners (x2)
- Other Directors will attend as required by the committee Chair

5.5 In the absence of the committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6 The Chair of the Trust Board shall not be a member of the committee but may be invited to attend meetings.

5.7 The Chief Executive (Accountable Officer) will be invited to attend meetings of the committee and will attend to discuss the process for assurance that supports the Annual Governance Statement.

5.8 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.

5.9 The committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and expertise e.g. Wales Audit Office, Internal Audit

5.10 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 they are unable to attend and the name of the member who will attend as the substitute.

Quorum

5.11 The quorum for meetings of the committee shall be two Non-Executive Directors.

5.12 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

5.13 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.

5.14 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.

5.15 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 no less than quarterly and otherwise as the Chair of the committee deems necessary, consistent with the Trust's annual plan of board business and calendar of meetings. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

6.3 The Chair of committee, External Auditor or Head of Internal Audit may request a private meeting if they consider that one is necessary.

Withdrawal of individuals in attendance

6.4 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 particular matters.

6.5 The committee may meet in private – without the presence of management – where necessary.

7. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1 Although the board has delegated authority to the committee for the exercise of certain functions as set out within these terms of reference, the board

retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.3 The committee, through its Chair and members, shall work closely with the board's other committees, including where appropriate joint (sub) 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 information;

in so doing, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall risk and assurance arrangements.

7.4 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.

7.5 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 committee shall provide a written, Annual Report to the board and the Chief Executive (Accountable Officer) on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

8.3 The board may also require the committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

8.4 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. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the committee, except in the following areas:

- Quorum (as set out in section 5)

10. REVIEW

These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

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

FINANCE AND PERFORMANCE COMMITTEE ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and committee terms of reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The committee met on 18 March 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The committee is established to enable scrutiny and review of the Trust's arrangements in respect of the:

    - overall financial position (both capital and revenue) of the Trust and its compliance with statutory financial duties.

- ability of the Trust to deliver on its core objectives as set out in the Integrated Medium Term Plan (IMTP).
- monitoring of the IMTP and ensuring achievement of key milestones.
- robustness of any cost improvement measures and delivery of key strategies and plans.
- 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.
- scrutinise business cases for capital and other investment.
- oversight of the development and implementation of the digital, estates, fleet, and environmental strategies.
- business continuity including emergency preparedness, resilience and response, cyber security, and cyber resilience.

MEMBERSHIP AND ATTENDANCE

6. The committee met six times in private and in public as scheduled in 2024/25 and was quorate on each occasion.

7. The committee is supported by the chair and three non-executive directors as members, and several prescribed attendees with good attendance. This year the new Joint Commissioning Committee meetings clashed with this committee's meetings, therefore the Executive Director of Strategy, Planning and Performance was deputised with full authority at a number of meetings.

8. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2024/25. The committee welcomed non prescribed attendees at various meetings as well as external guests.

9. The membership of the committee changed in year, as did the committee chair. Jayne Beeslee became Chair of the Committee effective 01 September 2024. The number of non-executive directors was reduced in year from four to three, with these changes.

COMMITTEE ATTENDANCE						
Name	**14 MAY 2024**	**16 JULY 2024**	**17 SEPT 2024**	**19 NOV 2024**	**16 JAN 2025**	**18 MAR 2025**
Joga Singh (Chair)						
Jayne Beeslee (Chair)						
Kevin Davies		Chair				
Bethan Evans						
Peter Curran			Chair			
Chris Turley						
Rachel Marsh	Hugh Bennett	Hugh Bennett	Hugh Bennett	Hugh Bennett		Hugh Bennett[1]
Lee Brooks						Mark Harris
Liam Williams				From Item 7	Penny Durrant	Wendy Herbert
Angie Lewis						
Carl Kneeshaw						
Jonny Sammut						
Trish Mills	Julie Boalch					
Hugh Parry						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

10. The only change to membership proposed for 2025/26 is the addition of the head of commercial when they are appointed.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

11. The committee's effectiveness was assessed through a facilitated discussion held at the meeting on the 18 March 2025, which included a review of its terms of reference and cycle of business.

Enhanced Report Writing and Assurance

- Respondents emphasised that reports should draw out key messages quickly and clearly by the use of concise executive summaries.
- There is a strong appetite for less volume overall, with a preference for quality over quantity. This would help the committee spend more time in meaningful discussion and debate, rather than navigating lengthy documents. Brevity in presentations was also suggested
- There was a call for a simpler and consistent format for presenting information—particularly in relation to key metrics. Members also stressed the

value of aligning on a small, agreed set of core metrics to improve consistency and reduce confusion.
- When reports fall short of providing adequate assurance or insight, feedback should be shared to improve future submissions.

Strengths of the Committee

- The committee is seen to operate efficiently, with positive feedback on its structure, governance support, and the hybrid meeting setup.
- Meetings are generally well-paced and well-chaired, with a good balance of engagement and participation.
- Members felt that the agenda is usually well-connected and that a significant amount of business is covered in a relatively short amount of time.
- Good quality reporting and discussions were also highlighted as current strengths.

Areas for Improvement

- Despite general satisfaction, several areas for improvement were identified. These include reducing duplication—particularly between the committee and board—and providing greater clarity on what business should come to the committee.
- A modular or more prioritised agenda could help focus attention on the most critical items, possibly supported by occasional deep dives into key issues and more time on risk.
- Some respondents questioned the current frequency of meetings and suggested reviewing it alongside quorum requirements.
- There was also a call for clearer boundaries around performance metrics and scrutiny functions to avoid ambiguity and overlap.

12. Changes to operating arrangements as a result of the above are set out at paragraph 19. Some areas not drawn through to changes include:

- The frequency of meetings was raised and the potential to duplicate matters coming to this committee and the board. This does occur, particularly in relation to the financial reporting and IMTP progress report. Whilst there is some reporting which must go to the board in any event, particularly related to finance, there is perhaps an opportunity during 2025/26 as the long term

strategy metrics of 'what good looks like' develops to take that to the board and report on IMTP progress less frequently from this committee to the board. However, given the focus on performance externally, it is not recommended to move this committee to a quarterly cadence whilst the board meets bi-monthly.

- The aim of the new templates, writing and presentation guidance is to reduce the volume of papers and ensure more succinct presentations which will go some way to reducing overall length of meetings. A new short form paper will be offered where a fuller SBAR report is not needed.

Management of the committee's work programme

13. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee other than the second Value Based Healthcare report (details below). The committee's business in 2024/25 included the following, full details of which are in the committee's AAA reports and minutes provided to the Board:

    13.1. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures. In September the committee were assured that the **EMS Operational Transformation Programme** purpose had been delivered, closed and evaluated. The committee noted that this was a significant initiative driven by the 2019 Demand and Capacity Review.

    13.2. The proposed **Board and Committee Level Key Performance Indicators for 2024/25** were presented to the Committee and endorsed at their July meeting. Additionally, the **MIQPR** is monitored at each meeting, with a particular focus on handover delays, lost hours and system pressures and the effect of this on performance. Notwithstanding this, good performance was noted throughout the year on ROSC (return of spontaneous circulation), Ambulance Care, and 111 performance.

    13.3. Following the meeting in September the board were made aware that that certain **Key Performance Indicators** were missing from the July/August 2024 Monthly Integrated Quality and Performance Report (MIQPR). These metrics include 111 clinical triage callback times (P1), National Reportable Incidents, timely responses to concerns within 30 days, implementation of the Duty of Candour, successful consult and close outcomes, NHS 111

dental calls, and consult and close volumes for NHS 111. This was due to data quality issues which had been identified within the 111 system, Advanced Practice Paramedics, and other quality indicators which were being addressed.

13.4. In May the committee were assured that the **commissioning intention arrangements for EMS and NEPTS** are built into the planning cycles, quarterly assurance cycles and support the work towards our strategic ambitions and transformational plans and monitoring of that will be included in the IMTP delivery reports.

13.5. **Financial performance** was monitored at each meeting, including budget position on revenue and capital. In addition to reviewing risk 139 (*the failure to deliver our statutory financial duties in accordance with legislation)* at each meeting. In September the committee noted that the EMT Band 5 business case had been submitted to the board. The risks relating to this were highlighted in the financial presentation and the Welsh Government monitoring return. The non-recurrent nature of this was stressed and the fact that this would not be sustainable going into 2025/26.

13.6. The risks in relation to the **EMT band 5 business case** continued to be highted to the committee throughout 2024/25 and were discussed in detail in January. The challenges that this poses for planning as part of the 2025/28 IMTP were stressed, including the fact that the allocation does not fully cover EMT band 5 costs, and there is no indication that these will be separately funded this year.

13.7. In January the committee discussed the **financial allocation for 2025/26**, noting an uplift to Health Boards of 1.77% compared to 3.67% this year. It is expected that this uplift will be passed through to providers, as has been the case in previous years. The only other funding assumed within the financial planning principles is for pay awards and the impact of the increase to employers National Insurance. The allocation letter also prescribes a savings target of at least 2%, which amounts to about £6.5 million for WAST. The Initial **2025/26 Revenue Budget** was received and endorsed by the Committee in March 2025.

13.8. The final 2023/24 **financial performance report for Month 12** was presented at the May 2024 meeting with a small surplus of £85k and the

capital expenditure of £22m being fully spent. Gross savings of £6.546m have been achieved against a target of £6.000m and the Public Sector Payment Policy was on track with performance, against a target of 95%, of 96.4% for the number, and 98.5% of the value of non-NHS invoices paid within 30 days. The committee congratulated all directorates for achieving this year end position.

13.9. An Audit Wales report, '**Review of Cost Savings Arrangements**' was received in November. This assessment was carried out across all NHS Wales bodies, and it looked at our approach to identifying, delivering, and monitoring sustainable cost savings opportunities. Overall, Audit Wales found that the Trust exceeded its overall 2023-24 savings target and continues to enhance its arrangements for identifying, delivering, and monitoring efficiencies and sustainable cost savings. The committee commended the teams on a positive report and noted that opportunities exist to reduce reliance on non-recurrent savings, strengthen financial capabilities across the organisation, and refine savings reporting to the board.

13.10. The committee received regular reporting on the **financial sustainability programme** and the identified initiatives including the support services review; service review; recruitment control panel; operations savings group; and income generation group.

13.11. The committee received an update on the delivery of the **Integrated Medium Term Plan** (IMTP) 2024-27 at each meeting with issues of delivery escalated where necessary. In May 2024 it reviewed the end of year position with respect to the 2023-26 IMTP and congratulated the team for the significant amount of work that was achieved. Updates on the development of the IMTP 2025-28 were received, as was the final version for endorsement to the Board in March 2025. Reports in year focused on the clinical model transformation and provided updates on the changes to the governance structures for the **Strategic Transformation Board** and its programmes, regarding the IMTP delivery structures. The committee took assurance from the detail regarding the revised structures, which consolidate the existing programme structures into a broader programme, framed around the revised clinical transformation model.

13.12. In March the committee received the proposed **IMTP 2025/28, which included the financial plan for 2025/26**. At this meeting the committee also received the draft Wellbeing Objectives for the Trust, which were under consultation. The Initial **Revenue Budget for 2025/26** was including with these reports at the March meeting.

13.13. In March the committee received an update/refresh to **the Quality and Performance Management Framework** for consideration, which was endorsed for onward approval by the board. Related to this in November the committee received the internal audit on the **Quality and Performance Management Framework which** returned an overall reasonable assurance rating, and one high priority recommendation related to the work programme and local frameworks.

13.14. The Committee received a number of reports on **Emergency Preparedness, Resilience and Response (EPRR)** and were assured as to EPRR arrangements and leadership. The **Welsh Government Annual Emergency Planning Report for 2023/24** was also reviewed regarding the Trust's compliance and readiness to meet its obligations under the Civil Contingencies Act 2004. This report highlighted capability gaps found through the Manchester Arena Inquiry work, a detailed series of papers on which were taken by the committee in closed session. Later in the year 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) increased in score from 15 to 20 and was escalated to the Board.

13.15. The Trust's **Incident Response Plan** was presented in July 2024 which sets out the framework for the Trust to respond to a range of incidents including mass casualty incidents and those requiring a specialist response. The committee had reviewed a significant re-write of the plan in October which took account of Manchester Arena Inquiry recommendations.

13.16. The **Business Continuity Annual Report 2023/24** was received in July 2024 and also presented at Board. The Committee were assured that the necessary plans and business continuity arrangements are in place for the most significant risks. A revised business continuity structure is in place to provide for senior management overview.

13.17. An update on the Decarbonisation Action Plan (DAP) was received by way of the **Environment, Decarbonisation and Sustainability Update** for May 2024 and September 2024 and January 2025. The committee noted the continuing progress of the Trust's Decarbonisation Action Plan (DAP) in response to the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan (NHSW- DSDP) which is overseen by the Decarbonisation Programme Board. The DAP has a range of actions which frame the Trust's decarbonisation response. Members were assured that an escalation plan is in development to ensure the Trust is undertaking all possible actions against identified risks and wider environmental considerations. In September the committee heard that the Trust has been successful in securing a proportionately higher share of government funding for decarbonisation projects, demonstrating efficient use of funds and delivery capabilities. Additionally, the service has been re-accredited with ISO 14001, marking it as the only ambulance service in the UK to hold this accreditation, reflecting its commitment to environmental management standards.

13.18. In September the committee received an update against the **2023/24 Estates Backlog Maintenance Update**, which demonstrated a significant reduction in backlog maintenance from over £15 million several years ago to the current levels, with a focus on reducing high and significant risk areas.

13.19. In September the committee received the annual **Waste Management Update for 2023/24,** which included compliance with changes to waste legislation in Wales (April 2024) require the Trust to recycle into four segregated waste streams, a move from two previously. Challenges with the requirements of the new Act were noted, including issues experienced with the contractor in the roll-out.

13.20. The annual **Fire Safety Compliance** report was received by the Committee in January 2025 with no issues to escalate to the Board.

13.21. **A value based healthcare update** was received in September 2024 which set out the progress of the key workstreams within its portfolio. A further update was not provided in the year as work was underway with external partners to develop this further. The work programme includes the following seven workstreams – Patient Recorded Outcome Measures

(PROMS), Patient Data Linkage, Patient Recorded Experience Measures (PREMS), Patient Level Information and Costing System (PLICS), Revenue Business Case Process, Evaluation Framework & Methodology, and Benchmarking. The portfolio for value based healthcare moved to the Executive Director of Quality and Nursing in year.

13.22. In September 2024 the committee received a deep dive overview of the **Cymru High Acuity Response Unit (CHARU),** highlighting its evolution, purpose, and current measurement. The committee found the presentation highly informative and particularly impactful, particularly with respect to utilisation and the cross-over to the clinical indicators being reported in the MIQPR.

13.23. In September a report was received on the activities undertaken by the Trust's **Hazardous Area Response Team (HART) and Special Operations Response Team (SORT),** a report against which is submitted to Welsh Government every quarter under the HART/SORT Service Level Agreement. The committee reviewed the annual report at this meeting.

13.24. In November the committee received an update on the **Mobile Data Vehicle Solution Project** following a survey that was delivered in summer 2024 with operational colleagues to gather feedback on the solution. Feedback highlighted key issues such as routing, graphical user interface design, mapping, incident management, and voice notifications and was not overall positive of the solution. These were shared and whilst many of these were already on their long-term plan as being common issues across all Trusts.

13.25. The committee reviewed the following internal audit reports in year:

- Data Quality (reasonable assurance);
- Quality and Performance Management Framework (reasonable assurance);
- Overtime Controls (reasonable assurance);
- 111 Digital Operations (substantial assurance);
- Vehicle Accident Management (limited assurance).

13.26. In May 2024 the committee received the draft **Digital Plan 2024-29,** which considered options to address essential resource gaps in our day to day digital services provision, and advancement of key digital

transformation initiatives supporting our IMTP and broader strategy. The final Plan was received for endorsement by the committee in July 2024, with the supporting Equality Impact Assessment.

13.27. Members received regular updates on the Trust's **Information Governance Toolkit**, which was undertaken to test the secure handling of patient data and compliance against legal and regulatory requirements. An improvement plan was in place, progress against which was reported to the committee throughout the year. Additionally regular **information governance reports** were received.

13.28. Updates were given in year regarding the implementation of the **Clinical Assessment Software** replacement, which went live on the 30 April 2024.

13.29. Regular updates were received on the **Digital KPIs** relating to data and analytics, ICT systems, service provision and projects within the IMTP.

13.30. Members **reflections** after each meeting included:

- In May the committee thanked colleagues and their respective teams for the effort in preparing well written papers and supporting good opportunities for scrutiny, challenge and support.
- In July the committee noted that it was the last meeting for the outgoing chair Joga Singh, who was thanked for his support and commitment to the Trust. Additionally, members agreed that the papers were of a high quality and there was feedback regarding how the agenda could be adjusted to better support meeting flow.
- In September the committee reflected that papers and presentations demonstrated transparency and good teamwork and integration across all areas, and the good progress being made.
- In November members reflected that the hybrid meeting worked well with a different room configuration and limiting use of the chat function. The papers were noted to be of a good quality and provided a good level of assurance.
- In January members reflected that the hybrid meeting approach worked well, and the papers were well presented and clear. However, there is a desire to ensure that sufficient time is allocated to items so that the meeting runs to time. Members commended the assurance received from directors and noted that 2025/26 will be a more challenging year, stressing there was a need to be clear on what was in,

and outside of, our control. The committee welcomed observers who commented that they felt welcomed and enjoyed the discussion.

- In March members reflected that the agenda and business was managed well, with sufficient time for each item which ensured comprehensive discussions. There was a focus on quality of information which provides good assurance. Additionally, members acknowledged the need to focus the committee's attention on relevant risks and minimising duplication where business is received at other committees.

13.31. As suite of **policies** were presented and approved in year. These were: Purchase Card Policy, the Waste Management Policy, Data Quality Policy, Records Management and the NHS Wales Procedure for Recovery of Overpayments (Salary and Expenses)

13.32. The committee **cycle of business** was approved.

13.33. **Risks** relevant to this Committee are reviewed at each meeting and the agenda is driven by these risks. The highest rated risks, 139 (failure to deliver our statutory financial duties in accordance with legislation) and 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), were the focus and drive agenda setting. Other risks related to cyber security, loss of critical IT systems, and recurrent funding from commissioners were reviewed regularly. A new risk was added to the corporate risk register in year and was presented to the board at its meeting in January. This is Risk 641 related to the **Manchester Arena Inquiry** with a score of 20. Members noted that a significant number of Inquiry recommendations had been implemented without additional investment, which has allowed for a reduction in the initial risk score.

13.34. The **annual effectiveness review** was conducted in the March 2025 meeting.

13.35. The **Audit tracker** was reviewed at each meeting, and good progress is being made to close management recommendations.

13.36. The **committee's priorities for 2024/25** are reviewed at each meeting and a more detailed update appears later in this report. The committee also reviews progress against its cycle of business at each meeting.

14. In private session the Committee took matters that were commercially sensitive and confidential. Most matters made their way to the Trust Board private session and where appropriate were reported in open session in accordance with the Standing Orders. Other matters taken in private session included updates on the Manchester Arena Inquiry recommendations, as well as cyber key performance indicators and closed business cases.

15. The board received a highlight (AAA) report from this committee by email circulation following each meeting which included alerts, advice, and areas of assurance. Where there was a shorter proximity of the meeting of this committee and the Board meeting, that report was provided verbally by the Chair and captured in the Trust Board minutes.

16. The committee is not serviced by any sub-committees or task and finish groups that this time.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

17. The proposed changes to terms of reference for this committee for 2024/25 are marked up in Annex 1 and include:

    17.1. The purpose section has been amended to include a responsibility to take account of the Trust's wellbeing objectives. Assurance on progress of these will be by this committee, noting that these are long-term objectives and therefore regular reporting of these will not be appropriate.

    17.2. Wording has been amended to avoid duplication and provide clarity, including:

    - The strategy development and delivery heading has been added and a delineation made between the long term strategy and complementary long term plans.
    - Removal of the need to receive assurance that a post-implementation review process was in place, as this was provided in 2023/24 via the Project Pathway Framework. Consideration of a post-implementation review trigger has been included following review of business cases/contracts over £500K and a note will be added to this effect on the cycle of business.

- The finance section has been revised to provide clarity around the revenue and capital approvals, including a specific section on endorsement of business cases/contract awards over £500K.
- A commercial section has been included, noting that the head of commercial will be appointed in 2025. They will join the membership of the committee on appointment.
- Clarity has been provided in the performance and planning sections, and a new infrastructure section added which deals with various estates and environmental issues. Previously reference to the estates plan and the fleet plan were included here but have now been moved to the long term plans section.
- The digital systems and strategy section has been removed and incorporated in the strategy and performance sections. Removal of the review of major projects does not mean they will not be reviewed, but that review will be triggered by the new section on post-implementation reviews and may also be driven by value and risk.
- The risk and audit section has been updated in line with the other committee terms of reference.
- Clarification on membership nomenclature
- Emphasis on the need for three Non-Executive Directors over and above the quoracy requirements

18. There are separate discussions taking place with the Executive Leadership Team on the appropriate leadership and committee oversight for the strategic objective 'being at the forefront of innovation and technology'. This may mean a refocus of the remit of the Academic Partnership Committee and that could lead to the digital elements of the Finance and Performance Committee being adjusted in year. This should be clearer in Q2.

19. The cycle of business for the committee has been amended in line with the adjustments to the terms of reference. Reporting frequency was discussed in the March meeting and has been reflected in the cycle of business for 2025/26 which was approved by Chair's Action.

PROPOSED CHANGES TO THE OPERATING ARRANGEMENTS

20. Proposed changes to operating arrangements for this committee are set out below. Some are relevant to arrangements across other committees also and they include:

    20.1. A board development session on the use of the MIQPR will be held on 24 April 2025, and the annual review of all MIQPR metrics will come through committees in May.

    20.2. A new finance dashboard is in development and will be considered by the committee in 2025/26.

    20.3. New report front covers and SBAR templates have been developed. They include a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will be accompanied by writing guidance and presentation guidance.

    20.4. Writing guidance will set out the purpose of executive summaries in an attempt to ensure they are reflective of the comments received by members of this and other committees, particularly as they relate to a greater focus on outcomes.

    20.5. Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee membership. This will ensure we are working towards a continuous improvement in paper length and assurance.

    20.6. A 'reading room' will be established in Ibabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight.

    20.7. Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged

to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.

COMMITTEE PRIORITIES

Priorities for 2024/25

21. The Committee received an update on progress against its priorities at each meeting. The 2024/25 priorities were:

Priority	Progress
The development and approval of the Digital Plan.	This priority has been delivered. At its meeting on in May 2024 the Committee received the Digital Plan Refresh 2024-29 and considered the options presented. The Committee noted that the funding for this Plan was included in the digital revenue allocation approved by the Executive Finance Group and included in the 2024/25 IMTP submission. At its meeting in July 2024 the Committee received final Digital Plan 2024-29 which was endorsement, and it was approved by the Trust Board on the 25 July 2024. This priority has been fulfilled by the Committee.
Oversight of the potential commercialisation streams in the Financial Sustainability Programme.	Whilst there was reporting on the financial sustainability programme in 2024/25, the head of commercial was not in post. That role has been re-advertised as at the end of the financial year and therefore the committee may wish to hold over this objective until 2026/27 when that programme has had an opportunity to get some traction. Progress more generally on the programme was reported in 2024/25.

Priority	Progress
Focus on the new elements of its terms of reference relating to Information Governance and Information Security.	This priority has been delivered. Receipt of the Information Governance Toolkit and Information Governance (IG) Reports have been included on the Committee's Cycle of Business for 2024/25. The information governance and information security assurance updates have been received at each meeting of the committee. The Data Quality Internal Audit Report was also received. The committee received a deep-dive item on cyber-security risks in closed session at its meeting in July 2024 and received cyber reporting throughout the year as cycled.

Priorities for 2025/26

22. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. The committee will do so at its May 2025 meeting, and these will be provided to the board at its May meeting.

23. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2025/26

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 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 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 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 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 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 Monitor the effectiveness of commissioning arrangements.

3.20 Review and consider matters relating to demand and capacity including proposals for reviews in this area and recommendations arising from such reviews.

Infrastructure

3.21 Review proposals for acquisition, disposal, and change of use of land/buildings.

3.22 Receive assurance on compliance with environmental regulations and national targets in relation to the environment and sustainability.

3.23 Receive assurance on compliance with fire safety and waste regulations.

Business Continuity and Cyber

3.24 Oversight and scrutiny of the Major Incident Plan and Business Continuity Plan and receive assurance that such plans are effective.

3.25 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.

3.26 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

3.27 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.

3.28 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.

3.29 Receive assurance on, and review effectiveness of the Trust's information security protocols.

3.30 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 Approval of policies within the remit of the committee

Risk and Audit

3.32 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 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 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.

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

PEOPLE AND CULTURE COMMITTEE ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The committee met on 18 February 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The committee is established 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.

MEMBERSHIP AND ATTENDANCE

6. The committee met four times as scheduled in 2024/25 and was quorate on each occasion.

7. The committee is supported by the Chair and three Non-Executive Directors (NED) as members, and several core attendees with good attendance. The membership of the committee changed in year following changes to the NED composition. Joga Singh left the Trust Board on the 31 August 2024 and following her appointment as a NED in Autumn 2024, Hayley Hutchings is now a member of the committee. The meeting of the committee in February 2025 was her meeting.

8. During the year the leadership structure within the People and Culture Directorate changed and the role of the Director of People and Culture was separated to provide for a Director of People and a Director of Culture Change. Angela Lewis begun in the role of Director of Culture Change in Autumn 2024. Carl Kneeshaw was appointed to role of Director of People, with November being his first meeting of the committee.

9. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2024/25. The Committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE				
Name	**9 MAY 2024**	**8 AUGUST 2023**	**16 NOVEMBER 2023**	**20 FEBRUARY 2024**
Ceri Jackson				
Bethan Evans				
Joga Singh				
Hayley Hutchings				
Hannah Rowan				
Angela Lewis				
Carl Kneeshaw				
Chris Turley		Left at end of item 13		
Lee Brooks	Sonia Thompson			
Liam Williams	Jonathan Turnbull-Ross			
Estelle Hitchon				
Andy Swinburn				
Alex Crawford				
Trish Mills	Julie Boalch			
Damon Turner				
Marcus Viggers				
Christian Fox	Hugh Parry			
Tim Cahalane				

	Attended
	Deputy attended
	Apologies received
	No longer member

10. The Chair of the Committee until 31 March 2024 Paul Hollard, completed his eight year tenure on the Board at the end of the 2023/24 financial year. Ceri Jackson became the Chair from 1 April 2024. Due to the aforementioned changes to the committee composition in year there are no changes to membership proposed at this time.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

11. The committee's effectiveness was assessed through a facilitated discussion held at the meeting on the 18 February 2025, which included a review of its terms of reference and cycle of business.

Enhancing Report Writing and Assurance

- Respondents strongly emphasised the need for clarity and precision in both the committee's requests and the submitted reports. They suggested implementing a standard pro-forma to minimise duplication and enhance focus. Additionally, the importance of having a clear objective for each report was highlighted, along with the suggestion to provide questions in advance to tailor presentations more effectively.
- Suggestions included shorter, less verbose papers, and fewer but more in-depth reports to allow for quality discussions. The use of visual aids and succinct presentations were also recommended to improve understanding and engagement.
- Participants expressed a desire for a shift towards a more strategic focus. They recommended linking reports together to provide a cohesive understanding of issues and employing thematic focuses to enhance the relevance of discussions.
- There is a call for a more manageable meeting agenda that allows ample time for discussions and deeper dives into significant topics. This includes taking papers as read to maximise discussion time and ensuring that reports are concise with a clear ask directed at the committee.

Strengths of the Committee

- The committee benefits from strong leadership. Responses praised the chairing style for being inclusive and keeping meetings on schedule. This effective governance helps maintain focus and ensures productive discussions.
- Members appreciate the high level of engagement and the quality of discussions during meetings. Features such as the hybrid meeting format were highlighted as particularly effective, allowing for broad participation. The respectful and open environment fosters good debates and challenging discussions, which are viewed positively.
- Good secretariat support and the responsiveness of the People and Culture team are crucial elements that contribute to the committee's success. The development of specific metrics and continuous feedback are also valued, enhancing the committee's effectiveness.
- The use of staff stories is a powerful tool for making real-life impacts tangible. Having the right people in the room, including supportive challenges from Non-Executive Directors enhances the richness of discussions and the committee's ability to reflect on and address key issues.

Areas for Improvement

- Respondents expressed a strong desire for a more strategic focus and a streamlined approach to meetings. Suggestions included reducing the number of reports and papers to allow for more in-depth discussions on fewer, more significant topics. There is a call for shorter agendas and clearer, more concise presentations to ensure that time is used effectively.
- The issue of overlapping content with other committees (MIQPR in particular) was mentioned. Recommendations included better coordination and consideration of overlaps, as well as potentially eliminating the SBAR format to simplify the documentation process.
- Providing questions before meetings and allowing more time for questioning during sessions were suggested to enhance engagement. Additionally, a focus on practical implications ('the so what') and actionable outcomes from discussions is encouraged.
- There is a need to focus meetings more on issues that directly impact the committee's objectives and less on operational details that could be managed at a different level. Respondents want themes for meetings that allow for

deeper exploration of specific issues and connecting the dots across various topics.

- The workload associated with preparing for committee meetings is a concern, with too much falling on too few people. Improving the diversity of the committee and ensuring presenters are concise and focused on outcomes are also highlighted as areas for improvement.

12. Changes to operating arrangements as a result of the above are set out at paragraph 20. Areas not drawn through to changes include:

- The length of the meetings arose frequently in feedback. All attempts will of course be made to reducing length of the meetings where that is appropriate. This is however a quarterly meeting with a large remit. The agenda will continue to be set with the chair and executive leads shortly after the last meeting with a strong focus on the flow, timing, and specifics for particular reports. This will be done with the above feedback in mind.

- An integral aspect of our annual effectiveness reviews is to ensure the committee focuses on the appropriate matters at the optimal times. Adjustments to the terms of reference and cycles of business have now been made to reflect this. Consequently, directors have considerable influence over the content of papers presented to the committee. We encourage report writers to consider this and reflect on the feedback regarding the volume and focus of papers, as well as approaches to presentations, when preparing submissions.

- The aim of the new templates, writing and presentation guidance is to reduce the volume of papers and ensure more succinct presentations which will go some way to reducing overall length of meetings. A new short form paper will be offered where a fuller SBAR report is not needed.

Management of the committee's work programme

13. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the committee and in this respect, it has discharged its responsibilities in providing assurance to the Board. The committee's business in 2024/25 included:

13.1. **The lived experiences of our people** were shared at the meetings:

- In May the Committee heard from a member of staff on the front line – **Matthew T Jones, a Locality Manager** in Pembrokeshire who attended the committee to share his learning on the work he has undertaken on the attendance and sickness within his locality. Matt's reflections included: having a safe space to learn from mistakes in the beginning of the project, linking into the People & Culture Plan, an excellent example of how a whole team in the Emergency Medical Service has been involved in supporting staff back into work following a period of absence, the work that has been done to support staff in complex cases and the innovation and creative thinking within his team.

- In August, **Kayleigh Wheeler, Operations Manager Ambulance Care**, shared her journey to her current leadership role at WAST. Despite facing homophobia, misogyny, and bullying, Kayleigh received support from colleagues and became active in the WAST Voices network. She aims to amplify quieter voices and address bullying and harassment through various campaigns and sessions. Her presentation highlighted her resilience and commitment to positive change at WAST. While challenges remain, Kayleigh believes the organisation is progressing with improved accessibility and transparency of senior leaders.

- In November, **Ela Lewis,** with a background in nursing (registered nurse) and currently a Senior Project Manager for the Connected Support Cymru project, shared her inspiring journey as a change champion. Ela highlighted the crucial role of creating a supportive environment where colleagues can express their emotions and collaborate effectively on the change journey. Ela's contributions, especially in volunteer coordination and the implementation of remote clinical devices, have been notably impactful, earning her widespread gratitude within WAST**.**

- In February the committee heard from **Mark Churchill**, a colleague from Ambulance Care spoke to the committee of his role. In his current role, Mark transports vulnerable and older patients within Ambulance Care. Mark emphasised the importance of building relationships, providing social support, and ensuring patient safety and comfort. He highlighted the dedication of his colleagues and their commitment to treating patients with dignity and respect.

13.2. The **2024-2030 Strategic Workforce Plan** was received in August. This was reviewed and endorsed by the committee before approval by the Trust Board. This Plan directly aligned to the focus of the IMTP and the Trust's long-term vision.

13.3. At the August meeting the committee received a suite of **annual reports in respect of 2023/24** for consideration which required approval by the Trust Board. These were the **Strategic Equality Plan Annual Report** 2023/24, the **Workforce Equality Monitoring Report** 2023/24, the **Gender Pay Gap Report** 2023/24, the **Welsh Language Annual Report** 2023/24. The latter report was presented bi-lingually, and the breadth and depth of the report was appreciated by members.

13.4. The committee began receiving a **Cultural Themes and Trends** report at every other meeting. In August data relating to employee relations cases, sickness and training and the impact on the culture at WAST, was received. It was note that there had been an increase in employee relations cases, but as of August 2024 over 200 individuals had received training in compassionate practices, and 70 had attended investigating officer training. In February the committee received an introduction to the 'WAST Way', which will launch in Q1/Q2 2025/26. The framework sets out clear leadership behaviours based on three core principles of 'care', 'valuing everyone', and 'connecting'.

13.5. Related to this at its meeting in February 2025 an update was received on the work around **compassionate practices** and the related actions in the compassionate practices action plan.

13.6. The committee noted the significant amount of change taking place across WAST which brings pressure on our people, both with respect to change itself, but also the pace of change. This was the primary focus for the meeting of the committee in November, at which a session was delivered on **change management**. The aim is for change management to become a natural part of every process, whilst having oversight of the impact of change on our people. d. Angela Lewis confirmed her commitment to ensuring that change management principles and techniques are embedded in the leadership work within the Trust, particularly through our 'The WAST Way'. This will ensure that change management is at the heart of leadership development. This following progress related to this work was noted:

12.6.1 **Change Community:** The Trust has established a change community focused on creating a culture of collaboration, trust, and growth. This community aims to build a supportive, non-judgmental environment where colleagues can practice new skills, test their thinking, build confidence and competence, and share experiences to learn from each other.

12.6.2 **Structured Approach**: The Trust has developed and implemented a structured approach to change management centred around the ADKAR model, which focuses on individual change to achieve organisational results. This model breaks change down into clear stages and is action and outcome focused.

12.6.3 **Embedding Change Management**: The approach is being embedded within the clinical model transformation programme, with dedicated change leads from the change community supporting program workstreams. The goal is to ensure a consistent approach to change management across the programme.

13.7. The committee received an update on the Trust's **Speaking Up Safely** arrangements at its meeting in February 2025, and it was noted at the November meeting that the Audit, Risk and Assurance Committee were assured on our speaking up arrangements. Additionally, the CEO roadshows in Autumn 2024 included a focus on speaking up, with board members pledging their support.

13.8. The **Partnerships and Engagement report** related to the remit of the committee was received in August. This focused on regional Partnership Boards and the Wellbeing of Future Generations Act. The report signifies a move towards more strategic engagement and partnership working, aligning with broader organizational and national priorities.

13.9. The committee received insights from the **NHS Staff Survey** which focused on stress and burnout in the workplace and the links between addressing these issues with our overarching People and Culture ambitions and Health and Wellbeing Plan.

13.10. The **Staff Development Outline Plan** was received in May. It was noted that this is a deliverable in the People and Culture Plan, which aims to provide equity in development opportunities for our people to undertake their roles and benefit from progression opportunities.

13.11. Related to this activity, the committee acknowledged the significant volume of **learning and development** taking place at all levels of the Trust. The committee was introduced to the '**WAST Way'** in year, a behavioural approach which intends to enable a culture of compassionate, inclusive and collaborative leadership includes leadership behaviours which are drafted and engagement on these is underway.

13.12. **Health and Safety updates** were received with a focus on RIDDOR compliance, risk assessment compliance, manual handling, the effects of diesel fumes on our people (which was also the subject of the advisory group WASPT discussions), and violence and aggression. These updates included several positive aspects such as high compliance rates for RIDDOR reporting which demonstrates a grip of control and flows of work in the Trust. Additionally in August, the committee received the **2023/24 Health and Safety Annual Report** which was approved. Members noted the maturing culture of health and safety in WAST and the focused attention the team had throughout the year.

13.13. The **Health and Well-being Plan 2025-2029** was received in February 2024 for comment and subsequently received in November 2024. The committee endorsed the Plan for submission to the Trust Board for approval. The plan showed the high-level outcomes, with local action plans sitting behind them focusing on meeting the basic needs of staff, promoting well-being, providing preventative and reactive support, all while maintaining service quality.

13.14. A follow up report on the **Seasonal Influenza Campaign 2023/24** report was received. The Trust's final uptake of staff vaccinated for the **Seasonal Influenza Campaign 2023/24** was 36.5%, which is a decrease of 8% from last year's campaign. Lessons learnt from this campaign have informed an extensive list of areas that require continued development for future flu campaigns.

13.15. The Committee received assurance on the processes in place for 2024 **registration and revalidation** with respect to the Nursing and Midwifery Council and noted 100% compliance.

13.16. **Updates are received from the Director of People and Culture** at each Committee, and these were changed in year to reflect a new look and a balanced view on both successes and challenges. Following the change to the structure of the People and Culture Directorate in year and the separation of the people and culture elements of the Director's remit, the committee began receiving updates from the Director of People and the Director of Culture Change as of November 2024.

13.17. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures.

13.18. The **MIQPR** and **People and Culture Plan metrics** were received at each meeting, with a particular focus on sickness absence levels, recruitment, PADRs, statutory and mandatory training, moving on interviews, and shift overruns. At the May meeting a deep dive was received on the **disciplinary processes and compassionate practices** approach in the Trust.

13.19. In private session in August, the committee received the **2023/24 Workforce Race Equality Standards Report** for 2024. The report and proposed action plan were endorsed and subsequently submitted to the Trust Board for approval.

13.20. The committee approved the following **policie**s in year:

- Homeworking Policy
- Professional Regulation Policy
- NHS Wales Respect and Resolution Policy
- Welsh Language Policy
- Driving At Work Policy
- Occupational Health Policy
- Recruitment and Selection Policy
- Occupational Immunisation Policy
- Equality Impact Assessment Policy
- Bank Worker Policy

13.21. In private session the Committee looks at **suspensions** over four months and **Employment Tribunal** cases.

13.22. **Reflections** are taken at the end of meetings and included:

- In May, it was noted that the first hybrid meeting post-Pandemic worked well, but that there are procedural considerations which must be considered given this approach. Additionally, it is important to ensure there are sufficient breaks included.
- In August it was noted that the meeting was well Chaired and there were many positive items being discussed, including the staff story and the progress shown within the Health and Safety Annual Report.
- In November, the committee felt that the discussions were less transactional and future focused, The importance of taking a holistic view of people and culture activities was noted.

13.23. The Committee **cycle of business** was approved in May 2024.

13.24. **Risks** relevant to this Committee are reviewed at each meeting and the agenda is driven by these risks. The highest rated risks, sickness absence (160), reputation (201) and latterly Trade Union relationships (163) were the focus and drive agenda setting. Risk 163 was presented in detail to the WASPT for the first time in May 2024, in recognition that this risk is dynamic.

13.25. The **annual effectiveness review** was conducted in the February 2025 meeting. As detailed earlier in this Return the approach to the 2024/25 review was different to previous years.

13.26. The **Audit tracker** and actions assigned to the committee were reviewed at each meeting. Good progress is being made to close management recommendations.

13.27. The reasonable assurance **Retention of Staff** Internal audit report was received, Key matters arising from included finalisation and ratification of the 'moving on interview' process. The purpose of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Trust in relation to staff retention.

13.28. The **Seatbelt Action Plan** Internal Audit was received, which gave a reasonable assurance opinion. The purpose of this audit was to review the deployment of the seatbelt action plan, to ensure the safety of crews and patients on board Trust vehicles, and to assess compliance.

13.29. The reasonable assurance Internal Audit on **Disciplinary Case Management** was received. The purpose of this audit was to assess the adequacy of the arrangements in place for the management of the disciplinary process, and to focus on the demonstration of compassionate leadership principles, in addition to compliance with the Trust's defined disciplinary processes.

13.30. The reasonable assurance Internal Audit report on **Volunteers Governance** was received. The purpose of the audit was to review the adequacy and effectiveness of the Trust's governance and operational management of volunteer activities.

13.31. The **Exposure to Fumes** internal audit report was received, with a reasonable assurance opinion. The purpose of this audit was to evaluate the actions being taken by the Trust to ensure the health and wellbeing of staff exposed to fumes as a result of delays in handovers of care at hospital.

13.32. The **Resourcing Policy** internal audit was received, with a limited assurance opinion. The purpose of this audit was to review the Trust's Resourcing Policy, its compliance with national terms and conditions, and to assess its application as an enabler for effective resource production.

14. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. In November that report was provided verbally due to the proximity of the meeting and the Board meeting.

15. The **Committee's priorities for 2024/25** are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

16. The Committee is serviced by one Sub-Committees, which is the Welsh Ambulance Service Partnership Team (WASPT). WASPT held its first meeting in April 2023 and the AAA Highlight Reports provided to each meeting set out the work of this advisory forum in the year.

17. The operational and corporate sub-structures that feed into WASPT, including local partnership forums were formed in 2023. These forums provide opportunities for resolution and escalation at a more local level, focusing WASPT on strategic issues.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

18. The proposed changes to terms of reference for this committee for 2024/25 are marked up in **Annex 1** and include:

    18.1. The purpose section has been amended to include a responsibility to take account of the Trust's wellbeing objectives.

    18.2. The delegated responsibilities have been re-ordered to align to the People and Culture Plan.

    18.3. Wording has been amended to avoid duplication and provide clarity.

    18.4. Additions include:
    - Assurance that workforce and resourcing plans are fit for purpose and ensure the right skills mix (noting that there is a desire to avoid duplication with other committees, particularly the Quality, Experience and Patient Safety Committee).
    - Enhanced assurance reporting on leadership development and succession planning
    - Inclusion of HEIW commissioning intentions
    - Clarification on membership nomenclature
    - Emphasis on the need for three Non-Executive Directors over and above the quoracy requirements

19. The cycle of business for the committee has been amended in line with the adjustments to the terms of reference. Reporting frequency was discussed in the February meeting and has been reflected in the cycle of business for 2025/26 which was approved by Chair's Action.

PROPOSED CHANGES TO THE OPERATING ARRANGEMENTS

20. Proposed changes to operating arrangements for this committee are set out below. Some are relevant to arrangements across other committees also and they include:

    20.1. Members were encouraged to pose questions to report writers before meetings and allowing more time for questioning during sessions were suggested to enhance engagement. There is functionality in Ibabs to do this.

    20.2. Bringing into the committee the progress reports on 'what good looks like' for the strategic objective of 'enabling our people to be the best they can be' will support the call for more of a strategic focus.

    20.3. A reduction in the reporting against the audit tracker is being considered by ARAC in an attempt to reduce volume for committees and increase assurance. More detail on this will come back to the committee in due course.

    20.4. New report front covers and SBAR templates have been developed. They include a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will be accompanied by writing guidance and presentation guidance.

    20.5. Writing guidance will set out the purpose of executive summaries in an attempt to ensure they are reflective of the comments received by members of this and other committees, particularly as they relate to a greater focus on outcomes.

    20.6. Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee membership. This will ensure we are working towards a continuous improvement in paper length and assurance.

20.7. A 'reading room' will be established in Ibabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight.

20.8. Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.

COMMITTEE PRIORITIES

Priorities for 2024/25

21. The Committee received an update on progress against its priorities at each meeting. The 2024/25 priorities were:

Priority	Progress
Impact of wellbeing initiatives on our people.	• The upcoming Cultural Themes and Trends Report (to be received at the February 2025 meeting) will include consideration of the employment relations cases, sickness absence and compassionate practices. There will also be a focus session (as part of the Cultural Themes and Trends item) on sickness absence received at the February 2025. • The Health and Wellbeing Plan which was received by the Committee in November 2024 - includes commentary on the Trust's approach to understanding the impact of wellbeing initiatives on our people. This Plan was subsequently approved by the Trust Board at its meeting in November 2024. • The Committee regularly receives the People and Culture Plan Metrics, the Workforce Scorecard, and the MIQPR, through which it will understand the impact of various wellbeing initiatives on our people. Additionally, the Committee receives the output of 'Pulse Surveys' and annual NHS Staff

Priority	Progress
	Survey, with the associated actions plans – both of which are programmed in the Committee's Cycle of Business.
Culture of conversations with a focus on communication and conversations with managers and their people.	• The Trust's focus on a 'Culture of Conversation' continues. A significant aspect of our improvement strategy is moving beyond simply focusing on the completion rates of PADRs. We are working towards making every PADR conversation meaningful, ensuring that these discussions reflect our values of compassion, inclusivity, and collaboration. • This shift aligns with the development of *Our WAST Way*, a new behaviours and development framework for leaders and managers that outlines their responsibilities in creating a positive and supportive work environment. The Committee will receive updates regarding the development of *Our WAST Way* at its meeting in February 2025. The '*Our WAST Way*' intends to incorporate the importance of change management skills for our people. It is noted that the Committee received an update on development on change management initiatives in the Trust at its meeting in November 2024. • Additionally, the Committee continues to have a focus on the organisational culture, with 'Cultural Themes and Trends' reports being brought forward regularly. The Committee received this report at its meeting in August 2024. The next 'Cultural Theme and Trends Report' will be received by the Committee in February 2025, in line with the Cycle of Business.

Priority	Progress
A continued focus on equality, diversity and inclusion and the implementation of the strategic equality objectives.	• The Committee has an ongoing focus on equality, diversity and inclusion – with the relevant business having been incorporated into its annual Cycle of Business. The Director of Culture will provide updates to the Committee regarding the work of the Equality, Diversity and Inclusion Steering Group (EDISG), as required. The EDISG will be supporting the implementation of the Strategic Equality Objectives from which the Director of Culture will provide assurance to the Committee. • The Trust is committed to ensuring that equality, diversity and inclusion are integral to all we do within People and Culture. Rather than viewing EDI as a separate initiative, we strive to make it a continuous golden thread that connects every workstream. By doing so, we help colleagues see and embrace EDI as foundational to our work, creating a space where decisions are influenced by our commitment to inclusion and equity. • Alongside embedding EDI into our everyday practices (through delivery of our Strategic Equality Objectives), we are committed to driving forward the successful delivery of our Statutory Action Plans. Specific initiatives will also include partnering with Higher Education Institutions to increase student diversity and launching targeted campaigns to attract candidates from a wide variety of backgrounds for the full range of career opportunities within WAST. • At the August 2024 meeting the Committee received the Strategic Equality Plan Annual Report for 2023/24, the Annual Workforce Equality Monitoring Report for 2023/24, the Annual Gender Pay Gap Report for 2023/24, and the Workforce Race Equality Standards Report for 2023/24, and the Welsh Language Annual Report for 2023/24. These are the key matters of annual

Priority	Progress
	reporting regarding equality, diversity and inclusion.
The Trust's approach to development of our people.	• At its meeting in May 2024 the Committee received the 'Staff Development Outline Plan' which is a deliverable of the People & Culture Plan. The aim of this is to provide equity in development opportunities for our people to undertake their roles and benefit from progression opportunities. • At the May meeting the Committee were assured that mapping was underway on professions and roles, which will define skills and competencies. An update will be given to the Committee at a future date. It is noted that the 'Learning and Development' reporting is still in development. • The People and Culture Plan metrics – which the Committee receives at every meeting – includes metrics regarding the statutory and mandatory training (giving organisational compliance figures) in addition to the MIST compliance. • The People and Culture Plan metrics provided to the Committee also include qualitative feedback regarding the Trust's learning and development initiatives, which enables us to take a continuous improvement approach to the development of our people.

Priorities for 2025/26

22. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. The committee will do so at its May 2025 meeting, and these will be provided to the board at its May meeting.

23. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

PEOPLE AND CULTURE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2025/26

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.

3.14. Receive and endorse the commissioning intentions for training and education through HEIW and others

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 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

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.

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE (QUEST) ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which the board's committees form an integral part.

4. The committee met on 04 February 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The committee is established to scrutinise improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm. It provides oversight of and seeks assurance on statutory and regulatory compliance, including but not limited to the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

MEMBERSHIP AND ATTENDANCE

6. The committee met four times as scheduled in 2024/25 and was quorate on each occasion.

7. The committee is supported by the Chair and three Non-Executive Directors as members, and a number of core attendees. The number of Non-Executive Directors was reduced in year to three, as of the 01 January 2025. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2024/25. The committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE				
NAME	**07 MAY 2024**	**13 AUGUST 2024**	**05 NOVEMBER 2024**	**04 FEBRUARY 2024**
Bethan Evans (Chair)				
Kevin Davies				
Ceri Jackson	Chair			
Liam Williams				
Andy Swinburn		From 1100[1]		
Lee Brooks	Jonathan Edwards	Pete Brown (open)		
Rachel Marsh	Hugh Bennett	From 1120[2]	Hugh Bennett until 2pm	
Jonny Sammut				
Trish Mills	Julie Boalch			
Mark Marsden				
Hugh Parry				
Henry Garrard				

	Attended
	Deputy attended
	Apologies received
	No longer member

8. The membership of the committee was revised effective quarter four of 2024/25 in response to changes to the Non-Executive Director membership of the Trust Board, as indicated above. This includes Rhiannon Beaumont-Wood as a member of the committee. The February 2025 meeting of the committee was her first meeting.

9. No changes to membership are proposed at this stage.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

10. The committee's effectiveness was assessed through a facilitated discussion held at the meeting on the 04 February 2025, which included a review of its terms of reference and cycle of business.

Enhancing Report Writing and Assurance

- Feedback highlights a strong preference for enhanced clarity and structure in the processes of report writing. Key points include the need for standardised templates and clear work programmes to streamline reporting and reduce redundancies. Tools such as AI writing aids and succinct executive summaries are also seen as valuable additions to support these goals, as well as a limited word count in papers.
- Respondents also advocate for better data flows to drive dashboard reporting and clarity on the role of the committee with respect to the MIQPR.
- There is a desire to better triangulate reports on the agenda, and alignment reports with strategic priorities, and to ensure they are outcome-focused and actionable.

Strengths of the Committee

- The effectiveness of the chairperson and the balanced dynamic of challenge and support within the committee were frequently praised.
- The leadership is noted for promoting an inclusive atmosphere and ensuring patient stories are central to discussions, which enhances the patient-centred focus. The integration of lived experiences and maintaining a consistent quality focus are seen as pivotal to the committee's success.
- The committee's strengths include strong engagement, regular attendance, a culture of openness and transparency, and robust reporting to the board with escalations where appropriate.

Areas for Improvement

- There is a consensus on the need for more efficient and effective meeting management. Suggestions include shorter meetings or splitting lengthy sessions over two days to maintain engagement and reduce fatigue.
- Respondents call for more concise agendas and reports, and effective executive summaries, which would allow better preparation and more strategic discussions. Presenters should assume the paper has been read and give over more time to questions. More clarity on the flow of papers through the internal governance routes may help to shorten the detail.

- There's also an emphasis on aligning meeting materials more closely with the organisation's strategic objectives and improving the timing of paper distribution.
- Additionally, a shift towards a greater focus on outcomes (the 'so what') and continuous improvement is recommended to enhance the dynamism and impact of committee sessions.

11. Changes to operating arrangements as a result of the above are set out at paragraph 17. Some areas not drawn through to changes include:

    - The length of the meetings arose frequently in feedback with some suggestions to move them to bi-monthly or split the quarterly meeting over two days. It was felt that at this stage this would not be appropriate, especially given that the remit of the committee was deemed to be appropriate. There is a regular 45 minute agenda setting meeting with the chair and executive leads shortly after the last meeting which discusses in detailed the flow, timing, and specifics for particular reports where appropriate.

    - An integral aspect of our annual effectiveness reviews is to ensure the committee focuses on the appropriate matters at the optimal times. Adjustments to the terms of reference and cycles of business have now been made to reflect this. Consequently, directors have considerable influence over the content of papers presented to the committee. We encourage report writers to consider this and reflect on the feedback regarding the volume and focus of papers, as well as approaches to presentations, when preparing submissions.

    - The aim of the new templates, writing and presentation guidance is to reduce the volume of papers and ensure more succinct presentations which will go some way to reducing overall length of meetings. A new short form paper will be offered where a fuller SBAR report is not needed.

    - There was feedback on the availability of papers, however the majority of papers are uploaded to Ibabs and the Trust's website seven days before the meeting. For this meeting however there was an issue with availability on the day of the meeting as some adjustments to the papers were made.

Management of the committee's work programme

12. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the

committee and in this respect, it has discharged its responsibilities in providing assurance to the Board. The committee's business in 2024/25 included:

12.1. In 2024/25 the Trust continued to review and evolve its clinical model, and the committee heard updates on the progress of this work through the **Clinical Model Transformation Programme (CMT)** in the context of wider system pressures. Assurance was given to the committee on the internal governance arrangements for the programme through the CMT Programme Board that reports to the Strategic Transformation Board demonstrating a commitment from the Trust to work towards safer care and continual improvements for patient safety. particular the committee received the following information and assurances on the CMT:

12.1.1. The committee heard of the introduction of the new **Clinical Navigator role,** which will allow clinicians to use their expertise to quickly assess patients and determine whether they require immediate emergency ambulance dispatch or are suitable for remote clinical management.

12.1.2. The **Clinical Advisory Group (CAG)** was established in year to provide clinical oversight and strategic support to the CMT. The committee heard that the CAG reports to the already established Clinical Quality Governance Group and the CMT Programme Board.

12.1.3. The committee received the **Quality Impact Assessment** (QIA) for the CMT in private session in November and a revised QIA in February 2025 in open session. Members gained assurance on the processes around, and the quality of the work associated with, this programme. The committee commended the Trust on its approach to this development and the challenge of successfully implementing service changes during a very busy period.

12.2. **The Putting Things Right** (PTR) (previously the Patient Safety Highlight Report) and **MIQPR reports** are received at each meeting. These include a range of metrics, some of which the board sees through the MIQPR and others that are specific to the committee. The outputs of discussions are reported to the board and escalations made where required. The MIQPR includes reporting on safeguarding measures, which is supported by receipt of the annual Safeguarding Report.

12.3. An update on the **Putting Things Right Recovery Plan** was received in May, which linked with the Joint Investigation Framework Internal Audit and outlined key improvement actions for the Trust over the following 12 months to aid the Trust meet its targets and ensure that patients and families receive the best service.

12.4. The **Datix 'Once for Wales' Concerns Management System** contains incident reporting data for patient, staff, and contractor safety concerns, as well as other bespoke modules. Challenges have been identified, and a recovery and improvement plan was reviewed which address the key issues and risks. The plan was noted in February, with concerns raised as to deliverability timescales and the resource to implement the plan. The committee will receive updates by way of exception reporting where there are significant risks posed to matters in the remit of this committee.

12.5. A **'no and low harm incident'** report was received by the committee. Members noted the large volume grade 1 and 2 complaints (none or low harm categories), which after investigation, are assessed as not having resulted in harm and are near miss opportunities for learning. Assurance that this committee was monitoring this was provided to the Audit, Risk and Assurance Committee (ARAC) by the Chair.

12.6. The **Learning From Deaths** bi-annual reports were received. These reports highlighted themes and trends that largely relate to delays attending in the community. The committee recognised that there is more to do to understand the differential impact of skill mix on patient outcomes and use of electronic patient clinical record (ePCR) records to identify patterns in death related to or following care.

12.7. The committee continued its quarterly **focus on clinical indicators** taking deeper dives into the indicators of **fractured neck of femur**; **hypoglycaemia** including a presentation on the care bundle criterion which is completed ePCR; **ST segment elevation myocardial infarction (STEMI) (heart attack)** including a presentation on criteria measurement, data quality, reporting, improvements, and next steps; and **stroke**. These have proved invaluable for the committee to understand these indicators more widely.

12.8. At the May meeting the committee received a position update on the **changes to the stroke categorisation** and assurance was given that there is no evidence that these changes have impacted the Amber 1 response times. The Trust continues to work with the Welsh Stroke Network in line with the UK guidelines and recommendations made by Health

Inspectorate Wales. Placement of the specialist hyper acute stroke units is still being determined which will influence the Trust's modelling in the future. A deep dive on the clinical indicator for stroke was held at the February 2025 meeting.

12.9. A theme which ran through a number of items at the February meeting included the importance of **data as intelligence** to drive continuous improvements for patient safety, as well as digital to support technology advancements/innovation. The need to prioritise digital projects, including the integration of Datix and other systems, to ensure alignment with organisational needs and available resources was emphasised. This is currently underway as part of the development of the IMTP 2025-2028.

12.10. Each meeting heard a **patient story** (and received and update on the previous meeting's patient story):

- In May the committee heard from **Fiona Maclean**, a Patient Experience and Community Involvement Manager, and **Julie Starling**, from Save A Life Cymru, who spoke about their efforts to actively promote the learning of life saving skills throughout the year. Through this work it has become clear that not everyone can perform CPR and for those who do, some were left with symptoms of Post Traumatic Stress Disorder. The Trust is working with Save A Life Cymru to improve the support available to the public.

- In August the committee heard from **Linda Erro Castillo**, who shared the experience of her family after calling am ambulance for her son Guy, who was in distress and unable to breath. Guy has learning difficulties, and Linda's concerns included the need to ensure that call handlers bear in mind the experience of vulnerable people who may not be able to answer questions in response to a 999 call. Guy's situation worsened and Linda was fearful that Guy was going to die and could not access the help he needed. Members sought to understand the pace of the work being done to improve the experiences of patients with learning difficulties and their families given similar issues have been raised in patient stories.

- In November the committee heard from **Sian Davies-Kumar**, a Palliative Care Paramedic who shared her experience supporting patients with end of life care. Sian described how she co-ordinated with the palliative care team, GP, district nurses, to set up the required support for the patient she attended. Her story exemplifies the aspiration to provide the best possible death in the place of choice,

with adequate support for the family. The committee noted the need for more consistent and comprehensive end-of-life care for more patients from the wider NHS system. It was heard that the future WAST clinical model aims to involve enhanced support from Advanced Paramedic Practitioners and the remote integrated care service to assist frontline clinicians and ensure appropriate escalation when needed.

- In February the committee heard from **Gemma** following her experience with the NHS Wales 111 Service where she made a formal complaint to the Trust about her experience as a deaf service user. Gemma's experience has highlighted the improvements needed to ensure equity of access and the Trusts' ability to respond to Deaf service users.

12.11. The Patient Experience and Community Involvement (**PECI**) bi-annual reports were received providing positive assurance we are meeting with and consulting with the public and out stakeholders, including with Llais (the Citizens Voice Body). The level of ambition and commitment was recognised, drawing through focus on continuous improvement and the value of patient experience reporting.

12.12. A report was given on various initiatives in **maternity and neonatal care**, which included improvements in neonatal and thermoregulation care and the use of the maternity red phone service, which offers a single point of access from the Trust to Maternity Units and has been implemented across four Health Boards.

12.13. An assurance report was received regarding infection, prevention and control **preparedness and emerging health risks with MPOX** and the Trust's preparedness for an outbreak of a highly contagious infectious disease as set out by NHS Wales Executive.

12.14. Members received a presentation on the revision to the **Clinical Plan**, previously known as the 'Delivering Clinical Excellence in Wales Clinical Strategy'. The content was significantly revised with a changing emphasis on how clinical data is used in terms of our ambitions, transforming our service and how patients are managed differently to prevent avoidable harm.

12.15. The Trust's **annual Clinical Audit Plan for 2024/25**, which allows the planning and prioritisation of clinical audits across the financial year, was approved. It is not always possible to predict all of the topics that

require evaluation and therefore this is a dynamic document which is updated quarterly with oversight by this Committee. This supports recommendations in the Audit Wales Clinical Governance Review 2022. An update on the progress against the Clinical Audit Plan through the audit tracker was received at each meeting and assurance provided to ARAC by the Chair that this plan was in place.

12.16. Various **Trust policies** have been received for approval throughout the year, following the update regarding the backlog of policies for review in 2023/24. These policies were noted as:

- Consent to Examination and Treatment
- Management of Controlled Drugs
- Non-Medical Prescribing
- Premises and Vehicle Cleaning
- Clinical Supervision
- Dispatch Cross Reference Table Policy
- Management of Medical Devices Policy
- Airway Policy
- Safeguarding Children and Adults at Risk of Harm Policy
- Violence Against Women, Domestic Abuse and Sexual Violence Policy

12.17. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures. A focus on the updates throughout 2024/25 included the recommendations related to the Manchester Arena Inquiry and ongoing challenges to recruit to the 111 Wales call handler roles. The Quality Impact Assessment for the Manchester Arena Inquiry Project was received in closed session which was approved by the committee.

12.18. **Reflections** are taken at the end of each meeting and included:

- In May: Members reflected that good assurance had been received and an appropriate level of discussion had taken place on each of the reports. An appreciation of the staff story was highlighted as an important element of the meeting along with recognition of the social responsibility on the action plan. Members thanked the Chair for stepping in at short notice and for excellent chairing.

- In August: Members reflected that the papers were of a good quality, as were the presentations. Members noted that there are challenges across the system in terms of patient journey and patient outcome,

and that the Trust is involved in the discussions about pathways and outcomes as a key partner. Additionally, contributions from wider attendees of the committee are always welcome.

- In November: Members reflected on the challenge of balancing detailed information with the need for concise reporting, thanked colleagues for the quality of presentations and reports, and that the level of challenge from members was considered to be robust. The need to consider how best to focus business to ensure concise reporting.

- In February: Members reflected that time allocations for items throughout the meeting were challenging, however the difficulty of managing such a comprehensive agenda was acknowledged. The Chair was commended for effectively conducting the meeting. Related to this point, there was consideration of how the meeting arrangements could be adjusted to allow for a more comfortable flow, including where it could be helpful to have pre-meeting discussions on more technical matters.

12.19. The Health and Care Standards (2015) have now changed to the **Health and Care Quality Standards (2023)** with six domains and six enablers. The domains are Safe, Effective, Timely, Efficient, Equitable and Person Centred. The enablers include Leadership, Culture, Information, Learning Improvement & Research, and Whole System Approach. An update on the work in developing a self-assessment against the Health and Care Quality Standards was received in February 2025.

12.20. The first **Duty of Quality Annual Report for 2023/24**, following the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 was received prior to approval by the Trust Board. The final iteration of the report was received in August after approval.

12.21. An update was received on the **Quality Strategy 2021-2024 implementation plan**, as well as the development of its successor, the Quality Plan 2025-2028. A key focus for the **Quality Plan 2025-2028** is co-production include understanding the voices of our citizens and service users as well as those of our people. The Committee approved the approach to the plan and an extension of the current strategy to 1 April 2025 to allow for its development.

12.22. The committee noted that the **111 Clinical Assessment Software Replacement Project** went live on the 30 April 2024, as planned. In closed

session the committee received assurance that there have been no reported clinical incidents, and no serious adverse incidence and no patient experience complaints related to the use of the system. The committee heard that whilst it was introduced as a replacement to the former system, however within the emerging Trust Clinical Model Transformation Programme there were significant opportunities for enhancing patient experience, reducing inequity in patients accessing services, and build more efficient Trust services and processes.

12.23. The Committee **cycle of business** was approved at its May meeting. Focus was given to including the Trust's compliance against the Health and Care Quality Standards throughout 2024/25.

12.24. The following **annual reports** were received for assurance and discussion:

- Mental Health and Dementia Annual Report 2023/24
- Annual Safeguarding Report 2023/24
- Annual Infection, Prevention and Control Report 2023/24

12.25. **Risks** relevant to this Committee – 223 and 224 – are reviewed at each meeting and the agenda is driven by these risks. Risks to the committee heard that lost hours due to handover delays remained significant throughout the year. This presents patient safety risks and extended waits in the community, with deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service. Members were assured that with reference to these risks, whilst not moving in score, the position is dynamically reviewed regularly and closely monitored at many of the Board's Committees as well as at internal forums. Furthermore, the approach to these risks was considered in year by the Trust Board, given that their score has remained catastrophic for a significant period. This thinking will develop throughout 2025/26.

12.26. The **annual effectiveness review** was conducted in the February 2025 meeting of the committee.

12.27. The revised **Audit** tracker and process was reviewed and good progress has been made to close down management recommendations throughout the year.

12.28. The follow up **Review of Quality Governance Arrangements** audit report from Audit Wales was received in February 2025. This report found that the Trust has made some improvements to its quality governance

structures, including responding to the duties of quality and candour, but that there is scope for future improvements in some areas to strengthen assurance relating to the quality and safety of its services.

12.29. Members received a presentation on **cancelled calls potential impact analysis** and were assured that the CMT and ongoing improvements in data analysis and reporting could help address challenges in providing timely ambulance responses affected by high demand and ongoing hospital handover delays.

12.30. The committee received a suite of **internal audit** reports:

12.30.1. **Serious Adverse Incidents** (reasonable assurance). The matters which required management attention included areas of non-compliance with Section 4 (Joint Investigation Process) of the NHS Wales National Policy and noted that a review of the National Policy should be undertaken;

12.30.2. **Electronic Patient Clinical Record: Clinical Compliance** (reasonable assurance). Management attention was required in respect of oversight of training completion, on the limitations of reporting and associated data quality;

12.30.3. **Seatbelt Action Plan** (reasonable assurance). The matters for management attention included the limited number of internal quality assurance inspections completed, improvements required around reporting of results and monitoring of related health and safety inspections;

12.30.4. **Clinical Audit** (reasonable assurance). The report actions included where (a) the Clinical Strategy lacks sufficient reference to clinical audit and its role within the Trust; and (b) the Clinical Audit Plan could be strengthened to demonstrate alignment between individual audits and the Trust risk register and priorities.

12.30.5. **Patient Experience and Community Involvement (PECI)** (reasonable assurance). The matters that required management attention included enhancement of the expected activity to be undertaken by the PECI team and enhancement of reporting on the impact and outcomes of the engagement activities.

12.31. The **Committee's priorities for 2024/25**are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

13. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This was also presented to the next public Board meeting by the Chair of the Committee. Each of the AAA report escalated the issue of handover delays and the impact of this on our patients and our people; the highest rated risks 223 and 224.

14. The committee is not currently serviced by any Sub-Committees.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

15. The proposed changes to terms of reference for this committee for 2025/26 are in **Annex 1** and include:

15.1. The purpose section has been amended to include a responsibility to take account of the Trust's wellbeing objectives.

15.2. The delegated responsibilities have been re-ordered to align to the Health and Care Quality Standards.

15.3. Wording has been amended to avoid duplication and provide clarity.

15.4. Additions include:

- Assurance that there is a quality management system in place
- Assurance that our services are evidence-based
- Specific assurance on medicines management
- Specific authority to approve the clinical audit plan
- Clarification on membership nomenclature
- Emphasis on the need for three Non-Executive Directors over and above the quoracy requirements

16. The cycle of business for the committee has been amended in line with the adjustments to the terms of reference. Reporting frequency was discussed in the February meeting and has been reflected in the cycle of business for 2025/26 which was approved by Chair's Action.

PROPOSED CHANGES TO THE OPERATING ARRANGEMENTS

17. Proposed changes to operating arrangements for this committee are set out below. Some are relevant to arrangements across other committees also and they include:

    17.1. Committee to maintain a strong focus on equality, diversity and inclusion in its strategic direction.

    17.2. Where possible in 2025/26 the introduction of more hybrid meetings.

    17.3. A reduction in the reporting against the audit tracker is being considered by ARAC in an attempt to reduce volume for committees and increase assurance. More detail on this will come back to the committee in due course.

    17.4. New report front covers and SBAR templates have been developed. They include a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will be accompanied by writing guidance and presentation guidance.

    17.5. Writing guidance will set out the purpose of executive summaries in an attempt to ensure they are reflective of the comments received by members of this and other committees, particularly as they relate to a greater focus on outcomes.

    17.6. Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee membership. This will ensure we are working towards a continuous improvement in paper length and assurance.

    17.7. A 'reading room' will be established in Ibabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight.

17.8. Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.

COMMITTEE PRIORITIES

Priorities for 2024/25

18. The Committee received an update on progress against its priorities at each meeting. The 2024/25 priorities were:

Priority	Progress
Continue to monitor the duty of quality and duty of candour i.e. Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act.	• An update on the Duty of Quality Implementation Plan was received by the committee in February 2025. With this report an update will be provided on the progress on developing self-assessments against the Health and Care Quality Standards. • The Duty of Quality Annual Report for 2023/24 was received by the Committee at its meeting in May 2024 and approved by the Trust Board in July 2024 for publication.
Monitor the delivery of the Quality Strategy (Plan)	• At the Committee in August 2024 the revised approach to the development of the Quality Plan for 2025-28 was approved, as was an extension of the current strategy until the 01 April 2025 to allow for the development of a robust Quality Strategic Plan for 2025-28. • Additionally, at the August 2024 meeting a general update on the delivery against the extant Quality Plan was received. This area of business is included on the Cycle of Business which will inform each agenda setting meeting.

Priority	Progress
Monitor the organisation's compliance with the Health and Care Quality Standards 2024	• At the November 2024 meeting of the Committee members noted that the Trust intended to prepare a position paper on the implementation of / compliance against the Health and Care Quality Standards 2024 for the meeting of the Committee in February 2025. This was received at the February 2025 committee. • The final Duty of Quality Annual Report for 2023/24 and the associated self-assessment against the Health and Care Standards was received by the Committee at its meeting in August 2024.

Priorities for 2025/26

19. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. The committee will do so at its May 2025 meeting, and these will be provided to the board at its May meeting.

20. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2025/26

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.

Patient Centred

3.20. Oversight of patient experience feedback, including themes, trends and learning, and approve the Patient Experience Plan on behalf of the Board.

3.21. 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. 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. Receive assurance that 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. Receive assurance that there is good collaborative team and partnership working to provide the best possible outcomes for its citizens.

3.25. 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. 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. 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. 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 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) 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.

REMUNERATION COMMITTEE ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The committee met on 13 March 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The Purpose of the Committee is to:
   (a) 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 within the framework set by the Welsh Government and in accordance with the Standing Orders; and

(b) 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.

(c) 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.

MEMBERSHIP AND ATTENDANCE

6. The committee has meetings scheduled four times a year, however given the nature of the work of this committee, they can sometimes be moved because there are limited issues to review. At other times additional meetings are required depending on demand.

7. The committee met in closed session four times in 2024/25 and was quorate on each occasion. The committee has been supported by the Chair and all of the Non-Executive Directors as members, as with several prescribed attendees.

8. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2024/25.

COMMITTEE ATTENDANCE				
Name	**21 May 2024**	**29 August 2024**	**5 December 2024**	**13 March 2025**
Colin Dennis				
Rhiannon Beaumont Wood				
Peter Curran				
Prof. Kevin Davies				
Bethan Evans				
Prof. Hayley Hutchings				
Ceri Jackson				
Hannah Rowan				
Joga Singh				
Jayne Beeslee				
Jason Killens				
Angie Lewis (until 01.11.2024)				
Carl Kneeshaw				
Trish Mills				
Hugh Parry				
Damon Turner			Henry Garrard	

	Attended
	Sent Deputy
	Apologies
	No longer a member.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

9. The Committee's effectiveness was assessed through a facilitated discussion held at the meeting on the 13 March 2025, which included a review of its terms of reference and cycle of business.

Enhanced Report Writing and Assurance

- Committee members are generally satisfied with current report writing and assurance processes. Respondents highlighted the effectiveness of concise papers, clear executive summaries, and well-structured reports that focus on key issues and risks.
- Suggestions for improvement included ensuring recommendations remain succinct and avoiding overly wordy summaries, while continuing to provide clear rationale and assurance - particularly where decisions involve significant changes.

Committee Strengths

- Excellent and consistent chairing was a standout theme, frequently mentioned as contributing to effective meetings.
- The committee is praised for fostering open and transparent discussions, including high-quality debates on high-stakes issues.
- Meetings are described as well-structured, efficient, and appropriately timed - neither overly long nor burdensome.
- Flexibility and agility were also noted as important assets, with the committee able to accommodate both planned and ad hoc meetings as needed.
- Remote working and a predictable flow of business further support the committee's overall effectiveness.

Areas for Improvement

- The majority of respondents indicated satisfaction with current committee processes, with many stating that no improvements are necessary.
- The only specific suggestion was to maintain focus on high-level Remuneration Committee issues and delegate more detailed matters to other committees where appropriate.

10. No specific changes to operating arrangements are proposed following the above positive comments, other than those that are relevant for all committees such as report writing guidance etc.

Management of the committee's work programme

11. The Committee has a cycle of business that is aligned to its terms of reference, albeit there are limited opportunities to proactively plan the work of this committee. All matters scheduled for oversight and review have been brought to the committee. The Committee's business in 2024/25 included:

    11.1. Approval of **settlement agreements** (three 2024/25). Additionally, in August, the first **annual settlement agreement report** was received by the committee who noted that for 2023/24 there was one settlement agreement which related to an exit package under the Voluntary Early Release Scheme approved.

    11.2. Approved a proposal **to temporarily change the portfolio in the People and Culture Directorate**, which would enable focused attention on both the people/education responsibilities and the newer, critical aspects of cultural transformation and employee engagement. This proposal included a split in the portfolio with effect from 01 October 2024, with a Director of Culture Change and a Director of People role being created, with the former being in place for a period of two years.

    11.3. Carl Kneeshaw joined the Trust and was welcomed to the committee as the Director of People from 1 November 2024. The meeting of the committee in December2024 was his first meeting.

    11.4. Following on from discussions throughout 2023/24, updates were provided throughout the year regarding the Very Senior Managers (VSM) banding disparities, and the Independent Review which has been commissioned by the Welsh Government. These issues include the timeliness of the JESP and pay award processes, inconsistencies in the application of salary ranges, comparability of the rates of pay across NHS Wales with similar roles in NHS England, anomalies of spinal points and the relationship between the top bands in Agenda for Change and the lower bandings of VSM pay.

    11.5. In August the committee received an update on the **2024/25 NHS pay award.** It was noted that discussions are continuing at a national level with Trade Unions and the Welsh Government due to meet in early September regarding the award, which was announced by the Chancellor

in July 2024. Welsh Government commissioned a targeted review on all aspects of **executive pay** with a particular emphasis on the job evaluation and recruitment processes. In March the committee heard that there is not yet a substantive update available and it will be progressed into 2025/26.

11.6. The committee reviewed the **CEO's outturn position for 2023/24 and his objectives for 2024/25** noting they had been cascaded to his direct reports and appraisals for all Directors for 2023/24 have now being completed. The committee noted the outturn position for 2023/24 was consistent with discussions throughout the year and showed significant progress despite the challenges throughout the year.

11.7. The annual eligibility checks for board members were received in August 2024 (having previously been circulated by email). Eligibility self-declarations were completed by board members in April 2024 with no adverse findings. Similarly, due diligence checks and disqualified director and trustee, insolvency and bankruptcy searches were carried out with no adverse findings.

11.8. The Committee cycle of business for 2024/25 was approved.

11.9. The annual **effectiveness review** was conducted in March 2025.

12. The Board received a highlight report from this Committee following each meeting which included alerts, advice, and areas of assurance. This was also presented to the next public Board meeting by the Chair of the Committee.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

13. The proposed changes to terms of reference for this committee for 2024/25 are marked up in **Annex 1** and include:
    13.1. The purpose section has been amended to include a responsibility to take account of the Trust's wellbeing objectives.

    13.2. Clarity on the objectives and outturn position of the CEO and cascading to the Executive Leadership Team.

    13.3. Clarification on membership nomenclature.

14. Given the somewhat reactive nature of the committee, it does not set annual priorities.

REMUNERATION COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2025/26

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;
(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.

ANNEX 11
CHANGES TO OPERATING ARRANGEMENTS 2025/26

Committee	Changes to operating arrangements
Board and all committees	• Further consideration to holding board meetings at venues other than Cardiff in 2025/26. • Introduce progress reports on 'what good looks like' for the strategic objective within committee remits will support the call for more of a strategic focus. • Revised approach to minutes for the board and committees. • Updated board skills mix and align to committees. • Where possible in 2025/26 the introduction of more hybrid meetings. • A reduction in the reporting against the audit tracker will be considered by ARAC in an attempt to reduce volume for committees and increase assurance. • New report front covers and SBAR templates. This includes a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will support the desire to use more presentations over SBAR where appropriate • Writing guidance will set out the purpose of executive summaries in an attempt to ensure they are reflective of the comments received by members of this and other committees. • Presentation guidance and support will be provided. • Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee members. This will ensure we are working towards a continuous improvement in paper length and assurance. • A 'reading room' will be established in Ibabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight. • Members were encouraged to pose questions to report writers before meetings and allowing more time for questioning during sessions were suggested to enhance engagement. There is functionality in Ibabs to do this, or directly by email. • Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.

ANNEX 11
CHANGES TO OPERATING ARRANGEMENTS 2025/26

Committee	Changes to operating arrangements
Academic Partnership Committee	• Consideration for greater use of presentations within meetings to reduce the number of papers received. This was specifically in reference to Academic Partnership Committee will be considered for all committees.
Audit, Risk and Assurance Committee	• The Corporate Governance Team will ensure that ARAC is aware of the discussion on internal audit reports from committees if they review them ahead of ARAC, and vice versa when they come to ARAC first. • Trending on risk scores will be added to the risk management report. • A paper setting out a more focused understanding of where the three lines of defence sit within the organisation and their importance will be cycled into the work programme. • The committee induction programme for ARAC and other committees will be rolled out as new members join.
Charity Committee (included for completeness but reporting separately to the Corporate Trustee on 29 May 2025)	• A further development session to be considered for Corporate Trustees in 2025/26 on trustee responsibilities. • Lived experience to demonstrate on new proforma the charitable impacts beyond staff benefits. • Committee to maintain a strong focus on equality, diversity and inclusion in its strategic direction.
Finance and Performance Committee	• A board development session on the use of the MIQPR will be held on 24 April 2025, and the annual review of all MIQPR metrics will come through committees in May. • A new finance dashboard is in development and will be considered by the committee in 2025/26.
People and Culture Committee	• Many of the issues raised are incorporated into the first section applicable to all committees and the board.
Quality, Patient Experience and Safety Committee	• Many of the issues raised are incorporated into the first section applicable to all committees and the board.
Remuneration Committee	• No changes proposed

ANNEX 11
CHANGES TO OPERATING ARRANGEMENTS 2025/26

Committee	Changes to operating arrangements
WASPT	• Continue with agenda setting meetings with the co-chairs and encourage themes for meetings to aid in the flow and triangulation as well as timing of individual items. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. This will ensure there is sufficient time for solution focused discussions and airing of issues. • The terms of reference provide that papers are available seven days before the meeting, however this does not always align with the Trade Union Partners pre-meeting timetable. Best endeavours are made to ensure papers are available for that pre-meet and likewise Trade Union Partners will endeavour to timetable that meeting within the seven days to allow for a full pack to be available. • Partnership working will continue in 2025/26 to ensure that there is continuous effort to maintain trust and openness, the details of which will be discussed in the group. Workshops are an opportunity to focus on this. • The sessions on how to run effective meetings and on financial reporting will be carried over into 2025/26. • There are opportunities to learn more about legislative changes, as well as policy issues through workshops post WASPT meetings, as well as taking advantage of employment-related sessions with the People Services Team which will be explored in 2025.

PROGRESS UPDATE ON CHANGES TO OPERATING ARRANGEMENTS
FOR BOARD AND COMMITTEES FOLLOWING 2023/24 EFFECTIVENESS REVIEWS (updates in red)

	Changes to operating arrangements
Board and all committees	• Committee Chairs will receive the Board Chair and CEO's Brief which will include prompts for relevant parts of the agenda where the AAA report is relevant. Complete and business as usual • Where appropriate board meetings will be held in different WAST locations to enable more accessibility to the board. The same will be done where appropriate for hybrid committee meetings. This has not been taken forward in 2024/25. The Audit, Risk and Assurance Committee to discuss this further at its 1 May meeting. • Board development sessions to be factored into the schedule for finance pressure points; MIQPR orientation refresher (interpretation and triangulation); roles and responsibilities of members of the board; psychological safety; monitoring strategy. A finance session was held in 2023, there have been a number of discussions on 'what good looks like' and the monitoring of strategy with the board, and the MIQPR session will take place in April 2025. Two governance sessions were held in 2024 on the roles and responsibilities of the board, and a number of culture-related and psychological safety discussions at People and Culture Committee. • Development of scope and engagement of external facilitator for long term board development This could not be provided by Academi Wales in 2024 due to changes in personnel and priorities, however a scope has been developed and will go to tender in Q1. • Guidance on report writing and presentation to board and committees. This has been developed and socialised with NEDs. The next stage is to finalise the guidance and take it to ADLT and ELT for approval. This will happen in Q1. • Trade Union Partner and Committee Chair induction session to be held. Complete. • Reflections targeted more on what went well/not so well rather than what was discussed during the meeting. There is a good mix of reflections at the end of each committee. • Revised monitoring report for the cycle of business. Complete
Academic Partnerships Committee	• Drawing out the reporting and assurance with more particularity where possible, including elements of external reporting This continues to be a work in progress and will come through in the revised remit of the committee • Clarity of reporting of key metrics for Research and Innovation, and legislative compliance As above

PROGRESS UPDATE ON CHANGES TO OPERATING ARRANGEMENTS FOR BOARD AND COMMITTEES FOLLOWING 2023/24 EFFECTIVENESS REVIEWS (updates in red)

	Changes to operating arrangements
	• Risk reporting where appropriate (an action carried over from the 2022/23 review) As above • University Trust Status remit of the committee clarified once granted Complete – benefits realisation presented • Arrange meetings to take place at education and training facilitates to develop understanding & improve visibility This has not been possible in 2024/25 but is planned for 2025/26 • Report from chair following research champion events Complete and business as usual • Continue work on research governance framework with a focus on its implementation at WAST Complete and business as usual • Clarity on the purpose and focus of the committee to be communicated to the wider organisation (an action carried over from the 2022/23 review) This continues to be a work in progress and will come through in the revised remit of the committee
Audit Committee	• The CEO will attend more frequent meetings in 2024/25 Complete and business as usual • Committee will cycle in a private meeting with Internal Audit and Audit Wales without any non-members present Complete and business as usual • Audit Committee Chair will establish quarterly meetings with Audit Committee NED members Complete and business as usual • Revised approach to effectiveness review surveys in 2024/25. This will see the committees receiving the simplified three questions of 'what does the committee do well', 'what could it improve on', and 'what are the development needs', and the board receiving the more comprehensive 27 question survey. The Audit Committee will continue to use the National Audit Office Effectiveness Toolkit. Complete
Charity Committee (included for completeness but reporting separately to the Corporate Trustee on 30 May)	• Ensure that all actions are closed off appropriately in meeting and on actions and decisions logs Complete and business as usual • Committee and Corporate Trustee development session to be arranged in 2024/25 when Head of Charity in post This has been carried over to 2025/26 as Head of Charity in post in mid 2024 • The effectiveness survey questions for 2024/25 to be tailored to the Charity and relationship with Corporate Trustee Complete

PROGRESS UPDATE ON CHANGES TO OPERATING ARRANGEMENTS
FOR BOARD AND COMMITTEES FOLLOWING 2023/24 EFFECTIVENESS REVIEWS (updates in red)

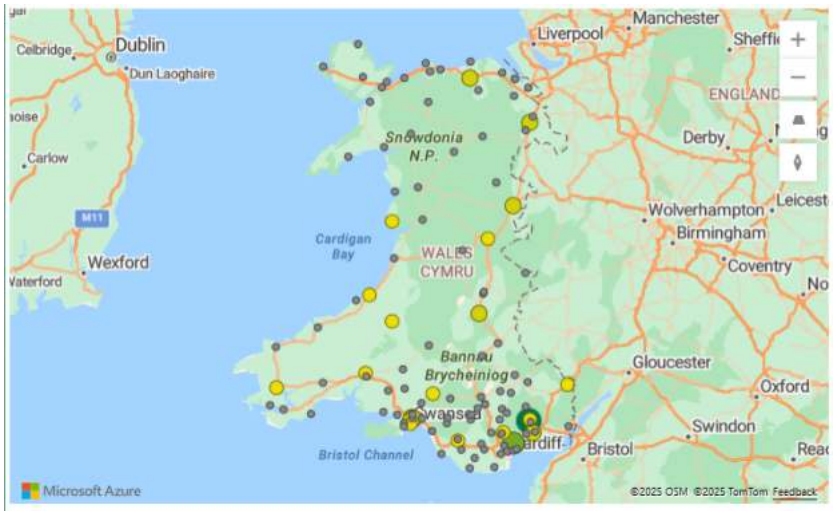
	Changes to operating arrangements
	• Separate Corporate Trustee meetings will be held at least twice a year, and the Charity Committee AAA report will be listed separately on board agenda in between these meetings Complete and business as usual • Consideration for member visibility to be increased through a bespoke list of areas/teams to visit and bringing back a short report on that in addition to the lived experience, as well as consideration for a spotlight on the Charity at future roadshows. This is an ongoing discussion with members and any visits are relayed at the committee and for the wider board at development sessions. The charity has been showcased at roadshows in 2024 and 2025, increasing its exposure
People and Culture Committee	• WASPT approved minutes to be included in meeting bundle as well as the AAA report Complete and business as usual • Next iteration of the cycle of business would need to reflect any attempts to combine assurance reporting, particularly as it relates to the MIQPR and people and culture metrics which respondents felt were duplicative and needed to be more concise for the remit of the committee A MIQPR session will be held at board development in April 2025 and the revised quarterly metrics on the people and culture plan were agreed by the committee in January
WASPT	• Encouraging trade union partner members and management members to disburse themselves around the table during in person meetings Complete and business as usual • Provision of the minutes of WASPT as well as the AAA report to the People and Culture Committee in open session Complete and business as usual • In addition to the AAA report from WASPT being circulated to members, consideration will be given to a 'hot topics' newsflash that could be circulated by email and included on Siren. This will draw from the AAA and include a link Complete and business as usual • In addition to retaining the two hour bi-monthly in person meeting, an additional one hour slot will be included for a workshop on a single issue of importance. This will include a lunch break which will be a good opportunity for members to get to know each other better. This will be scheduled in as soon as possible in diaries Complete and business as usual

PROGRESS UPDATE ON CHANGES TO OPERATING ARRANGEMENTS
FOR BOARD AND COMMITTEES FOLLOWING 2023/24 EFFECTIVENESS REVIEWS (updates in red)

	Changes to operating arrangements
	• Issues raised in the survey such as the desire to walk in each other's shoes, strengthen links between Trade union partner and management members, and working on personal relationships will be addressed in different operating arrangements, but also from the partnership working development sessions that have taken place and are planned as part of the ACAS action plan Complete • Where it is identified that the agenda may restrict timing of an item, whether that be in the agenda setting meeting with the joint chairs or the trade union partners pre-meet, the Board Secretary will review the overall timing and adjust where appropriate and with the agreement of the Joint Chairs Complete and business as usual • Specific sessions to include how to run effective meetings and financial reporting Complete • Introduction for individual trade union partners and staff who wish to observe board and committee meetings Complete and business as usual

ANNEX 10

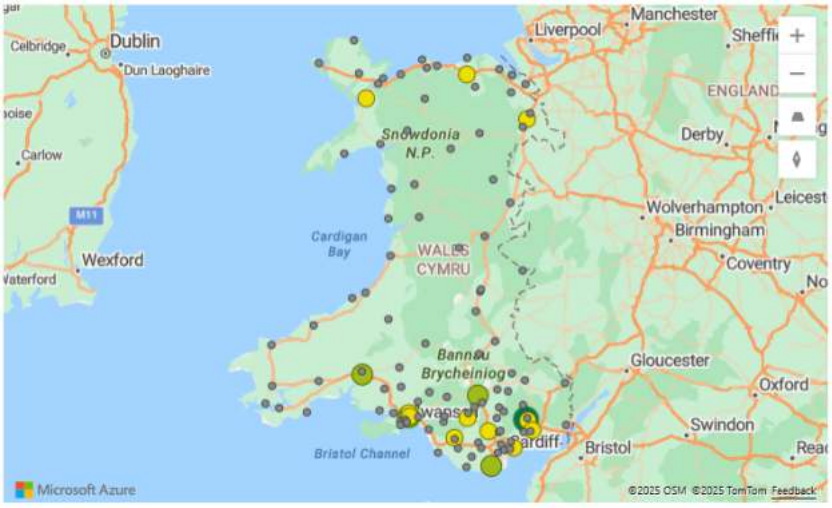
Exhibit 1 – Director visits 2024/25



In the map above, if a bubble is small and grey, this indicates a site which has had no visits. Sites which have been visited are coloured yellow to green, with the bubbles getting larger and greener based on the number of visits.

Premises Name	Total Visits
Vantage Point House Regional Administrative and Control Centre	9
Cardiff Area Ambulance Centre	5
Matrix One Administrative Building	3
Ambulance and Fire Service Resource Centre - Wrexham	2
Builth Wells Ambulance Station	2
Newport Ambulance Station	2
NHS 111 Wales Thanet House Control Centre	2
Ty Elwy Administrative Building	2
Welshpool Ambulance Station	2
Aberaeron Ambulance Station	1
Bryncethin Ambulance Station	1
Caerphilly Reporting Station	1
Carmarthen Ambulance Station	1
Cwmbran Ambulance Station	1
Haverfordwest Ambulance Station	1
Lampeter Ambulance Station	1
Monmouth Ambulance Station -	1
Total	**42**

Exhibit 2 – Non-Executive Director visits 2024/25



In the map above, if a bubble is small and grey, this indicates a site which has had no visits. Sites which have been visited are coloured yellow to green, with the bubbles getting larger and greener based on the number of visits.

Premises Name	Total Visits
Vantage Point House Regional Administrative and Control Centre	4
Matrix House Workforce Education and Development Centre	3
Barry Make Ready	2
Central & West Control Centre	2
Matrix One Administrative Building	2
Merthyr Tydfil Ambulance Station	2
Ambulance and Fire Service Resource Centre - Wrexham	1
Beacon House	1
Caernarfon Ambulance Station	1
Cardiff East Ambulance Station	1
Gelli Ambulance Station	1
HART Emergency Response Centre	1
Hawthorn Ambulance Station	1
Morriston Reporting Station	1
Newport Ambulance Care Hub	1
Total	**26**

Archwilio Cymru
Audit Wales

Welsh Ambulance Services University NHS Trust – Detailed Audit Plan 2025

Audit year: 2024-25

Date issued: April 2025

Document reference: **4819A2025**



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Introduction



Adrian Crompton

Auditor General for Wales

I am pleased to share my 2025 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 22) sets out how we will ensure those standards of quality are met. Our latest annual quality report, Audit Quality Report 2024, provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

- Assure people that public money is being managed well
- Explain how that money is being spent
- Inspire the public sector to improve

Our vision

- Fully exploiting our unique perspective, expertise and depth of insight
- Strengthening our position as an authoritative, trusted and independent voice
- Increasing our visibility, influence, and relevance
- Being a model organisation for the public sector in Wales and beyond

Our areas of focus

- A strategic, dynamic, and high-quality audit programme
- A targeted and impactful approach to communications and influencing
- A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I am also required to certify a return to the Welsh Government which provides information about the Trust to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and

- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.

Planning materiality

represents 1% of gross expenditure based upon 2023/24 audited financial statements/draft financial statements.

£3.063m

Performance materiality

represents 75% of materiality.

£2.297m

Reporting threshold (trivial)

represents 5% of materiality.

£0.153m

Performance materiality is used to minimise the likelihood, to an acceptably low level, that cumulative undetected and uncorrected misstatements will surpass materiality for the financial statements as a whole.

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Remuneration report

The remuneration of senior officers and non-executive directors per the banding category (excluding technically calculated pension entries which are not material by nature) £5,000

Related party disclosures

Related party disclosures with senior officers and non-executive directors £10,000

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and

- evaluate the rationale for any significant transactions outside the normal course of business.

Risk of fraud in expenditure recognition

There is a risk of material misstatement due to fraud in expenditure recognition and as such is treated as a significant risk [Practice Note 10].

There is a risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 11 shows a year-to-date surplus of £42,000 and a forecast year-end surplus/deficit of £nil. This, combined with the outturns for 2022-23 and 2023-24, predicts a three-year surplus of £147,000. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure.

The current financial pressures increase the risk that management judgements and estimates could be biased to achieve the agreed year end outturn and its financial duty.

There is a risk that cut off will not be correctly applied to expenditure incurred around the year end to ensure successful delivery of the year-end target.

Our planned response

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias, in particular manual accruals;
- perform detailed testing on a sample of key transactions before and after year end to ensure they are accounted for in the correct accounting period; and
- perform detailed testing on a sample of key year end balances to ensure they are appropriate and complete.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Remuneration report disclosures

There have been several new permanent and interim appointments to senior officer and board member posts during 2024-25 which need to be captured in the remuneration report.

There is a risk that these are not appropriately disclosed in the remuneration report as remuneration paid to senior officers and board members continues to be of high interest and is material by nature.

Our planned response

My audit team will:

- understand the movements in the senior management team during 2024-25;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates;
- ensure that pay is in line with regulatory requirements to support our regularity opinion; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2025.

Our planned response

My audit team will:

- review the indices used by management for reasonableness;
- evaluate the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Property, Plant and Equipment and Intangible Assets

Our 2023-24 audit identified numerous misstatements to the figures reported in the Property, Plant and Equipment (PPE) and Intangible Assets (IA) notes. There is therefore an inherent risk that we could uncover similar misstatements in our 2024-25 audit which could be material in value and required amendments.

Our planned response

My audit team will:

- Ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements;
- Perform detailed testing on a sample of disposals to ensure that they are no longer operational;
- Perform detailed testing on the classification of assets categorised as PPE and IA, particularly Assets Under Construction;

- Perform detailed testing on the classification of impairments in Note 15 Impairments; and
- We will perform detailed testing on the adjustments made to the opening balances in Note 13 PPE and Note 14 Intangible Assets relating to the classification of impairments following clarification of the treatment within the Manual for Accounts for 2024-25.

Capital investment

There is significant investment in capital projects and a risk that capital classified as Assets Under Construction is materially mis-stated:

- Capital expenditure up to month 11 was reported at £8m, with a forecast of £20m at year end.
- There is an element of judgement needed when determining the amount of costs to be capitalised on each project and the valuation of these assets at the end of the year.

Our planned response

My audit team will:

- understand the reasons for the peak in capital expenditure predicted in month 12 and assess impact on audit approach;
- perform detailed testing on a sample of additions and capital accruals; and
- review and challenge whether any assets under construction require impairment.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the Trust and the other body/party.

The Trust has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature.

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions

The financial statements include provisions for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions.

This subjectivity and uncertainty increases the risk of material misstatement.

Our planned response

My audit team will:

- Review management's estimation process for the valuation of provisions;
- Consider the competence, capability and objectivity of the management experts who are preparing the estimates; and
- Ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning **January to April 2025**	Planning meeting High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment Indicative audit fee Outline Plan Detailed Audit Plan
Fieldwork **May to June 2025**	Complete detailed risk assessment procedures and confirm testing strategy. Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting
Reporting **June 2025**	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru

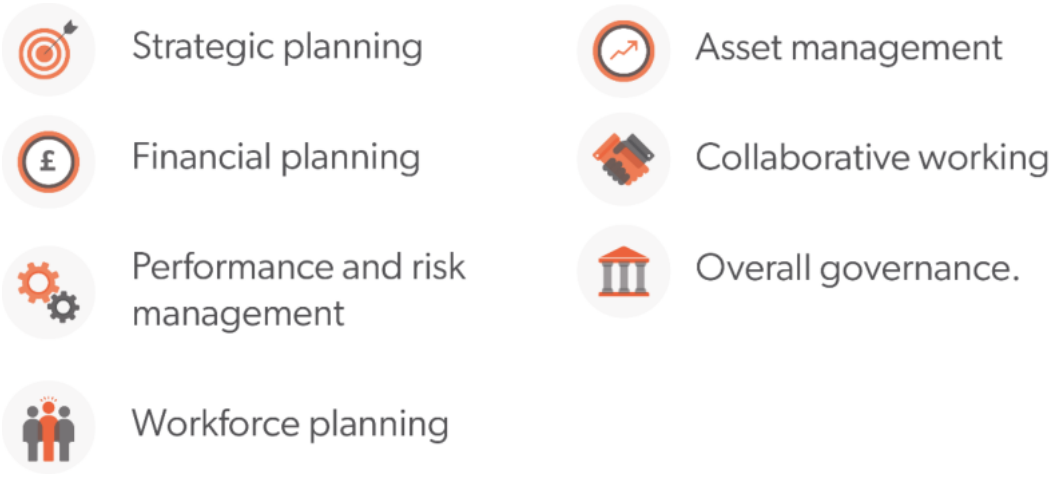
Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Trust and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:



My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Trust.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.



I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Trust. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my performance audit work.

Structured Assessment – core

Scope of the work

Structured assessment will continue to form a key part of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.

My core 2025 structured assessment work will review the following areas:

- Board and committee cohesion and effectiveness.
- Corporate systems of assurance.
- Corporate planning arrangements; and
- Corporate financial planning and management arrangements.

My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

Indicative timescales

Fieldwork to commence between June and August 2025 and reporting by the end of December 2025.

Structured Assessment – review of the arrangements to manage estates

Scope of the work

In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine the effectiveness of corporate arrangements to manage the Trust's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.

Indicative timescales

Fieldwork to commence between June and August 2025 and reporting by the end of December 2025.

Local project work – Review of Non-Emergency Patient Transport Service

Scope of the work

Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Trust. We intend to review the Trust's Non-Emergency Patient Transport Service to examine the effectiveness and efficiency of the service, with a particular focus on arrangements for the transfer and discharge service within this area of the organisation. The specific scope of this work will be determined and discussed with officers in the Trust over the coming months.

Indicative timescales

Fieldwork to commence between November 2025 and January 2026 and reporting by the end of March 2026.

Timing of Performance Audit Work

My team will work with officers in the Trust to arrange exact timescales for the individual projects and will be communicated regularly through our quarterly Audit, Risk and Assurance Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2026.

Audit fee

In January 2025 we published our 2025-26 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 1.7%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

A fee increase of 1.7% has been applied to both the audit of financial statements and performance audit work. However, an additional uplift of 1.9% has been applied to the audit of financial statements following our risk assessment and the additional risks identified from last year's audit which led to an additional fee being charged. However, the fees we charge may not exceed the full cost of undertaking the audit.

Your estimated total audit fee: £206,018

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Executive Director of Finance and Corporate Resources. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2025 (and 2024 for comparison)

Estimated fee for 2025 (£)[1]		Actual fee for 2024 (£)	
Audit of financial statements	Performance audit work	Audit of financial statements[2]	Performance audit work
£118,595	£87,423	£124,496	£85,987
Total fee: £206,018		**Total fee: £210,483**	

[1] The fees shown in this document are exclusive of VAT.

[2] Includes an additional fee of £10,000 in respect of additional unplanned work.

Audit team

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Dave Thomas dave.thomas@audit.wales	
	Financial Audit	**Performance Audit**
Engagement Lead	Gareth Lucey Gareth.lucey@audit.wales	Dave Thomas dave.thomas@audit.wales
Audit Manager	Yvonne Thomas yvonne.thomas@audit.wales	Darren Griffiths darren.griffiths@audit.wales
Audit Lead	Amy Lord amy.lord@audit.wales	Fflur Jones fflur.jones@audit.wales

I can confirm that my team members are all independent of the Trust and your officers.

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 a three lines of assurance model to demonstrate how we achieve this. We have established 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.



Supporting you

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our website to find:



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Information on our upcoming work and forward work programme for performance audit.



Data tools to help you better understand public spending trends



Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.



Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.



Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

AGENDA ITEM No	**16**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**0**

Partnerships and Engagement Report May 2025

MEETING	Trust Board
DATE	29 May 2025
EXECUTIVE	Director of Partnerships and Engagement
AUTHOR	Estelle Hitchon
CONTACT	estelle.hitchon2@wales.nhs.uk

EXECUTIVE SUMMARY

This is the first assurance report to Trust Board in relation specifically to the Trust's partnership and engagement portfolio following a recent decision to transfer the assurance mechanism for this area of the Trust's work from the People and Culture Committee to Trust Board.

This decision reflects the broad nature of the portfolio and the fact that one of the Trust's highest rated risks, in respect of reputation, is one which is pan-organisational and transcends committee remits. It is, therefore, felt that Board provides a more appropriate assurance route than individual committees.

This initial paper to Board provides a broad outline of current key priorities within the partnership and engagement arena. It is anticipated that a Board report will be provided twice yearly, with additional reporting as required and appropriate. Feedback on areas for focus in future reports is welcome to ensure Board members are confident in their levels of assurance.

Recommendations:

1) Board is asked to note the content of this report and
2) To provide feedback on areas of particular interest for future reports

KEY ISSUES/IMPLICATIONS

Not applicable

REPORT APPROVAL ROUTE
Executive Leadership Team for review and comment

REPORT APPENDICES
None

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

Background

1. For some years, the Trust's work in respect of partnerships and engagement has been reported via the People and Culture Committee, having previously reported to the Board.

2. Given the requirement for committees to receive assurance on matters within their purview and, given the pan-organisational nature of work in the partnerships and engagement realm, it has been agreed that reporting should revert to the Trust Board.

3. This report is the first to be considered by Board as part of these new arrangements. As such, it provides an overview of a number of key areas of work within partnerships and engagement. It is not intended to be an overview of every aspect of work in this area but, rather, focuses on a number of priorities which may be of particular interest to Board members.

4. In the event that further detail is required, or that assurance is required on alternative aspects of this work, this can be provided in a future report. Given the long term nature of partnerships and engagement activity, it is anticipated that reports will be provided to Board for assurance on a twice yearly basis, with extraordinary updates if required and appropriate.

5. Detailed below are partnerships and engagement priorities which may be of most interest to the Board at this present time.

Risk 201: Reputation

6. Risk 201 is one of the Trust's most significant risks and is focused on the potential damage to Trust reputation following a loss of stakeholder confidence.

7. The risk descriptor currently focuses on the likely impact on reputation if the stability of the Trust deteriorated to a level where service delivery fails to meet patient safety, national standards and contractual obligations, resulting in the loss of stakeholder confidence in the Trust, damage to reputation and increased external scrutiny.

8. This risk has been scored at 20 for some time, and has proven stubbornly difficult to de-escalate, given performance challenges and the levels of harm being experienced by some patients.

9. It has become increasingly evident that there are differential risks inherent in what is currently described as a single risk. For example, the Trust's reputation with Welsh Government and commissioners is in a stable and relatively

positive position. However, this is not necessarily the case for other stakeholders, as reflected in last year's reputation audit, nor with some patient groups where harm is most prevalent.

10. On that basis, it has been determined that a deep dive review should be undertaken to determine how this risk could be reprofiled to provide a more accurate assessment of the reputational risk facing the organisation. This is likely to result in a disaggregation of the current risk, ensuring the risk definition and mitigation are appropriately differentiated and withstand scrutiny.

11. At this stage, it is anticipated that this review will be completed by the end of quarter two, with the Assistant Directors' Leadership Team (ADLT) supporting the Director of Partnerships and Engagement in the deep dive process.

12. Any amended risk(s) will be included in an updated Board Assurance Framework and will be reported through the usual governance routes.

Regional Partnership Boards: Membership and Impact

13. As Board will know, the Trust has been represented on six of the seven Regional Partnership Boards (RPBs) for some time. Membership of Gwent RPB has now been secured, with the Executive Director of Strategy, Planning and Performance representing WAST. It is important to note that WAST is a non-statutory partner on RPBs.

14. It is fair to say that the various regional partnership boards operate differently, but that all face similar challenges in working collaboratively to optimise the use of Regional Integration Funds (RIF) to deliver improved and integrated health and care services across Wales.

15. The Trust has historically secured some funding for services through RPBs, including falls services and the initial trial of the mental health response vehicle, both in the Gwent area. This funding has allowed the Trust to test innovative models of care which may otherwise not have been possible.

16. Recently, Cardiff and Vale's "Safe @Home" initiative which includes the Trust's APP Navigator model, was recognised for its work in admission avoidance at the Cardiff and Vale Regional Partnership Board Conference Awards.

17. While membership of regional partnership boards provides collaborative funding opportunities, it also provides an opportunity to engage effectively with a broad range of statutory and non-statutory partners and to identify areas for further partnership work at a time when visibility is key.

18. It is likely that there will be further evolution of the regional partnership board model over the coming years, which means that representation remains important for the Trust as it seeks to extend its influence and consolidate its position as a health and care system leader.

Political Engagement: the next 12 months

19. Political engagement has been key to securing support for the Trust's strategic direction in recent years.

20. With likely future changes to the composition of the Senedd following the 2026 election and, therefore of government, coupled with a significantly increased number of Senedd members, many of whom will be new, it is important that the Trust maintains its momentum of regular briefing and engagement.

Wellbeing of Future Generations Act: embedding and compliance

21. As Board members will be aware, the Trust has been subject to the Wellbeing of Future Generations Act 2015 since 30 June 2024 and recently published its wellbeing objectives.

22. The Act places a statutory duty on the Trust to think and act for the long term, ensuring no detriment to future generations and ensuring that its approach to working is one rooted in collaboration and engagement, based on the five ways of working outlined in the Act.

23. This year's structured assessment by Audit Wales will review the Trust's process in agreeing its wellbeing objectives, while those objectives will need to be embedded in the organisation, including in its decision-making processes.

24. Similarly, the Trust will need to assess its position against the maturity matrix for the implementation of the Wellbeing of Future Generations Act, as well as reflect on the findings of a recent Audit Wales report into the implementation of the Act, *No time to lose: Lessons from our work under the Well-being of Future Generations Act*.

25. The Trust has recently been asked to provide both written and oral evidence to the Senedd's Equalities and Social Justice Committee's post legislative scrutiny of the Well-being of Future Generations (Wales) Act 2015. Written evidence is currently being drafted, with a date in July for oral evidence.

Clinical model and performance management framework changes: public and stakeholder communication

26. Given the Cabinet Secretary for Health and Social Care's announcement in March that WAST will be subject to a new performance management framework (target) for the most life-threatening calls for a pilot period of a year from July 1, 2025, an external communication plan has been developed to ensure consistent communication of the changes, and the continued evolution of the WAST clinical model.

27. Working closely with Welsh Government, the external communications plan outlines a range of approaches to ensuring patients, the wider public and stakeholders understand the July 1 change. The plan has also been shared with Llais colleagues.

28. It is anticipated that there will be further public and stakeholder interest in the Trust's refreshed clinical model and performance framework, not least because of any potential changes as a result of the continued work of the task and finish group in reviewing the categorisation of amber calls. Communication will be kept under review and refreshed as required, including reflecting and acting on any feedback received.

29. It should be noted that the external communication plan is a product of the partnerships and engagement workstream within the Trust's transformation programme and is a sister product of the wider Programme Engagement Plan (PEP).

Future Reports

30. Recognising that this is the first report to Board in this format, feedback from Board members on areas of particular areas of interest for inclusion in future reports is welcome.

Recommendations

1) Board is asked to note the content of this report and
2) To provide feedback on areas of particular interest for future reports

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

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

GOVERNANCE REPORT

MEETING	Trust Board
DATE	29 May 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report sets out where applicable the **Chair's Action's** taken since the last Board meeting and corresponding ratifications required**, use of the Trust Seal**, **decisions made in private session and any other governance matters**. There have been no decisions made in private to report since 27 March 2025.

Chair's Action – Ratification

2. There have been two decisions made by Chair's Action since the meeting of the Trust Board in March 2025. The first decision was made in early April 2025 and the second was made in mid-May 2025. The second Chair's Action has been presented to the Board for ratification in closed session: -

2.1 Approval of the *St John's Ambulance Cymru Level 1 Falls Contract*
On the 08 April 2025 the Trust Board approved, via Chair's Action, a request for the approval of the award of the Level 1 Falls Contract to St John Ambulance Cymru (SJAC). This approval noted that any extension beyond the first 12 months was contingent upon satisfactory performance and service.

Decision to apply the Trust Seal

3. The Board is asked to approve the application of the Trust Seal to documents in relation to the surrender and grant of a new lease between Dyfed Powys Police & Crime Commissioner (Landlord) and the Welsh Ambulance Services University NHS Trust (the tenant).

Use of the Trust Seal

4. The Trust Seal was applied on the 27 March 2025 in relation to Land Transfer Deed (Form TP1), the parties to which were The Police and Crime Commissioner for North Wales and the Welsh Ambulance Services University NHS Trust.

Other Governance Matters

5. There was an extraordinary board meeting held on 07 May 2025. This was originally scheduled as a private session however it became clear just prior to the meeting that it was suitable for a public session. The papers presented to that meeting, which includes the Equality Impact Assessment, are attached for transparency at Annex 1 and 2, and the decision made by the Board in that session is as follows: -

The Board:

1) Endorsed the requirement for the Trust to alter its model of service delivery and reporting to meet Welsh Government instructions;
2) Was assured that the organisational preparedness met with the appropriate requirements to implement the changes safely and effectively.

6. RECOMMENDATIONS: The Board is asked to:

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

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Annex 1: 07 May Trust Board Papers – New Ambulance Performance Framework (which includes the letter Welsh Government as annex 1.a). Annex 2: 07 May Trust Board Papers - Clinical Model Transformation Equality Impact Assessment

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

AGENDA ITEM No	3
OPEN or CLOSED	CLOSED
No of ANNEXES ATTACHED	2

New Ambulance Performance Framework

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

EXECUTIVE SUMMARY

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

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

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

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

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

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

Table 1: New Ambulance Categories & Measures

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

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

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

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

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

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

Quality Impact Assessment (QIA) / Equality Impact Assessment (EqIA): a detailed Quality Impact Assessment has been undertaken on the changes to the ambulance performance framework. The QIA is currently being finalised in

readiness for submission to CQGG on the 12th May. A CMT programme wide EqIA has been drafted and is currently in the review stage in readiness for submission to the CMT Programme Board on the 6th May.

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

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

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

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

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

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

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

Evaluation: As part of the wider changes to the Integrated Clinical Services Model, the Trust along with Commissioners are working jointly to procure an independent external partner to undertake a detailed and comprehensive evaluation. A key aspect of the evaluation process will focus upon evaluating the impact of the changes to the ambulance performance framework following the introduction of the Purple Arrest and Red Emergency categories.

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

Recommendations:

Trust Board is asked to: -

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

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

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

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

SITUATION

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

BACKGROUND

999 Ambulance Targets (Red)

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

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

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

Table 1: *Current Red Ambulance Response Target*

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

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

Health & Social Care Committee Recommendation

6. During a review of ambulance performance, the Senedd's Health & Social Care Committee (H&SC) discussed the broader system challenges impacting ambulance service provision and the limitations associated with the current 8-minute ambulance performance target.
7. As a result, the H&SC Committee published a series of recommendations in Aug-24 to enable improvement. One of the recommendations, accepted by the Cabinet Secretary for Health and Social Care, was to '*review the existing national target for ambulance response, and to determine whether it is still appropriate.*'

WAST Integrated Clinical Services Model

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

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

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

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

ASSESSMENT

National Ambulance Target Review Task Group

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

13. The Task Group, chaired by WG, included a broad mix of expert leads including policy leads and statisticians, ambulance commissioners, and senior clinicians with experience of ambulance and pre-hospital emergency care. WAST membership included senior executive directors (Rachel Marsh, Andy Swinburn and Liam Williams).

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

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

New Ambulance Performance Framework

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

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

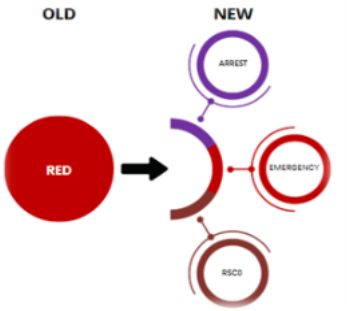
17. It was recognised that the current 'Red' category had broadened overtime in terms of the level of acuity, reaching circa 15% of all verified 999 incidents. The current category includes patients with an immediate threat to life and patients with a less acute presentation that may not require an immediate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

Fig 1: Cardiac Chain of Survival



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

Fig 2: Old & New Categories



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

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

21. The RSC0 category whilst outside of the scope of the new ambulance targets, will include the remaining conditions from the previous Red category that have been deemed suitable for rapid clinical screening (where a clinician may listen live to the incident, or become involved as soon as the call has concluded, and determines the appropriateness for further clinical assessment or a face to face response).

Table 2: New Ambulance Categories

Category	Descriptor	Types of Complaint
PURPLE ARREST	**ARREST:** Refers to incidents where a person is in cardiac or respiratory arrest.	▪ Cardiac arrest ▪ Respiratory arrest
RED EMERGENCY	**EMERGENCY:** Refers to incidents where a person is at risk of cardiac or respiratory arrest.	▪ Choking ▪ Major trauma
RSC0	**RCS0:** incidents that have been deemed suitable for rapid clinical screening.	▪ Breathing problems ▪ Allergy

Purple Arrest Category Measures

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

23. The overarching clinical outcome measure for the Purple Arrest category is the % of Return of Spontaneous Circulation (ROSC) along with key measures across each link in the chain of survival. These clinically focussed measures will shift the emphasis from speed of a WAST response to a broader system response focussed on clinical effectiveness and improving patient outcomes.

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

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

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

Table 3: Purple (Arrest) measures

Category	Measures
PURPLE ARREST	**Purple: cardiac arrest 'bundle' of measures** ▪ % of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return Of Spontaneous Circulation) ▪ Time of call handler to commence CPR instructions ▪ Time to defibrillator at scene /patient side

	▪ Median response time target range of 6-8 minutes ▪ 90% receive an ambulance response within 20 mins

Red Emergency Category Measures

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

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

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

Table 4: Red (Emergency) measures

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

RCS0 Category Measures

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

Welsh Government Approval

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

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

WAST Preparedness

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

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

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

Project Management & Delivery

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

37. The Executive Sponsor for the group is Lee Brooks (Executive Director of Operations) and the Senior Responsible Officer is Greg Lloyd (Assistant Director of Clinical Delivery). The group includes a broad range of internal WAST leads and external commissioners. The group meets weekly with full project support and underpinned with the full package of project management processes.

Governance Process

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

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

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

Quality Impact Assessment / Equality Impact Assessment

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

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

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

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

Data Definitions & Performance Reporting

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

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

Monitoring & Assurance

47. In addition to the key performance metrics for the new categories, a key requirement in readiness for go-live is to ensure that there are robust daily performance and quality reporting arrangements in place to monitor the patient safety and service delivery impacts of the changes. An overview of the monitoring

and assurance arrangements are required to be submitted to WG by the end of May and will follow the agreed internal governance arrangements for approval.

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

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

Operational Readiness

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

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

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

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

Communications (Internal & External)

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

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

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

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

Evaluation

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

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

Finance

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

Risks

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

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

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

Next Steps

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

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

RECOMMENDATIONS: The Trust Board is asked to: -

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

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

APPENDICES

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

Attachment 2: CMT Programme Equality Impact Assessment

Grŵp Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Gweithrediadau, GIG Cymru

Health and Social Services Group
Director of Operations, NHS Wales

Llywodraeth Cymru
Welsh Government

Jason Killens
Chief Executive
Welsh Ambulance Services University NHS Trust

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

20 March 2025

Dear colleagues,

New emergency ambulance performance framework

Firstly, thank you to you and your teams for your contributions and support in reviewing the appropriateness of the existing ambulance response target.

I am writing to inform you that the new Emergency Ambulance Performance Framework has been approved by the Cabinet Secretary for Health and Social Care and will be implemented from 1 July 2025 for an initial 12-month pilot period.

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

As part of this implementation, we expect the development of clear and precise definitions for the new performance metrics. These definitions will be crucial in accurately measuring and reporting performance against the new framework, and in identifying areas for continuous improvement. We expect this work to be concluded **by the end of May 2025**.

I have issued a copy of this letter to colleagues with responsibility for statistics for awareness and to enable alignment where required.

In the lead up to 1 July we will continue to work closely with you to ensure the successful implementation of the new framework, and in doing so will agree monitoring arrangements for assurance purposes by **the end of May 2025**.

Please ensure that all relevant individuals and teams are informed and prepared for the upcoming changes.

Rapid review: opportunities to support accelerated delivery of plans to improve outcomes for people in out of hospital cardiac arrest

To support the delivery of the new performance framework, you will be aware the Welsh Government has approved a recommendation for the transfer of the NHS Wales Save a Life Cymru (SaLC) programme from Public Health Wales to the Welsh Ambulance Services University NHS Trust (WAST). We understand the transitioning process has commenced.

The Cabinet Secretary has requested a rapid review of the opportunities to build on the current NHS Executive SaLC programme plans to improve survival rates from out of hospital cardiac arrest, and sought recommendations on key actions that could be accelerated in the short and medium term.

We should appreciate your support in collaborating with SaLC over the coming weeks to undertake this review which should focus on the following key areas, and others where action could make a positive impact:

- Provision of education and CPR training
- Improving accessibility to defibrillators; and
- Increasing community awareness and involvement

Please work with the SaLC programme team to garner their significant expertise and insight in this field and initiate the review as soon as possible. We will set up a roundtable discussion to be held over the next few weeks to initiate conversations. Following this, I should be grateful if you would submit a jointly approved report with recommendations by the **end of June 2025**.

Funding to secure automated external defibrillators (AEDs)

Finally, I can confirm we have approved your request for funding of £506,635 to secure 500 AEDs in 2024/2025.

This funding is provided in line with the principles of the case submitted via the NHS Wales Joint Commissioning Committee. It is intended to enable delivery of the new framework and our collective focus on improving outcomes for people in cardiac arrest.

Should you have any questions or require further information, please do not hesitate to contact me.

Thank you for your assistance.

Yours sincerely,



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

Cc: Judith Paget, Director General Health and Social Services / NHS Chief Executive, HSCEY Group, WG
Nick Wood, Deputy Chief Executive, NHS Wales, HSCEY Group, WG
Aled Brown, Head of Emergency Care Policy, HSCEY Group, WG
Ryan Pike, Head of Hospital Statistics
Dr Julie Starling, Clinical Director, NHS Wales Save a Life Cymru Programme

Appendix 1: New ambulance performance framework

Category	Descriptor	Types of complaint	Response targets / standard(s)
Purple: arrest	**ARREST** Refers to incidents where a person is in cardiac or respiratory arrest	- Cardiac arrest - Respiratory arrest	**Purple: cardiac arrest 'bundle' of measures** 1. % of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return Of Spontaneous Circulation) 2. Median (average) time to bystander CPR 3. Median time to defibrillation 4. Median response time target range of 6-8 minutes 5. 90% receive an ambulance response within 20 mins
Red: emergency	**EMERGENCY** Refers to incidents where a person is at risk of cardiac or respiratory arrest	- Choking - Major haemorrhage - Major trauma	1. Median ambulance response time target range of 6-8 minutes 2. 90% receive an ambulance response within 20 mins *Clinical performance indicators (to be developed)*

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





EQUALITY, DIVERSITY, & INCLUSION DEFINITION DOCUMENT

Clinical Model Transformation (CMT) Programme

VERSION: 1

Version Control

Status	Version	Author(s)	Date	Changes
Draft	V0.1	EDI Task & Finish Group (see General Information)	07/03/2025	Document development and initial draft of content.
Draft	V0.2	Heather Holden	07/04/2025	Review and minor revisions to narrative and completion of Themes section including EqIA and SEIA.
Draft	V0.3	Heather Holden	11/04/2025	Minor revisions following Head of Inclusion and Engagement review.
Final	V1	Heather Holden	30/04/2025	Revisions following feedback from CMT Board members and the inclusion of the Welsh Language Impact Assessment domains; ready for CMT Board approval.

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1. General Information

Given the evolving nature and system-wide scope of the Clinical Model Transformation (CMT) Programme, and recognising the potential scale of impact on patients and service delivery, a dedicated Task and Finish Group was established to determine the most effective approach to embedding Equality, Diversity, and Inclusion (EDI) considerations across the programme. Chaired by the Head of Inclusion and Engagement, the group reviewed the Trust's statutory responsibilities under the Equality Act 2010 and considered best practice in inclusive programme design. This EDI Definition Document represents the collective output of the CMT EDI Task and Finish Group. It has been co-produced by group members and formally endorsed for approval by the Head of Inclusion and Engagement.

Title:	**Equality, Diversity, & Inclusion Definition Document – Clinical Model Transformation (CMT) Programme**
Assessment Lead:	**Heather Holden**, Head of Transformation (CMT Programme Manager)
Who has been involved in undertaking this equality assessment:	**Hayley Jones Dunne**, Organisational Development Manager **James Houston**, Head of Strategy Development **Kat Cobley**, Head of Inclusion and Engagement **Kelsey Rees-Dykes**, Strategy, Planning, and Performance Business Partner **Lauren Price**, Strategy and Transformation Engagement Manager **Leanne Hawker**, Head of Patient Experience & Community Involvement **Melfyn Hughes**, Welsh Language Services Manager **Rachel Watling**, Head of Communications **Sarah Davies**, Head of Change and People Insights **Sarah Parry**, Strategy Development Manager
Approval Route:	Clinical Model Transformation Board (Approval)

2. Overview

Our Evolving Service Offer – Integrated Clinical Services Model

In response to ongoing pressures and evolving healthcare demands, the Welsh Ambulance Services University NHS Trust (WAST) is evolving its service offer into an expanded Integrated Clinical Services Model. This shift is aimed at ensuring that patients receive the appropriate care in the right setting and at the right time, thus improving outcomes and reducing pressure on emergency departments. Traditional response models, prioritising rapid transport for high-acuity emergencies, have shown limitations in addressing the full spectrum of patient needs, particularly in the context of an ageing population and rising demand for urgent care. WAST now faces a broader case mix with many patients requiring urgent care rather than emergency transport.

The evolving model moves away from a conveyance-based emergency response focus towards an integrated model that connects our core services into a cohesive system. This approach allows WAST to better meet the healthcare needs of the people of Wales by offering a broader range of care options, including addressing urgent and emergency needs within the community.



Our **Evolving** Service Offer

Integrated Clinical Services Model

The Clinical Model Transformation (CMT) Programme is a Trust-wide change programme structured around five core workstreams designed to better integrate our core services (999, 111 Wales, and NEPTS) into an evolved clinical services model. This approach aligns with national healthcare strategies, including the Welsh Government's vision of providing equitable and accessible care that meets patients' needs in the community. The model supports the "shift left" approach, which aims to treat patients within their communities, thereby reducing the strain on hospital emergency departments and supporting the Welsh Government's Six Goals for Urgent and Emergency Care.

The transformation also builds on WAST's strategy, "Delivering Excellence," which envisions the ambulance service as a gateway to urgent and emergency care across Wales. By enhancing its clinical capability and focusing on integrated care pathways, WAST seeks to play a more pivotal role in reducing avoidable conveyance to hospital and facilitating access to alternative care settings.

Purpose of the Document

In accordance with the Equality Act 2010, all policies must be subject to an Equality Impact Assessment (EqIA) to enable resources to be targeted effectively and to help reduce inequalities. The EqIA is a process to consider how policies will affect people differently based on their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights.

The process by which organisations assess equality impact is to be determined locally. Across WAST the Integrated Equality Impact Assessment Form is the accepted standard to evidence EDI consideration, however given the complexity of the CMT programme, it was agreed that a more extensive document was required that fully recorded evidence of due regard to the equality duties. This bespoke EqIA document was agreed by the EDI Task & Finish Group, and approved by the CMT

Board and Strategic Transformation Board, with its key purpose being the provision of evidence that the Trust Board's decisions are compliant with statutory requirements for the Public Sector Equality Duty, Socio-economic Duty, Welsh Language Duty, Human Rights Act and Armed Forces Covenant.

This document provides an overarching account of EDI considerations across the CMT programme and will be updated iteratively in line with programme developments. Alongside this overarching EqIA, individual projects within the programme will, where appropriate, be subject to a standard EqIA. The requirement for project-level assessments will be determined with the support and guidance of the Head of Diversity and Inclusion, to ensure a consistent and proportionate approach to equality analysis throughout the programme lifecycle.

3. Consultation & Engagement

In line with the Welsh Government's Guidance on Changes to Health Service Policy (2023), the Trust is responsible for determining what constitutes a significant service change. This determination plays a crucial role in guiding the Trust's approach to public consultation and engagement on any changes being planned by the Trust.

A service change that is deemed significant, informs whether formal public consultation is required. The proposed changes to the Clinical Services Model are not new in concept and are an acceleration and expansion of incremental service changes that have been underway for some time and are in alignment to the longstanding policy direction and strategic commissioning objectives set out for the organisation to deliver against. The proposed model changes are therefore viewed as an 'evolution' of the current model rather than a 'transformational' change whereby new services are being introduced. For example, the Trust implemented remote clinical assessment for 999 calls more than five years ago and has typically managed circa 15% of 999 cases in this way. The proposed model is seeking to expand and enhance that already existing clinical service offer.

To ensure compliance with the WG Guidance on Changes to Health Services, the Trust undertook detailed internal debate to consider the options and sought advice from Llais. Based on the output of these discussions it was agreed that the proposed changes to WAST's clinical service model did not constitute 'substantial' service change, and therefore formal public consultation is not required. It was agreed however, that this position would be reviewed periodically to ensure there were no further developments of the model that could change the position regarding public consultation.

Whilst public consultation is not required, from a public perspective Llais advised that the Trust would be required to undertake regular and transparent communications with the public to keep them informed of the changes throughout the lifecycle of the programme. Similarly, a watching brief should be kept as the programme evolves and the matter should be re-evaluated as the programme moves forward to ensure nothing has changed in terms of the engagement requirement.

From a broader system perspective, it was acknowledged that WAST cannot undertake changes unilaterally and would be required to undertake proactive engagement and collaboration with external system stakeholders and partner organisations. A detailed Programme Engagement Plan (PEP) has been approved by the Clinical Model Transformation Board (CMT) setting out the engagement approach and timescales. The PEP segments the various stakeholders into four distinct

groups with a more detailed breakdown of the individual stakeholders / groups and timescales for engagement. The Trust is continuing to undertake proactive engagement as outlined in the plan.



Key document references:

1. CMT Consultation Paper (CMT_P&E SBAR Public Engagement Approach_Sept 24_Final.pdf)
2. Programme Engagement Plan (Programme Engagement Plan_Working Draft_v0.3 Feb 25.pdf)

PECI Team Public Engagement Events

The Trust has a legal duty to engage with the public, service users and communities to listen and capture their experiences and to involve them in influencing, designing, and delivering services as set out in:

- People's Experience Framework (formerly 'Framework for Assuring Service User Experience')
- Health and Social Care (Quality and Engagement) (Wales) Act 2020-21
- The Quality Standards (Apr 2023)
- NHS Wales Performance Framework
- Social Services and Well-being (Wales) Act 2014-18
- Well-being of Future Generations (Wales) Act 2015-19
- The National Principles for Public Engagement in Wales (2011)20
- A Healthier Wales 2022

The PECI team adopts a continuous engagement model, enabling consistent dialogue with communities to share information, gather feedback and experiences, and inform service design and delivery across the Trust. Although there has been no formal or programme-specific engagement undertaken solely in relation to the evolving Clinical Model Transformation (CMT) Programme, the insights, feedback, and experiences gathered through this continuous engagement approach have been used to shape and influence the thinking behind the programme's development. Engagement will continue throughout the life of the programme to ensure that community voices remain central to service evolution.

Over the past year the PECI team has attended 250 events and engaged with more than 16,000 individuals, with a particular focus on these from protected characteristic groups and communities who may experience inequalities, including:

- Condition specific groups
- Older people
- People with learning disabilities
- LGBTQ+ communities
- People with lived experience of mental health conditions
- Children and young people
- Carers
- Ethnic minority communities

Feedback gathered through this engagement highlights recurring themes, including concerns around emergency response times, the repetition of questions when calling 999, and inaccuracies in estimated times of arrival (ETAs), despite explanations provided. Within Non-Emergency Patient Transport Services (NEPTS), delays in arranging return journeys following appointments remain a notable source of dissatisfaction.

Conversely, positive feedback consistently emphasises the compassion, kindness, and professionalism demonstrated by Trust staff.

Continuous engagement has also highlighted disparities in service experience, particularly among Deaf service users and individuals with learning disabilities, helping the Trust to prioritise improvements and address inequalities.

Key Stakeholder Engagement

This section details the engagement approach with key external stakeholders and system partners. The engagement approach is set out in the Programme Engagement Plan and is a dynamic plan to take into consideration the changing landscape in which the organisation operates. The engagement grouping and timescales set out in this document are therefore subject to change as the engagement approach is continually updated and refined.

Group 1: Key Political & System Stakeholders

To gain traction to implement changes to the clinical services model, the Trust will require key political and system support from a range of influential stakeholders. Securing stakeholder support during this first phase of engagement is critical to the success of the transformation programme

The objective of this phase of engagement with Group 1 stakeholders is to secure "in principle" support and endorsement from the identified political and system stakeholders to:

- Continue the development and implementation of the proposed evolution of the WAST Clinical Services Model; and

- Agree in principle to the proposals to review the call categories and future ambulance performance metrics.

The keys stakeholder groups identified

Key Political & System Stakeholders		
Welsh Government	Health Board CEOs	Ambulance Commissioner
Policy leads for health	Joint Commissioning Committee	Llais

Key Stakeholder & Phasing	Aug	Sep	Oct	Nov	Dec
Group 1: Key Political & System Stakeholders					Pause & Reflect
Welsh Government					
Welsh Government Policy leads					
Joint Commissioning Committee					
Llais					
NHS Chief Executives					

Group 2: External Stakeholders & Partners

Subject to formal 'support' and 'endorsement' from Welsh Government and commissioners (as outlined in Group 1), the Trust will undertake a period of focussed engagement with key external stakeholders (e.g., Health Boards, National Programmes and Clinical Groups) alongside wider partner organisations.

The Objective of the engagement activities to be undertaken with stakeholders in Group 2 is to:

- Inform external stakeholders of the proposals to evolve WAST's Clinical Services Model;
- Undertake local collaboration to support key winter improvement initiatives;
- Engage with external clinical groups / clinicians to ensure that they are supportive of the proposals
- Engage with Health Board Clinicians / Operational leads to identify opportunities post remote clinical assessment to appropriately access Health Boards services (where WAST is unable to resolve the call).

Welsh Government	Clinical Engagement	System / Programme	Health Board	Patient Advocacy Groups	Professional Bodies
• IQPD • JET • WBFGA Commissioner • Older Persons Commissioner	• Six Goals CPAG / CLUCA • All Wales Medical Directors (MDs) • Executive Directors of Nursing (EDON) • Directors of Therapies (DOTHs) • Directors of Primary Care • National OOHs Forum • National Clinical Directors • GPC Wales	• Six Goals Programme Board + Goal Groups • Strategic Programme for Primary Care • Regional Partnership Boards	• Chief Operarting Officer (COOs) • Directors of Planning (DOPs)	• Stroke Asscociation • Britis Heart Foundation • British Lung Foundation	• AACE • Royal College of Nursing

Key Stakeholder & Phasing	Timescales	Jan	Feb	Mar	Apr
Group 2: External Stakeholders & Partners	December - April				
2a. Priority Clinical Engagement	January - February				
Welsh Government Clincal Leads	January - February				
Six Goals Programme Leads & Clinical Groups	January - February				
NHS Clinical Groups (including All Wales Medical Directors, GPC Wales, GP OOHs, Primary Care forums, EDONs, DOTHs)	February - March				
2b. Wider System Engagement	February - April				
Operational Goups (including COOs)	February - April				
Strategic Health Board groups (DOPs / ICAPs)	February - April				
Wider system / programme engagement (Regional Partnership Boards, Six Goals delivery boards)	February - April				
Patient Advisory Groups (Stroke association, BHF, BLF)	February - April				
2c. Stakeholder to be kept informed	February - April				
Professional Bodies (AACE, College of Paramedics)	April onwards				
Partner Organisations (Police, Fire, St Johns)	April onwards				

Key document reference:

1. Programme Engagement Plan (Programme Engagement Plan_Working Draft_v0.3 Feb 25.pdf)

IMTP Engagement and Consultation

This programme is key component of the Trust's Integrated Medium-Term Plan (IMTP), which outlines a strategic approach to improving population health outcomes, enhancing service delivery, and building system resilience. The IMTP is developed in a way that places strong emphasis on collaboration, equity, and the active participation of stakeholders across the health and care system, including those with protected characteristics. A robust EqIA has been completed as part of the IMTP development process and has been considered in the development of this EDI Definition Document.

The IMTP development process is underpinned by a programme of extensive and continuous engagement. This includes engagement with Formal and Informal Trust Board across multiple months (December, January, February and March), ensuring that strategic alignment and executive ownership are embedded from the outset.

Ongoing staff and patient engagement have informed the design and prioritisation of the IMTP. This has included CEO-led roadshows, the Trust's Behaviours and Values reset, WAST Live interactive sessions, and targeted activity through platforms such as Viva Engage. Specific equality, diversity and inclusion engagement has been facilitated by the Patient Experience, Community Involvement (PECI) team, ensuring that the voices of people with protected characteristics, as defined under the Equality Act 2010, are reflected and embedded in the IMTP and the associated transformation programmes. These efforts are detailed further in Appendix 1 of the IMTP.

Robust cross-organisational scrutiny has also been a core feature of the development process. Plans are reviewed across all directorates and via a multi-disciplinary project group, including representation from People and Culture, Capital and Estates, Finance, Planning, and Performance. This collaborative approach ensures all plans are aligned with statutory duties and organisational priorities and are tested for potential differential impacts on diverse groups.

The Trust's recognised partnership with Trade Union representatives, including their active role in Board strategy sessions and forums such as the Corporate Partnership Forum and WASPT, has further strengthened the equality dimension of this programme. Trade Union partners have acted as advocates for colleagues with protected characteristics, contributing to accessible communication materials and shaping the equality commitments of the programme.

Throughout its development, the IMTP has been subject to iterative review with the Joint Commissioning Committee (JCC), ensuring alignment with commissioning intentions and system-wide priorities. Engagement with the Interim Ambulance and 111 Commissioning Group, JCC Development Sessions (including Health Board CEOs), and informal discussions with senior JCC colleagues have enabled a shared understanding of the programme's equity and inclusion considerations.

Furthermore, the Head of People and Engagement plays a pivotal role in assessing the IMTP and associated transformation initiatives through an equality's lens. This oversight ensures that actions are in place to address the specific challenges faced by people with protected characteristics in accessing and benefiting from our services, and that the Trust is compliant with the Public Sector Equality Duty.

As a result, the programme has been shaped by a holistic and inclusive approach to planning and engagement, reflecting the Trust's commitment to connecting systems, connecting people, and creating choice—while ensuring equity and accessibility are embedded at each stage of design and delivery.

Key document references:

EQIA IMTP 25-28 v2 7.3.25.pdf

Trust Wide Staff Engagement and Consultation



The Trust uses a range of well-established mechanisms to routinely listen to its people. These include WAST Live – a regular interactive forum where the Executive Team provides updates and responds directly to staff questions – and CEO Roadshows, which offer twice-yearly, in-person opportunities for direct dialogue with staff across Wales. These sessions increasingly include dedicated discussions on the CMT Programme, enabling colleagues to raise questions, share local insight, and contribute to shaping service redesign.

Staff perspectives are further informed through structured cultural and workforce metrics, analysis of the NHS Staff Survey, and the work of staff networks, which promote inclusion and a sense of belonging. This feedback loop helps the programme team to identify emerging risks, workforce pressures, and areas where service transformation may require additional support or adaptation to ensure safe, sustainable implementation.

Clinical Model Transformation Workshops

A high-level concept of the future clinical service model, referred to then as "Inverting the Triangle", was developed in 2021/22, and formed a key discussion point with internal stakeholders as part of the CEO Roadshows in October 2021. This initiated several internal stakeholder workshops to understand ongoing challenges and explore the possibilities of a new clinical service model.

An initial internal workshop, held in December 2021, with representatives from Strategy, Planning & Performance, Medical & Clinical, Quality and Operations directorates, explored the first steps required to developing the transformational change to the clinical response model. The output of this workshop produced an emerging first version of the future clinical service model.

A secondary internal workshop, held in February 2022, with leads from across all directorates, further explore the future clinical services model and enabling functions. The output highlighted the need to undertake a comprehensive stakeholder analysis to ensure key partners and influencers were involved, supported and shaped the future vision of the Trust.



Engagement commenced with Trade Union Partners in May 2022, the workshop explored the emerging ideas and opportunities within the future model, and to identify how we best engage and involve our people.

In May 2024, it was agreed that the "Inverting the Triangle" concept required dedicated time and space to evolve into a formal programme of work. A 5-day collaborative workshop was held with internal stakeholders to support the design of the future clinical services model,

and to develop the implementation and delivery approach required for the programme. The output to this identified a requirement for a Clinical Model Transformation Programme and 5 key priorities to be delivered as part of Phase 1 of the programme.

A 2-day collaborative workshop held in January 2025, gave opportunity for internal stakeholders to reflect and commenced the planning for Phase 2 of the programme. Phase 2 delivery commenced in April 2025, and it is anticipated that further collaborative workshops will be held as progress is made to deliver the CMT Programme.

4. Stakeholder Identification

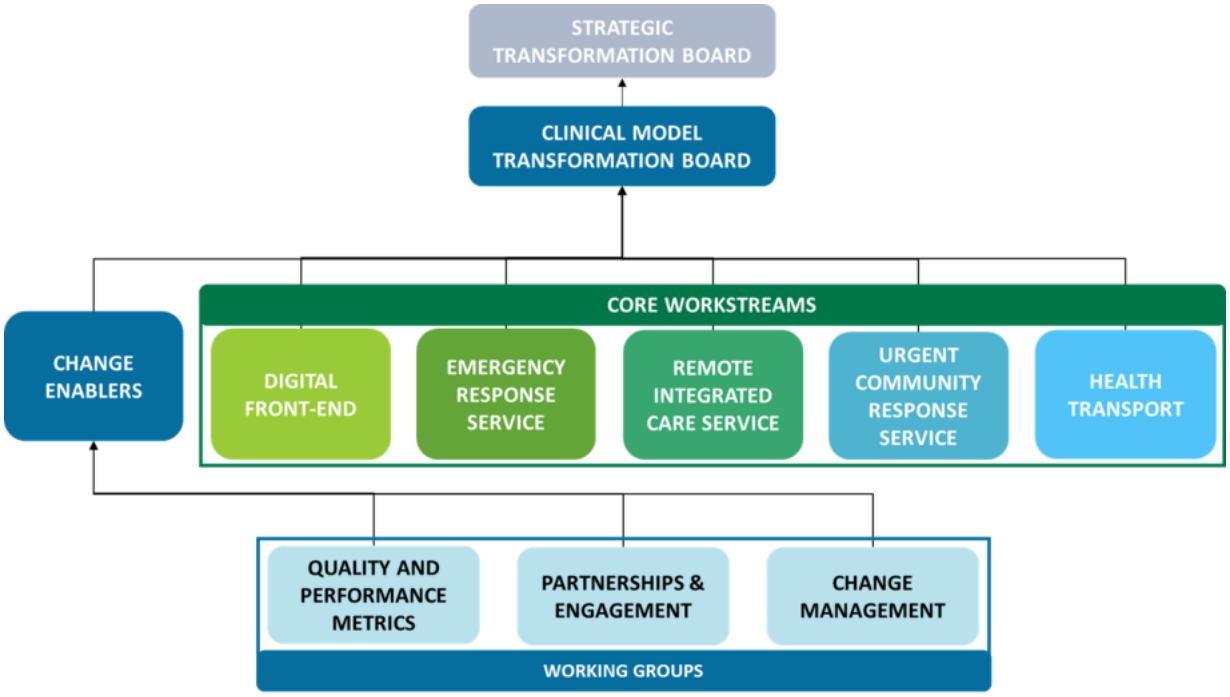
As part of our ongoing plans to evolve and develop the future clinical services model, we are engaging and collaborating with a diverse range of stakeholders. Through our comprehensive stakeholder mapping process, we have identified three key stakeholder groups (listed below) that are crucial to this initiative and subject to the EQIA. These groups will play a significant role in shaping and refining our clinical services model to ensure it meets the needs of all involved.

Group 1: Key Political & System Stakeholder	Group 2 – External Stakeholders & Partners	Group 3 – Patient, Public & Local Communities
• Welsh Government • Senior Civil Servants • Commissioners • Senior Health Board Leadership • Patient Advocacy Groups (Llais)	• Clinical Engagement • System / Programme • Health Board • Patient Advocacy Groups • Professional Bodies	• Members of the Public • Local Communities • Patients and representatives • Regional Health Boards

The assessment and understanding of the impact of planned changes on specific staff groups will be undertaken within individual workstreams. Given the scale and complexity of the programme, each workstream will identify and evaluate how their specific changes will affect different staff groups. This approach ensures that those with the most direct understanding of the proposed changes and their local context take ownership of this vital process, enabling a more accurate and meaningful assessment. As many of the planned changes are still being defined, it will be essential to embed change impact assessment as an ongoing, iterative process. Support and guidance will be provided to workstreams to ensure they have the tools, frameworks and expertise needed to conduct thorough and effective change impact assessments.

5. Programme Delivery and Assurance

Programme Governance



The CMT Programme is structured around five core Workstreams and three cross-functional Enabling Groups, all of which report into the overarching CMT Board (the Sponsor Group). This Board provides a forum for holistic oversight, strategic prioritisation, and vision setting. The CMT Board convenes every six weeks, aligned with the Strategic Transformation Board (STB), and reports into the bi-monthly Finance & Performance Committee.

In addition to the formal six-weekly Programme Board meetings, Executive Sponsors and Senior Responsible Owners (SROs) for the five core Workstreams meet informally on a fortnightly basis to discuss emerging issues and provide strategic direction. A smaller SRO group, which includes representatives from the three cross-functional Enabling Groups, also meets informally every two weeks to support operational coherence and alignment.

Projects and initiatives are delivered under each of the five core Workstreams, each with an appointed Executive Sponsor and SRO. Responsibility for ensuring that EqIAs are completed, where required, sits with the respective Workstream SRO. The Transformation Support Office will provide guidance and oversight, maintaining a programme-wide record of EqIA status as part of robust governance and assurance processes.

Early and ongoing engagement with EDI and PECI teams will be actively encouraged and championed by programme leadership, to ensure that equality and inclusion considerations are embedded throughout programme design, delivery and evaluation.

EDI Definition Document Approval Route

The CMT Board will be responsible for formal approval of this EDI Definition Document following local sign-off by the Head of Inclusion and Engagement (see Version Control). Once endorsed by the Head of Inclusion and Engagement, the EDI Definition Document will be shared with all CMT Board members, and a 10-working day consultation period will commence. Feedback and recommendations will be collated from Board members and incorporated into the final EDI Definition Document submission. This will then be formally presented to the CMT Board for approval, with the Board's decision recorded within the Programme Decision Log and CMT Board minutes and noted in Version Control.

6. Quality Assurance

The primary driver for transitioning to an evolved clinical services model is to improve clinical outcomes and reduce the risks and harm faced by patients in our communities. The goal is to ensure that all patients receive safe, timely care, with the right advice or intervention, in the right place, every time.

The programme's quality management approach is supported by established clinical and operational governance structures, primarily through the Clinical Quality and Governance Group (CQGG) and the newly established Clinical Advisory Group (CAG). The CAG provides clinical oversight and expert guidance on complex issues in alignment with strategic programme objectives, ensuring that clinical standards are maintained throughout the transformation.

Operating as a subgroup of CQGG, the CAG advises on clinical safety, integrates diverse clinical perspectives, and upholds ethical standards, thereby reinforcing consistent quality assurance. The CAG will convene regularly throughout the lifecycle of the programme and will formally report into CQGG via regular AAA reports, ensuring that quality management processes remain transparent, systematic, and aligned with WAST's strategic goals.



The proposed clinical model aligns with the legal requirements set out in the Duty of Quality Act, which mandates NHS organisations to foster a culture of continuous improvement in healthcare quality. This model focuses on enhancing the quality of services and health outcomes for the population on an ongoing basis.

Here is how our approach addresses the six key quality domains:

Safe – We will enhance patient safety by prioritising those most in need. By enhancing clinical decision-making early in the call process, we can better assess individual patient needs and ensure the appropriate service is delivered to resolve care episodes safely.

Timely – Enhancing our ability to identify clinical needs will allow us to tailor services based on patient urgency. This will enable us to preserve ambulance resources for those in critical need while providing timely, remote care and personalised care plans for patients with less urgent conditions.

Efficient – Our goal is to deliver optimal clinical outcomes by accurately assessing and addressing each patient's unique needs. Through personalised care planning, we can provide the right care and advice, ensuring resources are used effectively to achieve the best outcomes.

Person-centred – By leveraging clinical information earlier in the pathway, we can better identify the services that meet each patient's individual needs. This approach ensures more personalised and tailored care plans, providing a safer and more appropriate resolution to each care episode.

Equitable – We will prioritise proactive removal of barriers, individualised care, and will include diverse voices in the design and delivery of our evolving clinical services model.

Efficient – Clinically informed decision-making will ensure that patients receive the right care at the right time, reducing unnecessary touchpoints and ensuring that responses align precisely with their needs.

A Quality Impact Assessment (QIA) will be completed for each workstream to objectively assess the impact of planned changes against the six key quality domains and to risk assess and plan mitigation against any negative impact on the quality-of-service delivery. The Clinical Quality Governance Group (CQGG) will be responsible for formal approval of QIAs as the established organisational governance route, and copies of approved QIAs will be shared with CMT Board for information and programme assurance. In line with existing clinical quality governance arrangements, approved QIAs will also be shared with the Quality Experience & Safety Committee (QuESt) for information and audit.

7. Research & Data Sets

The following publications have been used to inform the CMT Programme and support the aims of the programme to improve the health and wellbeing of the people of Wales.

Working Together for a Healthier Wales - Public Health Wales

Health in Wales

The Covid-19 pandemic has had significant effects on the people of Wales, and its social and economic consequences have been felt unequally across our society. They have disproportionately affected those who already had the greatest health and social needs. In Wales, life expectancy and healthy life expectancy have failed to increase over the last decade, and we continue to see obvious and continuing inequalities in health.

Typically, people living in the poorest parts of Wales already die more than six years earlier than those in the least deprived areas. The current cost-of-living crisis will add to what were already increasing differences in health between the well-off and the less well-off.

'Rising to the Triple Challenge of Brexit, Covid-19 and Climate Change for health, well-being and equity in Wales', shows that the people of Wales have been significantly affected by all three of these

challenges. For example, Brexit, Covid-19 and climate change have affected employment, trade and other factors which affect people's health, such as alcohol use, the cost of food, and mental well-being.

Wales is a country:

- with an ageing population and low fertility rate, which will increase our dependency ratio (the number of dependants aged from 0 to 14 and over 65, compared with those aged 15 to 64) in the future;
- which has clear and continuing health inequalities, with healthy life expectancy for women and men almost 17 and 12 years lower in the most deprived areas compared with the least deprived;
- where the gap between the least and most deprived areas in Wales for premature deaths from non-communicable diseases (those not caused by an infection) has been increasing in recent years, and the rate of premature deaths from this cause is now almost two and half times greater in the most deprived areas compared with the least;
- where around one-third of people are following less than three of the five 'healthy behaviours';
- where 1 in 7 of adults in Wales smoke;
- where loneliness is twice as likely among people living in the most deprived areas; and
- where there is a large backlog of patients waiting for treatment (at January 2023, there were around 576,000 patients on treatment waiting lists in Wales).

Population and household estimates, Wales - Office for National Statistics

The population Census Data from 2021 and NHS research projects allow us to anticipate population health needs over the next 10 years and beyond. The data is already showing an ageing population with increasing health and wellbeing needs. An increase in migration and in people with a disability will also have an impact upon how we plan to deliver effective healthcare services to meet the needs of the people we serve.

The 2021 Census shows us that Wales has seen an increase in migration and ethnic diversity with a growing Polish and Romanian population. Polish was the most common main language after English or Welsh followed by Arabic. Approx 900 people in Wales use British Sign Language (BSL) as their main language.

Other publications also support the aims of the CMT and demonstrate we need to change the way in which we deliver our services.

Age friendly Wales: our strategy for an ageing society [HTML] | GOV.WALES

Understanding-Wales-ageing-population-5.4.pdf

Learning disability delivery and implementation plan 2022 to 2026 [HTML] | GOV.WALES

[Social Model - Disability Wales]

[Workforce Race Equality Standard - NHS Wales]

8. Strategic and Policy Alignment

Long-Term Strategy

'Delivering Excellence', the Trust's long term strategic framework sets out an exciting future vision for the organisation up to 2030. The strategy articulates the organisational ambition to become a trusted provider of high-quality care, ensuring patients receive the 'right advice and care, in the right place, every time', with an increasing emphasis on managing and resolving more care closer to home.



The strategy recognises the important role the service must play to respond to the changing health needs of the population, whilst playing a more integral role across the health and care system to help reduce pressure and flow across secondary care services.

A core element of the strategy focuses on the opportunity to transform the clinical services model. To date our service transformation ambitions have been visualised through the concept of 'Inverting the Triangle'. This concept focussed primarily on transforming our response to patients who call 999 - moving away from the traditional ambulance model of care of clinical logistics and conveyance to a future where the majority of care needs are met and resolved in or close to the patient's home.

The principles of this concept still hold true. But working across such a complex and interconnected health and care system, we want to broaden our thinking and adopt a more holistic approach to maximise the benefits for our patients and the wider health system by bringing our 999, NHS 111, and Ambulance Care services closer together as an integrated offer.

Integrated-Medium Term Plan 2025 – 28

The Trust's Integrated Medium-Term Plan (IMTP) outlines our strategic vision and the steps we will take to enhance and improve our services, ensuring that we continue to meet the needs of the public & our patients, our people and our partners across Wales.



We know that too many patients continue to come to harm, have poor experiences of care, and have difficulties in navigating our complex health and care system meaning they don't always get the right care or advice in the right place at the right time.

Over the last 12 months, the CMT Programme has been established to intensify the focus on evolving our clinical model to deliver the excellent, personalised care that remains at the heart of our Long-Term Strategy, and our IMTP.

Wellbeing and Future Generation Act

The CMT Programme is closely aligned with the principles and ambitions of the Well-being of Future Generations (Wales) Act 2015. The aim of the Act is to ensure that public bodies across Wales are working together to ensure that Wales develops as a prosperous, culturally rich, economically vibrant, healthy and well educated country, where people can thrive both at work, and at home.



The CMT Programme exemplifies these principles through its ambition to design sustainable, equitable, and clinically-led models of care that respond to the evolving needs of the population. By supporting access to care closer to home, reducing unnecessary hospital conveyance, and improving coordination across the health and care system, the programme makes a meaningful contribution to prevention and long-term health outcomes.

Collaboration with Health Boards, third sector organisations, and local communities is central to the programme's approach, ensuring that care pathways are designed inclusively and reflect local needs and priorities. The emphasis on engagement, co-design, and continuous improvement reinforces the involvement principle, helping to shape services around the people who use and deliver them.

By contributing to a more integrated and responsive urgent and community care system, the programme supports the delivery of a healthier, more resilient Wales, and plays an important role in ensuring the Trust meets its duties under the Act.

Strategic Equality Plan

Strategic Equality Plan 2024-2028 Welsh Ambulance Service NHS Trust

The Trust's 4-year Strategic Equality Plan sets out the Trust's commitment to eliminate discrimination and improve equity for all. This programme of work supports all four of our Strategic Equality Objectives to:

- Design equitable services
- Be an employer of choice
- Lead by example
- Create allyship

People and Culture Plan



Our People and Culture Plan 2023-2026 is designed to cultivate a supportive and inclusive environment for our people, which in turn acts as an enabler for the successful implementation of the CMT Programme.

In terms of developing a skilled and adaptable workforce, the Plan emphasises the importance of continuous professional development, ensuring that our people possess the right skills; this is key to ensuring our people are able to deliver changing services.

By focussing on creating an environment where colleagues feel valued and supported, the Plan enhances employee engagement and motivation. An engaged workforce is more likely to embrace and drive the changes proposed in the Clinical Model Transformation Programme, leading to improved patient outcomes and service efficiency.

Aligned with this, the Plan sets out our ambition to build change capability and capacity across the organisation and to ultimately embed change management principles as core leadership skills and competencies. This focus on developing change-ready leaders and teams ensures that change management becomes an integral part of how we work, enabling more effective and sustainable transformation. Effective change management will be vital to the success of the Clinical Model Transformation Programme, helping to drive adoption, minimise resistance and deliver meaningful, lasting impact.

The Plan's focus on digital readiness ensures that our people are equipped with both the technology and the skills to utilise it effectively; this digital competence will be crucial for elements of the programme.

By developing leaders who embody inclusive and compassionate leadership, the Plan ensures that there is strong guidance to navigate the complexities of clinical transformation. Effective leadership is essential for managing change and creating a culture that supports innovation and continuous improvement.

The Plan addresses the need for a sustainable workforce, aligning staffing levels and skills with the demands of the service. This proactive approach to workforce planning ensures that the right people are in place to deliver our clinical services.

In summary, the People and Culture Plan 2023-2026 provides a robust framework that not only aligns with but also facilitates the objectives of the Clinical Model Transformation Programme. By focusing on workforce development, engagement, digital readiness, leadership and sustainability, the Plan aims to enable creation of the necessary conditions for programme success.

Welsh Government Six Goals Programme



The Welsh Government Six Goals Programme has been established at a national and local level to support improvement in the urgent and emergency care system. The Trust has a vital role to play across each of the goals, and our Long-Term Strategy and Clinical Model Transformation Programme aligns with the goals and priorities set out in this policy.

The Six Goals programme is identified as a high priority stakeholder group within the PEP. Proactive engagement and collaboration is required to ensure strategic and operational alignment with changes across the Urgent & Emergency Care system and presents an opportunity as a mechanism to help support and deliver wider system improvements to underpin the proposed changes to the Clinical Services Model.

9. Programme Communication & Engagement Plan

To effectively communicate progress with service users, staff, and stakeholders throughout the CMT Programme, we will implement a comprehensive change management strategy based on the ADKAR model, which guides individuals through the stages of change.

ADKAR Model Stages



Awareness: Raising awareness about the programme's purpose, key milestones, and benefits through whole organisational comms and workstream-specific resources.

Desire: Addressing why this change matters, focusing on what's in it for all colleagues and the entire organisation through leadership visibility, Trade Union partnerships, two-way feedback channels, and clear messaging.

Knowledge: Providing detailed training and resources, including FAQs, role-specific guidance, and super-users, via support from Change Leads embedded in the workstreams.

Ability: Ensuring colleagues have the time, space, tools, training, and support they need to adopt new processes through hands-on support, regular check-ins, and mentoring.

Reinforcement: Celebrating successes and milestones and reinforcing new ways of working through continuous feedback loops, recognition, and ongoing support.

By implementing these mechanisms, we aim to foster a transparent, inclusive, and responsive communication environment throughout the transformation process.

Change management is necessary to ensure that everyone understands, accepts and supports the changes happening within the organisation. This approach will allow us to tailor our communications and engagement plans at each stage of the change process to meet the varying needs of our stakeholders.

To ensure comprehensive and effective communication, we will implement a multi-faceted approach that includes whole organisation, targeted, and proactive communications and engagement strategies.

Whole Organisation Communications and Engagement: We will provide regular updates at 4-6 weekly intervals through various methods including email communications, newsletters, videos, podcasts, infographics, surveys, and presentations. This ensures that everyone stays informed about the programme's purpose, key milestones, and benefits.

Targeted Communications and Engagement: These will be developed in line with commissioned requests and programme milestones. For example, the fortnightly updates via the RICS Roundup series (newsletter and video) will be extended across all workstreams as we embed this approach throughout the entire programme.

Proactive Communications and Engagement: A proactive change management internal communications plan will be developed upon completion of programme and workstream milestones and objectives. This will help us communicate effectively without overwhelming people with unnecessary information.

Ensuring Accessibility of Communications

To ensure that our communications are accessible to all stakeholders, we will implement the following strategies:

Inclusive Language: All communications will be crafted in clear, inclusive language to ensure they are easily understood by everyone, regardless of their role or background.

Multiple Formats: Information will be available in various formats, including written documents, videos, and audio recordings, to cater to different preferences and needs.

Accessibility Standards: We will adhere to accessibility standards, ensuring that all digital content is accessible to people with disabilities, including those using screen readers.

Opportunity for Feedback

We have established multiple feedback channels including surveys and dedicated email addresses where stakeholders can share their thoughts and concerns.

We will undertake regular interactive sessions like Q&A forums, focus groups, and workshops and these will be held to gather real-time feedback and address any issues promptly.

All feedback will be reviewed and integrated into the ongoing change management process, ensuring that stakeholder input is valued and acted upon.

Impact of Communication Strategies on Patient Experience

The communication strategies implemented during the Clinical Model Transformation Programme are designed to significantly enhance the patient experience in several ways:

- Clear, consistent, and inclusive communication ensures that patients are well-informed about their care plans, reducing confusion and anxiety
- Regular updates and transparent communication build trust, leading to higher levels of patient satisfaction
- By providing information in multiple formats and languages, patients are more likely to engage with their care, leading to better adherence to treatment plans and improved health outcomes
- Establishing feedback channels allows patients to voice their concerns and suggestions, ensuring that their needs and preferences are considered in the care process
- Tailoring communication to meet the specific needs of different patient groups ensures that all patients receive relevant and understandable information, enhancing their overall experience

By prioritising effective communication, we aim to create a more patient-centered healthcare environment that fosters trust, engagement, and satisfaction.

10. Monitoring Impact & Outcomes

Patient Experience & Community Involvement

Through its continuous engagement model, PECI engages with the public, patients, their carers and families to understand how they experience the services provided by the Trust. People's experience feedback, once captured, is shared internally, and is fundamental to enhancing the patient experience and identifying areas for improvement or celebrating and building on what is working well.

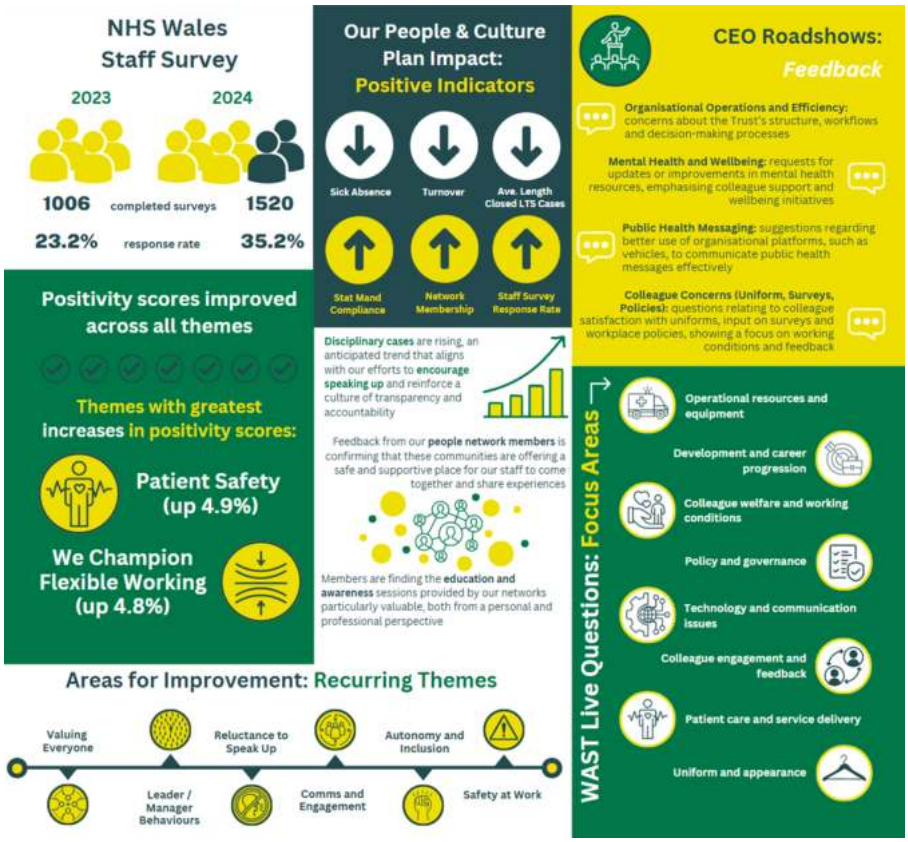
The team will continue to systematically collect, analyse and utilise feedback to help shape our service priorities and improvements, using thematic analysis to identify and monitor any impacts on patient experience related to our evolving clinical services model. Aligning with the national ambition for an 'Always On' system, the PECI team is also embedding a structured approach to capturing positive feedback in real time, ensuring that every opportunity to learn from what is working well is maximised. This will include continuous monitoring of feedback through four core surveys that are always available to the public via the Trust website, with survey responses/ feedback reported to the weekly Quality Management Group. Feedback will be used to service redesign and delivery plans, supported by strong PECI representation across the programme including the Partnerships & Engagement Workstream Group.

- 999 EMS - Experience Survey
- NHS 111 Telephony service – Experience Survey
- NHS 111 Website – Experience Survey
- Non-Emergency Patient Transport Service (NEPTS) – Experience Survey

Staff Experience and Wellbeing

The Trust maintains a strong commitment to understanding and improving the lived experience of its staff. This is particularly important in the context of the CMT, where operational changes have a direct impact on roles, responsibilities, and working environments.

Staff feedback is routinely gathered through a range of established mechanisms, including the NHS Staff Survey, Cultural Early Warning Indicators, WAST Live sessions, and CEO Roadshows. These platforms allow staff to share their experiences, raise concerns, and shape organisational priorities. Insights gained from these channels are routinely analysed and used to inform both service planning and workforce development initiatives.



In addition to these Trust-wide processes, the CMT Programme has implemented programme-specific staff engagement and survey activity to understand the impact of transformation on those directly involved. A dedicated staff survey was undertaken in January 2025, with findings used to shape changes in programme delivery and inform local implementation plans. This feedback directly led to adjustments in communication and engagement processes, demonstrating a person-centred approach to continuous improvement.

The programme is committed to ongoing dialogue with its workforce, recognising that continuous feedback is essential to delivering sustainable change. As the programme progresses, staff experience will be monitored through a combination of programme-specific surveys, targeted engagement sessions, and integration of staff-related indicators within quality and performance frameworks. This balanced approach will ensure that staff impact is considered alongside service and patient outcomes, enabling a more holistic understanding of the effects of transformation. Regular feedback cycles will support iterative improvement, ensuring that the programme continues to reflect the needs and insights of those delivering care on the front line.

11. Integrated Impact Assessments

Equality Impact Assessment

As part of this Equality Impact Assessment, each of the nine protected characteristics, alongside other key groups identified as experiencing potential health inequality, have been individually assessed. The purpose of this assessment is to consider both the positive and negative impacts of the Clinical Model Transformation Programme, and to identify where individuals or groups may be disproportionately affected. This approach supports the Trust in fulfilling its statutory responsibilities under the Public Sector Equality Duty and in delivering equitable, person-centred services that reflect the diversity of the population we serve.

Theme	Impact	Mitigation
Age	**Positive Impacts:** Personalised, age-appropriate care models – The CMT programme supports age-responsive care by improving access to tailored clinical pathways for both children and older people. Examples include service models aligned with the National Service Framework for Children, Young People and Maternity Services and the All Wales Falls Framework. Rapid clinical prioritisation – The introduction of Rapid Clinical Screening for 999 originating patients will enable quicker assessment of patients' clinical needs, which can be particularly beneficial for older adults who may have complex medical histories or multiple comorbidities. Early identification of age-specific needs, such as frailty or risk of falls, can lead to more appropriate and timely interventions, including identification of the most appropriate specialist response (e.g. Falls Response), reducing the likelihood of conveyance and admission. Similarly, younger patients, especially children and infants, can have different physiological responses to illness or injury, which may be overlooked in standard assessment protocols. The introduction of clinical review early in the patient journey provides the opportunity for early identification of higher-risk markers that were not recognised through MPDS assessment. Improved remote and digital access – The Digital Front End workstream will introduce symptom checkers and chatbot support which may particularly benefit working-age adults and parents seeking rapid, trustworthy health advice for themselves or children.	

<table>
<tr><th>Theme</th><th>Impact</th><th>Mitigation</th></tr>
<tr><td></td><td colspan="2">Enhanced care closer to home – The programme's clinically-led ambition to reduce avoidable conveyance and instead provide remote or community-based care can especially benefit older adults, reducing risks of hospital-related deconditioning.</td></tr>
<tr><td></td><td>Negative Impacts:
Digital exclusion risk for older adults – Increased digitalisation of access to NHS111 Wales and remote clinical triage may disproportionately impact older adults, particularly those with low digital literacy or limited access to internet-enabled devices.

Risk of reduced confidence in new pathways – Older people or carers of very young children may feel uncertain about transitioning from traditional service models (e.g. 999 conveyance) to newer models of remote assessment or digital self-care tools.</td><td>Mitigation:
Ensure new digital tools are co-designed through the formal public and patient reference group; group establishment is a key deliverable within the IMTP 2025-28.
Use accessible UX standards. Apply Age UK and NHS digital usability standards to digital front ends.
Continued availability of our telephony services as a non-digital alternative, maintaining flexibility and choice.
Implement clear, age-appropriate public messaging to explain changes and maintain trust, particularly around emergency care access for children and frail older adults.</td></tr>
<tr><td>Disability</td><td colspan="2">Positive Impacts:
Personalisation and reasonable adjustments – The programme builds on digital and data infrastructure (e.g. new EPCR "Needs" tab) that enables staff to better identify patients with learning disabilities, autism or neurodivergence, and make appropriate reasonable adjustments.

Clinically determined response priority – Rapid Clinical Screening (RCS) will improve experience and outcomes for our most complex patients such as those with learning disabilities or dementia. These patients can experience difficulties in articulating the significance of the medical emergency when prioritised using a scripted tool. Evidence also shows that patients in these categories may also present later and as such may have been experiencing symptoms for a protracted period before seeking help. RCS will allow appropriate response priorities to be applied and a personalised response by connecting patients to the most appropriate specialist response (e.g. Mental Health Response Vehicle), reducing the likelihood of conveyance and admission.</td></tr>
</table>

Theme	Impact	Mitigation
	Supportive mental health focus – The evolving clinical model includes specific improvement priorities around mental health care, in both acute and crisis contexts, including the implementation of pan-Wales specialist Mental Health Response Vehicle cover. Enhanced staff awareness and culture – Through the PECI engagement work and internal people plans, there is a focus on inclusive culture, including furthering the understanding of disability, neurodivergence and mental wellbeing. This is being supported by patient stories, mandatory training and digital system prompts.	
	Negative Impacts: Digital barriers – The increasing digitalisation of care pathways and remote triage, if not inclusively designed or implemented, may inadvertently exclude individuals with cognitive, communication, or sensory impairments, or those who experience anxiety in digital environments. Capacity and mental health – People experiencing acute mental distress or cognitive impairment may struggle to engage with remote, digital or standardised assessment tools, risking inappropriate triage or unmet need.	**Mitigation:** • Inclusive design principles embedded to ensure that chatbots, symptom checkers and self-care tools are accessible for people with communication or sensory impairments, including compatibility with screen readers and use of plain English/Welsh. • Continued availability of our telephony services as a non-digital alternative, maintaining flexibility and choice. • Reporting dashboard for the new ePCR "Needs Tab" will track key trends and enhance data capabilities with regards to learning disabilities, including autism and neurodiversity. • Data insights will inform training needs and support the integration of a learning disability specialist within the Remote Clinical Care Team. The data will be shared across clinical teams and governance structures to embed continuous improvement, aligning with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Theme	Impact	Mitigation
Sexual Orientation	**Neutral Impact:** No direct differential impact identified – The service delivery changes proposed through the CMT Programme are not expected to disproportionately affect people based on this characteristic. Access to services, clinical triage, and decision-making are guided by presenting clinical need and best practice.	
Gender Reassignment / Gender Identity	**Neutral Impact:** No direct differential impact identified – The service delivery changes proposed through the CMT Programme are not expected to disproportionately affect people based on this characteristic. Access to services, clinical triage, and decision-making are guided by presenting clinical need and best practice.	
Sex / Gender	**Neutral Impact:** No direct differential impact identified – The service delivery changes proposed through the CMT Programme are not expected to disproportionately affect people based on this characteristic. Access to services, clinical triage, and decision-making are guided by presenting clinical need and best practice.	
Race	**Neutral Impact (with potential Positive Impact):** The programme is designed to deliver equitable access to emergency, urgent and community-based care through the rapid identification of critical care needs, and clinically-led, person-centred pathways. While the programme does not introduce specific changes relating to race or ethnicity, its overarching ambition to reduce fragmentation and improve timely access has the potential to positively impact racially minoritised communities, many of whom currently face disproportionate barriers in navigating the healthcare system. However, the impact cannot be assumed to be uniformly positive. Evidence from national reports and patient experience feedback indicates that individuals from Black, Asian and minority ethnic backgrounds may face language barriers, cultural misunderstanding, and systemic bias that can affect both their access to care and the quality of care received. Without targeted action to address these risks, there is potential for existing disparities to persist or widen under the new model. An opportunity for a positive impact with regards to Race is in the development of the Digital Front End. Enhancements such as enabling the public website to be navigable in multiple languages could provide a more accessible and trusted route into services for individuals who are not confident in English or Welsh. This may particularly benefit those for whom digital interaction is preferred over telephone-based services, where accents, dialects, or confidence in spoken communication can act as barriers. However, this must be balanced by ensuring non-digital alternatives remain accessible to those who are digitally excluded.	

Theme	Impact	Mitigation
Religion and Belief	**Neutral Impact:** No direct differential impact identified – The service delivery changes proposed through the CMT Programme are not expected to disproportionately affect people based on this characteristic. Access to services, clinical triage, and decision-making are guided by presenting clinical need and best practice.	
Pregnancy and Maternity	**Positive Impacts:** Community-based models – As the clinical model evolves, the emphasis on care closer to home and reducing unnecessary conveyance may benefit new mothers or those in late pregnancy, for whom long waits or travel to ED may present physical and emotional challenges.	
	Negative Impacts: Potential triage ambiguity – Without clear protocols or training, there is a risk of under-recognising obstetric emergencies within non-specialist triage systems or through digital pathways, which may lead to delayed care.	**Mitigation:** • Robust clinical guidelines and decision support tools to ensure pregnancy-related concerns are rapidly identified and escalated appropriately. • Specialist input into pathway design, ensuring maternity and neonatal leads are actively involved in the design and governance of care pathways. • The Online Symptom Checker tool will meet all contemporary clinical standards, including the NICE Evidence Standards Framework for Digital Health Technologies, and DCB0129 compliance (Clinical Risk Management Standard). • Track and analyse any complaints, incidents or patient stories related to pregnancy and maternity to identify patterns and inform continuous improvement.
Marriage and Civil Partnership	**Neutral Impact:** No direct differential impact identified – The service delivery changes proposed through the CMT Programme are not expected to disproportionately affect people based on this characteristic. Access to services, clinical triage, and decision-making are guided by presenting clinical need and best practice.	
Unpaid Carers	**Neutral Impacts:** No direct differential impact identified – The service delivery changes proposed through the CMT Programme are not expected to disproportionately affect people based on this characteristic. Access to services, clinical triage, and decision-making are guided by presenting clinical need and best practice.	

<table>
<tr><th>Theme</th><th>Impact</th><th>Mitigation</th></tr>
<tr><td rowspan="2">Socio-Economically Disadvantaged</td><td colspan="2">Positive Impacts:
Equity-driven service design – Use of modelling tools (e.g. ORH, Optima) to align resources with community need, including areas with high deprivation. This supports the delivery of more equitable access across Wales, especially in under-served and rural communities.

Reduced conveyance and improved local care – The shift toward care closer to home may be particularly beneficial for individuals with limited means, helping to reduce reliance on hospital transport and mitigating indirect costs (e.g. travel, childcare, lost income due to extended ED stays). The approach supports the prudent healthcare principle of care closer to home and reinforces resilience within communities.

Public health and prevention focus – The programme supports the Trust's broader commitment to improving health outcomes through population health strategies, which includes action on the wider determinants of health that disproportionately affect socio-economically disadvantaged communities (e.g. transport barriers).</td></tr>
<tr><td>Negative Impacts:
Digital poverty – Increased reliance on digital access points (e.g. symptom checkers, online triage, chatbot services) may exclude individuals without consistent internet access, devices, or sufficient data literacy.

Compounded access challenges – People in deprived communities may face multiple, intersecting barriers (e.g. poor housing, food insecurity, low health literacy), which can compound health inequalities and impact engagement with new care pathways.</td><td>Mitigation:
Maintain and clearly promote non-digital access options (e.g. telephone triage, paper information, face-to-face access via community services) to avoid excluding those experiencing digital poverty.
Work with third sector and community partners to co-design inclusive services, particularly in areas with high deprivation. Use the public and patient reference group Ensure new digital tools are co-designed through the formal public and patient reference group to hear lived experience and influence service models.</td></tr>
</table>

Intersectional Disadvantages

We recognise that individuals may face multiple, intersecting disadvantages which influence their ability to access and benefit from health services equitably. This includes people who experience more than one protected characteristic (e.g. race and disability, gender identity and socio-economic status), which can amplify barriers and impact experiences of care.

For example:

- An older adult with a disability living in a rural, deprived area may face compounded access issues due to mobility challenges, digital exclusion, and limited local service provision.
- A neurodivergent person from an ethnic minority background may face cultural, linguistic and communication barriers that affect how they interact with triage or digital tools.

These intersectional challenges can increase the risk of poorer health outcomes, delayed access to care, and reduced trust in the healthcare system. The availability and accessibility of services, which can vary significantly by geography and local commissioning arrangements, may further intensify these disparities, particularly in rural or socio-economically disadvantaged areas. This issue is explored in more detail within the Health domain of the Socio-Economic Impact Assessment.

The CMT Programme actively supports the Trust's Strategic Equality Objectives, with a clear commitment to inclusive service design and equitable access for individuals facing multiple and intersecting forms of disadvantage. Recognising that people's experiences are shaped by a combination of factors – such as age, disability, ethnicity, gender identity, and socio-economic status – the programme seeks to respond with sensitivity and flexibility through its design and delivery. A key part of this approach involves leveraging the Patient and Public Reference Group, which is intended to reflect the diversity of Wales and capture lived experiences across protected characteristics.

Socio-Economic Impact Assessment

This Socio-Economic Impact Assessment (SEIA) has been undertaken in line with the Trust's statutory obligations under the Socio-economic Duty. The Duty provides a framework for improving decision-making by ensuring that the potential impacts on individuals and communities who are socio-economically disadvantaged are fully considered. Through this assessment, the programme seeks to place tackling inequality at the heart of its design and delivery, aligning with the broader ambition to do things differently in Wales. It supports the Trust's commitment to delivering fairer, more inclusive services and builds upon existing good practice across public services.

<table>
<tr><th>Theme</th><th>Impact</th><th>Opportunity</th></tr>
<tr><td rowspan="2">Education</td><td colspan="2">Positive Impacts:
The programme supports the Trust's broader ambitions to add social value by enhancing access to employment and skills development, particularly for those facing educational disadvantage. Although not an education programme, the evolution of our clinical model is expected to generate new and evolving roles across clinical and support functions, creating opportunities for recruitment through local partnerships, apprenticeships, and volunteering pathways.

This approach supports individuals – particularly young people and those furthest from the job market – by providing structured entry points into the healthcare workforce. These initiatives align with the Trust's existing commitments to widening access and working with education providers and employability schemes across Wales.

The programme also acknowledges that some patients may face challenges due to limited literacy or additional learning needs. To mitigate this, there is a clear commitment to inclusive service design, ensuring that communication methods and digital interfaces are accessible and understandable to all, regardless of educational background.</td></tr>
<tr><td>Negative Impacts:
Literacy barriers – There is a potential risk that individuals with low literacy, limited health literacy, or learning disabilities may find it more difficult to engage with redesigned digital front-end access models – particularly tools that require digital navigation or symptom interpretation.</td><td>Opportunities:
Ensure new digital tools are co-designed through the formal public and patient reference group; group establishment is a key deliverable within the IMTP 2025-28.
Apply plain language principles and visual aids across patient-facing materials and digital tools, ensuring accessibility for people with varying literacy levels.
Promote work placements, volunteering, and apprenticeships linked to the programme through community networks and outreach, with specific focus on under-represented groups.</td></tr>
<tr><td>Health</td><td colspan="2">Positive Impacts:
The programme is fundamentally aligned with improving health outcomes for the population of Wales, with a particular emphasis on addressing variation in access and experience. The programme supports the delivery of care closer to home,</td></tr>
</table>

Theme	Impact	Opportunity
	including a reduction in unnecessary conveyance to hospital and improved use of community pathways, which can directly benefit those who face barriers linked to poverty, transport, or complex social needs. The model is designed around clinically-led triage and decision-making, helping to ensure that patients with the greatest need receive the most appropriate care, regardless of socio-economic status. Use of advanced analytics (e.g. ORH and Optima) enables targeted resource allocation to areas with higher demand or evidence of unmet need, including rural and deprived communities. By reducing reliance on physical attendance at Emergency Departments and supporting more efficient care journeys, the programme also considers the hidden health costs of socio-economic disadvantage – such as stress, time off work, and difficulty attending follow-up care. It reinforces prudent healthcare principles by seeking to prevent harm and minimise waste.	
	Negative Impacts: Socio-economic deprivation – People living in socio-economic hardship may still experience difficulty navigating complex care systems or lack the confidence, transport, or digital access needed to fully benefit from some aspects of the new model. In particular, the cost and availability of travel for follow-up care or diagnostics, especially in rural areas, remains a system-wide challenge and is outside the full control of the Trust. Geographic variation in service provision – While the is designed to promote care closer to home and reduce reliance on Emergency Departments, the ability to deliver this vision consistently across Wales is influenced by geographic variation in community service provision. In rural areas and certain Health Board regions, the availability of community-based care and intermediate services remains limited or fragmented. This	**Opportunities:** • The introduction of coordinated care planning within the CMT model provides a critical mitigation against health inequalities. By proactively arranging onward referrals and follow-up care, the programme aims to reduce the administrative and logistical burden on patients – particularly those facing barriers due to transport, digital exclusion, or health literacy. • Through integrated care planning, the Trust will work with both internal services (e.g. Non-Emergency Patient Transport Service) and external Health Board partners to enable timely, supported access to community-based care, helping to bridge the gap between initial contact and long-term condition management.

Theme	Impact	Opportunity
	can result in uneven access to alternatives to hospital conveyance, undermining the programme's equity goals. Availability of referral pathways – Pathways available to WAST staff vary based on local commissioning decisions and/or agreement with service providers to accept WAST referrals. This means that patients in some areas benefit from more developed services than others, despite presenting with similar clinical needs. This disparity risks exacerbating existing health inequalities, particularly for socio-economically disadvantaged populations who may already face transport, digital, or housing-related access barriers. Complex needs barriers – Digital or telephone triage may not fully capture the needs of those with complex social circumstances, mental health needs, or communication barriers, unless staff are specifically trained to recognise these dynamics, and front-facing solutions are designed with and for users with a diverse range of accessibility requirements.	• Ensure clinical triage training includes awareness of social determinants of health, to support holistic assessment and appropriate escalation. The programme recognises that Health Board engagement is critical – both to maximise use of existing pathways and to co-design new models of care in areas of unmet need. The programme is committed to working collaboratively with regional partners to expand the scope of community-based options, strengthen escalation routes, and ensure that triage decisions are not constrained by geography. This commitment is demonstrated through the establishment of the Executive-led Partnerships & Engagement Enabling Group, commissioned to develop and deliver a comprehensive communication and engagement plan with key external political and clinical leaders.
Living Standards	**Positive Impacts:** The programme takes account of the broader impact of poverty and deprivation on people's ability to access and navigate health services. By redesigning care pathways to provide more clinically-led, timely and coordinated care closer to home, the programme directly supports individuals who may otherwise face financial and logistical barriers to reaching hospital-based care.	

Theme	Impact	Opportunity
	Groups more likely to experience poverty – such as those with disabilities, lone parents, and those living in areas of high deprivation – stand to benefit from a system that reduces unnecessary Emergency Department attendance, prevents deterioration in the community, and promotes earlier intervention through structured care planning. The programme also promotes person-centred triage and proactive referral, reducing fragmentation and supporting patients with complex needs who may otherwise fall between services. This is particularly important for those experiencing housing insecurity or socioeconomic instability, where continuity of care and support with navigation are critical.	
	Negative Impacts: Socio-economic deprivation – Patients experiencing deprivation may still face practical barriers to accessing care – such as transport costs, unstable living conditions, or competing priorities (e.g. caring responsibilities, insecure employment). Some groups (e.g. those who are homeless or living in rural deprivation) may also be less likely to engage with digital access routes or may fall outside routine follow-up systems without active coordination.	**Opportunities:** • Embed holistic care planning and referral pathways into the service model, enabling WAST to support individuals in accessing the most appropriate services and reducing dependence on self-navigation. • Collaborate with Health Boards, local authorities, and third sector organisations to ensure that patients with complex social needs are referred into appropriate community support networks, including transport schemes, housing advice, and welfare services. • Maintain non-digital access options for all key services and ensure that frontline staff are trained to identify signs of socio-economic vulnerability during triage or on-scene assessments. • Use equity data and lived experience feedback to monitor uptake and access by deprivation decile and adapt service delivery where required.
Work	**Positive Impacts:** The programme is expected to generate a range of employment, apprenticeship, and volunteering opportunities as new clinical models are implemented and workforce roles evolve. These opportunities will support the Trust's wider role as an anchor	

Theme	Impact	Opportunity
	institution, with a commitment to enhancing economic inclusion and improving access to meaningful employment across Wales. The programme will also involve the creation or adaptation of roles in areas such as clinical triage, care planning, digital health and mental health support. These roles provide opportunities for entry-level access as well as upskilling for existing staff, particularly through apprenticeships and career progression schemes. This approach supports individuals from low-income or economically inactive backgrounds, including those living in in-work poverty. By coordinating care more effectively and reducing delays in accessing the right service, the programme also helps patients maintain stability in employment, particularly those with long-term conditions who may otherwise experience frequent disruptions to work or require emergency care at short notice.	
	Negative Impacts: Inequity of opportunity – There is a risk that some individuals, particularly those unable to work due to ill-health or caring responsibilities, may not immediately benefit from new employment or volunteering pathways if recruitment and training are not inclusive or flexible enough to accommodate diverse needs. Additionally, the shift towards more digitally-enabled roles and service delivery may disadvantage those without digital confidence or qualifications unless supported entry points are provided.	**Opportunities:** • Ensure that recruitment and apprenticeship schemes linked to the programme include targeted outreach to economically disadvantaged communities and individuals currently excluded from the labour market. • Build in flexible working opportunities and supported learning pathways to accommodate those with health conditions, caring responsibilities, or limited prior qualifications. • Partner with education and employability providers to promote WAST careers in communities with high unemployment or work poverty, offering volunteering as a stepping stone into paid work. • Implement the Trust's Digital Skills Strategy (2025–2030) and align it with the forthcoming People Development Plan, supporting staff to develop the

Theme	Impact	Opportunity
		digital confidence and capabilities needed to thrive in an increasingly digitally-enabled environment. • Monitor the demographic profile of applicants and successful candidates into new roles arising from the programme to ensure equity of opportunity across socio-economic groups.
Justice and Personal Security	**Positive Impacts:** The programme supports improved access to care for individuals experiencing crisis or harm in their home or community environments. Through its commitment to person-centred triage, enhanced mental health pathways, and care planning, the programme provides opportunities to identify safeguarding concerns earlier and coordinate appropriate responses, particularly for those at risk of domestic abuse or coercive control. By enabling more care to be delivered in the home or local community, the model may also support individuals who are reluctant to attend Emergency Departments due to safety fears or past experiences of trauma. This is particularly relevant for vulnerable populations, including women, children, and individuals with insecure housing.	
	Neutral Impacts: No direct negative impact identified – The programme does not directly impact policing, community safety infrastructure, or housing policy. However, it is designed to interact safely and effectively with these services through multi-agency working where safeguarding risks are identified.	
Participation	**Positive Impacts:** The programme is underpinned by a commitment to meaningful engagement with the public, patients, and staff, particularly those from under-represented or disadvantaged communities. Continuous engagement throughout the programme's development – via CEO roadshows, patient experience surveys, and direct PECI-led activities – has ensured that diverse voices shape the evolving clinical model. The establishment of a Patient and Public Reference Group, planned for 2025–26, will provide an inclusive and sustained platform for individuals from different socio-economic backgrounds to contribute to service design and evaluation. This will support broader participation in shaping healthcare and help reduce barriers experienced by people in deprived, rural or otherwise marginalised communities.	

Theme	Impact	Opportunity
	The programme's focus on equity and choice in access (e.g. through hybrid digital and non-digital channels) also contributes to inclusive participation, ensuring people can engage with services in a way that suits their circumstances and capabilities.	
	Negative Impacts: Under-represented groups – There is a risk that groups facing digital exclusion, language barriers, or mistrust of public services may remain under-represented in engagement activity unless proactive outreach is undertaken. Individuals with limited time or confidence, such as unpaid carers, shift workers, or those in insecure employment, may also find it difficult to participate in traditional engagement models.	**Opportunities:** • Ensure the Patient and Public Reference Group includes representation from socio-economically disadvantaged communities, with accessible formats, flexible participation methods, and reimbursement for time where appropriate. • Collaborate with community and third sector partners to extend engagement reach into under-served or disengaged populations, using trusted intermediaries to build relationships and capture insight. • Continue to promote non-digital routes to engagement and information-sharing, ensuring that those without internet access or digital skills are not excluded from participating in service shaping or feedback processes.

Welsh Language Impact Assessment

WAST is fully committed to promoting and facilitating the use of the Welsh language in line with its statutory responsibilities under the Welsh Language (Wales) Measure 2011 and the associated Welsh Language Standards. This commitment is deeply embedded in the organisation's values and is a central feature of the Trust's Integrated Medium-Term Plan 2025–28, which seeks to provide a service in Welsh without having to ask for it and having the Welsh language as visible as the English language.

While this programme does not include discrete Welsh language initiatives, it is being delivered in full compliance with the Trust's Welsh Language Policy, the Welsh Language Standards, and the More Than Just Words Action Plan 2022–27. These policies ensure that all new or modified services, including those delivered digitally, are accessible to Welsh speakers and promote the principle of the Active Offer – where services in Welsh are provided proactively, without the user needing to request them.

In particular, as part of our programme's focus on enhancing digital access and tools (e.g. enhanced symptom checkers and improvements to the NHS111 Wales website), we will ensure that all patient-facing content is bilingual and meets accessibility standards. We will also continue to support the positive improvements in the NHS 111 service, promoting the recruitment of Welsh-speaking call handlers and Welsh language confidence-building for NHS 111 staff.

Moreover, the programme's alignment with the wider IMTP ensures that ongoing progress to increase bilingual capability across the workforce – such as promoting the mandatory Welsh language awareness course and increasing compliance in the number of staff completing it – will enhance the user experience for Welsh speakers accessing digital and telephone-based care.

To further improve our compliance with the Welsh Language Standards and introduce an element of objectivity, a Welsh Language standards baseline has been developed which will be promoted across the Trust. This will be a key tool through which Welsh Language can be considered across the programme and will be promoted by Programme leadership.

In accordance with Standard 110 of the Trust's Welsh Language Standards Compliance Notice, the Trust must also develop a Welsh Language Clinical Consultation Plan that sets out objectives and actions to increase the organisation's capacity to undertake clinical consultations in Welsh. This is particularly significant given that the introduction of Remote Integrated Care – a cornerstone of the new clinical model – will increase the number of patients accessing clinical consultations remotely.

This programme contributes directly to the Trust's strategic ambition of embedding bilingualism as business as usual. By ensuring parity of service for Welsh speakers, we aim to strengthen the accessibility, inclusivity and cultural competence of the care provided across our system – supporting our broader goals of connecting systems, creating choice, and improving health equity for all people in Wales.

Theme	Yes/No	Rationale
Will the proposal ensure that patients and carers can choose to live and receive services through the medium of Welsh? Will the proposal have a positive effect on opportunities for persons to use the Welsh language? Will the proposal encourage staff to use Welsh in the workplace and to have opportunities to learn and improve their Welsh?	**Yes**	• Current processes to access services bilingually will be followed. • All public facing communications will be available in both Welsh and English. • All aspects of the 111.Wales website will be available bilingually, ensuring equitable access to digital services. This will include the Chatbot and Online Symptom Checker, increasing opportunities for people to receive information or access information in Welsh. • We will continue to promote the recruitment of Welsh-speaking staff, encouraging the use of Welsh in the workplace, and increasing our capacity to offer services bilingually. • In accordance with Standard 110 of the Trust's Welsh Language Standards Compliance Notice, the introduction of a Welsh Language Clinical Consultation Plan will further encourage staff to use Welsh in the workplace.
Will the proposal act as a catalyst for Welsh cultural awareness, understanding, activity and integration?	**Yes**	• The transformation of our digital front-end will increase our ability to deliver our digital services through the medium of Welsh. Welsh speakers will benefit from the ability to self-service using an updated Online Symptom Checker tool, offering a safe and convenient alternative to the 111-telephony service. This will fully integrate the

Theme	Yes/No	Rationale
		Welsh language into our digital provision and offer an alternative to the 111-telephony service for non-first language English speakers.
Will the proposal increase the department/division's ability to deliver services through the medium of Welsh?	**Yes**	• The transformation of our digital front-end will increase our ability to deliver our digital services through the medium of Welsh. Welsh speakers will benefit from the ability to self-service using an updated Online Symptom Checker tool, offering a safe and convenient alternative to the 111-telephony service.
Will the proposal treat the Welsh language no less favourably than the English language?	**Yes**	• Current processes to access services bilingually will be followed, ensuring that Welsh speakers receive services to the same standard as those who access the same services through the medium of English. • All public facing communications will be available in both Welsh and English. • All aspects of the 111.Wales website will be available bilingually, ensuring equitable access to digital services. This will include the Chatbot and Online Symptom Checker, increasing opportunities for people to receive information or access information in Welsh. • We will continue to promote the recruitment of Welsh-speaking staff, encouraging the use of Welsh in the workplace, and increasing our capacity to offer services bilingually. • In accordance with Standard 110 of the Trust's Welsh Language Standards Compliance Notice, the introduction of a Welsh Language Clinical Consultation

Theme	Yes/No	Rationale
		Plan will further encourage staff to use Welsh in the workplace.

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 May 2025
Committee Meeting Date	1 May 2025
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The board will note that this first of five ARAC meetings in 2025/26 is dedicated to governance issues, particularly the annual committee effectiveness reviews, the self-assessment against the Corporate Governance Code and registers related to the Standards of Business Conduct Policy. For this reason, some of the usual standing items are not presented.

ADVISE

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

2. A **pre-meet** was held with Audit Wales, Internal Audit and the committee Chair ahead of the meeting.

3. The **Audit Wales** progress report and Audit Plan for 2025/26 were received. Materiality with respect to the **audit of the financial accounts** is set at 1% of gross expenditure, with lower materiality for areas deemed more important to the users of the accounts, such as remuneration of senior officers and related party disclosures. Risks identified during planning include the risk of management override, which is a mandated risk included in all audit plans. Specific risks for the Trust include property, plant, and equipment and intangible assets. The audit will begin on 7 May following receipt of the accounts on 2 May. The deadline for completing the audit has been moved forward two weeks this year, with the audited accounts presented to the board on 26 June and the Auditor General scheduled to sign off the accounts on 27 June. There are no significant issues to highlight to the board at this stage.

   The **performance audit** update included the review of urgent emergency care, which is currently in clearance. Fieldwork is due to begin on the review of digital systems to support transformation, with the project brief now issued and agreed. The 2025 structured assessment associated deep dive on managing estates and local review of non-emergency patient transport service will begin later in the

year.

The audit fee has been slightly increased this year due to the potential for additional work around property, plant, and equipment and intangible assets.

4. Members **reflected** that the particular focus on the annual board and committee effectiveness review demonstrated the substantial, excellent work delivered by the Board Secretary and the wider Corporate Governance Directorate. The outputs of this provided significant assurance to the committee of the effectiveness of the current board and committee arrangements. Members commented on the positive, constructive and collaborative nature of the meeting.

ASSURE

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

5. The **Annual committee effectiveness reviews for 2024/25** were received. This committee approved its annual report and terms of reference following discussion on its effectiveness in March.

   The board will receive a report on the effectiveness of its committees (and its own effectiveness) at its 29 May meeting, as well as all committee annual reports and terms of reference for approval, however the following key issues were discussed by members of ARAC:

   - The extensive reviews of terms of reference, assurance reporting, and operating arrangements across all seven committees provided an all-encompassing view of the areas of oversight and scrutiny that is delegated by the board. ARAC is of the view that this is an appropriate spread for WAST's size and complexity.
   - All committees are effective in the way in which they operate, noting that they all met as scheduled, were quorate for each meeting, delivered extensively and diligently on their delegated responsibilities, and have reflected on changes that would make them more effective and add value.
   - In addition to the Chair of this committee, Chairs of the Finance and Performance Committee, QUEST Committee, Charity Committee and People and Culture Committees were in attendance to present their annual reports and provide their views on the process and outputs of the reviews. All welcomed the shift in terms of reference to a more strategic overview.
   - Further work will take place in Q1 and Q2 on the opportunities that arise in the Academic Partnerships Committee reaching its natural crossroads. This includes a fresh look at the spread across committees in an attempt to affect material change to frequency and volume, and to address areas of concern related to quoracy resilience. The core group of ARAC NEDs, Executive Director of Finance and Corporate Resources (committee lead) and Director of Corporate Governance/Board Secretary will be the sounding board for this work and the outputs will come back in September.

   ARAC thanked the Corporate Governance Team, Chairs and all members of committees for their engagement in this important work. Audit Wales and Internal Audit also commended the transparent approach and thoroughness of the reviews.

6. The committee received assurance that the Trust is complying with all elements of the **Corporate Governance Code 2017** as stated in the corporate Annual Report that will come to the board in June. There are no elements currently showing an 'explain' rating.

7. The Internal Audit progress report was received and members noted that turnaround times both for internal audit and the Trust are Amber. The 111 Wales Website audit is the only audit that is at risk of not being completed for 2024/25 due to temporary capacity issues with Internal Audit, however this will not affect the ability of the Head of Internal Audit to provide an overall end of year opinion.

   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:

   - **Risk Management and Board Assurance Framework – Reasonable Assurance**. The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risk through the Board Assurance Framework and the Corporate Risk Register. The key finding is that the current BAF (essentially the Corporate Risk Register, but in more detail and linked to the IMTP) will develop in 2025 into a strategic BAF that will focus more explicitly on its strategic objectives. Notwithstanding this concern, the reporting of the current key risks in the BAF through the Board and its Committees is working effectively. Findings have not been raised with respect to the strategic BAF and risk appetite as the oversight of these programmes of work sit with this committee.

     All six objectives in the audit were rated 'reasonable assurance' with the only matter requiring management attention being the need to ensure risk management documentation is updated to reflect the changes in approach that are envisaged over the coming months.

   - **Occupational Health and Wellbeing Support – Reasonable Assurance**. The purpose of this review was to evaluate the programmes in place at the Trust to improve the Occupational Health and Wellbeing services and promote staff wellbeing, and arrangements in place to monitor effectiveness.

     Despite efforts to achieve a 6% sickness absence target, the Trust's rates remain higher than NHS England Ambulance Services, with recent figures showing an 8% sickness rate compared to NHS England's 6.5% (however there was caution proposed by ARAC given England's different operating context). There has historically been a low uptake of support services, including management of referrals to Occupational Health and Wellbeing provision. The implementation of the Health and Wellbeing Plan approved in November 2024 as well as the occupational health and wellbeing referral system, permitting both self-referrals and manager referrals, aim to improve the timeliness of the support provided.

     All four objectives in the audit were rated 'reasonable assurance' and there were four medium priority management actions raised. These included the need for detailed deliverables in the Health & Wellbeing Plan, enhanced performance reporting, improved reporting to assess the quality and impact of initiatives, and regular feedback from managers on attendance management

training sessions. A verbal update confirmed actions due by the end of Q4 had been completed.

Members noted the importance of addressing musculoskeletal issues, particularly for staff in sedentary roles, and the need for leadership and management to encourage physical breaks. Additional assurance was provided on proactive measures, including increased physiotherapy referrals and improved performance for referral to first contact.

The People and Culture Committee has an oversight of the audit actions and will receive this report at its May meeting. Next steps include continued focus on proactive health and wellbeing measures and regular updates to that committee on metrics and deep dives into absence management and occupational health usage.

- **Speaking Up Safely – Reasonable Assurance**. The purpose was to review the implementation of the framework and assess its impact in promoting a culture that enables staff to raise concerns.

  The NHS Wales Speaking Up Safely (SUS) Framework (WHC/2023/036) highlights the importance of fostering a culture where individuals can raise concerns without fear of victimisation or detrimental treatment. The Trust has implemented several measures to support this, including the appointment of a lead Guardian and the use of the Work in Confidence (WIC) platform to record and manage concerns. Following high-profile cases, the Welsh Government has mandated NHS organisations to undertake self-assessments against the framework and develop action plans to address any gaps. The Trust has completed its self-assessment and is working on an action plan to ensure compliance and continuous improvement – this will come into the People and Culture Committee for oversight.

  Three objectives in the audit were rated 'reasonable assurance' and one (review and analysis of recurring themes and trends) was rated 'limited assurance'. There were five medium, and one high priority management action raised. Those actions include developing an action plan to address gaps identified in the self-assessment, consistently issuing surveys post-closure of SUS cases to gather feedback, enhancing training for staff to embed the framework's requirements, and triangulating concerns data from all sources for effective oversight. It was agreed that recommendation 6, an annual speaking up safely report to this committee, was not required as the ARAC responsibility for ensuring arrangements for 'whistleblowing' were in place and effective is discharged with an annual assurance report to that effect from the Chair of People and Culture Committee.

  The committee discussed the challenges of auditing cultural impact and noted significant progress in this area which, for several reasons including confidentiality and the qualitative nature of information, was difficult to capture and audit. It was recognised that the Trust has made progress in addressing concerns and taking proactive action in problematic areas, noting also that there has been an increase in the NHS staff survey related to colleagues feeling able to raise concerns. The People and Culture Committee has an oversight of the audit actions and will receive this report at its May meeting.

8. The annual reports on **board members' interests and the gifts and hospitality register** were received. The registers will now be made publicly available on the Trust website. The increase in

reporting gifts and hospitality requests was noted. This importance of transparency, especially with suppliers, and the efforts to improve communication around gifts, hospitality, secondary employment, and sponsorship was recognised.

RISK MANAGEMENT

Members approved the 2025/26 risk reporting schedule which had been aligned to the board and committee cycle.

COMMITTEE AGENDA FOR MEETING IN JUNE		
Committee effectiveness reviews for 2024/25	Internal Audit Progress Report and the audit reports listed above	Audit Wales progress report and Audit Plan for 2025/26
Self-assessment against the Governance Code 2017	Annual Report on Board Member Register of Interests 2024/25 Gifts, Hospitality & Sponsorship Register 2024/25	Risk reporting schedule 2025/26

COMMITTEE ATTENDANCE						
Name	**1 May 2025[1]**	**24 Jun 2025**	**2 Sep 2025**	**2 Dec 2025**	**2 Mar 2026**	
Peter Curran						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Chris Turley						
Audit Wales	Fflur Jones					
Julie Boalch						
Judith Bryce	Jon Sweet					
Christian Fox						
Carl Kneeshaw						
Osian Lloyd						
Trish Mills						
Liam Williams						
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

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

The papers for this meeting can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	29 May 2025
Committee Meeting Date	9 May 2025
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. **Handover delays continue to present patient safety risks and extended waits in the community** with red performance being outside of what is acceptable to deliver a safe emergency service. The Trust's focus is to implement a change in how it responds to patient demand through the Clinical Transformation Programme (CMT). The committee also received an update on the Ministerial Advisory Group regarding handover delays, which aims to move to a 45 minute position. There was optimism about the firm positioning of this initiative and a commitment to work with the system to achieve it, noting that the standard is 15 minutes.

2. The Trust has navigated a particularly challenging winter, with demand levels comparable to the exceptional pressures of 2022/23, including the impact of multiple community viral infections. In contrast to previous years, the 'no send' policy from the Clinical Safety Plan was not routinely applied, enabling the Trust to provide care to more patients with urgent needs. While this decision supported patients, it also meant that the Trust held more risk directly - risk that would ordinarily sit across the wider system - which contributed to an increase in incidents and complaints.

3. Although this impact was anticipated, it has nonetheless placed additional and increased pressure on our response times to complaints and investigations, particularly affecting the **30-day target for complaints, and the backlog of overdue investigations**. Against this backdrop - and in the context of the two recent Public Interest Reports from the Public Services Ombudsman for Wales and the annual Welsh Risk Pool Concerns Assessment - committee members sought assurance on progress toward recovery and on timely learning. They noted the following positive developments and mitigating actions:

   - The PTR and Datix recovery plans previously reviewed by the committee;

- Investment in the PTR team in 2024/25 to help manage the backlog of investigations, and now additional investment in audit capacity within operational and clinical teams, with recruitment underway and impact expected in Q2;
- Continued confidence in incident reporting systems, including enhancements to support earlier learning from complaints and incidents;
- A proactive approach to learning from the point of care, including through patient complaints and Medical Examiner processes;
- Organisational risks 223 and 224 continuing to inform our assurance arrangements and current response structures;
- A new, specific risk relating to audit processes and overdue investigations in development;
- Operational and QIA reporting refined to better capture demand pressures and the changes implemented in response.

There was a recognition that the key driver to making this required change is the ability of the system to reduce the significant impact experienced by people as a result of the breadth and depth of handover delays.

4. The committee will review progress against the recovery plans in August 2025 to gain further assurance.

ADVISE

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

5. Members expressed thanks to **Mr and Mrs Cope, parents of Dylan Cope.** Dylan's story, shared by his parents Corinne and Lawrence, detailed the tragic death of their nine-year-old son, Dylan from sepsis in December 2022. Dylan experienced severe abdominal pain, initially suspected to be appendicitis, but later diagnosed as having flu, following a hospital assessment. Dylan was subsequently discharged from hospital but when his condition worsened, they contacted NHS 111 Wales (111) for advice. Whilst waiting for a call back from a clinician Dylan's condition rapidly deteriorated. Dylan became critically unwell and following emergency surgery at the University Hospital of Wales in Cardiff Dylan tragically died several days later from a ruptured appendix and sepsis.

   Members felt strongly that the board should also hear Dylan's story, and the video will be shared at the May board meeting. There were multiple failings and missed opportunities which may have prevented Dylan's death, and members were moved both by the circumstances that led to his death, and the drive that Mr and Mrs Cope have to ensure that his legacy is meaningful change at all levels. This includes to the delivery of services in 111, but also in the aftermath of tragedy, in details such as delivery of communication and the need for humanity and compassion to be at the forefront.

   Members were told that changes to the Remote Clinical Service were implemented with Dylan in mind, including multiple safety nets for red flag sepsis symptoms. Additionally, an advanced clinical practitioner has been employed to improve paediatric care and support audits and learning opportunities. Improvements in the approach to correspondence have been made, with further adjustments sought through relevant Welsh Government regulations.

The committee acknowledged the ongoing efforts to ensure Dylan's legacy leads to meaningful change, and thanked Mr and Mrs Cope for their candour and their courage in sharing Dylan's story, and likewise for the WAST staff who have been supporting Mr and Mrs Cope.

6. The Committee received **an update following the patient story from Gemma, which was received by the committee in February.** Gemma shared her experience as a profoundly deaf British Sign Language user in accessing healthcare.

7. **The Strategic Quality Plan 2025-27** was received and endorsed for approval by the board. The plan is attached at Annex A. Members acknowledged the need to prioritise the implementation of the plan, balancing its ambition with capacity and resource availability. Members were assured that quality is embedded into the CMT programme and noted the importance of educating and training staff to integrate the strategic levers into their roles.

8. The Committee received the **Operational Update for Q4 2024/25,** and of note highlighted scrutiny on the Manchester Arena inquiry, business continuity challenges, the CMT programme, end-of-shift pod implementation, ambulance care cancellations, integrated care planning, and ECNS audit. Discussions on the overdue investigations and bottlenecks from an audit perspective are noted in the alert section above.

9. The **Health Inspectorate Wales** report on the Emergency Department at the Grange University Hospital, and the **Llais** report entitled Getting Urgent and Emergency Healthcare in Welsh Hospitals were received.

10. Members' **reflections** on the meeting included:

    - The deeply moving story of Dylan and the need to keep the patient at the heart of what we do.
    - Robust discussions and good updates provided throughout the agenda.
    - Concerns regarding capacity challenges within the Trust, particularly regarding concerns and investigations progress.
    - The need for balance throughout the agenda regarding presentations and discussion was acknowledged, given the extensive business for the committee and the length of the meetings.
    - The committee welcomed Jayne Beeslee, Non-Executive Director, who observed as part of her ongoing induction. Additionally, Sian Lane, a colleague from the Joint Commissioning Committee, observed the meeting.

11. The committee **met briefly in private** to approve the minutes of the February private session.

ASSURE

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

12. The **Monthly Integrated Performance Report (MIQPR)** was received, with members noting that the board will receive and discuss the MIQPR at its meeting in May. The report highlighted high levels of call abandonment in the 111 service and the need for improved call answering performance. Clinical

response times for P2 and P3 categories were discussed, noting that many calls are not being returned within the expected two and four-hour windows. This was the subject of discussion in Dylan's story also. The impact of handover delays was emphasised, with significant lost hours and long waits for red and amber calls. The importance of focusing on inequalities data and metrics, including geographic and protected characteristics, to better understand and address disparities in service delivery was raised, as were challenges in improving flow into SDEC pathways and the need for better collaboration with Health Boards to operationalise direct referrals.

13. The **Putting Things Right (PTR) Report** for Q4 2024-25 was received. The board will note the alert above regarding response times to complaints, but also of note was good work around compliance with the five working day target for issuing Duty of Candour initial letters.

14. The Public Service Ombudsman of Wales (PSOW) has published two **Section 23 Public Interest Reports** involving the Trust during March 2025 (one issued jointly to WAST and Swansea Bay University Health Board). The joint report detailed a missed opportunity for clinical review from CSD and a poor standard of complaint investigation. The second report identifies issues with clinical record-keeping and aspects of the complaints handling process; delays in information sharing and a lack of completeness within the investigation. The recommendations have largely already been undertaken, with evidence of completion being provided to the PSOW.

15. The **Annual Welsh Risk Pool (WRP) Concerns Assessment** has received an overall substantial rating, notwithstanding four areas of limited assurance regarding management of concerns, organisational learning and WRP reimbursement process. The Report highlights that processes for legal case management are considered to be an exemplar arrangement. Actions to address the issues will be monitored via the audit tracker

16. **The Learning from Deaths (mortality reviews) report Q3 and Q4** detailed the operationalisation of the National Mortality Review Framework, including case volumes, triage, and learning elements. The disproportionate impact on older people was highlighted, with concerns about the provision in the system of equitable services to all communities. The thematic learning from medical examiner referrals indicated areas for improvement in end-of-life care and advanced care planning. There are continued efforts to improve collaboration with primary care and community services to enhance advanced care planning and end-of-life care.

17. The **Quality Impact Assessment (QIA) for the Urgent Community Response** under the CMT programme was received. Members noted that this as a key component of the programme, and is crucial for improving outcomes, preventing unnecessary hospital admissions, and aligning to the strategic priorities within NHS Wales. The QIA was comprehensive, and members took assurance on the approach and outcomes.

18. The **Medicines Management Assurance Report** was received. The technical and detailed discussion highlighted the efforts to improve compliance, accuracy and monitoring within the Medicines Management system. The Advance Paramedic Practitioners are providing leadership and expertise, particularly in the use of antimicrobials, which is crucial for maintaining high standards of care. The transition to electronic systems improves accuracy and monitoring. Members were assured on the ongoing improvements despite the recognised challenges.

19. **Internal audit on Roll-out of Penthrox** was presented. The audit assessed the impact of the rollout of Penthrox on patients and staff and highlighted the need for updated training modules for Community First Responders, improved access to Omnicell cabinets and safes, better protocol compliance, and reporting on the benefits of Penthrox. Four medium-rated recommendations were made and accepted by management, and the actions will be monitored by this committee.

20. Committee received a presentation on the **clinical indicator related to Return of Spontaneous Circulation (ROSC)** which emphasised the continuous improvement in ROSC rates despite extended response times and the importance of measuring patient outcomes that matter most to them, such as survival to discharge without neurological deficits. The discussion highlighted the importance of evolving metrics to better reflect patient outcomes and the need for system-wide measures to improve care pathways and patient experiences.

21. The **Clinical Audit Plan and Action Tracker update for Q4 2024/25** was received with no escalations.

22. The **Patient Experience and Community Involvement (PECI) biannual report (October 2024 to March 2025)** was received. The report emphasised the importance of the patient experience as a critical dimension of quality within WAST. The report highlighted efforts to increase real-time feedback from service users and the focus on patient-reported outcome measures, versus experience measures. The significant work undertaken by the PECI team was noted, which included attendance at 96 events and engaging with over 5000 people.

23. Members received a presentation on the **health inequalities maturity matrix and population health plan** which described the progress made, its ambition and recognised the benefits of multidisciplinary collaboration to reduce and address health inequalities. The board's endorsement of the population health principles, commitments, aims, and vision will continue to strengthen the approach and keep momentum. The plan supports delivery of the Trust's strategic objectives and compliance with the health and care quality standards, including equitable, timely and effective services.

24. An update was received on the **Audit tracker** with 40% (18% last quarter) of committee related internal audit actions due in quarter were closed in quarter. The committee was assured that appropriate plans were in place to address those actions overdue.

25. The outputs of the Committee's **annual effectiveness review** were discussed and the terms of reference and annual report that were approved by Chair's Action were ratified. The committee set its priorities for 2025/26 as:

    - Focus on the clinical model transformation, ensuring robust quality assurance and patient experience improvements.
    - Continued monitoring and reporting on performance against the duty of quality and duty of candour.
    - Prioritising the implementation of the new strategic quality plan to ensure tangible outcomes.

RISKS

Risks Discussed:

The Trust's two highest scoring **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 remain unchanged at a score of 25.

It's important to note that the focus of the committee agenda remains on the system pressures and the impact this has on people which is discussed and highlighted throughout the meeting. The discussions are directly related to managing and assuring members against the risks identified, particularly those associated with the clinical model transformation and patient care.

It was noted that patient safety risks and learning opportunities may not be identified in a timely way if the number of open, uninvestigated incidents is not addressed.

New Risks Identified:

A risk relating to concerns in relation to the overdue investigations and audit processes and the need to put more scrutiny on the Putting Things Right recovery plan and the wider organisational impacts is in development.

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q4 2024/25	Patient story	Quality Plan 2025-27 and EqIA
Quality Impact Assessment (Urgent Care Response Service)	Putting Things Right Report with Annual WRP concerns assessment and section 23 Public Service Ombudsman for Wales reports	Monthly Integrated Quality and Performance Report and annual review of metrics
Medicines management assurance report	Internal audit – roll out of Penthrox	Learning from deaths (mortality reviews) report Q3 and Q4
PECI Biannual report	AACE benchmarking tool public health update	Focus on clinical indicator – ROSC
Clinical audit tracker	Audit tracker	Feedback from effectiveness review and setting of priorities
Risk management and BAF	Duty of quality implementation closure report (consent item)	HIW report (consent item)
Llais report – getting urgent and emergency healthcare in Welsh hospitals (consent item)		

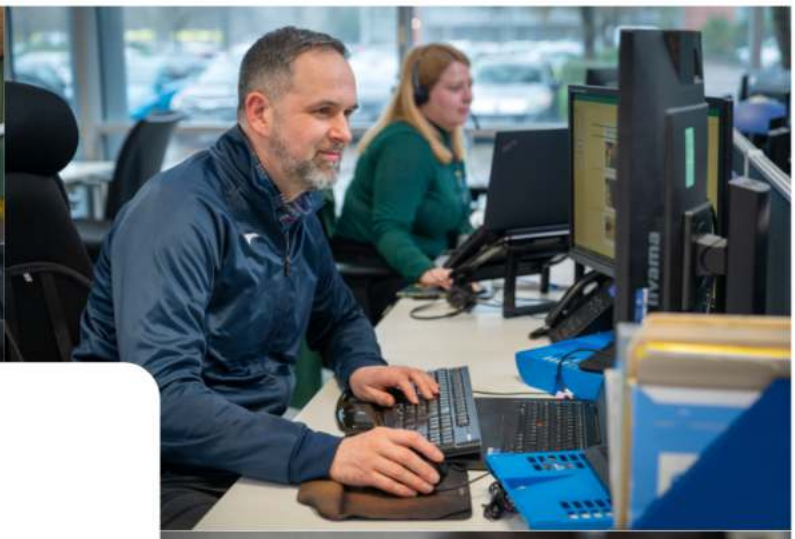
COMMITTEE ATTENDANCE					
NAME	**9 MAY 2025**	**13 JUN 2025**	**5 AUG 2025**	**4 NOV 2025**	**3 FEB 2026**
Bethan Evans (Chair)					
Ceri Jackson					
Rhiannon Beaumont-Woods					
Liam Williams					
Andy Swinburn					

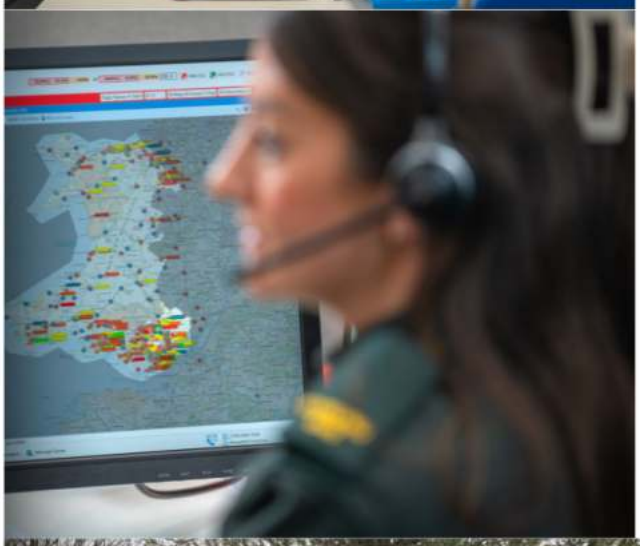
Lee Brooks	Peter Brown				
Rachel Marsh					
Jonny Sammut	Keith Williams				
Trish Mills					
Mark Marsden					
Hugh Parry					
Henry Garrard					

	Attended
	Deputy attended
	Apologies received
	No longer member

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









Strategic Quality Plan 2025-2028

Published: DD/MM/YYYY

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Forward

As the Board Leads for the Welsh Ambulance Services University NHS Trust on Quality, Safety, and Patient Experience, we are proud to present the Strategic Quality Plan 2025–2028.

This comprehensive roadmap outlines our vision to enhance the quality of care delivered by the Welsh Ambulance Services University NHS Trust.

The plan reflects our unwavering commitment to excellence in healthcare and is the product of meaningful collaboration with our patients, staff, and communities. We have actively listened to the voices of those we serve and those who serve, ensuring that our strategy is rooted in real-world needs and aspirations.

We are dedicated to continuous improvement, striving to ensure that every patient receives compassionate, personalised care. Our vision includes strengthening system partnerships and aligning our services with the broader health and care objectives across NHS Wales. This approach underscores our commitment to supporting the health and wellbeing of our staff, volunteers, and the communities we serve.

We invite you to join us on this journey toward a brighter, healthier future for all.



Liam Williams

Executive Director of Quality & Nursing



Bethan Evans

Non-Executive Director

Introduction

Our Strategic Quality Plan for 2025-28 outlines a comprehensive and forward-thinking approach to enhancing the quality of healthcare services provided by the Welsh Ambulance Services University NHS Trust. It is designed to address the evolving needs of our population, ensuring that our services are not only efficient and effective but also equitable and inclusive.

Our vision is to deliver excellence in healthcare by focusing on key areas such as:



By building capability and capacity within our teams and leveraging data and insights for evidence-based decision-making, we aim to strengthen system partnerships to ensure that our services are aligned with the broader health and care objectives across NHS Wales.

The plan emphasises the importance of quality management systems and continuous improvement, highlighting our commitment to inclusivity and equity, ensuring that all patients receive compassionate and personalised care. Additionally, the document outlines our approach to corporate parenting, leadership development, and community involvement, demonstrating our dedication to supporting the health and wellbeing of our staff, volunteers and the communities we serve.

A key aspect of this strategic plan is its co-produced approach, developed through listening to our people, the broader organisation and our community networks. By engaging with our People and Community Network, we have included insights from lived experiences and community feedback, ensuring that our plan aligns with the needs and preferences of those we serve. To ensure our Strategic Quality Plan remains relevant and effective, it is important to maintain an open dialogue with all stakeholders to gather insights and suggestions on how we can adapt to changing environments. The implementation of this plan will facilitate open communication to build trust and ownership of the quality of our services.

Through this plan, we will enhance our ability to deliver high-quality care, improve patient outcomes, and drive innovation in healthcare. Our long-term vision is to transform the Welsh Ambulance Services University NHS Trust into a trusted provider of high-quality care, ensuring that patients receive the right advice and care, in the right place, every time.

Population Health

As a Trust, we aim to ensure our daily interactions with our patients, the public and our people improve health and wellbeing. Our Quality Plan aims to promote key initiatives to combat population health challenges in Wales by preventing ill-health, reducing future risks, and advocating healthy lifestyles and choices, helping our patients, staff and volunteers to stay healthy.

> A quality ambulance service will deliver a **population health approach**, which aims to "improve physical and mental health outcomes and promote wellbeing, whilst reducing health inequalities within the population" (Buck *et al.* 2018).

The Association of Ambulance Chief Executives (AACE) recognises the opportunity of strengthening the role of the ambulance sector in **reducing health inequalities**, and it has developed an implementation toolkit setting out how ambulance services could approach this through four key enablers:



Work has already started on how we can focus on those enablers within Wales. In April 2024, we completed a 'maturity matrix' to identify our current achievements against the four key enablers and identified gaps and opportunities for our future population health approach.

1. Building Public Health Capacity and Capability:

A quality health service includes prevention. It is important that all of us recognise our role in promoting prevention and the opportunities around supporting our patients, ourselves, our colleagues and our communities to live healthy lives. Identifying opportunities to support our people to have key skills in this, as well as input from public health specialists, will support WAST in delivering a service with population health embedded within it.



2. Data, Insights, Evidence, and Evaluation:



A quality driven health service uses data and insights to deliver an evidence-based approach, with regular monitoring and evaluation to ensure that it is delivering the right service to meet the needs of the population. We are facing a changing population, with an increasing ageing population and higher levels of complex health conditions. By turning data into knowledge, we will understand the level of health needed in the population now and for the future. As we better understand health inequalities, we can better deliver and adapt services to meet the aims of a population health approach.

A quality health service needs to be well-connected and able to access the right information at the right time. When healthcare providers share data safely and effectively, it helps tailor care to individual needs and improve outcomes. Our Digital Plan for 2024-29 outlines how we will use data, information, and insights to support better decision-making and enhance the care we provide. We have already started this work—for example, through the Welsh Demographic Service (WDS) lookup, which links patient records using NHS numbers. This important step helps us better understand the full journey of care, supporting more joined-up services and moving us closer to a value-based approach that puts patient outcomes first.

3. Strategic Leadership and Accountability:

A quality health service will have population health embedded within strategy and policy, with senior leadership support and advocacy. Within WAST, our strategy 'Delivering Excellence, Our Vision for 2030' highlights the importance of population health and delivering equitable care, but more can be done to strengthen this approach and increase accountability for everyone in the organisation to consider how we can support our patients, and our people, to have the best health outcomes and wellbeing we can.



4. System Partnerships:



A quality health service will work with other health and care providers to support the best health outcomes throughout a patient's journey, with everyone working to the same population health objectives. Aligned with the Health and Care Quality Standards 2023, we will continue our journey towards a 'Whole Systems Approach', understanding how the decisions we make impact our system partners across NHS Wales and the emergency services. We will collaborate with system partners to identify improvements, innovations, and transformations that consistently and sustainably meet the changing needs of our service users and achieve positive

Value Based Health Care

Our long-term strategy emphasises the importance of achieving optimal health outcomes for our patients by delivering services in the most efficient and **value focused** manner. Value can be considered across four pillars:

- Appropriate care to achieve a patient's personal goals (personal value)
- Achievement of best possible outcomes with available resources (technical value)
- Equitable resource distribution across all patient/client groups (allocative value)
- Contribution of healthcare to societal participation and connectedness (societal value)

We are committed to embedding the principles of **personal value** by measuring the outcomes that matter to people and using data and intelligence to drive innovation, improvement and learning for us as an organisation. Embedding co-production and lived experience methodologies within our planning and innovation design principles, through engagement with our People and Community Network, will provide insights into how we can improve the personal value of our population.

In evaluating **technical value**, the principles of value-based healthcare ensure that available resources are utilised in an equitable, sustainable, and transparent manner to achieve better outcomes and experiences for our population, and that we optimise our contributions to research and innovation to deliver and evaluate evidence-based practice and share our learning with the wider ambulance sector. When considering patient outcomes, it is essential to account for both clinical results and patient-reported outcomes, which include the experiential and relational impacts of the services received. Striking a balance between these factors will enable us to provide a high-quality service that is focused on value, ensuring responsible use of public funds to deliver enhanced patient outcomes.

Building on the work of the Digital Plan 2024-2029 and population health, with a focus on data insights and intelligence, and the deliverables from our long-term vision for 2030 'Delivering Excellence', we will strengthen how we use our data as intelligence to inform how resources are distributed to add **allocative value,** promoting and monitoring for equity of services both through what we deliver, and using our intelligence to inform the wider health and social care system where inequities or gaps are found.



We play a vital role in delivering **societal value,** not only through the way we provide care to patients and the public, but also by how we engage with communities, support wellbeing, and create employment, volunteering, and development opportunities for people across Wales. Set out in our well-being objectives, as a

newly named organisation under the Well-Being of Future Generations (Wales) Act 2015 and aligning with our strategic population health and long-term strategy for 2030 objectives, we will continue to provide quality by being a socially responsible and inclusive employer, as well as continuing our work through engaging with volunteers and communities across Wales.



In pursuit of delivering value in healthcare across Wales, the Welsh Value in Health Centre's *Strategy to 2024* underscores the importance of a whole-system approach encompassing prevention, early and accurate diagnosis, timely intervention, ongoing care, and end-of-life support. Aligned with this vision, we will continue to embed value-based principles across our directorates and workstreams, working in partnership with system leaders and identifying the unique and meaningful contributions that our ambulance service can offer to the broader health and care landscape in Wales.

Person Centred Care

Communication

Feedback from our service users reinforces that person-centred care means being respectful and responsive to each individual's preferences, needs, and values. Patients consistently highlight the importance of empathetic, caring, and communicative staff and volunteers who can offer reassurance during often stressful situations—whether in person or over the phone. This must be complemented by clear, high-quality communication that treats patients as equal partners and supports shared decision-making. As we progress on our transformation journey, it is essential that we equip our people with the skills and training to strengthen compassionate communication, ensuring meaningful engagement with all communities and meeting patient needs and preferences wherever possible.







This commitment extends to how the organisation responds when things have not gone well. We recognise that how we communicate with individuals who have had negative experiences is crucial to rebuilding trust in our service and ensuring meaningful learning. Our approach will increasingly incorporate restorative practices, focusing on personalising our responses to complaints, patient safety incidents, claims, and redress ensuring we address the aspects that matter most to those affected and fully explore opportunities for improvement.

In line with the Duty of Candour, we will continue to build on our practices of being open and transparent when helping patients and their loved ones understand how their care was delivered, and where changes will be made to provide better care or an improved experience in future. We will continue to build our culture of candour in all our work through education and training, increasing our people's confidence in offering meaningful apologies and holding sensitive conversations. Whilst it is the Patient Safety Team who lead on enacting and monitoring the implementation of the Duty of Candour, we must all understand our responsibilities.

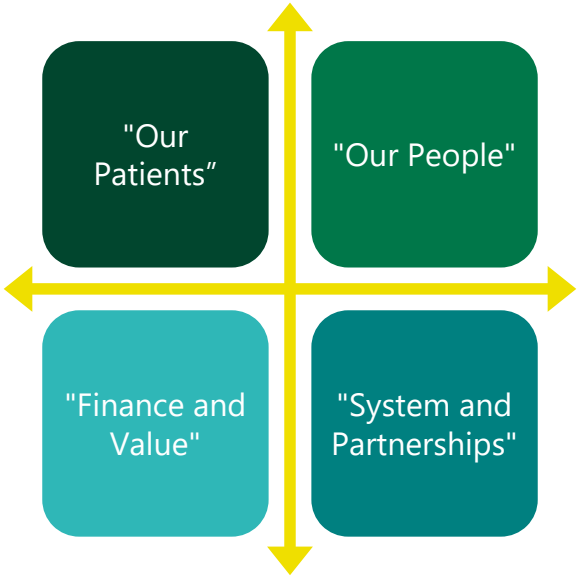
Hearing our Citizen's Voice

Ensuring that patient impact is at the heart of all decision and discussions we will take a collaborative approach to quality discussion both internally and with our service users and system partners. We will review our governance processes to include an annual review of the actions we have taken based on our Citizen's Voice and ensure that we continually improve our approach to learning in this way.

We have a shared commitment to delivering the best possible service to the public, including learning from poor experiences and outcomes, and fostering a culture of continuous improvement.

Traditionally, we have used time-based metrics for our three services (111, 999 and Ambulance Care) to gauge patient safety and clinical outcomes. We recognise the need for a more balanced assessment involving patient safety measures, experiential measures, and the relationship between process (lead) and outcome (lag) measures. In March 2025, the Welsh Government announced the creation of a new purple category which we will introduce for responses to life-or-death cardiac and respiratory arrests. The associated changes to the response targets will focus on outcomes with links to the chain of survival metrics for cardiac arrest and an intention of linking our data with health board intelligence to create the national cardiac database.

Through our Clinical Model Transformation (CMT) Programme, we will implement this new purple category. Supported by a Metrics Workstream, the programme will develop a scorecard approach aligned with our Quality and Performance Management Framework balanced across the four quadrants:



This more balanced approach ensures that performance is assessed through a wider lens moving beyond time-based metrics to include key factors such as safety, experience, and relational aspects of care. While further development of these measures is ongoing, our Quality and Performance Management Framework is designed to promote this broader perspective

In support of this, the CMT programme will undergo a collaborative and independent evaluation to assess its impact within the Quality and Performance Management Framework.

Community Involvement

The Trust's People and Community Network offers members of the public a platform to engage in and contribute to our work. We are committed to expanding the network to better reflect the full diversity of the communities we serve. Plans are in place to grow membership with a particular focus on age, geography, diversity, equity, inclusion, and Welsh language representation. These plans, developed through a population health lens and aligned with the Trust's Integrated Medium-Term Plan, aim to strengthen meaningful community involvement and ensure all voices are heard in shaping our services.



Through our continuous engagement cycle with patients and the public, we will work to provide assurance on compliance with the Health and Social Care Quality Engagement Act by increasing the reporting of impacts and outcomes of our engagement activities and ensuring that experiences and feedback are considered to inform service change.

Corporate Parenting

> Corporate parenting refers to the "collective responsibility of partners when a child enters care...to safeguard and promote the rights and life chances of care-experienced children and young people". (*Welsh Government 2023, Corporate Parenting Charter - A Promise from Wales.*)

We are committed to our responsibilities as a Corporate Parent and are dedicated to addressing the specific needs of care-experienced children and young people. This means ensuring their voices are heard, their views are considered, and they are actively involved in decisions that affect them, while keeping them informed

throughout. Our communication must be clear, compassionate, and tailored to support their understanding and confidence. To truly fulfil these commitments, we must adapt our systems and ways of working. With this in mind, we have identified key actions to support meaningful and lasting change.

5 Key Actions:

- Identify care-experienced children and young people accessing the Trust's services.
- Collaborate with children, young people, and partner agencies to understand their needs.
- Adapt systems and processes to meet these needs once identified.
- Provide additional training for WAST staff and volunteers to better support care-experienced individuals.
- Ensure the voices and wishes of care-experienced children and young people are actively considered in all decisions.

Leadership and Governance

Leadership Development

Empowering leadership and effective governance are essential for delivering high-quality patient care and as such, our Quality Plan aligns with our People and Culture Plan and is guided by the "Our WAST Way" principles and the Health and Care Quality Standards 2023. The Quality Plan highlights the need for clear direction, accountability and a culture of continuous improvement.





A culture of learning and growth flourishes when staff and volunteers feel valued, respected and supported. When leaders embrace compassionate, inclusive practices, they create an environment where people are confident to speak up, challenges are constructively addressed, teamwork thrives, and innovation is encouraged. This in turn empowers staff and volunteers to deliver compassionate and patient-centred care.

Investing in leadership development equips leaders with the skills for collaboration, accountability and innovation. By building effective partnerships and seeking continuous feedback, we ensure services remain relevant and effective, creating a cycle of improvement that benefits our staff, volunteers, patients and communities.

We will:

- Embed compassionate leadership practices at all levels, ensuring leaders model inclusivity and create environments where staff and volunteers feel supported, valued, and empowered. *(Culture)*
- Develop and support leaders at all levels to integrate quality into daily decision-making and uphold high standards of care. *(Capability)*
- Build effective partnerships with trade unions, internal teams and external networks to co-produce and collaborate on key initiatives. *(Capacity)*
- Strengthen change management capability to drive innovation, transformation and efficiency, while embracing new models of care and service delivery. *(Capability)*
- Continue to pursue a holistic mature health and safety culture to enable our staff and volunteers to work as reasonably practicable whilst providing excellent care to our patients.

By committing to these actions, we will establish a culture where leadership inspires quality, collaboration and continuous improvement.

Quality Governance

Our quality governance structures provide integrated forums where feedback, intelligence and collaboration is embraced, and specialists are aligned with local leaders to create an environment of continuous improvement. By growing these relationships and embedding the Health and Care Quality Standards 2023 into how we monitor and evaluate our transformation, innovation and improvement we can

identify and mitigate risks, driving quality into everything we do. We will review our Quality Impact Assessment processes to ensure that they are proportionate and user-friendly, supporting the professional judgement of our leaders as a developing tool to identify risks and consequences of our proposals. Embedding assessments at every level of improvement and transformation will create an environment that is focused on quality and safety.

To turn data into knowledge, we use Datix Cymru, our electronic concerns management system to record, monitor, and investigate incidents, feedback, claims, inquests and mortality reviews. The quality of our insights depends on the accuracy of the data, its alignment with service areas, and our ability to theme findings for learning and improvement across the organisation. We will enhance the governance and configuration of our information platform to ensure user-friendliness and provide accessible training materials. These improvements will enable timely learning and support our continuous improvement journey.

Quality Management Systems

Quality is at the heart of the NHS in Wales, and as such, quality management systems are essential for ensuring that our healthcare services are safe, effective and continuously improving. They provide a structured framework for monitoring and evaluating the quality of care, identifying areas for improvement and supporting the implementation of necessary changes.



A robust quality management system brings all information surrounding quality together to implement effective change and improvement in care. Our commitment to continually developing our quality management systems will ensure that all functions within the organisation are aligned with the goal of delivering high quality services and compassionate person-centred care.

Quality Control

As part of our operational activity, it is important to have clear quality control processes. These daily management processes are designed to monitor the quality of the services we deliver and ensure sustainable results by creating and maintaining the culture and processes for those closest to the work to act and to keep the system in control, escalating when appropriate. Quality control processes are an integral part of our quality management systems and are not restricted to our frontline service delivery.

Through the work of our Quality and Performance Steering Group, we will support all teams to assess their quality management systems and identify opportunities for improvement, ensuring that all functions have robust quality control processes in place. Insights gained from these activities will be shared through our quality governance structures, promoting a culture of continuous learning and improvement across the Trust.

Our approach to learning is a maturing one as we seek to learn from what routinely goes well in addition to adverse events. Our quality control analysis should also promote 'double loop' learning, encouraging us to question underlying assumptions about the traditional role of the ambulance service. This reflective approach enables us to challenge established ways of working, fostering innovation and transformation to better meet the evolving needs of our population.

Quality Improvement

A robust quality management system relies on effective improvement processes to ensure the consistent delivery of safe, high-quality care, alongside efficient resource use and productivity gains driven by innovation and technology. Embedding a culture of continuous quality improvement requires a balance between sound change management principles and the application of proven quality improvement methodologies. These methodologies are essential for helping teams fully understand the root of a problem before designing and implementing meaningful change. To embed this approach across the organisation, we must create the conditions and build the capacity for our people to think differently and drive improvement. This includes developing training and specialist expertise, and

providing experiential learning, coaching, and mentorship—empowering staff and volunteers at all levels to lead and deliver effective quality improvement initiatives.

Organisational improvement should address both immediate issues as well as longer-term strategic changes, enabling agile change in response to specific goals or risks but also addressing systems-based improvement, seeking to understand and influence complex, interconnected healthcare systems. We will take a systemic view through quality improvement methodology, considering our operational complexities, to create a supportive environment for change through co-production methods with those who need, use and deliver our services.

Creating a culture of inclusivity and equity we will focus on delivering compassionate, patient-centred care through strengthening communication, fostering empathy, and encouraging openness within and between departments which is vital for achieving continuous quality improvement.

By celebrating individual and team contributions and embedding collaborative approaches, we will enhance our cultural competence and address diverse needs effectively.



- Quality improvement methodology: Build an organisational improvement methodology around the Institute for Healthcare Improvement (IHI) principles and frameworks.
- Building capacity and conditions: Develop the capacity and conditions for staff and volunteers to think differently and balance change management principles with quality improvement methodologies.
- Quality improvement training: Provide training that includes data analysis which equips staff with necessary skills for continuous improvement and creates a supportive system of improvement.
- Systemic view of improvement: Utilise quality improvement methodologies to take a systemic view, considering complexity and co-production methods involving all stakeholders.

- Developing skills and empowerment: Develop skills for staff at all levels to deliver quality improvement projects and become empowered to drive change.
- Demonstrating impact: Develop systems to demonstrate the impact of improvements at national, regional, and local levels, including small projects to large-scale interventions.

Quality Assurance

Our quality assurance systems ensure that the care and services we provide to our patients and service users is safe and meets the standards we require. These standards are aligned to the Health and Care Quality Standards 2023. Through quality assurance, we monitor our processes and procedures ensuring that we are identifying opportunities for learning and improvement in the services we deliver, following quality improvement initiatives that monitor activity to ensure improvement has been achieved. Assurance comes in many forms including internal and external audit, inspection, peer review or statutory/regulatory reporting. It may even be in the form of feedback from our patients and service users.

In line with the Duty of Quality, we are committed to ensuring we have robust quality management systems across all functions of our organisation, and we continue to support our teams in developing and continually improving their quality assurance processes. This means we will work with teams across the organisation to ensure we have clear quality statements in place to describe what quality means for each function. We will support quality assurance self-assessments to identify improvements we can make in our internal processes and will support the development of information and intelligence data to help us monitor our services in line with the Health and Care Quality Standards 2023. Our quality impact assessments will guide our monitoring and evaluation standards, providing assurance that we have achieved the improvements set out, therefore we will continue to develop our quality impact assessments processes to make it clearer and easier for leaders and innovators to consider the impacts of our decisions on our people, our patients and our stakeholders. Through the continual improvement of our quality assurance processes, we will help to reduce risks, improve results and build public trust.

Quality Planning

The Quality and Performance Management Framework offers a consistent approach for improving service quality and patient outcomes by monitoring and enhancing performance across individual, team, and organisational levels.

Central to the framework is the role of effective planning in driving improvement. This includes strategic plans aligned with the Trust's overarching purpose, Integrated Medium-Term Plans (IMTPs), and more detailed programmes or directorate-level strategies. The framework also ensures alignment at the individual level through personal development reviews, connecting staff contributions directly to organisational goals.

The Quality and Performance Management Steering Group will support teams in evaluating their quality management systems, identifying areas for improvement, and embedding robust quality control processes. Insights from these activities will be shared through our quality governance structures to drive continuous learning and improvement across the organisation.



Implementing a quality planning approach ensures compliance with the Health and Care (Quality and Engagement) Wales Act, facilitating strategic decision-making that considers the 12 health and care quality standards. As an organisation, we will evaluate our performance against these standards to identify opportunities for improvement, foster learning, and establish monitoring mechanisms. Furthermore, we will enhance our quality impact assessments processes to provide clarity and simplicity, enabling leaders and innovators to assess the impacts of our decisions on our people, patients, and stakeholders.

'Delivering Excellence' is the Trust's long-term strategic framework which sets out the future vision for the organisation up to 2030. The strategy articulates the organisational ambition to shift away from being perceived as a 'traditional ambulance and transport service' to becoming a trusted provider of high-quality care, ensuring patients receive the 'right advice and care, in the right place, every time', with an increasing emphasis of managing and resolving more care closer to home to improve patient outcomes, but being there for patients with a serious injury or illness that require immediate emergency care. The strategy provides a clear vision for the whole organisation and is therefore focused upon the continued evolution of our Clinical Service Model, along with changes across the broader organisation. We will continue to use quality impact assessments to inform our decision-making processes in this domain. These assessments aid in identifying the effects of our transformation efforts, enabling us to mitigate potential harm to patients and staff, as well as to recognise risks affecting our organisation and the broader NHS Wales community.

Our long-term strategy was developed with valuable input from staff, service users, and wider health system stakeholders. It addresses key challenges across Emergency Medical Services, Non-Emergency Patient Transport Services, and NHS 111 Wales. Informed by demographic trends and data from Public Health Wales, it also reflects public expectations and concerns. The strategy aligns with key national policies, including *A Healthier Wales*, the *Well-being of Future Generations (Wales) Act*, the *NHS Wales Quality Framework*, and the strategic priorities of our commissioners.

Over the past three years, the strategy has been re-framed in response to the post-COVID context and is now structured around six strategic objectives. Quality remains central—acting as a key driver in our commitment to being a quality-led and clinically driven organisation. As we reach the midpoint in delivering this strategy, we will begin a formal review of *Delivering Excellence* in 2026/27, engaging with stakeholders to shape our future direction and organisational ambitions.

Our Quality Plan will play a vital role in shaping these future strategic aims. By undertaking a population health needs assessment and considering projected demographic changes, we will ensure our services are designed to meet both current and future health needs across Wales.

Our Integrated Medium-Term Plan (IMTP) delivers our strategic ambitions in a phased approach over a three-year period, aligned with NHS Wales planning guidance and the commissioning intentions of our partners. It includes a defined set

of quality-based outcomes and metrics, framed around the questions ‘what does good look like?’ and ‘what will be different?’. These outcomes have informed the development of targeted improvement plans, delivered through transformation programmes, projects, and quality improvement methodologies. This structured approach enables ongoing evaluation of progress against our deliverables and ensures we remain focused on achieving our intended outcomes.





Delivery is driven through our organisational transformation programmes and supported by directorate-level plans. These directorate plans provide opportunities to enhance service quality both internally and externally and can incorporate findings from quality and performance management self-assessments. At an individual level, staff are encouraged to align their personal objectives with both directorate and organisational plans, strengthening the connection between individual contributions and strategic priorities.



Inclusivity and Equity

Inclusivity and equity are fundamental to delivering compassionate, patient-centred care. Compassionate practices are also essential to nurture and support a healthy workforce to deliver our services. Our Quality Plan aims for all quality initiatives to align with the overarching objectives of our Strategic Equality Plan which reflect the diverse needs of our workforce and patients, creating equity in access, outcomes and experiences.

Through the embedded use of quality impact assessments and by embedding a collaborative approach to transformation and improvement we will consider the needs of our staff and our service users. More detailed equality impact assessments will be undertaken to ensure that all our strategic decisions consider the potential impacts upon people who are disadvantaged. This includes our service users with a protected characteristic, unpaid carers, Welsh speakers, veterans, and people who are impacted by socioeconomic disadvantage. Feedback from people with lived experience, carers and those with complex needs tell us the importance of personalised care particularly when linked to assessment protocols.

Recognising and celebrating individual and team contributions builds a culture of inclusion, where everyone feels valued and can drive continuous quality improvement. A diverse workforce that reflects the communities we serve enhances cultural competence and allows us to better understand the individual needs and challenges of our service users.

We will:

- Ensure that our policies and plans meet the needs of all our services users and the people we rely upon to deliver these services by undertaking robust impact assessments *(Capability / Design Equitable Services)*
- Implement support mechanisms to attract and retain a diverse workforce that reflects the communities we serve by promoting inclusivity and offering equitable opportunities for growth and success *(Capacity / Be an Employer of Choice)*
- Build cultural competence through targeted training, helping staff and volunteers to understand the barriers faced by diverse patient groups e.g. those from ethnic minority backgrounds, those with sensory loss, learning

disabilities, or other physical and social challenges *(Capability / Create Allyship)*

- Celebrate diversity and create fair opportunities for all staff and volunteers to contribute, thrive, and feel a sense of belonging *(Culture / Lead by Example)*

By embedding inclusivity and equity into all aspects of leadership and service delivery, we will create an organisation where every individual, patients and staff alike, feel valued, respected, and empowered to contribute to quality outcomes.

Technology and Innovation

Our Digital Plan describes the Trust's commitment to quality digital technologies in supporting clinical decision making, facilitating a seamless patient experience, and underpinning excellent service delivery. In the UK, emergency services like the Welsh Ambulance Service are often considered 'data rich but information poor' – with effort often spent more on sharing data outside of the organisation to commissioners, partners and stakeholders for monitoring performance and downstream decision making, leaving limited capacity to interpret the rich sources of data to better understand operational and clinical quality and impact. However, aligned with Welsh Government and Digital Health and Care Wales ambitions of a centralised National Data Resource, the Trust's Digital Plan explains how we will assure the data we collect, ensures compliance with information standards, and securely, ethically and confidentially shares data with decision makers and partners to enable better insight of patient experience, outcomes, and risk across NHS Wales.

As the Trust evolves to become even more evidence-based in its decision making and approach, it is essential we maintain trust in the quality of the information and technology that enable these decisions.

Following the introduction of the electronic patient care record (ePCR), we are now bringing together the operational, clinical and wider system data to triangulate intelligence and understand patient safety and outcomes. Additionally, ePCR information has value to our clinical workforce, helping individuals identify areas for professional development and understand the impact of their decisions on quality care. We will review our ePCR configuration to ensure that it better supports our clinical workforce whilst providing a rich source of data intelligence to support our endeavours in understanding our role in health inequality. As part of this work, we

will also explore how we can improve visibility of clinical assessment and decision making to inform treatment plans and care planning, to ensure our actions are efficient and effective.

The Digital Plan also explains how our approach to digital foundations, digital transformation and digital innovation is centred on meeting the diverse needs of our communities (patient, public and workforce) in more accessible and responsive ways. Many of the projects in our five-year Digital Plan directly demonstrate the commitment to quality services, care and decision making, for example:

- Promoting digital skills for our workforce - fostering a digitally literate and confident workforce for now and future generations.
- Measuring impact through quantitative and qualitative data, as well as public engagement - supporting the evolution of the Quality and Performance Management Framework as well as collaborations across NHS Wales for Health Protection and Population Health Management.
- Adopting system-wide interoperability standards to ensure patient information and journeys flow seamlessly, such as the integrations with Welsh Clinical Portal and Welsh Demographic Service.

Monitoring a Quality Service

The Trust is a commissioned service, with its three main services: NHS 111 Wales, Emergency Medical Services (999) and Non-Emergency Patient Transport Service (NEPTS), all commissioned by the Joint Commissioning Committee.



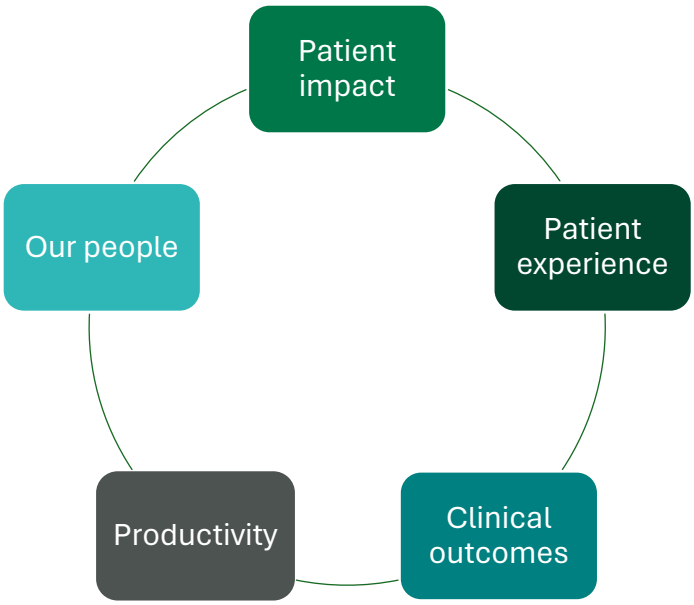




Each of these three services is commissioned along a five-step patient pathway, which ensures we take a focused person-centred approach to monitoring the quality of services we provide. However, we recognise that the data monitored through these pathways is almost exclusively time based, supported with some clinical indicators which measure the application of "bundles" i.e. clinical process.



As the Trust moves through its Clinical Model Transformation, we will review our metrics to ensure a continued and improving focus on:



It is particularly important that we align with our Digital Plan to ensure we:

- Have linked patient data across NHS Wales
- Understand the patient outcomes across the entire patient pathway and not just the five steps which are integral to us as an ambulance service.

To achieve this, we will liaise with our commissioners on proposed changes ensuring that we work collaboratively and are supported by a more nuanced set of data.

The Joint Commissioning Committee was newly established in April 2024 and as such, continues to develop its governance mechanisms. An expected area of development is the creation of a Quality and Safety Committee with which the Trust will provide intelligence on the patient pathways beyond time-based metrics. By fostering a collaborative relationship between the Trust, the Joint Commissioning Committee and the health boards across NHS Wales, we can move to a more integrated approach to patient care, addressing not just the immediate medical needs but also the experiences of our patients to positively impact on our relationship with our population.

View results

Respondent

41 Kate Blackmore

00:03
Time to complete

About this EQIA

1. Name *

Kate Blackmore

2. Job Title *

Assistant Director for Quality Governance

3. Email Address *

kate.blackmore@wales.nhs.uk

4. Team / Directorate *

Quality Governance - Quality, Safety & Patient Experience (QSPE) Directorate.

5. Executive Lead for this work *

Liam Williams

6. Governance Approval Route *

Quality, Patient Experience and Safety (QuESt) Committee/Trust Board

7. What are you impact assessing? (Insert document title) *

Strategic Quality Plan 2025-2028

8. What type of document are you impact assessing *

- ( ) Policy / Procedural Guidelines
- (•) Strategic Plan
- ( ) Business Case / Service Development
- ( ) Service Change / Closure

9. Who has been involved in undertaking this EQIA? *

Head of Inclusion & Engagement
Welsh Language Service Manager
Trade Union Representative

10. EQIA Start Date *

4/24/2025

11. Provide an overview of what you are impact assessing *

Please describe the overall aims and objectives and who will benefit. How will you achieve this and measure any outcomes and success. Please include any timeframes for this work.

Our Strategic Quality Plan for 2025-28 outlines a comprehensive and forward-thinking approach to enhancing the quality of healthcare services provided by the Welsh Ambulance Service University NHS Trust. It is designed to address the evolving needs of our population, ensuring that our services are not only efficient and effective but also equitable and inclusive. The plan creates a linkage between other strategic plans and will be published on our website. The plan will be supported by an implementation plan that sets out clear actions and objectives including the responsible leaders and the timelines for delivery.
Oversight of assurance will be provided through our Quality Governance infrastructure through to QuESt committee.

Links to objectives and other areas of work

12. Does this work link to the WAST Behaviours? (please tick each relevant behaviour)

For further information on WAST behaviour please click here: The Culture Champions Network (sharepoint.com)

- [x] Take ownership
- [x] Broaden our understanding
- [ ] Respect others
- [ ] Show belief in each other
- [ ] Practice ethically
- [x] Continually improve our service
- [ ] Be inclusive of the whole team

13. Does this work help to achieve the Strategic Equality Plan Objectives? (please tick each relevant objective)

- [x] We will design equitable services
- [x] We will lead by example
- [ ] We will be an employer of choice
- [ ] We will create allyship

14. Does this work help to achieve the Wellbeing Goals of the Wellbeing of Future Generations Act? (please tick each relevant option)

For further information on the Wellbeing Goals please click here: The Well-being of Future Generations | GOV.WALES

- [ ] A Prosperous Wales
- [ ] A Resilient Wales
- [x] A More Equal Wales
- [x] A Healthier Wales
- [ ] A Wales of Cohesive Communities
- [ ] A Wales of Vibrant Culture and Thriving Welsh Language
- [ ] A Globally Responsible Wales

15. Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. For further information on the Human Rights Act, please click here: Human rights in health and social care | EHRC (equalityhumanrights.com)

Tick whether this work applies to any of the following:

- [x] Article 2: The right to life
- [ ] Article 3: The right not to be tortured or treated in an inhuman or degrading way
- [ ] Article 5: The right to liberty
- [ ] Article 6: The right to a fair trial
- [ ] Article 8: The right to respect for private and family life, home and correspondence
- [ ] Article 11: The right to freedom of thought, conscience and religion

16. Is this work aligned to the FREDA Principles?

- [ ] Fairness
- [x] Respect
- [x] Equality
- [x] Dignity
- [ ] Autonomy

17. Does this work link to any other policies, plans or related areas of work?

Please list any other documents that need to be read in conjunction to what you are impact assessing.

People & Culture Plan
Strategic Equality Plan
Digital Plan
Health & Social Care (Quality & Engagement) (Wales) Act 2020
Integrated Medium Term Plan
Organisational Strategy: Delivering Excellence 2030

Consultation and Engagement

18. Please provide details of any consultation and engagement that you have done

This could include consultation and engagement with specific staff groups, community groups and individuals. If you have engaged with people with a protected characteristic, please provide details here.

Patient Experience and Community Involvement teams engaged with our People & Community Networks to understand their expectations of WAST as a Quality service.
All directorates were engaged with through their cycle of business to provide feedback on their expectations of the Quality Plan and WAST as a quality organisation.
A survey was issued to all staff to provide feedback to the same questions that were asked to our People & Community Networks to understand their expectations of WAST as a Quality service provider and what that means to them.
Attendees at the WAST Quality Event in July 24 were provided with an opportunity to engage on the development of the plan through a Menti survey informed by table group work.
Following feedback a cross directorate Task & Finish Group was set up to consider the emerging themes and design the strategic plan including engagement with a Public health Wales Registrar to provide specialist advice in this area.

19. Were there any emergent themes from the consultation and engagement?

Overarching themes:
1. Leadership & Governance:
Emphasize the importance of strong leadership and clear direction to maintain high quality patient care. Linking this to the People & Culture plan and 'Our WAST Way' as well as the Health & Care Quality standards 2023. The importance to set clear goals and foster an environment where all staff understand their roles in maintaining standards. Particular focus on supporting leadership at lower levels (band 6/7) to drive quality into their leadership and everything they do.

2. Developing and implementing QMS that are safe and effective across the organisation. Creating capacity and conditions for people to think differently and balance change management principles with quality improvement principles. The need for continuous improvement through robust quality management systems. Quality improvement methodology and training that includes analysis of data, equipping people with the rights skills and capacity to use those skills in the endeavour of continuous improvement.

3. Patient Centred Care
Ensuring that patient impact is at the heart of all decision and discussions with a collaborative approach to quality discussion. A shared commitment to delivering the best possible service to the public, including learning from mistakes and fostering a culture of continuous improvement. Ensuring that information regarding experiential and relational measures are used when evaluating our service with equal importance alongside time-based metrics

4. Communication & Collaboration
Strengthening communication across the organisation by creating open feedback channels and enhancing cooperation with hospitals and community services. (integration with health boards, other UK ambulance services and blue light partners) Encouraging openness within and between departments and teams with clarity of strategy, purpose and roles. Emphasize the importance of seeking continual feedback for improvement and reinforcing the good practices that support quality. Fostering a culture of empathy and clear communication within the service through training to enhance compassionate communication.

5. Inclusivity & Equity
Ensuring that quality initiatives are inclusive of everyone considering age, physical or social needs and other demographic factors. Addressing the needs of specific groups, such as patients with sensory loss or learning disabilities to provide equitable care.

6. Technology & Innovation
Leveraging technology to enhance service delivery and patient experience including real-time updates through mobile application and better post call communication via text or email. The importance of data and information standards with a focus on improving data utilisation across the organisation which measures patient outcomes alongside operational performance.

Service User Feedback Themes:
1.Timeliness and Responsiveness :
2. Empathy and Communication:
3. Capacity and Resources:
4. Expertise and Specialized Care:
5. System Efficiency and Coordination:

6. Technology and Innovation:
7. Equity and Access:

Staff Feedback Themes:
1. Leadership and Governance:
2. Employee Well-Being and Support:
3. Training and Development:
4. Operational Efficiency:
5. Communication and Collaboration:
6. Quality and Continuous Improvement:
7. Patient-Centred Care:
8. Recognition and Reward:
9. Work-Life Balance:

20. Have you made any changes or amendments as a result of the consultation and engagement?

The strategic quality plan was designed as a co-produced document. Engagement was undertaken pre-emptively and feedback was collated & themed to identify strategic opportunities to align with the visions of our stakeholders.

21. Do you plan to undertake any further consultation and engagement? Please provide details

The task & finish group including trade union partners was utilised to identify the strategic opportunities based on the feedback received and following the drafting of the plan it was shared with CQGG and ELT for comment. The associated action plan is also being created through the T&F group collaboratively with content leads.

22. How will the outcome of the final decision be shared?

The strategic quality plan will be shared internally on our quality sharepoint pages and externally via our Duty of Quality website presence. it will be publicised through events such as the WAST quality event in July 2024 and will be referenced in our Duty of Quality Annual Report.

23. Please provide details of any further evidence that you have used to inform your plans?

This could include external research, population data, etc

External research and engagement with Public Health registrar to support the development of strategic change for organisational understanding of Population Health and Value Based health Care.
Other health board Quality Strategies that coincide with timelines
Legislation requirements.

EQIA

Use this section to identify any potential impact your plans may have upon people with a protected characteristic and other community groups. You can learn more about the Equality Act 2010 and the protected characteristics here: Protected characteristics | EHRC (equalityhumanrights.com)

For further guidance and video tutorials on equality impact assessment, please visit this page on SIREN:
Equality Impact Assessments (sharepoint.com)

PLEASE NOTE: You may identify a potential positive and a negative impact against some of the protected characteristics. If this happens, you should tick both the 'positive' and 'negative' options and provide your narrative for each in the box below.

AGE

Think about older people, children and young people, young adults, etc, and how your plans may affect them differently.

24. What impact will your plans have upon people within different age groups *

- (●) Positive Impact
- ( ) Negative Impact
- ( ) No Impact

25. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of patients.

26. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Disability

This includes disabilities affecting mobility, sensory loss, long-term health conditions, hidden disabilities, learning disabilities, mental health conditions and neurodiversity. Further detail on disability and the Equality Act can be found here - Disability: Equality Act 2010 - Guidance on matters to be taken into account in determining questions relating to the definition of disability (HTML) - GOV.UK (www.gov.uk)

27. What impact will your plans have upon people with a disability? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

28. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of patients.

29. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Sexual Orientation

30. What impact will your plans have upon LGBTQ+ people? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

31. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of patients.

32. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Gender Reassignment / Gender Identity

This includes people who identify as a gender which may be different to their sex assigned at birth. This includes people who are trans or non-binary.

33. What impact will your plans have upon people due to their gender reassignment or gender identity? *

- (●) Positive Impact
- ( ) Negative Impact
- ( ) No Impact

34. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of patients.

35. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Sex

Think about how your plans may impact men and women differently

36. What impact will your plans have upon people due to their sex? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

37. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of patients.

38. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Race and Ethnicity

Think about how your plans may impact upon people from Black, Asian and Minority Ethnic backgrounds.
This includes Gypsy, Roma, Traveller Communities and could include White people from a non-British background.

39. What impact will your plans have upon people due to their Race and Ethnicity? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

40. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of patients.

41. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Religion and Belief

Think about how your plans may affect people who practice a specific religion or live their life according to a set of beliefs.

42. What impact will your plans have upon people due to their religion or beliefs? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

43. Please state why you have selected the above options *

The Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of embedding inclusivity and equity into all aspects of leadership and service delivery, we will create an organisation where every individual, patients and staff alike, feel valued, respected, and empowered to contribute to quality outcomes. The plan links specifically to our strategic equality plan.

44. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Pregnancy and Maternity

Think about how your plans may impact upon people who are pregnant or on maternity

45. What impact will your plans have upon people who are pregnant or on maternity? *

- [ ] Positive Impact
- [ ] negative Impact
- [x] No Impact

46. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. There are no specific wellbeing initiatives within the plan but there is a strong link to our people & culture plan particularly around leadership.

47. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Marriage and Civil Partnership

Think about how your plans may impact those who are married or in a civil partnership and those who are not.

48. What impact will your plans have upon people who married or in a civil partnership and people who are not *

- [ ] Positive Impact
- [ ] Negative Impact
- [x] No Impact

49. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. There are no specific wellbeing initiatives within the plan but there is a strong link to our people & culture plan particularly around leadership.

50. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Unpaid Carers

An unpaid carer is someone who provides help and support to a family member, friend or neighbour who cannot manage without the carer's help.

51. What impact will your plans have upon unpaid carers? *

- [ ] Positive Impact
- [ ] Negative Impact
- [x] No impact

52. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. There are no specific wellbeing initiatives within the plan but there is a strong link to our people & culture plan particularly around leadership.

53. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Armed Forces Covenant

Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life.

Consider their unique experiences when accessing and using public services compared to the general population. Think about their unfamiliarity with civilian life, frequent moves around the country and the subsequent difficulties in maintaining support networks.

54. What impact will your plans have upon people who belong to the Armed Forces Community? *

- [ ] Positive Impact
- [ ] Negative Impact
- [x] No Impact

55. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. There are no specific wellbeing initiatives within the plan but there is a strong link to our people & culture plan particularly around leadership.

56. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Welsh Language Impact Assessment

For further information on the requirements of the Welsh Language Standards and Welsh Language Impact Assessment, please click here:
https://ambulance.nhs.wales/about-us/welsh-language-standards/
Or please contact Melfyn.Hughes@wales.nhs.uk for further advice.

57. Will your plans ensure that patients and carers can choose to live and receive services through the medium of Welsh? *

- ( ) Yes
- ( ) No
- (•) Not applicable

58. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

There is no specific content related to language preferences for service users as part of strategic plans to improve the quality of our services however the plan does include the importance of compassionate communication without specifying the language in which this communication is undertaken. The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities, whilst language is not specifically referenced within the determinants of health access to services through the medium of Welsh could be considered as part of general cultural conditions. Objectives around data linkage and recording for health inequalities and recording of language preferences will help identify quality improvement initiatives for this group of patients.

59. What impact will your plans have upon the opportunities for people to use the Welsh language? *

- [ ] Positive Impact
- [ ] Negative Impact
- [x] No Impact

60. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

Whilst data linkage will create opportunities for improvement initiatives based on the intelligence available it is uncertain at this time what impacts those improvement initiatives may have .

61. Will your plans encourage staff to use Welsh in the workplace and provide opportunities for staff to learn and improve their Welsh language skills? *

- ( ) Yes
- ( ) No
- (•) Not applicable

62. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

Whilst there is no specific content regarding staff opportunities for use of welsh language there is intended to be training opportunities for compassionate conversations which will consider the medium of communication as part of these initiatives.

63. Will your plans encourage Welsh language cultural awareness, activity and integration? *

- ( ) Yes
- ( ) No
- (•) Not applicable

64. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

There is no specific content related to language cultural awareness as part of strategic plans to improve the quality of our services however the plan does include the importance of compassionate communication without specifying the language in which this communication is undertaken. The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities, whilst language is not specifically referenced within the determinants of health access to services through the medium of Welsh could be considered as part of general cultural conditions. Objectives around data linkage and recording for health inequalities and recording of language preferences will help identify quality improvement initiatives which may include cultural awareness activity.

65. Will your plans increase the Trust's ability to deliver services in the medium of Welsh? *

- ○ Yes
- ○ No
- ◉ Not applicable

66. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

n/a

67. Do your plans treat the Welsh language no less favourably than the English language? *

- ○ Yes
- ○ No
- ◉ Not applicable

Socioeconomic Duty

The Socioeconomic Duty aims to improve outcomes for people who experience socioeconomic disadvantage. This may include people on low incomes, lone parents, students, the homeless, etc. People who live in rural and urban areas can be affected by socioeconomic disadvantage in different ways. For example, consider the impact of fuel poverty, wifi poverty, job opportunities, unemployment rates, access to health and social care systems, etc.

When assessing the impact of your plans, please consider the following domains:

Education:
Consider the impact of education on the local population, children and adults with additional learning needs, basic literacy levels and those less likely to have access to training opportunities and qualifications
Think about how careers support, including apprenticeships and volunteer work placements can be promoted to support young people furthest from the job market.

Health:
Consider the expected health outcomes of the local population. What are the current health needs and what action can be taken to increase access to healthcare for those who experience socio-economic disadvantage? Have the costs of transport and travel been taken into account? Think about the design of the built environment on the physical and mental health of patients, staff and visitors.

Living Standards:
Consider the impact of poverty and deprivation. Are there groups who may be disproportionately impacted by poverty e.g. disabled people / lone parents / unemployment / homelessness. This domain includes issues of accessibility of transport, healthy food, leisure activities, road safety and the quality and safety of play areas and open spaces.

Work:
Welsh Ambulance Services NHS Trust provides numerous opportunities for people to access work. Will this plan impact on employment / apprenticeship / volunteering opportunities? What are the implications of the proposal for people on low income, those who are economically inactive, unemployed, and people who are unable to work due to ill-health. Consider people living in work poverty.

Justice and Personal Security:
Consider local crime rates and feeling safe. Think about people who live in less safe areas and those more likely to be victims of domestic violence and abuse. Evidence suggests that domestic violence incidents are becoming more complex and serious, with higher levels of physical violence and coercive control.

Participation:
How is participation enabled, how is engagement sustained with people with lived experience of socio-economic disadvantage and how has this informed your proposal? Think about digital exclusion and digital poverty, people living in rural areas and those unable to access services and facilities.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see https://gov.wales/more-equal-wales-socio-economic-duty

68. What impact do your plans have upon those who are affected by socioeconomic disadvantage? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

69. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of patients.

70. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

EQIA Outcome Decision

71. Using the information provided in this assessment, are you able to proceed with your plans?

- (•) Yes
- ( ) No

72. What are your next steps? Please provide details of any required changes, further changes and consultation, decisions, etc. *

Plan is scheduled for approval at QuESt committee on 9th May and will be submitted with an associated executive summary on how the plan was created as well as a draft implementation plan of the detailed actions associated with delivering the strategic context. The implementation plan will be monitored regularly with updates shared to senior leadership and committee governance infrastructures. This regular monitoring of the plan will allow for dynamic prioritisation, reprioritisation and update based on insights and intelligence from across our organisation.

Thank you for completing this EQIA.

Please ensure that you tick the box which allows you to edit your EQIA after submission. This will allow you to make any necessary updates as required.

PEOPLE AND CULTURE COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

The papers for this meeting can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	29 May 2025
Committee Meeting Date	15 May 2025
Chair	Ceri Jackson

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No alerts arose from this meeting.

ADVISE

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

2. The committee heard from **Mandy McWatt, Emergency Ambulance Practitioner (EAP),** who shared her experiences with menopause and her career progression within the Welsh Ambulance Service. She highlighted the challenges she faced due to menopause symptoms, including memory issues, emotional struggles, and physical health problems. Despite these challenges, Mandy has recently successfully completed the EAP course and is also a Culture Champion at Newtown Station. Mandy was encouraged not to discount her long-standing aspiration to become a paramedic merely because of her age, which she felt was now a barrier to commencing training.

   Mandy hugely values her colleagues, and she strives to embody WAST's organisational behaviours. Members greatly appreciated hearing Mandy's story and discussed how resources for staff regarding the effects of menopause on women could be improved. Mandy was encouraged to continue her professional and personal development within the Trust. Her story highlighted her personal resilience, dedication to her role, and the importance of compassionate practices and support from your employer during challenging health events.

3. The **report from the Director of Cultural Change** and the **Director of People** was received with the following of particular note:

   - Our WAST Way, the programme aimed to provide leadership development opportunities for all

staff, is being launched on 28 May.
- The development of the health diagnostics programme, which includes signposting to charities and other support services. The programme, based on individual health assessments for staff over the age of 46 who wish to participate, was promoted at the recent CEO Roadshows.

4. The **Q4 Operational Update** from the Executive Director of Operations highlighted several matters of interest related to our people and our culture, including:

   - The Community Welfare Responder Project was presented at the ALF (Ambulance Leadership Forum) conference, garnering interest from others.
   - EMSC sickness absence has improved due to consistent policy application and supported with improved working environments, with positive feedback on the EMSC restructure. Culturally, the shift to 'keeping people at work' continues.
   - Turnover for band 3 entry-level roles remains high due to the challenging nature of call handling, but these roles often serve as stepping stones within the Trust. The approach to recruitment is constantly under consideration with a history of testing various approaches. The future may provide opportunity to increase reward through cross-training and direct contact resolution.
   - There has been good progress with respect to EAP training.
   - The Glangwili end of shift pod has been deployed to reduce shift overruns and improve meal breaks.
   - The NEPTs roster review working parties are ongoing, with the team actively responding to feedback

5. **Reflections** on the meeting were that it was well chaired, and discussions and energy were positive. Presentations were succinct and papers well structured. Robust triangulation of organisational activities was demonstrated which provided assurance to the committee of the progress of various workstreams. It was also considered how the committee could move towards having more of a strategic focus with regards to future business and reporting.

ASSURE

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

6. Feedback from the **2024 NHS Staff Survey** was received and it is summarised here at **Annex 1**, aligned to organisational themes of Our WAST Way. Action plans are being developed in directorates to develop targeted actions. Three priority focus areas have been identified, those being burn-out and well-being; regular, meaningful check-ins with managers; and involvement in change. The committee also looked in more detail at the responses on abuse from patients/public, which shows a marked increase in 2024. Additionally, colleague involvement in decision making and change results indicate that those working closest to the frontline may feel the least included in shaping decisions that impact them.

   There is a structured approach to feedback to staff on our responses to the issues raised over the next 12 months. The People and Culture Plan metrics report below also indicates continued increase in network membership which, taken in conjunction with the staff survey participation rate, is a promising indicator that cultural initiatives are enabling inclusivity.

7. The Committee scrutinises performance across several metrics within its remit. Whilst the board receives the **Monthly Integrated Quality and Performance Report** (MIQPR), there are a range of additional metrics this committee receives, including wider **People and Culture Plan Metrics** (quantitative this quarter). Given this, the following areas of assurance will be of interest to the board noting the context our people are operating it and the good progress despite this:

   - March 2025 showed a Trust wide reduction in sickness absence, indicating that the positive impact of the focus on wellbeing, compassionate practices and supportive work environments is being felt by colleagues. The reasonable assurance internal audit on Occupational Health and Wellbeing (below) also supports this.
   - A slight increase in turnover was noted, primarily due to higher than average retirement rates. This trend is attributed to the workforce profile and individuals choosing to retire earlier or pursue second careers post-Covid.
   - An increase in PADR completion rates is reflected for March (82.38%); this represents the highest recorded rate within this dataset. PADR process improvements are in progress with a focus on making the conversation the core of the process, with the form acting as a simple tool to guide (not define) the discussion.
   - Once again there has been an increase in statutory and mandatory training compliance (87.84%, against a Welsh Government target of 85%). At 31st March 2025, 90.44% of colleagues required to attend Mandatory In-Service Training (MIST) had done so.
   - There has been an increase in formal employee relations cases, particularly related to safeguarding, indicating that staff feel more empowered to escalate concerns.

8. The **Annual Health and Safety Report** at **Annex 2** was received and approved. Its focus was on continuous and quality improvement through workplace inspections, internal audit and legislative compliance. The report acknowledged the sustained focus on diesel fumes impacting capacity to progress proactive objectives. This links to the MIQPR and WASPT highlight report which note progress on the use of fans outside A&E departments to reduce diesel fumes exposure. Additionally, the staff survey noted a sharp rise in reports of abuse from patients and the public; double the number reported for the same period last year. This increase suggests a combination of societal issues, increases in mental health problems, pressure across the health system, as well as a shift in internal culture where colleagues feel more confident speaking up. Members noted the need to connect the data on violence and aggression incidents with other reports to provide a comprehensive view in the MIQPR.

9. The vision in 2021 for the **Volunteer Strategy 2020-25** was for volunteers to add value to user experience and the care we provide; for our volunteers to have personally rewarding experiences; and that volunteering would strengthen the contribution made to community resilience. Members received a look back at the first four years and agreed that that vision is being realised and reviewed the significant achievements to date, including:

   - Development of the Community Welfare Responder role
   - Volunteer service transition through an organisational change process

- Development of a volunteer responder pathway
- Expansion of the St John Ambulance Cymru VAR schemes
- Volunteer management system – Go Assemble
- Volunteer conferences
- Significant increase in volunteer car drivers
- VCS oncology project
- Volunteer Steering Group refresh

The discussion emphasised the reach, impact, and ambition of the volunteer service, highlighting its significant contributions to patient care and community resilience, as well as ongoing efforts to expand and enhance volunteer roles. There is a commitment to integrate volunteers into the People and Culture Plan, ensuring their contributions are recognised and supported, and promoting diversity and inclusion within volunteer roles. The Committee recorded its thanks to Rhodri Jones, who was the inaugural Chair of the Volunteer Steering Group, whose tenure concludes this month.

10. The **Strategic Equality Objectives** for 2024-2028 are design equitable services; lead by example; be an employer of choice; and create allyship. A six-monthly progress update on those objectives was received and members were assured of progress, which includes:

- Sexual safety training programme
- People network growth and development
- Women's health and wellbeing sessions
- TU funded sanitary initiative and women's uniform
- Inflammatory bowel disease awareness campaign
- Ramadan and Iftar event
- Carer Confident Level 1 Award
- HIV education workshop
- Culture Champions open days
- EQIA policy and impact assessment guidance
- Executive Champions for equity, diversity and inclusion
- Allyship and Active Bystander training positive feedback
- Inclusive recruitment initiative within Digital Team, with members noting that the success here is a blueprint which could be replicated further in the organisation
- Maternity skin tone training resources

Members agreed there was a very good depth and breadth of the equality, diversity and inclusion work, with positive green shoots of improvements in the gender pay gap.

11. The **Internal Audit on Occupational Health and Wellbeing Support** was rated as reasonable assurance. The Audit, Risk and Assurance Committee (ARAC) received the audit on 1 May and their AAA report before the board sets out the issues discussed there. Members of the People and Culture Committee received those comments and noted that work is progressing to mitigate the identified actions, with several actions already completed. The focus for the Trust is now on using data to inform engagement of services and ensuring proactive health and well-being measures.

12. The **Speaking Up Safely Internal Audit** was rated as reasonable assurance. The Audit, Risk and

Assurance Committee (ARAC) received the audit on 1 May and their AAA report before the board sets out the issues discussed there. Members of the People and Culture Committee received those comments, and also acknowledged the progress made and the continuous efforts required to improve the speaking up culture within the organisation.

13. The Welsh Ambulance Services Partnership Team (WASPT) is the board's local partnership advisory forum. The **WASPT highlight report** sets out the ongoing projects, upcoming challenges, and the steps being taken to address them in partnership. The following was noted from the March 2025 WASPT meeting:

    - The first WAST Social Partnership Conference was held on 31 March 2025 and was a successful day with great engagement.
    - The Wellbeing Objectives were shared, noting they had been developed in partnership.
    - The WAST Charity (Elusen Gwasanaeth Ambiwlans Cymru) strategy was shared with members, with views considered in the next iteration.
    - Good progress on diesel fumes was noted.
    - With respect to skills mix, options are being costed and any red line issues identified.
    - There was positive feedback from staff on the EAP course, highlighting topics like ECG interpretation which was also shared in the staff story earlier.

    Trade Union colleagues fed back to this meeting their experience at the recent ALF Conference and the benefits of that exposure and sharing challenges and opportunities.

14. The outputs of the Committee's **annual effectiveness review** were discussed and the terms of reference and annual report that were approved by Chair's Action were ratified. The committee's priorities for 2025/26 are a focus on equality, diversity and inclusion, as well the development of our people.

15. The **Audit Tracker** was reviewed and the Committee noted excellent engagement and progress with 75% (17% last quarter) of internal audit management actions due in the quarter now closed. Rationale for the closure of Audit Wales recommendations under the 2023/24 Review of Workforce Planning Arrangements were discussed. Whilst the actions were not implemented in full as originally intended, the committee was satisfied that the risks raised in the report were appropriately mitigated.

16. In the private session the committee reviewed progress against seven **suspensions over four months** which is a decrease from ten reported in the last quarter. Three cases are with the **Employment Tribunal** (an increase of five from the previous quarter). Members were assured on actions in place to manage these cases.

RISKS

Risks Discussed: The four risks within the remit of this Committee were discussed and whilst this data was presented to the Trust Board in March 2025, the risks have all been reviewed during this period with the

activity due to be considered by the Executive Leadership Team on 21 May 2025.

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 20 (5x4) despite there being a significant reduction in absence levels. The Assistant Directors Leadership Team will undertake a deep dive of the risk on 28 May 2025 as part of a revised approach to risk.

201 – Damage to the Trust's reputation following a loss of stakeholder confidence which remains at a score of 20 (4x5). The tension in the reputational risk was noted that while the Trust has positive relationships with stakeholders, the patient experience remains poor due to harm in the community. A deep dive will be conducted on the risk over the summer to consider splitting it into a stakeholder risk and a patient experience reputational risk. This approach aims to address the different aspects of reputation and ensure the risk is accurately profiled. It is likely that this will be the last time that the committee will see this risk in this way.

163 – Maintaining effective and strong Trade Union partnerships remains unchanged at a score of 12 (3x4) has been closely reviewed the risk in advance of a discussion at the Trust's partnership team meeting in May 2025 to determine if any additional mitigation is needed and to evaluate its movement over time. It was acknowledged that while relationships are good there are considerations such as the National Pay Award and the upcoming change in senior leadership which could impact on stability.

558 - Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences remains unchanged at a score of 15 (3x5).

New Risks Identified: No new risks identified at this meeting for the register.

COMMITTEE AGENDA FOR MEETING		
Directors Update	Operations Quarterly Report Q4	Staff Story and Staff Story Update
NHS staff survey and action plan	WASPT highlight report	People and Culture Plan metrics and workforce scorecard
MIQPR	Volunteer Strategy Action Plan update	Strategic Equality Plan progress update
Annual health and safety report	Internal Audit on Occupational Health and Wellbeing Support	Risk management and BAF
Audit tracker Q4	Feedback from effectiveness review and priorities	Internal Audit on Speaking up Safely

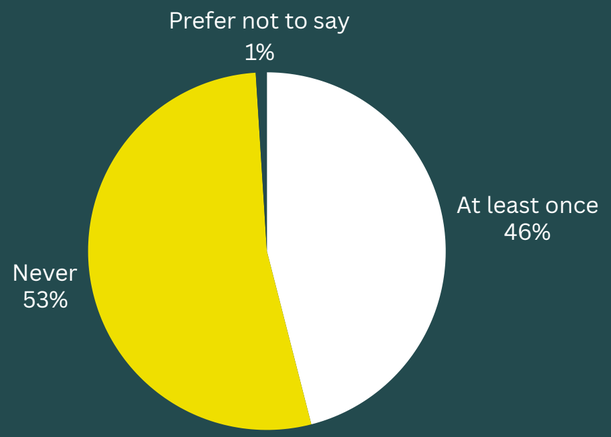
COMMITTEE ATTENDANCE				
Name	**15 May 2025**	**12 August 2025**	**13 November 2025**	**10 February 2026**
Ceri Jackson				
Bethan Evans				
Hayley Hutchings				
Hannah Rowan				
Angela Lewis				
Carl Kneeshaw				
Chris Turley				
Lee Brooks	From item 6			
Liam Williams	Penny Durrant			
Estelle Hitchon				
Andy Swinburn				

COMMITTEE ATTENDANCE				
Name	**15 May 2025**	**12 August 2025**	**13 November 2025**	**10 February 2026**
Alex Crawford				
Trish Mills				
Damon Turner				
Marcus Viggers				
Christian Fox				
Tim Cahalane				

	Attended
	Deputy attended
	Apologies received
	No longer member

In the last 12 months how many times have you personally experienced abuse at work from patients / service users, their relatives, or other members of the public?

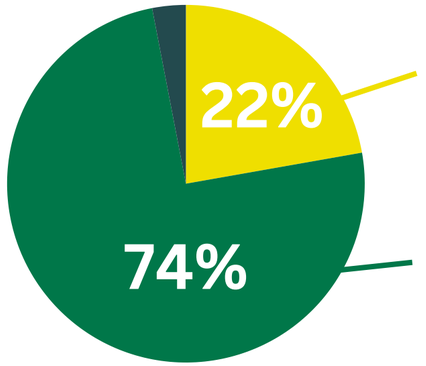
2024



696 respondents (46%) report personally experiencing **at least one** such incident in 2024, up from **292** (29%) in 2023

In the last 12 months how many times have you personally experienced harassment or bullying at work from:

Managers / Team Leaders

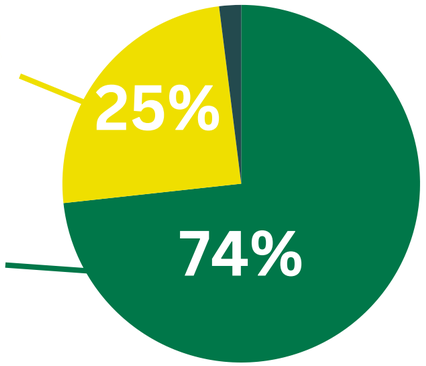


at least once

never

1.7% improvement in negativity score and 4.7% improvement in positivity score compared with 2023

Other Colleagues



1.4% improvement in negativity score and 3.2% improvement in positivity score compared with 2023



21



respondents reported having personally experienced **physical violence** at work from other **colleagues**, on at least one occasion

compared with 7 in 2023

41%

(617 respondents)

report **not having enough energy for family and friends** during leisure time



32% report this is **sometimes** the case; **27%** report that this is **rarely or never a problem**

(2.4% increase in negativity scores compared with 2023 data)



satisfied with the opportunity for **flexible working** patterns (799 respondents)

(7.8% increase in positivity score and 6.1% decrease in negativity score compared with 2023 data)

Themes



Burnout



Handover delays



Overruns



Working patterns



Bullying



Stress

Free Text Responses

"Great flexibility. I get to work from home which allows me to work additional shifts and cover shortfalls. I feel well supported"

"I am struggling at the moment to enjoy coming to work. The service is extremely busy and we are expected to work every weekend which is the busiest time. I am stressed and find it difficult to remain positive at work when it is relentless at the moment. There is not much consideration for people with children trying to balance work and home life"



I have been with the organisation for a number of years and so much has changed in that time, good and bad. There is so much more pressure within the organisation and low morale with the staff. I would like to remain within WAST but will be looking for a different role as the role I am in at present has become a lot more stressful and mentally exhausting"

"I think WAST is trying really hard to address cultural issues, it takes time and we have to keep working at it and making sure colleagues feel safe. There is a genuine desire to make this a great place to work for everyone"

"I feel that a lot of people on the road are feeling burnt out as they are spending far too much time stuck outside of the hospital with patients and it feels as if there is nothing being done about it. A lot of people are trying to find ways off the EAs to not be stuck outside the hospital with patients as it is unfair for the patient and for the crew. In a run of four shifts I may see two or three patients of my own the rest of the time I am taking over other crews so they can go for meal breaks or finish later at the end of a long shift. I really hope that in the future either we are waiting a lot less and able to get to patient within a reasonable time frame or the ambulance is made to be more comfortable for both the crew and the patient. A lot of the time patients are in pain because the stretcher is not designed to be on for extended periods of time and I go home with lower back pain from the seats in the back of the ambulance"



65% agree / strongly agree that their line manager works **together** with them to come to an **understanding** about their problems

up from 61.4% in 2023 but also with a 0.8% increase in negativity score compared with 2023 data

67%



agree / strongly agree that their line manager is interested in **listening** to them when they describe **challenges** they face

(up from 63.1% in 2023 but also with a 0.3% increase in negativity score compared with 2023 data)



"My line manager gives me **clear feedback** on my work"



62.5%



22.3%

(5.4% increase in positivity score and 1.3% decrease in negativity score compared with 2023 data)



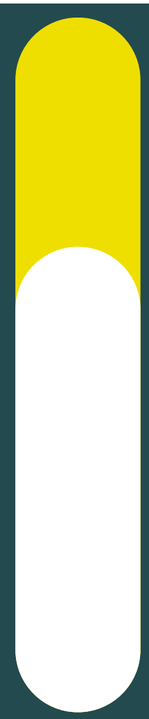
report having felt **pressure from their manager** to come to work (*361 respondents*)

(0.2% increase in negativity score and 0.2% decrease in positivity score compared with 2023 data - minimal shift)

65.1%

feel their line manager takes effective action to help them with any problems they face

up from 61.2% in 2023



Themes

- Leadership behaviours
- Confidentiality
- Focus on targets
- Manager support
- Communication
- Trust



Free Text Responses

“Organisation focuses on getting calls answered and dealt with in the shortest possible time for statistical reasons. Not interested in staff retention and the reason why people leave. Happy staff are productive staff.”

“I am lucky to have a very supportive manager who has helped me through a challenging year for myself with medical problems, they deserve a lot of credit!”

“There is a tendency to micromanage. Very free and easy with letting you know what you have not done correctly, never any positive feedback”

“Management never communicate with staff members to “check in” to see how staff are doing”

“My manager is absolutely amazing, they are a great leader to us all, they are exceptionally knowledgeable and the best person to learn from and develop your skills and knowledge base. They are caring, kind and thoughtful and always there to listen. They are the best manager I have had within my career and it will be hard to leave their team when the time comes”

“My manager has not taken forward any of the concerns that I have raised to them about inappropriate behaviour and I have heard from colleagues that they have betrayed my trust as they have shared my concerns with a few of them”

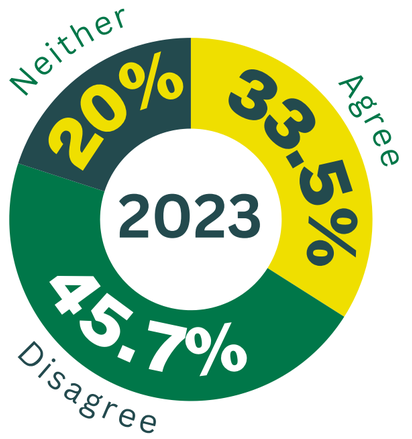


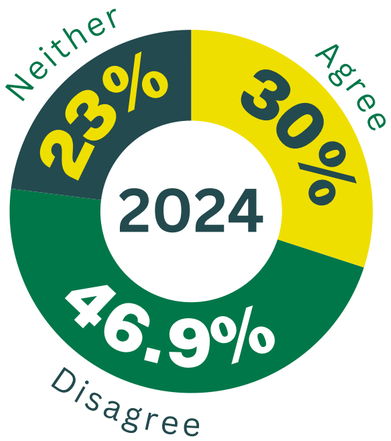
55%

agree / strongly agree that there are frequent **opportunities** for them to **show initiative** in their role

(4.2% reduction in positivity score and 4% increase in negativity score compared with 2023 data)

"I am **involved** in deciding on **changes** that affect my work / area / team / dept"





(3.5% reduction in positivity score and 1.2% increase in negativity score compared with 2023)



47%

of respondents feel they have a **choice** in deciding **how** to do their work

(0.6% reduction in positivity score and 1.1% increase in negativity score compared with 2023 data)

46.1%

feel **confident** that WAST would **address** their concern

(4.4% increase in positivity score and 0.3% reduction in negativity score compared with 2023 data)

50.1%

feel **able to speak up** about anything that **concerns** them at WAST



(up from 47.8% in 2023 and negativity score reduced by 3.8%)

Themes

- Inclusivity / exclusivity
- Managing change
- Speaking up
- Addressing concerns
- Autonomy
- Development

Free Text Responses

"I feel that staff are not listened to when it comes to change. I often feel undervalued as a member of staff, and that what I do is not good enough or not enough"

"I enjoy working in WAST and would love to stay for as long as possible. However, I find that to progress in my career I would have to look elsewhere as WAST do not have enough development opportunities for lower banded staff (3-7) across the organisation, not just in my department. I would also feel happy to raise concerns to my manager as I feel they have my best interests in mind at all times. However I know others who have raised concerns and have felt the organisation has let them down"

"I've felt a really positive change since joining this organisation and my immediate line manager and current team have been very welcoming, and I have felt included and a valued part of the team"

"Though I have only been at the organisation for a brief time I have been made to feel very welcomed and appreciated within my role. I have felt supported by nearly every colleague and there is always friendly help available when I have questions or I am not sure"

"Overall I enjoy my job but I feel frustrated that I am not encouraged to use my own initiative during my daily duties"

"There are too many competing priorities, a clear long-term vision but no clear steer on where to practically focus collaboration efforts first, and significant change fatigue across the organisation. We are burning our people out"

Welsh Ambulance Services University NHS Trust

Health & Safety Annual Report 2024-2025



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

Health & Safety Annual Report 24-25
Version 1.0
Released: 25 April 2025

Nicola White- Head of H&S
Nicola.white3@wales.nhs.uk

1. Introduction
2. Keeping Our People Safe
3. Workplace Safety
4. Violence and Aggression
5. Display Screen Equipment / Manual Handling
6. Quality Improvement
7. Working in Partnership
8. Good Practice Support Conclusion
9. Challenges
10. Growing the Team
11. Moving forward



Introduction



The Welsh Ambulance Service University Trust (WAST) success within Health & Safety (H&S) is driven by the Organisation's desire for continuous improvement on its journey to a cultural state of Interdependency.

The Health and Safety Annual Report provides the Trust Board with the necessary assurances that the Organisation continues to make significant strides to compliancy with the Health & Safety at Work Act 1974 and other supporting pieces of secondary legislation.

It provides an overview of how the Trust has performed over this reporting period in relation to ensuring a safe working environment. Priority is given within the report to celebrate the success and achievements of the dedicated H&S team as well as sharing the good practices from our WAST colleagues, our improved systems and processes and our challenges.

The Executive Director of Quality and Nursing is the executive lead for Health & Safety within WAST. The Head of H&S has responsibility as he named professional for the management of H&S. This role provides assurance with the Trusts Statutory Legislation above. The Head of H&S takes the Organisational lead on all H&S matters.

The H&S team works collaboratively with senior managers and colleagues to promote a mature H&S culture, both articulated and lived at each level in the Organisation. External partnership is also integral to the team's role, WAST contribution to the work of our partner agencies is also highlighted within this report.

Keeping Our People Safe- Health & Safety Risks

Retained target score since November 2023

Corporate Risk 199 - 'Failure to embed an Interdependent and mature health and safety culture causing harm or a breach in compliance'.

Risk 199 was raised in August 2019 and assessed as 20 (4x5).
Following significant work completed as part of the Working Safely Programme and investment into the Workforce Review, Risk 199 was reviewed and approved as reaching its target score of 10 (2x5) on the 7th December 2023.

This risk was de-escalated to the QPSE risk register and is reviewed on a quarterly basis.

Keeping our People Safe -Legislative Compliance

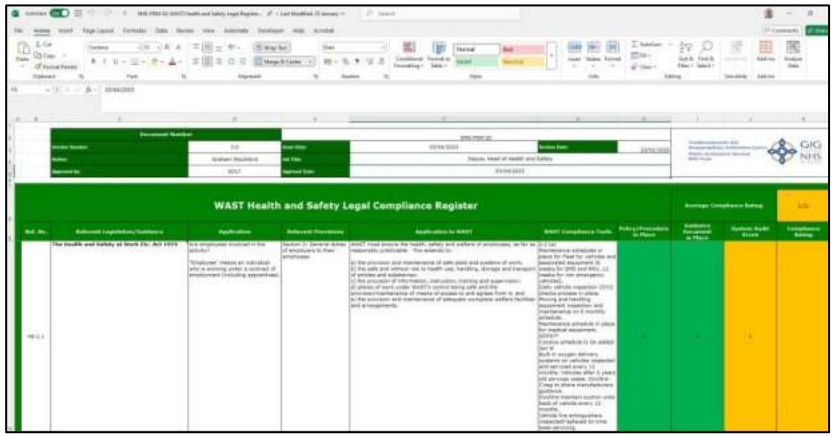
Internal audit - The Health and Safety (H&S) function was subject to an internal audit by Shared Services Partnership during Q3 2024/25 on 'Exposure to Fumes'.

The Auditors recognised the Trust's commitment to managing and improving exposure to diesel fumes and the work undertaken to date. Subsequently the Trust received a 'Reasonable' level of assurance across all 3 assessment criteria

The Trusts Legislative Compliance Register was subject to review by the H&S function in Q4 2024/25. Work undertaken by the Estates team increased the Trusts compliance to The Regulatory Reform (Fire Safety) Order 2005 increased overall legislative compliance levels from 2.22/3 to 2.32/3 continuing to provide a moderate leave of assurance was approved by the group on 17th April 2023. Further work continues to increase compliance levels further.

Assurance summary[1]

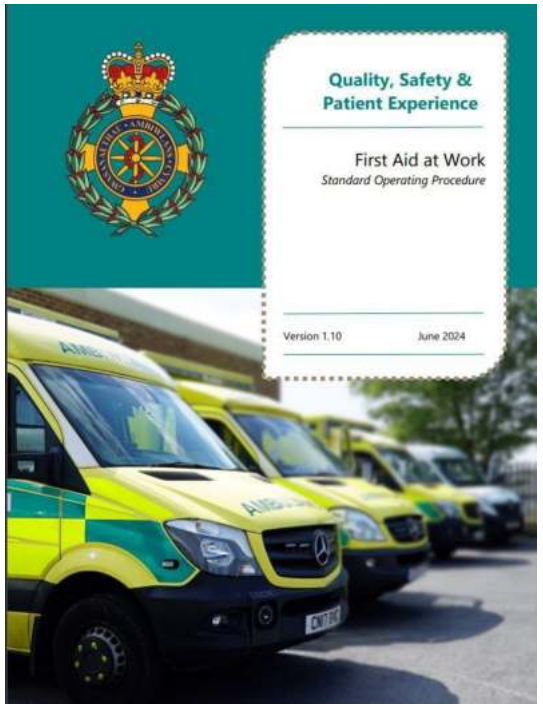
	Objectives	Assurance
1	Guidance documents	Reasonable
2	Monitoring and managing compliance with the Workplace Exposure Limits.	Reasonable
3	Reporting of emissions and their impact	Reasonable



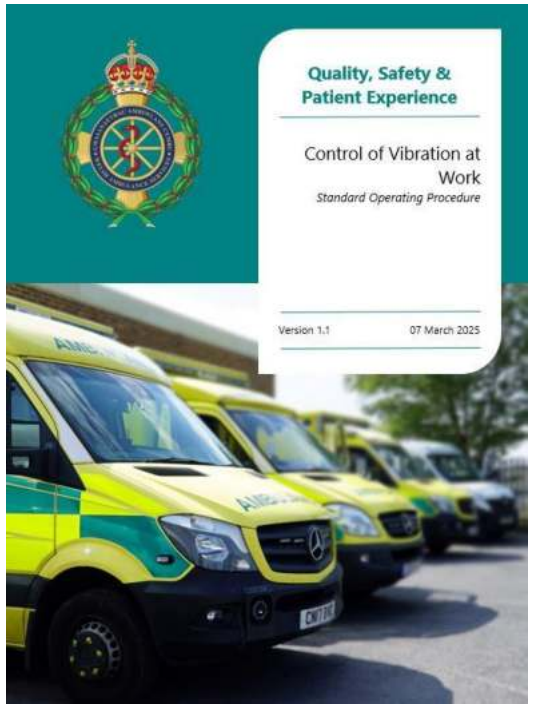
Keeping Our People Safe –Documentation Developed



ED Bladeless Fan SOP



First Aid at Work SOP

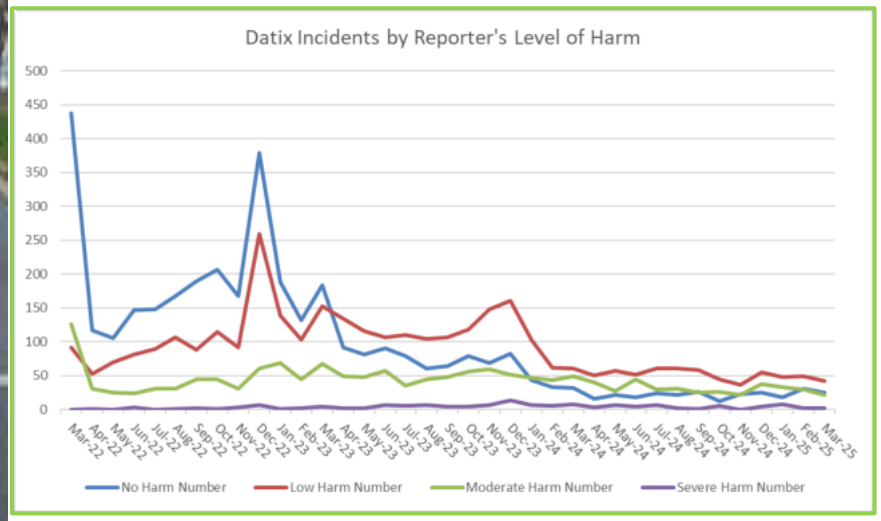


Hand Arm Vibration SOP

Keeping Our People Safe- Non-Patient Incidents







Health and Safety Performance within this report for 2021/2025 relates to the Welsh Ambulance service University Trusts performance of top 5 H&S reported incidents.

The H&S team priority is to ensure that WAST colleagues work as safe as reasonably practicable within dynamic environmental conditions. This involves supporting investigations and applying lessons learned to prevent re-occurrence.

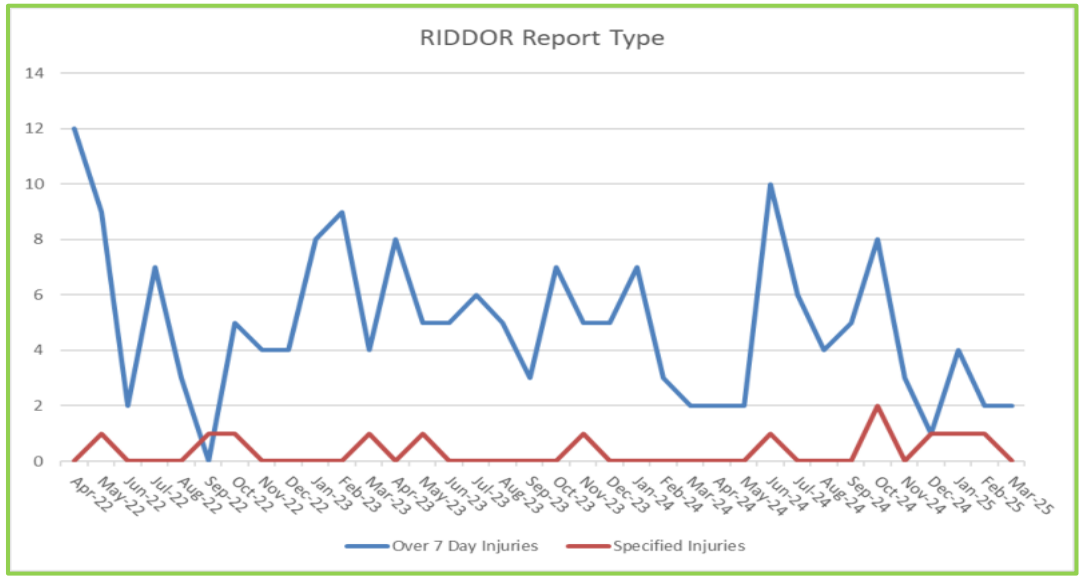
DATIX reported incidents have significantly decreased by 52% from April 2021 (284) - March 2024 (149).

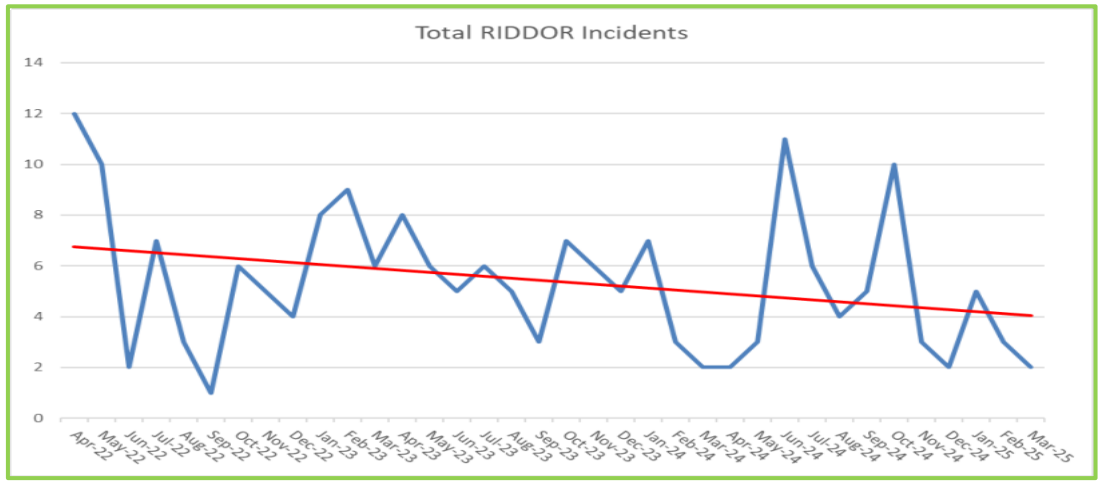
A significant number of incidents were recorded for missed meal breaks during the previous winter was not replicated during winter 23/24 and improvements in the way such incidents are recorded has further improved the ability of the Trust to analyse and trend harm incidents.

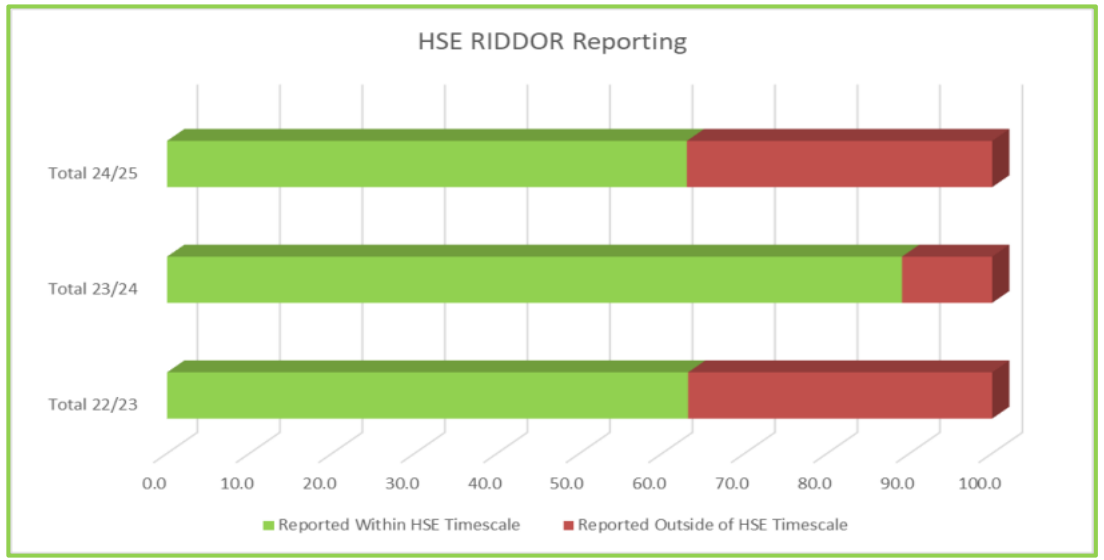
The incident frequency rate per 1000 Emergency Ambulance (EA) journeys has reduced b 61% from 16.79 in April 2022 to 10.37 by the end of March 2024

Keeping Our People Safe- RIDDOR

The total number of **RIDDOR** reported incidents have decreased by 64% from April 2021/22 (155) to March 2024/25 (56).





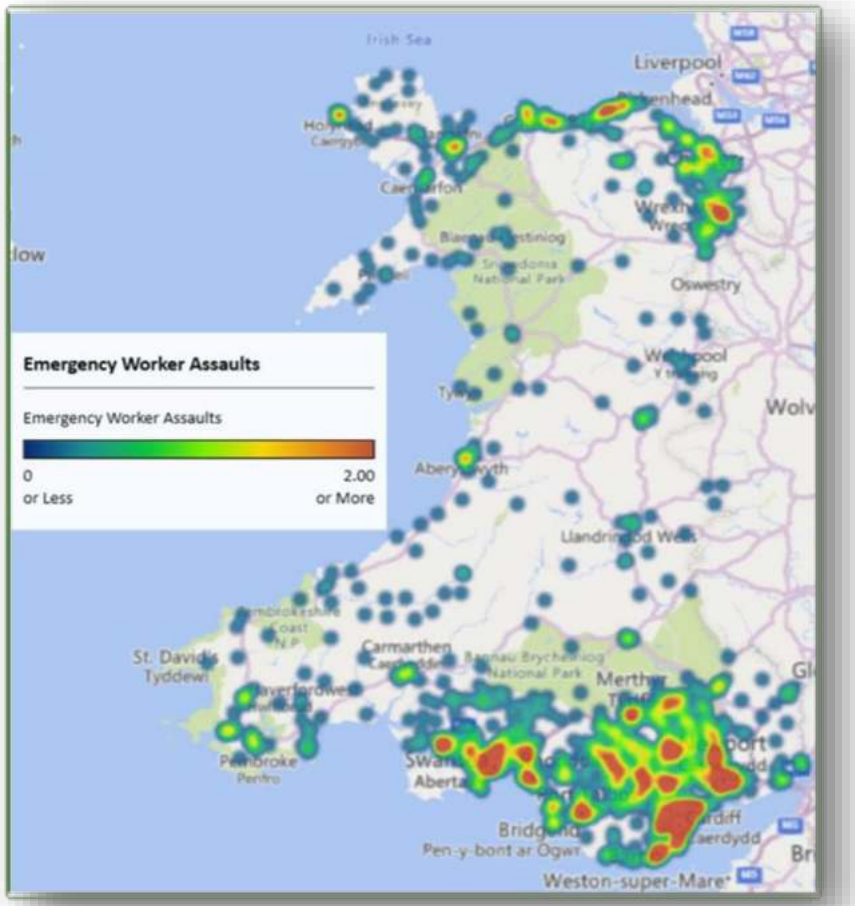


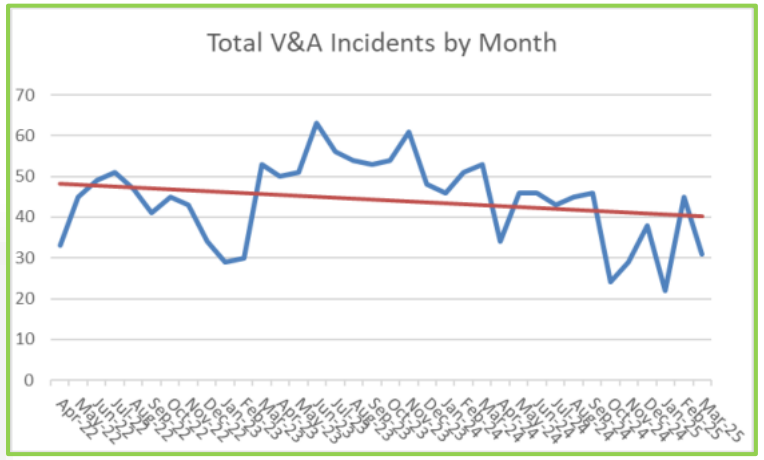
Categories for **RIDDOR** reportable incidents-

- Over 7-day injuries –reduction of by 66% from 2021-2025
- Specified Injuries - reduction of 50% from 2021 to 2025
- Most common trend manual handling injuries-patient handling and slip, trips and falls.

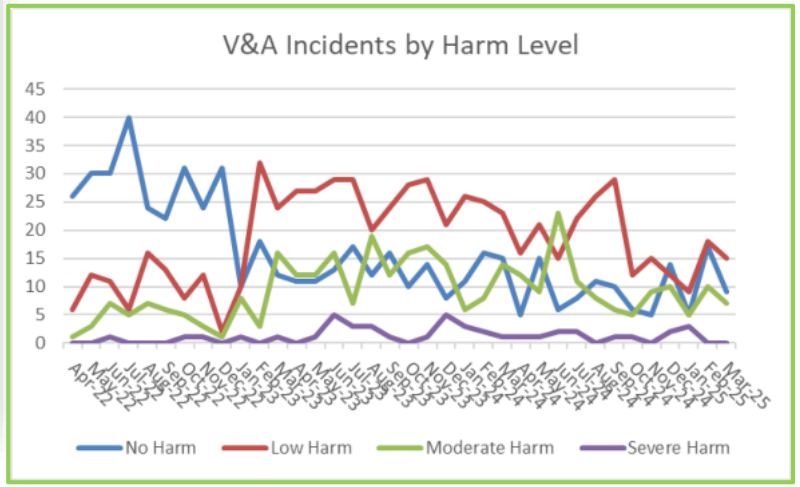
RIDDOR submissions have declined by 21% since 2021-2024. During 2024/25, compliance was impacted by the increase in information required by the HSE requiring additional time to obtain the information from line management.

Keeping Our People Safe - Violence and Aggression

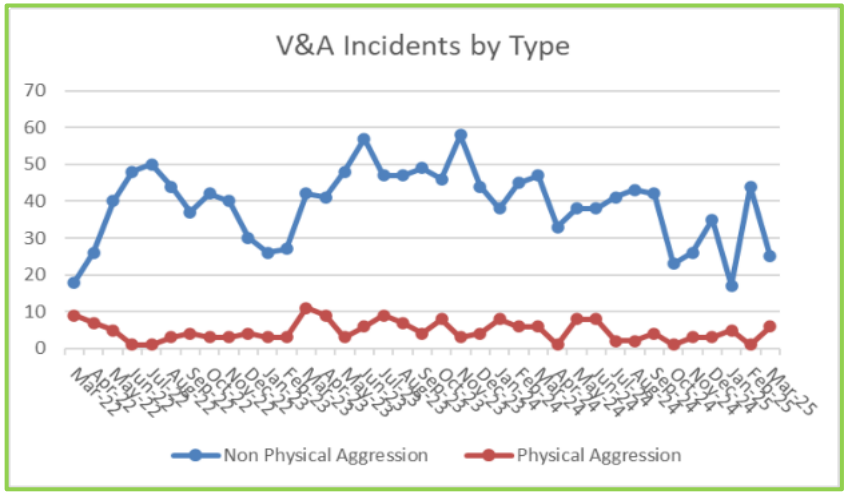




Statistics within WAST demonstrate majority of incidents are verbal abuse and aggressive behaviours mainly affecting the contact centres for 999 & 111



The trend over the last 3 years has shown a slight increase in V&A incidents. This trend has started to show a decrease as a result of the work undertaken by the V&A case management team together with other factors.



The number of moderate and severe harm V&A incidents remains low. The increase in low harm incident reports can be attributed to improvements in H&S reporting culture and the introduction of the Datix Cymru platform that enables better recording of V&A incidents.

Keeping our People Safe - Violence and Aggression

Following review of V&A 2023 Actions remaining resourcing V&A Function & Volunteers/Students systems / Communications. Risk 400 updated

V&A Manager continued to provide strategic input to NASeG, AVC and the AACE Training V&A improvement meetings.

Case with Police reference -77.
Cases in Court -19

The Trusts V&A Manager advises the Chair of the AVC and Case managers Group with the sharing of best practice promoting violence reduction strategies

WAST provides quarterly report to the AVC for review and reflection in collaboration with the Crown Prosecution Service, Police and Welsh Government.



19 Freedom of Information requests responded to in relation to behaviours of Violence, Aggression, Assaults & Sexual Safety

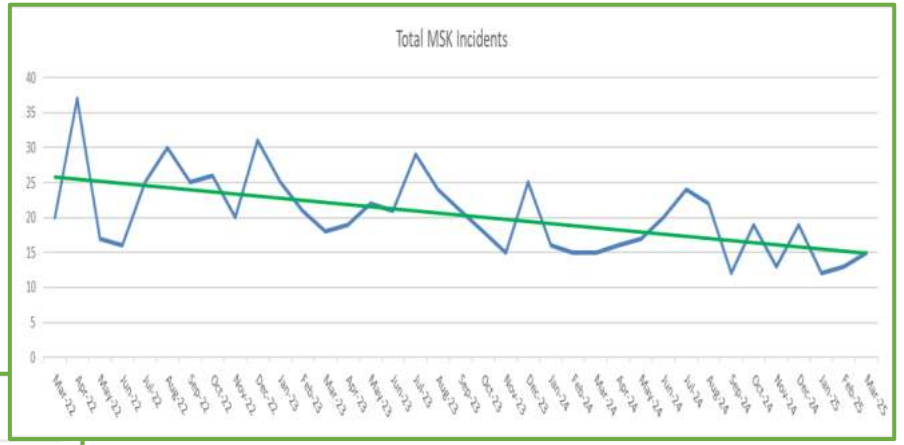
Guidance advice & data sharing with JESG partners by V&A Manager #With us not Against us campaign, to raise awareness of violence against emergency workers across Wales

Improved visibility within Trust Senior Management Team via SOT and Pan Wales Business Management to provide support and guidance to managers. Supported by online tools via intranet page

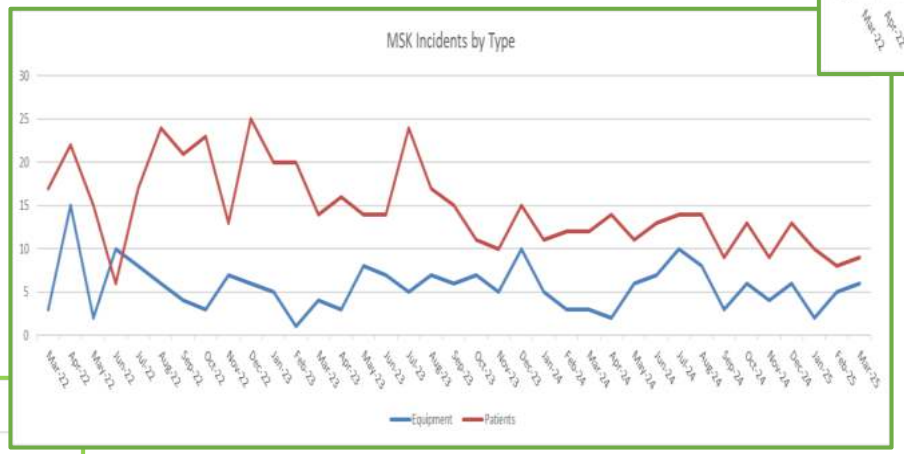
WAST CM attends The All-Wales Case Managers Group The group reports to the AVC and Heads of Health & Safety.

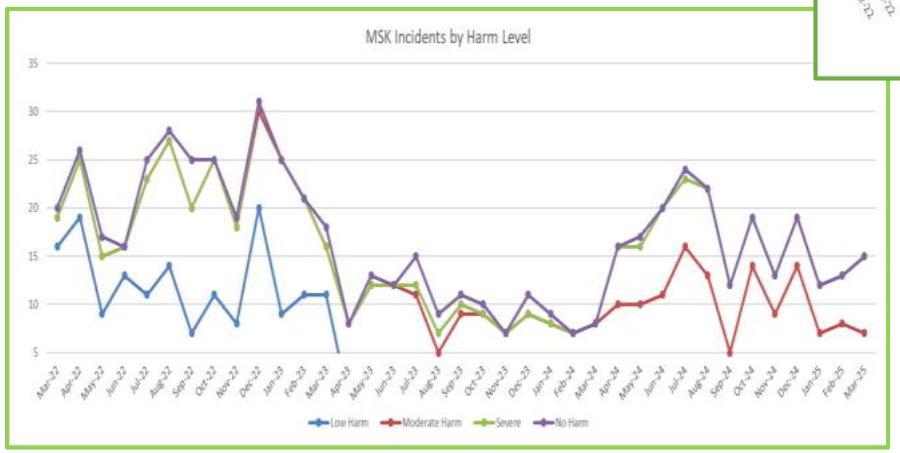
Keeping Our People Safe - DSE and Manual Handling

The downward trend in manual incidents has continued through the year with the incident frequency down from 2.86 to 1.25 per 1000 EA Journeys since April 2022.



Handling of patients remains the most frequently reported cause of injury.





The DSE/Manual Handling Advisor has undertaken a deep dive of incidents and made recommendations to lower incident numbers and harm levels even further. This being worked through via a task and finish group.

Keeping Our People Safe

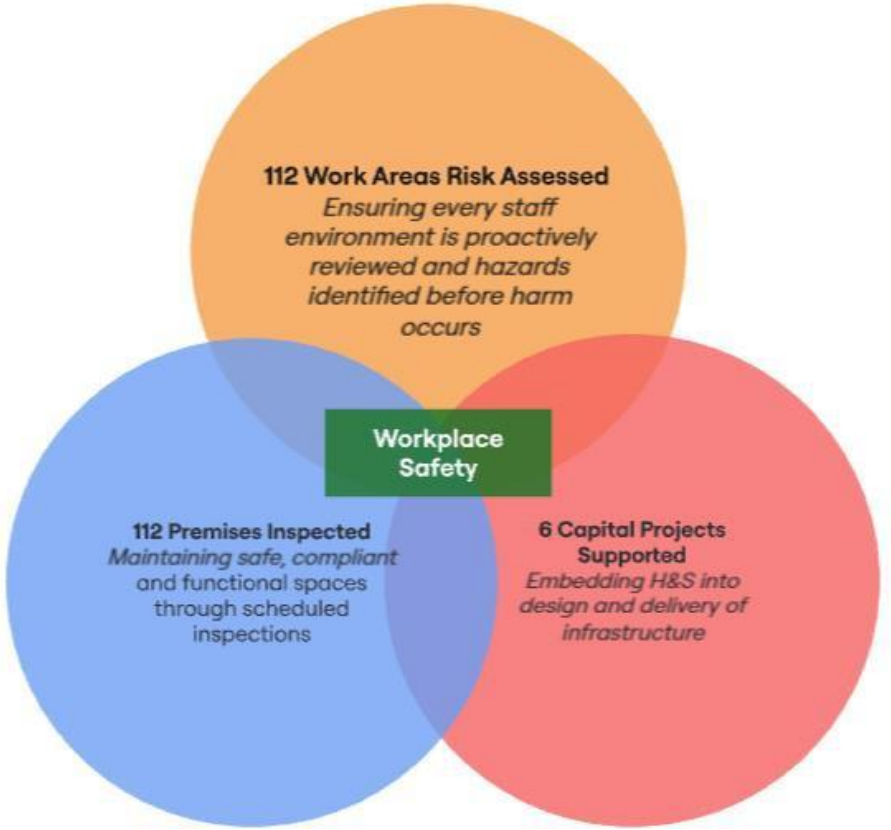
Workplace Risk Assessments - undertaken in all 112 premises in conjunction with Operational Teams and Trade Union Partners.

Workplace Inspections – all 112 inspections undertaken Pan Wales collaboratively with Operational Teams and Trade Union Partners. The inspection template also covers Estates related statutory legislation and integrates the requirements of the Equality Act 2010.

Noise Assessments have been undertaken in all 111 and Clinical Contact Centers Pan Wales and found to be below statutory legislative limits for long term exposure and short term 'peak' exposure levels.

First Aid Risk Assessments – all 112 RA undertaken





Capital Works Supported in Partnership;

Swansea Ambulance Project Group,
Pontadawe refurbishment
Glynneath refurbishment
Merthyr
Hawthorn Roof
Monmouth
Bryn Tyrion relocation
Ty- Elwy
Snowdon House 111

Workplace Risk Assessments

During recent visits to stations to review workplace risk assessments with Managers it was clear to see some of the hard work that has been carried out to make stations safer for staff.

One station that particularly impressed was Cwmbwrla, with lots of ongoing improvements taking place, not just in Health and safety.

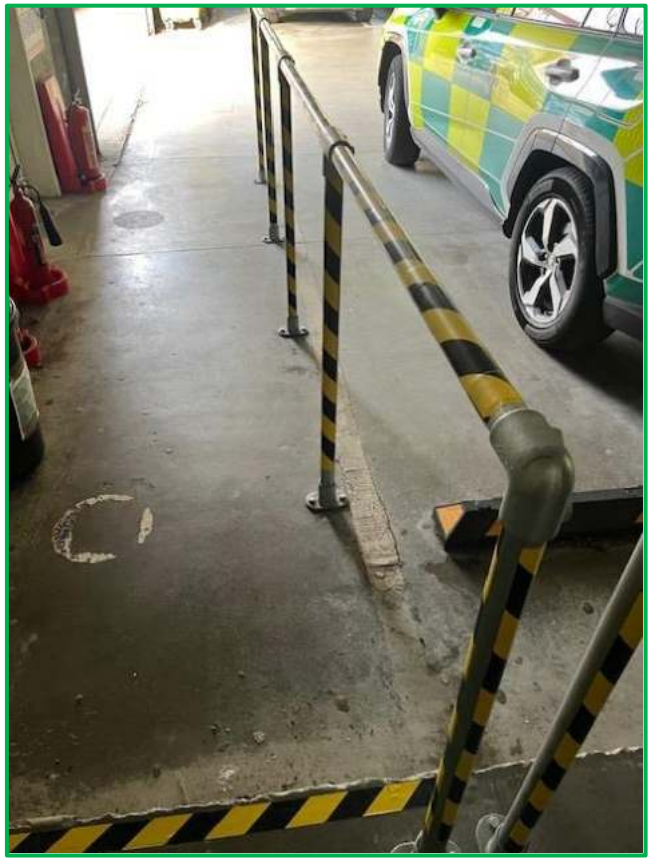
- Cleaning shadow boards have been implemented to assist with better IPC control.
- Vehicle bags have had itemisation labels applied to make it easier for staff to identify exactly what the bags should include, and tags applied so staff know when the bag has been opened and requires checking.
- Kerbs and handrails have been identified with black and yellow for ease of identification
- Equipment used for training has been clearly identified with red training tape to prevent it being accidently used elsewhere.

KEEP UP THE GREAT WORK!



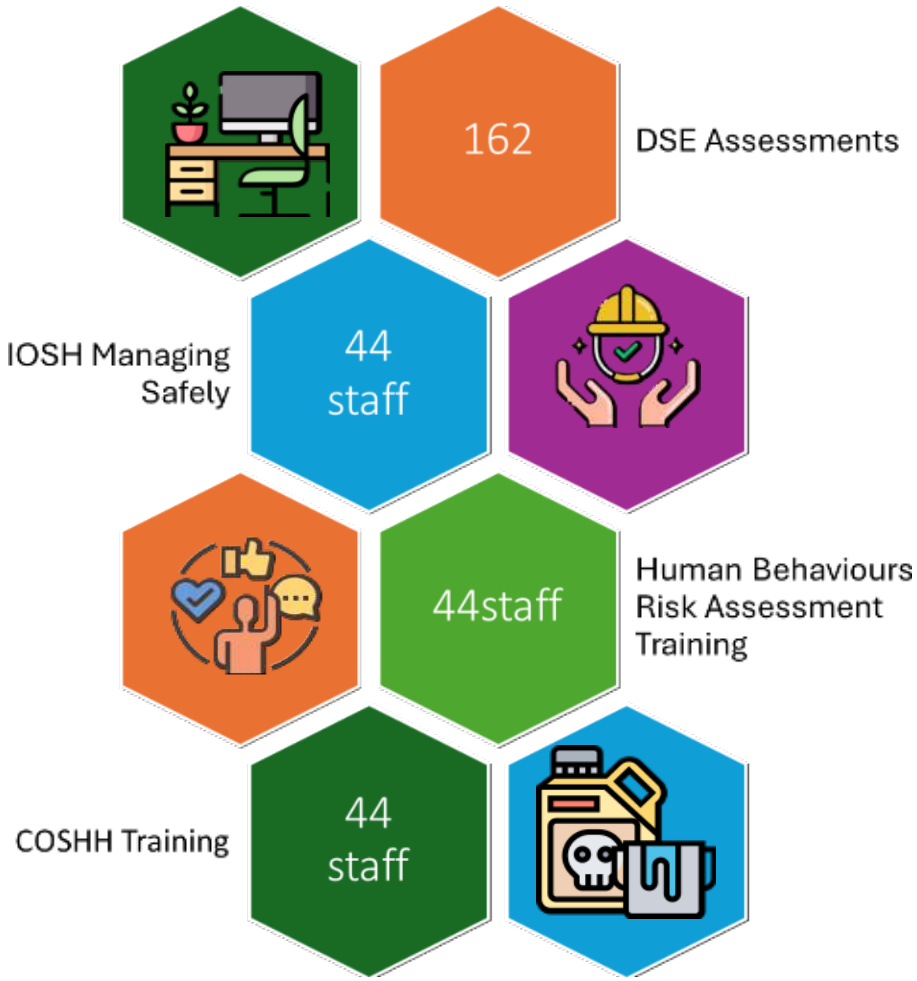






Keeping Our People Safe

Training Highlights (IOSH MS, Human Behaviours & COSHH)	
8	Trade Union Partners
11	DOMS
4	Locality Managers
4	Paramedics
2	Emergency Technicians
1	Ambulance Car Staff
4	OTL's
6	Corporate
2	HART
1	Fleet
1	NEPTS Control



Quality Improvement



Several pieces of work have been undertaken which support the Duty Of Quality;

Governance:

- Local Partnership Forum's -improved Governance routes for local H&S related items,
- Terms of Reference revised on Partnership arrangements for National HSW Committee
- V&A and Lone Working policies reviewed,
- Health & Safety Induction training reviewed to include culture and human factors elements,
- Responsibility for the management of non-patient safety personal injury claims
- Change Risk Assessment developed to be embedded into Trust processes,

Continuous improvements:

- Bladeless fan introduction at ED's to reduce fume and improve patient thermal comfort,
- Manual Handling Deep-Dive - thematic review undertaken and recommendations to be taken forward,
- Quarterly newsletter undertaken in Partnership and includes health related topics.

Continuous Professional Development:

- ISO 45001 Lead Auditor, IOSH Management of Noise in the Workplace, Public Health V&A Prevention L3, NVQ L6 Health & Safety Practice training undertaken by team members.
- Head of H&S achieved Chartered Fellow of IOSH status as recognized for 'giving back to the profession'
- Utilisation of staff on alternative duties to support Case Management and raise awareness,

Supporting NHS Wales:

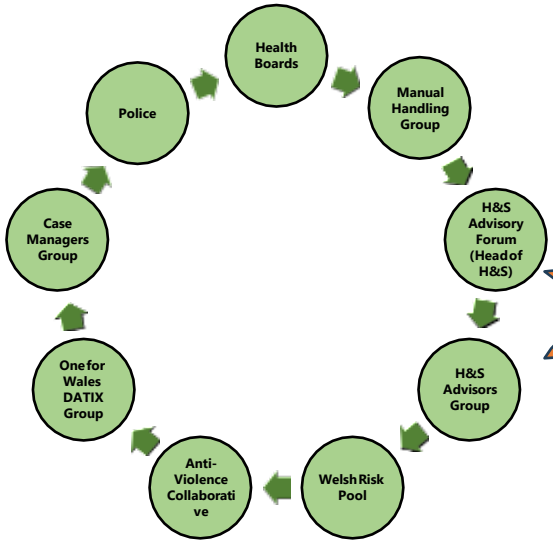
- Acted in the capacity of Chair for All Wales DATIX coding group,
- Continued to support Welsh Risk Pool (WRP) DATIX coding groups,
- Supported Complex Case Management process

Supporting UK Sector:

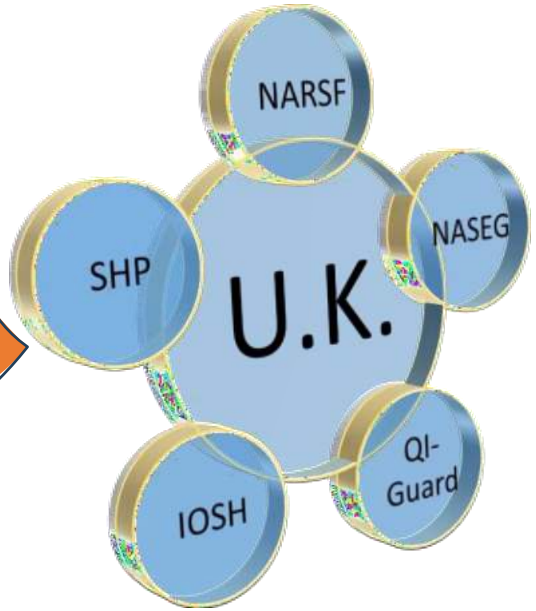
- Responding to incidents involving Electric Vehicle awareness session delivered to stakeholders and incorporated into national sector training package via NARSF and DTAG.

Working in Partnership Wales & U.K.

Wales NHS Stakeholders



UK Wide Partners





Raising The Ambulance Sector Profile -International

SHP (Safety & Health Practitioner) Podcast

Following the publication of the Trusts Working Safely Programme in IOSH January 2024 edition the Trusts CEO was invited to kick off a suite of CEO podcasts for the internationally renowned SHP magazine.
SHP is an online magazine and is an international source for health and safety news, opinions and stories with 175K professionals within its database. It provides breaking industry news, in-depth features, in-court stories, legislation updates, and the latest industry products.

The Trusts CEO provided a podcast in relation to his experience and perception of what an effective Health & Safety culture means to him and also the Trust. This was released on SHP media platforms during Q2 2024.

CEO Spotlight – From the front…–The Safety Conversation with SHP – Apple Podcasts



IOSH Videos

The Trust's CEO was also asked to provide a personnel video on the Trust's Working Safely Programme which was published on IOSH platforms on 24 December 2024.

IOSH membership consist of 50,000 members spread over 130 countries and is acknowledged as the world leading H&S accreditation body.

https://www.youtube.com/watch?v=-hjk1o42lUk

Institution of Occupational Safety and Health

Good Practice Support

Further support provided by the function

- Delivery of 2 x IOSH Leading Safely Training events in England to QiGARD members.
- Provision of advice on the management of DEEE to NARSF colleagues.
- In collaboration with LAS leading on H&S Culture Change framework under development sector wide initiative.
- Continued to support Welsh Risk Panel Personal Injury Claims review panels,
- Supporting improvements with the provision of advice and documentation to NARSF colleagues.

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

QIGARD
Quality Improvement, Governance and Risk Group

- Supported the IPC function in the development of Amber level PPE risk assessments for volunteer staff and bladeless fan risk assessments.
- Provided professional judgement on Neo-Mate SOP and risk assessment
- Undertaken lighting and noise surveys within control centers
- Pilot undertaken on use of vibrating tools at Fleet Workshops
- Continued provision of Mentor support to LAS H&S Manager



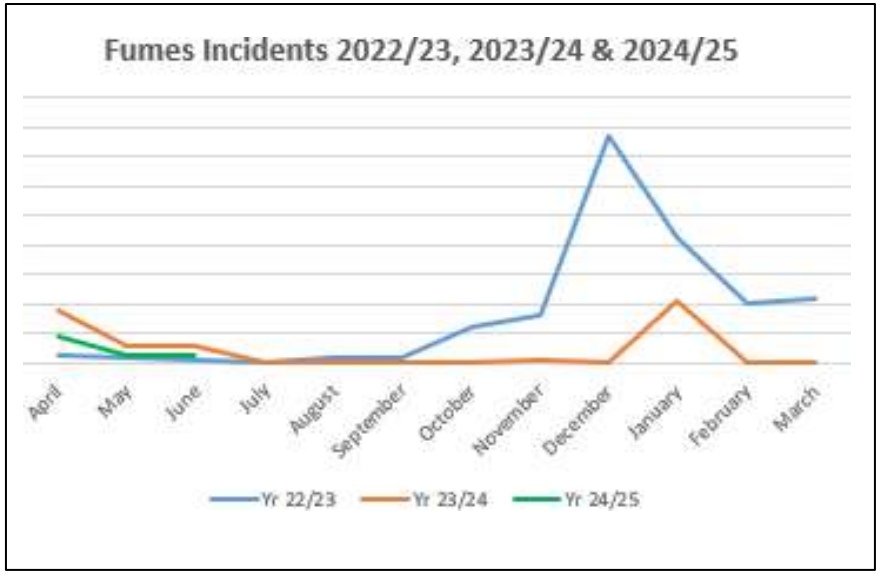
Challenges











Significant time and resources were expended on the introduction of controls to reduce the amount of Diesel Engine Exhaust Emissions emitted whilst ambulances experience extended delay times outside of Emergency Departments.

A Fume Mitigation project was established to manage the implementation of further work required to minimise DEEE at ED's. These included the following:

- Identification of a bladeless fan with filtration to BSEN
- Undertaking risk assessment for the IPC risk of introducing bladeless fans
- Undertaking risk assessment on the use of bladeless fans at ED's
- Meetings with All-Wales IPC Teams to clarify risk level for the introduction of bladeless fans
- Meetings with Health Board Ventilation Groups to grant permission for use of fans on HB site
- Survey of electrical infrastructure at ED sites to understand design constraints regarding installation of 230v shorelines
- Meeting with Health Board Electrical Safety Teams to agree 230v installation design
- Electrical contractor coordination for installation of 230v equipment
- Creation of secure storage for bladeless fans and asset tracking
- Creation of Safe Operating Procedure for the use of bladeless fans
- Quality assurance process implementation

Growing the Team

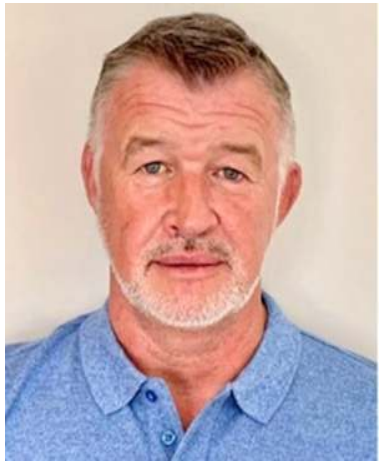
Jonathan Cushen (H&S Manager –North & Central)



This year marks nearly 10 years for me in the world of Health & Safety. I joined the NHS in 2020 as the Health & Safety Advisor at Prince Charles Hospital, before moving to the Welsh Ambulance Services NHS Trust in 2022 as the Health & Safety Manager for the North and Central regions.

Since joining WAST, I've continued to grow in the role, gaining wider exposure across different directorates and working with a brilliant mix of people - from paramedics and corporate staff to trade union partners. I feel lucky to be part of such a passionate, supportive team, and getting to travel through some of the most beautiful parts of Wales while doing it is a real bonus.

Phil Lloyd- V&A Manager



Previously I was the Security & Case Manager for Hywel Dda University Health Board. I was a member of the team that introduced the Obligatory Response to Violence in Healthcare in 2018. I joined WAST in 2022.
"I am passionate in delivering a safer place for all staff to work in and in doing so demonstrating the highest standards of care to both staff and the public we serve."
Prior to joining the NHS in 2016, I served as a Senior Investigating Officer in South Wales Police, Regionally and Nationally in Counter Terrorism Policing and Major Crime. A committed Detective throughout my career on retirement after 31 years' service I qualified as an Accredited Financial Investigator with the National Crime Agency and became a member of the Welsh Regional Asset Recovery Team.
I am an advocate of lifelong learning obtaining my NEBOSH General Certificate, and RSPH Level 3 Violence Aggression Strategic Management whilst supported by WAST. I have enrolled on the Level 7 master's course which focusses on trauma led clinical interventions to prevent and reduce incidents to staff.

Natasha McBeth- Interim V&A Case Manager



I joined WAST in December 2015 as the Receptionist, then appointed as the Mental Health Administrator in December 2018. In May 2020 I was aligned to the H&S team to help during Covid. I thrived here and really supported the H&S function during very difficult times. Most recently in June 2024 I secured a secondment as the Trusts Violence & Aggression Case Manager.

Since 2015 I have worked independently towards achieving work-based qualifications and gained NVQ L2, NVQ L3 and NVQ L4 in Business Administration, NVQ Level 3 in leadership & Management, IQT Bronze, Welsh Level 1 and is a qualified Agile Project Manager. More recently I completed IOSH Managing Safely, Public Health Level 3 in Violence Prevention Reduction and I am enrolled to undertake the NEBOSH General Qualification in Occupational H&S starting in May 2025 followed by Level 7 in Violence prevention Reduction starting in Sept 2025

Hollie Ryan – Business Support Officer



I joined WAST in September 2024, returning to work from Maternity Leave after having my first child. I have a BA Degree in Business Management, and my most recent post was as an Associate Project Manager in the pharmaceutical industry. I have a further background in administration and project coordination from the manufacturing sector.
I am thoroughly enjoying my time as part of the Health and Safety team and look forward to advancing my knowledge, starting with my current enrolment in the NEBOSH General Certificate of Occupational Health and Safety course. I aim to continue to furthering
my education in Health and Safety with various courses and training opportunities, whilst also learning each day from my colleagues within the team.

Conclusion



Paper compliance is reassuring and sustained; however, continuous improvement is required to address ensure safe behaviours are always demonstrated.

This is partially being addressed via Human factors awareness delivered to Senior Management Team and integrated within RA and thematic reviews and additionally via the Quality and Safety inspections undertaken by operations function.

Continued sustained focus on DEEE has impacted on H&S Function capacity to progress the Trusts IMTP 'H&S Culture Change' objective.

Operational teams continue to take increased ownership and accountability for health and safety within their respective portfolios.

The Trusts H&S profile has continued to be publicised on national and international levels raising awareness on the importance of staff safety within the profession.

V&A – the Case Management profile is being further professionalised by increasing their knowledge and competence via H&S and specific V&A related qualifications. Level 7 Violence Prevention and Reduction Masters) to commence Sept 2025. Centred on recognised trauma/clinical informed responses

Moving Forward (IMTP)

- Development of a H&S strategy incorporating H&S culture change.
- Continue to improve V&A via the further professionalisation of the Case Management role
- Continue to improve Manual Handling processes for reduction in severity and reported incidents
- Continuation of succession planning and resilience

Thank you for listening

For any questions and/or support, please contact Nicola White.

Nicola.white3@wales.nhs.uk

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

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 May 2025
Committee Meeting Date	15 May 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 Chair provided an update on the process being adopted for the **recruitment of the Chief Executive Officer**. Gatenby Sanderson will be leading the recruitment, and it is anticipated the advert will go live the week commencing 19 May and closing 13 June. Selection and interview panels are being formed with further details to be provided as they are finalised.

3. The Chair's Action taken to approve the committee's **annual report and terms of reference** was ratified.

ASSURE
(Areas of assurance the Committee has received)

4. No items of assurance were tabled for this meeting.

RISKS

Risks Discussed: N/A

AGENDA	

COMMITTEE ATTENDANCE				
Name	**15 May 2025[1]**			
Colin Dennis				
Rhiannon Beaumont Wood				
Peter Curran				
Bethan Evans				
Prof. Hayley Hutchings				
Ceri Jackson				
Hannah Rowan				
Jayne Beeslee				
Jason Killens				
Carl Kneeshaw				
Trish Mills				
Hugh Parry				
Damon Turner				

	Attended
	Sent Deputy
	Apologies
	No longer a member.

[1] Extraordinary meeting

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 May 2025
Committee Meeting Date	20 May 2025
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No alerts arose from this meeting for particular escalation to the board.

2. Whilst not an alert for escalation, the **Energy Management Internal Audit** was presented which received substantial assurance and included three medium rated recommendations. The Trust maintains an ISO accreditation in this area, which likely contributed to the positive audit outcome. The report highlighted that energy management involves a national contract for energy, meaning the Trust does not contract directly with energy suppliers which adds a layer of complexity to implementing some recommendations.

ADVISE

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

3. The **Information Risk Policy** was approved.

4. The **Operations Update for Q4 2024/25** was received, with the following of note for the board:

   - The training for drone operations has been completed successfully, with all staff passing the training, and now awaiting the first use of drones in an operational context for which we remain alert. The drones are expected to enhance situational awareness, improve patient safety, and provide operational benefits. Initial feedback from staff trained is positive.
   - SORT (Special Operations Response Team) growth is progressing with ongoing recruitment and discussions with WG about capital for vehicle purchases being carried over from 24/25 to 25/26.
   - With respect to the Manchester Arena Inquiry (MAI), four scrutiny sessions with Commissioners have been concluded, with positive feedback from the WAST team. We now await the Commissioners' output, and we are informed to expect that around August. Four recommendations have slipped from last year but are expected to be completed in a couple of

months and will be monitored through incorporation in our risk management approach.

- Eligible patient journey cancellations due to capacity constraints reached 900 in March. Discussions and an options appraisal are ongoing to address this issue however increasing complexity requiring more stretcher transport and changing service design increasing average travel distances are contributory factors.
- A new two-way SMS system has been developed to reduce short notice cancellations and improve patient experience by confirming transport needs in advance.
- Quality and support days continue to be implemented to provide additional support to staff, with positive feedback noting this will feature as a staff story at a future People and Culture Committee meeting.
- The pressures regarding investigations were noted, including this received consideration at the Quality Committee meeting.

5. A **report on commissioning** was originally scheduled for presentation at this meeting. However, as the paper was submitted later than planned, it will now be circulated to members and brought to the July meeting to ensure it receives appropriate consideration.

6. Members **reflected** that the meeting was chaired well, that papers were clear, and that whilst the discussion on priorities was difficult, it was navigated well. Positive feedback was expressed on the use of the Ibabs reading room which allowed focus on more concise reports during the meeting. It is seen as a useful tool to streamline the meeting process and reduce the volume of detailed documents in the main agenda.

ASSURE

(Detail here assurance items the Committee receives)

The following items will also be presented to board at their 29 May meeting however members may benefit from the following points of discussion from the committee:

7. With respect to the **financial position for month 12 2024/25**, the Trust is reporting a small revenue surplus £70K for month 12 and year end, subject to audit. In line with the financial plans that support the IMTP, gross savings of £6.838m have been achieved in month 12 against a target of £6.421m. The financial risks for 2024/25 have been managed effectively, with one financial risk escalated to Welsh Government in relation to the re-banding of the EMT 2/3 posts. Discussions continue with commissioners on this issue.

8. A stable **month 1 2025/26** position was reported with a cumulative year to date position reporting a small underspend of £4k with the savings plan overachieving by £50k of which an element of this is recurrent. Significant risks are highlighted early in the year relating to funding streams and the savings target which has increased to £8.5m for 2025/26. Capital plan for 2025/26 is planned at c£32.2m of which c£26.2m is related to All Wales Capital programme schemes and the residual balance of c£6m for discretionary programmes. There is likely to be an increasing pressure on spend and unavoidable costs throughout the year with an emphasis on profiling, spend against budget and savings delivery. Members noted the challenges relating to digital savings targets given inflationary rates in technology pricing.

9. The board will receive the **Monthly Integrated Quality and Performance Report** (MIQPR) for March/April 2025 at its May meeting and the output and plan of action following the board development session on the MIQPR in April, however of note:

    - The average jobs per shift is shown at 2.64 (amber rating). Members questioned if this should be red due to its impact on staff morale, productivity, and patient care. The low figure is mainly due to persistent handover delays - 21,183 lost hours in April. A separate productivity report is being considered to explore this further
    - Members asked if more board-level involvement with Health Boards is needed with respect to their plans to address handover delays. A Ministerial Taskforce, including Jason Killens for WAST, is addressing the 45-minute handover and 4-hour ED targets. Formal engagement awaits the recommendations of the taskforce though testing informally appetite at one health board to operationalise an approach is underway. Updates will be included in the patient harm report and of note were the ongoing efforts to ease burdens and improve flow into emergency departments through the Clinical Model Transformation (CMT) program.

10. The board will receive the **Integrated Medium Term Plan (IMTP) Delivery and Assurance Report (end of year report)** at its May meeting, however of note:

    - The recent initial recruitment for Head of Commercial was unsuccessful. The job description is being revised to better align with market expectations, with plans to use internal networks and LinkedIn. The role is key to driving efficiencies and commercial opportunities.
    - The CMT programme is rated amber due to documentation and workload pressures. The Chair and the Executive Director of Strategy, Planning and Performance will discuss whether reporting on the programme could make use of a more focused highlight report for more focused oversight and alignment with strategic goals.

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

11. 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:

    - The team is working with a supplier on an enhanced Interactive Voice Response (IVR) system for 111 and NEPTS. The new IVR will be able to take basic demographic details from the patient, such as name and date of birth, which will save each call taker approximately 15 seconds. This timesaving, when rolled up across the volume of calls in Wales, is significant.
    - Recruitment into the new digital posts following additional investment during 2024/25 is progressing well.
    - A Copilot artificial intelligence (AI) pilot is running for approximately 150 participants. An engagement session has been conducted called "promptathons" to help users improve their prompting with AI. The feedback has been positive. Linked to this, an AI policy is being developed in response to the increasing prevalence of AI and the need for a structured approach.
    - The Trust is planning to relax the restrictions on the copy and paste function across devices in a safe and controlled manner commencing with the ePCR tool which will be particularly helpful for neurodiverse users.

- The Microsoft Hello project, which involves introducing facial recognition software on laptops, is progressing.
- Early infrastructure and architecture work has commenced for the Computer Aided Dispatch (CAD) replacement, which is a significant upcoming project.

12. The **Information Governance (IG) Report** highlighted ongoing efforts to enhance information governance and data protection within the Trust, addressing both compliance requirements and operational challenges. Of note for the board:

    - Despite recent improvements in reducing the backlog of Data Protection Impact Assessments two recent instances of non-compliance occurred where processes launched without IG and cyber assurance. The IG team is actively working with process owners to mitigate risks and reinforce the need for assurance prior to go-live to prevent recurrence.
    - Freedom of information compliance rates dropped from 84% in January to 27% in February due to fluctuating request volume and complexity. The team is working to define "complex" requests and apply exemptions where appropriate.
    - The Trust met all actions in its 2024/25 IG Toolkit Improvement Plan and submitted on 31/03/25, achieving or exceeding 'Minimum Expectations' in all areas except 'Training & Awareness'. IG training compliance stands at 78.98%, below the 85% target for the IG toolkit, though it's the highest rate achieved in WAST. Improvement efforts include LMS365 integration, targeted sessions, manager reminders, and digital access for staff on the move.

13. Members received the **Environment, Decarbonisation and Sustainability update** including reporting against the Trust's Decarbonisation Action Plan highlighting that while significant progress has been made there are still challenges related to funding, technological advances and national infrastructure particularly national support for rapid charging for vehicles. The Environment Strategy will be refreshed being realistic, pragmatic, and ambitious in setting future goals, considering external factors and commercial challenge. See further below regarding the decarbonisation risk next steps.

14. The **Q4 audit tracker** was produced with no escalations reported for either internal or external audit management actions. There was excellent closure of audit recommendations in quarter of 95%, including those escalated last quarter that had been on their third revised date. The committee agreed last year to focus each report on the data quality internal audit following escalations to the board in November and whilst dates on some management actions have moved, the committee were assured that these related to focus on the new clinical model and recent recruitment into the digital team.

15. The outputs of the **Committee's annual effectiveness review for 2024/25** were discussed and the terms of reference and annual report that were approved by Chair's Action were ratified. The committee's priorities for 2025/26 are a focus on financial sustainability, CMT performance, and resilience including information security and progress on any MAI recommendations. The committee's terms of reference has a focus on the strategic forward look which will be supported by developing reporting on 'what good looks like' metrics for the long term strategic objectives.

16. In **closed session** members received the update on the cyber KPIs, cyber audit actions and the cyber risk. There were no escalations to the board with respect to those items. The closed session also

considered the outline business case for the Emergency Services Network which was endorsed for approval by the board. They also discussed and endorsed the 2025/26 capital plan for approval by the board. All items taken in closed session were done on the basis of commercial or security sensitivity and will be reported to the open session of the board in due course.

RISKS

The committee received the **Risk and Board Assurance Framework report** noting that whilst this data was presented to the Trust Board in March 2025, the activity during this period is due to be considered by the Executive Leadership Team on 21 May 2025. All risks have undergone their quarterly review, with no changes in scores. It was emphasised that the highest rated risks are considered when setting the agenda ensuring that these are integrated into the papers and discussions throughout the meeting.

Risk 542 Decarbonisation noting that this is a complex and multifaceted risk and challenging to mitigate given its nature and external dependencies; however, there is an aspiration to reduce this from a score of 16 to 8. It was agreed that a deep dive will be undertaken in conjunction with a review of the risks that sit underneath it at the programme board level. A detailed update will be presented at the next meeting. This will include a detailed review of controls, mitigations impacting the risk score.

COMMITTEE AGENDA FOR MEETING		
Financial position month 12 2024/2 Financial position month 1 2025/26	IMTP Delivery/Assurance update End of year report	MIQPR Annual review of metrics
Information governance report and update on IG toolkit	Digital reporting	Environment, decarbonisation and sustainability update
Internal audit on energy management	Report on commissioning	Risk management and BAF
Audit tracker	Information risk policy	Feedback from effectiveness review

COMMITTEE ATTENDANCE						
Name	**20 May 2025**	**22 Jul 2025**	**16 Sep 2025**	**18 Nov 2025**	**20 Jan 2026**	**17 Mar 2026**
Jayne Beeslee (Chair)						
Bethan Evans						
Peter Curran						
Chris Turley						
Rachel Marsh	Hugh Bennett					
Lee Brooks						
Liam Williams	Wendy Herbert					
Carl Kneeshaw						
Jonny Sammut						
Trish Mills						
Hugh Parry						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

WELSH AMBULANCE SERVICES NHS TRUST

MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 4 FEBRUARY 2025 VIA TEAMS

Meeting started at 09:30

PRESENT:

Bethan Evans	Non-Executive Director
Ceri Jackson	Non-Executive Director and Vice Chair of the Board
Rhiannon Beaumont-Wood	Non-Executive Director

IN ATTENDANCE:

Claire Appleton	Assistant Director of Putting Things Right (Left after item 12/25)
Kate Blackmore	Assistant Director of Quality Governance (Left after Item 12/25)
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations (Left after item 12/25)
Jonathan Chippendale	Consultant Paramedic
Kathryn Cobley	Head of Inclusion and Engagement (Item 4/25 only)
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Leanne Hawker	Head of Patient Experience & Community Involvement (Left after Item 9/25 and rejoined at 16/25)
Wendy Herbert	Deputy Director of Quality and Nursing
Fflur Jones	Performance Auditor, Audit Wales (joined at item 5/25, left after 12/25)
Geraint Jones	Healthcare Inspectorate Wales (Left during item 13/25)
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit, NWSSP (Left after Item 12/25)
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Left after item 12/25)
Trish Mills	Director of Corporate Governance/ Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner (Left during item 8/25)
Alex Payne	Corporate Governance Manager
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine (Left after Item 12/25)
Liam Williams	Executive Director of Quality and Nursing

OBSERVERS:

Maxine Evans	Joint Commissioning Committee (JCC) - Risk Manager (Left after item 12/25)
Emma Gracia-Young	Investigating Supervising Officer (Left after Item 12/25)
Michelle Kennedy	Deputy Director of Remote Clinical Care
Jacqueline Maunder	JCC - Committee Secretary & Associate Director of Corporate Services (Left after Item 12/25)
Charlotte Walker	Older People Improvement Lead (Left after Item 12/25)

APOLOGIES:

Henry Garrard	Trade Union Partner
Angela Mutlow	Director of Operations Llais

01/25 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Henry Garrard and Angela Mutlow.

Declarations of Interest
There were no further declarations of interest to those already listed in the Register.

Minutes
The Minutes of the meeting held on 5 November 2024 were confirmed as a correct record.

Chair's Action
Approval of the High Intensity User Policy; The request was for the approval of the updated High Intensity User Policy v1.13. This request was made in the interests of time and with a desire to seek approval for implementation as soon as possible (prior to the next meeting of the Committee in early February 2025). The Committee were asked to ratify the Chair's action.

Action Log
The action log was considered:

Action 51/24: *Impact of Changes to Stroke Categorisation: The Committee noted that updates on the location of stroke units will be provided in due course. Although the timeline was uncertain, Andy Swinburn agreed to keep the Committee updated*. It was suggested that this action was closed and an update brought back at a future date. It was clear that no progress has been made, and a definitive decision was unlikely to be provided imminently. It was agreed that this action was closed.

Action 68/24: Putting Things Right Report Quarter 2, July - September 2024. *The Committee asked that relevant colleagues consider the structure of the Putting Things Right Report and what the Committee needs to focus on. This should be considered for the next report.* Liam Wiliams advised that the report had been updated, and it was agreed that the action was closed.

Committee AAA report dated 5 November 2024

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Committee's last meeting on 5 November 2024.

RESOLVED: That

(1) Apologies were recorded for Henry Garrard and Angela Mutlow.
(2) The Minutes of the Open meeting held on 5 November 2024 were confirmed as a correct record.
(3) The Committee ratified the decision made by Chair's Action to approve the High Intensity User Policy. The item of business was issued via email on 12 December 2024 and approved as requested. The confirmation of the decision was confirmed via email on 18 December 2024.
(4) Consideration was given to the Action Log and the AAA report as described above.

02/25 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2024/25 Q3

Lee Brooks presented the report and drew the Committee's attention to the following:

1. Manchester Arena Inquiry and Grenfell Fire Inquiry: There was good progress on these inquiries and expressed optimism about starting the scrutiny process with commissioners soon.

2. Powys Major Incident and December Critical Incident: The Committee were updated on the Powys major incident and the December critical incident, highlighting the challenges faced, including high call volumes and extended handover delays at Emergency Departments (ED). He mentioned that debriefs for these incidents were either completed or will follow.

3. Critical Incident Response: Details were provided on the response to the critical incident, including command arrangements and proactive media engagement, which helped manage the situation. He noted that the critical incident debrief will follow as normal.

   Mental Health Response Vehicle (MHRV): There were some good initial results from the MHRV which was introduced in November, noting there were encouraging outcomes.

4. Clinical Model Transformation: Lee Brooks highlighted the role of integrated care, particularly the care planning desk and the CPSS winter desk, in managing patient care and reducing the need for ED visits.

5. Welsh Call Answer Rate: The Welsh call answer rate in 111 services has improved, emphasising the team's efforts to improve overall performance.

Red Breathing Problem: There had been an increase in red breathing problems, particularly in the 06 and E01 determinant codes. Further analysis was undertaken which revealed more red activity originating from 111 calls compared to 999 calls. This was unusual and prompted further investigation. Lee Brooks explained that the team implemented a clinical validation to ensure it was appropriate to pass the call to 999 for an emergency response. This process led to a reduction in red activity moving from 111 to 999 for breathing problems in the 0-4 age group, indicating that these calls could be effectively managed within the 111 service. He highlighted the need to review the trigger words used in the call handling systems and the hand-off mechanism from a 111 call handler to a 999 call handler to address potential over-triaging

Rhiannon Beaumont-Wood acknowledged the importance of continuing with the clinical validation role or a similar model, particularly for paediatric cases, as children can become very sick quickly. She emphasised the need to keep a close eye on these cases to ensure safety. Lee Brooks confirmed that the clinical validation process was being assessed, with a paper expected soon to discuss the synergies between the call handling systems used in 111 and 999 process.

Liam Williams highlighted that the Trust has updated the call handling system to increase the number of questions that would require a higher priority response, particularly for sepsis. These changes were validated through external peer review and an international review. Liam asked the Committee to note the addition of a children's Nurse and a Physiotherapist as Advanced Clinical Practitioners (ACPs) to strengthen specialist knowledge within the Trust. He also mentioned the involvement of a Specialist Registrar (SPR) from Public Health Wales (PHW) to improve understanding and data flow between community-acquired infections and urgent emergency demand.

Rhiannon Beaumont-Wood inquired about the additional impact or collaboration from partners when the major incident was declared, asking if it was effective in terms of getting other stakeholders on board to help manage the challenging situation. Lee Brooks explained there will be a debrief process, which was not yet complete, and part of that will consider the impact of the collaboration.

Ceri Jackson asked for an update on the Cymru High Acuity Response Unit (CHARU) rollout, emphasising its importance for managing the most serious calls. Lee Brooks explained that it was moving in a positive direction with the Unit Hours Production (UHP) on CHARU, especially with hitting 90% on a weekly basis.

RESOLVED: That the report was received.

03/25 COMMITTEE EFFECTIVENESS REVIEW

Trish Mills provided a slide show on the Committee Effectiveness Review and drew attention to the following area of consideration within a committee effectiveness review.

- Broadly the idea of the Committee Effectiveness review was to consider the purpose and delegated remit of the Committee, the reporting and assurance and the use of Mentimeter for colleagues to provide ideas and comments.

- Aligning our Purpose: The aim was to ensure that Quest's responsibilities and activities were closely aligned with Health and Care Quality Standards, as well as long-term objectives for delivering excellence. This was a crucial step in maintaining a high level of quality, patient experience, effectiveness, and safety.

- Committee Delegated Remit and Reporting: This considered how to enhance the oversight of strategic direction and delivery within committees, especially given the long-term nature of strategic plans. These could be annual or biannual updates that provide a snapshot of how the plans were progressing. This ensured continuous monitoring without waiting for the full plan to be completed.

- Develop a system where strategic updates were integrated into regular committee reports. This could involve a brief section in each report dedicated to strategic progress, ensuring it remained a consistent part of the discussion.

Trish Mills added that each meeting could have a thematic focus on different aspects of the strategic plan which can assist in the flow. Going forward, workshops or sessions dedicated to envisioning what success looks like in 2028 would help clarify long-term objectives and ensure everyone was aligned on what "good" looks like.

It was suggested that the Quality and Performance Management Framework (QPMF) might better sit with this Committee rather than the Finance and Performance Committee. However, that framework is focused on floor to board quality and performance and is suited to the remit of the latter committee. Issues related to quality that arise could be referred to this committee.

Members noted the need for more frequent reporting on mental health legislation and infection prevention and control (IPC). Liam Williams explained that bringing together segmented services like Mental Health Response Vehicle (MHRV) and remote care into a cohesive mental health service could enhance coordination and response.

The Committee considered adding specific references to evidence-based practice in the Terms of Reference (ToR). The importance of robust data-driven decision-making was also emphasised by Rhiannon Beaumont-Wood.

Liam Williams highlighted the challenge of balancing high aspirations with the reality of external influences that impact the ability to deliver the desired quality of care, and how that can be reflected in the ToRs.

There was a discussion on whether to rename the Citizen Voice and Patient Experience section of the terms of reference to "Person-Centred Care" to better reflect a holistic approach, which was agreed. The need to include population health understanding and continuous engagement in service design in reporting was also highlighted.

Rachel Marsh highlighted the importance of leveraging public engagement to inform and improve the Trust's core service model. This was a crucial aspect of ensuring that services were designed to meet the needs of the community effectively.

Governance:

A comprehensive plan was in place for focusing on the Strategic Board Assurance Framework (BAF) in 2025/26, with a clear link to strategic direction and risk management. There was a robust structure in place for the reporting of the Monthly Integrated Quality Performance report (MIQPR) and Putting Things Right (PTR) Reports. Referencing the Duty of Candour report within the PTR report enabled the reporting process to be more streamlined. There was regular reviewing and refining of the reporting processes, which will help ensure they remained effective and aligned with the strategic goals.

Mentimeter Engagement: The Committee used Mentimeter to gather feedback on the effectiveness review, with participants contributing their thoughts on various aspects of the Committee's work. Trish Mills thanked everyone for their engagement and for their comments, noting that their comments will be circulated in due course. It was also noted that the changes to the ToR and Annual Report will also be circulated through a Chair's' Action as the committee would not have an opportunity to meet again before the Audit, Risk and Assurance Committee on 1 May where these documents would be presented.

RESOLVED:

1. **Members reviewed the committee's terms of reference and changes as agreed will be circulated for email approval by Chair's Action. The re-ordering of the terms of reference to align to the Health and Care Quality Standards was agreed for 2025/26.**
2. **Members reviewed the cycle of business and agreed to changes as agreed and this will be circulated for approval by Chair's Action**
3. **The Committee reviewed the draft Annual Report ahead of it being finalised and circulated for email approval by Chair's Action.**

04/25 PATIENT STORY

Liam Williams advised that the Putting Things Right (PTR) Team has recently recorded video about a Deaf patient/complainant, Gemma Hearn and the PTR staff who have been assisting her. They all expressed the challenges in responding to a Deaf complainant.

The patient story highlighted the challenges faced by Gemma, a profoundly deaf British Sign Language (BSL) user, in accessing healthcare services. Gemma experienced significant communication barriers, leading to distressing and embarrassing situations.

Several key issues were identified: Miscommunication due to language barriers, as BSL has its own grammar and structure different from English, limited access to suitable sign language interpreters, especially in urgent or emergency situations. The story has shown that the need for increased education and awareness among healthcare staff regarding the deaf community's needs.

Leanne Hawker emphasised the importance of recognising that not all deaf people have learned to read or write in English, and that communication technologies should have a strong visual emphasis. It was recognised that there was a need to adjust questions in 111 and 999 services to accommodate the deaf community's needs. There was potential for staff training in BSL to improve communication with deaf patients.

Wendy Herbert asked whether the Trust has made progress in addressing the issues faced by deaf users, as this was not the first time such a story has been raised.

Jonny Sammut highlighted the need for patient voice in co-designing future technologies and mentioned ongoing work with Microsoft on translation software that includes BSL components. He asked for collaboration to improve this area.

Ceri Jackson asked about the legal context and the accessible healthcare standards, emphasising the importance of continuous effort in improving services for the deaf community. Ceri Jackson also inquired about collaboration with charity partners to maximise opportunities for improving services for deaf users.

Bethan Evans inquired what the Trust needed to put in place for staff to be able to engage with patients, regardless of their personal circumstances.

Emma Gracia-Young explained that she was the first point of contact for Gemma, and it was a powerful story. The main challenge was securing a BSL interpreter, which took months due to availability issues. She added there was excellent work happening within the Trust, in the 111, and 999 services, but it was not always visible. She expressed there was a need for more BSL-trained staff or accessible interpreters. The meeting she had with Gemma and the team was very moving and highlighted the importance of continued efforts to improve services for the deaf community.

Kathryn Cobley acknowledged that the Trust was not in a better place regarding services for deaf users, despite efforts. She highlighted there were significant political and systemic challenges that need to be addressed. She emphasised the need for a robust review of all current systems and procedures related to booking interpreters and providing accessible communication. She raised concerns about capacity issues within the Trust, including the need for a working group, training, and time for staff to attend training. She emphasised the importance of addressing these capacity challenges to improve services for deaf users.

The Chair asked that the People and Culture Committee (PCC) monitor the progress of the wider accessibility initiative, focusing on supporting deaf individuals and others facing barriers to accessing services and engaging with the Trust. It was agreed that as Chair of the PCC, Ceri Jackson would take this action forward.

Liam Williams stressed the importance of the Trust's role as a partner in multi-agency meetings and the need for effective communication skills. He highlighted the potential of digital solutions to address communication needs and improve patient care.

The Chair thanked Gemma for sharing the story and all the colleagues involved.

The Committee received an update following the patient story from Sian Davies-Kumar at the last meeting and noted that the Palliative Care Paramedic model 3-year initial trial phase has now ended. The committee heard that the Trust was considering what the model should look like going forward.

RESOLVED: The Committee received the Patient Story via a video from Gemma Hearn and noted the update on the previous story relating to Sian Davies-Kumar and the Palliative Care Model.

05/25 AUDIT WALES QUALITY GOVERNANCE FOLLOW UP REVIEW 2024

Liam Wiliams acknowledged the support from the Audit Wales team in completing the review, which involved revisiting the work from 2022 and the audit for 2024. He emphasised the importance of having well-structured management actions to ensure clarity and the ability to close them effectively.

Liam noted that having actions reopened from a previous audit was never ideal, but it was a fair assessment that identified the need for additional work to reach the right place. He stressed the need for ongoing assurance through reporting cycles and committee reviews.

Fflur Jones acknowledged that the review saw many areas of progress in implementing the recommendations from the 2022 review. She noted that actions were taken against every previous recommendation, even if some were not fully complete. She mentioned there were opportunities to take things further to provide fuller assurance, as the report focused on the level of assurance provided to the Committee. Fflur Jones highlighted the positive response from the Trust in addressing both the 2022 and 2024 recommendations, being specific about when they would consider closing off those recommendations to avoid similar situations in the future.

Rhiannon Beaumont-Wood sought an understanding on the timeline for improvements in the mortality review and the full implementation of the Duty of Candour. Liam Williams explained there has been good progress in identifying cases, working with medical examiners, and learning from coroner inquests. The Trust was working to improve data collection and making certain fields mandatory in the Electronic Patient Care Record (ePCR). The Trust was also exploring how to track patients through the entire pathway, which involved working with Digital Health and Care Wales (DHCW) and using the national data resource.

Liam Williams commented that the Trust was fulfilling the Duty of Candour where there was clarity required on catastrophic or serious harm. However, identifying and reporting moderate harm remained a challenge, and more work was needed in this area.

Wendy Herbert agreed with Liam's points and highlighted the challenges faced when the Joint Investigation Framework was invoked. She noted that it became difficult to determine who was responsible for triggering the Duty of Candour when the investigation was shared with Health Board colleagues. She mentioned that when the incident clearly sat within the

Trust, the team triggered the Duty of Candour immediately. However, in joint investigations, the process took more time.

Ceri Jackson asked for more details on the progress with achieving robust outcome data through the work with DHCW. Liam Williams commented there was a commitment from the ELT to work with DHCW. The Trust was enhancing the use of ePCR data to better understand the quality of care and segment data more effectively will undoubtedly improve patient outcomes. Additionally, having Health Boards contribute their data will enable more comprehensive pathway analysis and a better understanding of population health impacts.

Bethan Evans acknowledged there was a strong commitment to continuous improvement and collaboration within the Committee. Both she and Ceri Jackson were open to further discussions offline to explore how to move forward effectively. It was agreed that the respective chairs, including vice chairs, could support the efforts related to the Duty of Candour by leveraging their roles in the Quest chairs network. This support would help in addressing the challenges and ensuring the necessary improvements were made.

RESOLVED: That the review was acknowledged and the associated responses in the review were noted.

06/25 THE DUTY OF QUALITY IMPLEMENTATION PLAN – UPDATE

Liam Williams mentioned that the closure report would need to be brought back for formal noting at a future meeting. The Committee discussed the presentation of the report, and it was agreed it would be listed under Consent items at the next QuEST Committee meeting.

RESOLVED: The Duty of Quality Implementation Plan Closure report would be presented at the next QuEST meeting under the Consent Items.

07/25 HEALTH AND CARE QUALITY STANDARDS: UPDATE ON THE SELF ASSESSMENT

Liam Williams explained that Health & Social Care (Quality & Engagement) (Wales) Act 2020 came into effect on 1 April 2023, introducing the Health & Care Quality Standards 2023, which replaced the 2015 Standards. These Standards applied to both clinical and non-clinical functions.

Rhiannon Beaumont-Wood inquired about the ongoing work with the quality outcomes framework and the approach the Trust was taking. She expressed support but sought to understand more about the framework's development. Kate Blackmore explained there were several components that have not been fully translated into the current documentation. These components included a RAG Rating: A system to measure performance (Red, Amber, Green).Trend Analysis: Tracking whether performance was improving or deteriorating.

Rhiannon Beaumont-Wood also asked about the culture within the Trust regarding the ownership of Health and Care Quality Standards, acknowledging it can be challenging to ensure these Standards were fully embraced. Liam Williams highlighted ongoing conversations with the Joint Commissioning Committee (JCC) about commissioning arrangements and the promotion of a quality and safety approach.

Liam emphasised the importance of data and analysis, noting that the new Framework will likely focus on outcomes informed by data. He acknowledged that the delay in the Framework's release was partly due to the need for comprehensive data analysis. He added there has been considerable progress in the culture around quality improvement (QI) and equality impact assessments (EQIAs) within the Trust over the past 18 months. There was a recognition that more work was needed, particularly at the middle and operational levels.

Bethan Evans added that at the next, all Wales Quality Chairs Group an agenda item was listed which will discuss the approach to the Duty of Quality and Candour.

RESOLVED: That the Quality, Patient Experience & Safety Committee note the Health and Care Standards Assessment Framework being adopted organisationally to secure assurance on compliance.

08/25 DATIX RECOVERY AND IMPROVEMENT PLAN

Liam Williams stressed that the plan sets out a journey for improvement rather than being a complete solution. The focus was on making the system more intuitive and ensuring that staff have confidence in reporting incidents, knowing that their reports will lead to actionable improvements.

Kate Blackmore highlighted the collaborative workshop held in September, which identified gaps and improvements at both local and national levels. She added that the recovery plan included improving the structure of the system and providing education tools for staff to understand their responsibilities and actions required for reporting.

Trish Mills mentioned the challenges faced with the once-for-Wales risk module and the decision to look for other solutions for managing risk.

Rhiannon Beaumont-Wood inquired about the integration of different software and the potential use of AI to assist with data assimilation. Kate Blackmore responded that they were working on ensuring data was centrally held and reportable and were considering the use of robotic processes such as Power BI to help systems communicate.

Ceri Jackson suggested that Jonny Sammut should speak to Jayne Beeslee, Non-Executive Director on the Trust Board (in her capacity as the Board Digital Champion) about the Datix recovery and improvement plan, particularly in the context of the All Wales digital network. It was agreed that Jonny Sammut would update Jayne Beeslee, with regards to her involvement in the All Wales Digital Network and the issues which are being addressed through this Improvement Plan.

Liam Williams assured the Committee that the Trust was taking a comprehensive approach to managing violence and aggression incidents. It ensured that line managers and the violence and aggression team were actively addressing and supporting these incidents.

Bethan Evans asked of the level of confidence in realising and delivering on the Datix recovery and improvement plan, noting that many of the finish dates stated in the plan have

already passed. Kate Blackmore acknowledged that some timelines do need to be revisited and proposed providing a t report at the next Committee meeting to update on timelines, closed actions, and any necessary extensions. The Chair suggested that a report should only be brought back if there were any significant risks identified.

RESOLVED: The Committee:

(1) Noted the current risks and challenges within the Datix Web and RL Datix Cymru platforms; and

(2) Noted the attached Recovery and Improvement Plan designed to mitigate the challenges stepped out in this paper.

09/25 PUTTING THINGS RIGHT REPORT QUARTER 3, OCTOBER 2024 – DECEMBER 2024

Claire Appleton provided an overview of the Putting Things Right (PTR) report, highlighting the following points:

1. The report was structured differently from previous assurance reports, with data and intelligence presented separately from the report content.
2. The report includes a heat map visualisation to focus on improvements since April 2024.
3. The report was divided into sections covering quality controls, internal and external assurance, and the impact of actions taken.
4. Delays and high demand continue to shape the Putting Things Right (PTR) and legal services agenda, affecting both emergency and non-emergency transport services.
5. External activities, such as prevention of future death reports from coroners, have referenced extensive delays in reaching people in the community.
6. There was concern about whether there was sufficient capacity and resourcing to respond to quality and safety asks through PTR and legal services, especially given the competing priorities and pressures.
7. Complaints management has improved, and there was a focus on learning from external assurance and driving internal improvement.

Kate Blackmore added that the new format of the report was a significant improvement, especially with the focus on triangulating intelligence as opposed to just presenting metrics; this will provide a more comprehensive understanding of the data and its implications.

Claire Appleton commented that the Team were dealing with some significant challenges related to delays and the limitations of the current data extraction methods. There was still a lot of work to be done to improve the coding structures and data availability.

Members found that the new format with the streamlined structure made it easier to identify and focus on key priority areas, which was crucial for effective decision-making and governance.

Bethan Evans asked how far developed the iteration of the new format was, and were there any other updates the that the Team was working on to have included in the report. Wendy

Herbert explained that the Trust was focusing on how to enhance patient experience and prevent patient harm, to achieve this, required comprehensive and accurate information. She added it was crucial to strike a balance between providing comprehensive information and ensuring that the key points remained clear and actionable.

RESOLVED: The Committee received the Putting Things Right (PTR) report for discussion and were satisfied with the assurance given regarding the Trust's PTR function.

10/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR) – NOVEMBER/DECEMBER 2024

Rachel Marsh advised that the Monthly Integrated Quality and Performance Report (MIQPR)presented at the meeting was the same as the one reviewed at the Trust Board last week – due to the reporting schedule - and drew the Committee's attention to the following areas:

In December, the average response time for Amber 1 patients was 33 hours, with some patients waiting even longer. A major factor affecting response times was the handover lost hours, which exceeded 25,000 hours in December 2024.

The report outlined various actions being taken to address these issues, including the Clinical Model Transformation Programme and investments in remote clinical capacity and frontline resources.

Rachel Marsh acknowledged the presence of Joint Commissioning Committee (JCC) colleagues at the meeting, and emphasised the importance of reducing ambulance delays, aligning with the Cabinet Secretary's target of the number ambulances being delayed over an hour by the end of next year.

Rachel also mentioned the ongoing issue of patients cancelling their ambulance requests due to long response times, which likely led to harm as these patients may deteriorate while making their own way to an Emergency Department.

Liam Williams added there has been a small increase in the number of flagged safeguarding reports for children, and a slight deterioration in the number of reports for adults. While the numbers were not necessarily significant, it was important to note the considerable work the safeguarding team was doing to address internal safeguarding issues and support the wider community.

RESOLVED: The Committee considered the November/December 2024 Integrated Quality & Performance Report and actions being taken and acknowledged that it provided sufficient assurance.

11/25 FOCUS ON CLINICAL INDICATOR – STROKE

Jonathan Chippendale provided the Committee with a presentation which focused on the points below:

1. Measurement and Importance: Jonathan explained the four clinical indicators for stroke care: Face, Arm, Speech, Time (FAST) test, blood glucose measurement, blood pressure, and GCS (Glasgow Coma Scale). Each indicator was crucial for diagnosing and managing stroke patients effectively.

2. Data Quality and Reporting: Jonathan highlighted the importance of accurate data recording and the challenges faced in ensuring data quality. He mentioned that the automated data often showed lower compliance compared to manual data checks.

3. Performance Trends: Jonathan presented performance trends from April 2022 to December 2024, showing an improvement in compliance with the stroke care bundle, which was closely linked to the recording of the fast test.

4. Improvements and Next Steps: Jonathan discussed the interventions made since April 2024, including changes to EPCR (Electronic Patient Care Record) scripting, clinician education, and the introduction of nudge tools to remind clinicians to complete necessary documentation.

5. Clinical Indicator Recovery Plan: Jonathan referenced the ongoing Clinical Indicator Recovery Plan, which aimed to further improve compliance and data quality with regards to the Stroke related clinical indicators

Rhiannon Beaumont-Wood asked of the ongoing provision of data to clinicians to drive improvement from the bottom up. She was curious to understand if the approach of providing data to clinicians would continue. Jonathan clarified that the responsibility for monitoring and improving clinical indicators has been transferred to the Clinical Intelligence Assurance Group (CIAG), which will continue to oversee these efforts.

RESOLVED: The Committee noted the presentation on the Stroke Clinical Indicator.

12/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Due to the reporting cycle, Julie Boalch explained that the data presented today was the same as that presented to the Board on 29 November 2024.

Julie Boalch provided an overview of the two highest scoring risks 223 (*the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) with the scoring of 25 remaining unchanged. The two risks continue to be dynamically reviewed to provide assurance to the Committee.

It was noted that the discussions today have highlighted the work being done to mitigate the highest rates risks; as detailed in various reports, standards and frameworks.

The Trust was also exploring new ways to manage mitigations within its control, such as consulting on nurse attendance levels and implementing the clinical navigator role and winter desk.

Ceri Jackson sought assurance on the trajectory of consult and close and any challenges. Lee Brooks commented there was a need to refine the data as the consult and close data was related to the Emergency Communication Nurse System (ECNS) deployment for 111. An approach has been developed and was awaiting verification. The unverified data shows a positive trend regarding consult and close, but formal verification was needed before it can be included in the reports.

Trish Mills commented there were key initiatives underway to address the highest-rated risks (223 and 224) that have been on the risk register at a rating of 25 for some time. The goal was to better visualise and understand what the Trust Board has control over, and how far along it was in managing these risks.

Liam Williams added that the Trust was working on creating improvement trajectories to address significant unmet needs, particularly within the amber cohort of patients. The focus was on making things safer rather than completely safe, which was a realistic approach given the circumstances.

Jacqueline Maunder highlighted the importance of the ongoing dialogue with Trish Mills and Julie Boalch due to the synergies between the top scoring risks of both the Trust and the Joint Commissiong Committee. She emphasised the need for a whole system approach to manage these mitigating actions.

RESOLVED: The Committee noted the contents of the report.

13/25 CANCELLED CALLS POTENTIAL IMPACT ANALYSIS

Jonathan Chippendale provided the Committee with a presentation which looked at a retrospective data analysis of a 12-hour period during an "app perfect day" in the Swansea Bay Health Board area. The aim was to understand the system impact of increased utilisation of Advanced Paramedic Practitioners (APP) and one Palliative Care Paramedic (PCP). He highlighted that on this day, there were 149 calls related to 104 incidents, with additional incidents already on the stack and ambulances waiting to hand over at the hospital. The analysis focused on the outcomes and system impact of managing patients in the community and reducing conveyance rates.

During the "APP perfect day" analysis, it was found that a significant portion of calls were cancelled by patients who then self-presented at the Emergency Department (ED). He noted that approximately 50% of these cancelled calls likely resulted in patients going to the ED on their own. This was identified as a major issue, as it indicated unmet care needs and a significant impact on the ED's workload. The analysis showed that despite efforts to manage patients in the community, a substantial number of patients still ended up seeking care at the ED.

On a specific Thursday, February 15, Swansea Bay went into a Business Continuity Incident, leading to significant changes in hospital operations, such as placing senior clinical decision-makers at the front doors. This day saw the lowest average handover time for any Thursday that year, suggesting that coordinated efforts between the hospital and ambulance service

made a noticeable impact. The new clinical model and urgent care response service were expected to further enhance these efforts in the future.

Liam Williams acknowledged that the information contained in the presentation was comprehensive and detailed. Liam Williams suggested it would be beneficial for a more comprehensive evaluation and benefits realisation report be presented to the Committee. It was therefore agreed that Liam Williams would consult with Rachel Marsh and Andy Swinburn to undertake this task.

RESOLVED: The Committee noted the presentation on the cancelled calls potential impact analysis.

14/25 CLINICAL AUDIT PLAN 2025/26 AND ACTION TRACKER

Jonathan Chippendale advised that following a review by Audit Wales of the Trust's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to the Quality, Experience and Patient Safety Committee (QuEST) for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

Jonathan confirmed that the 2025/26 Clinical Audit Plan has been developed in consultation with the Clinical Intelligence Assurance Team (CIAT), the Clinical Intelligence and Assurance Group (CIAG), and senior clinical and non-clinical managers within the Trust.

The plan included 10 new audits including the Electronic Patient Care record (ePCR) and Drug Administration documentation. The plan will be updated quarterly, and the ongoing monitoring of clinical indicators will continue through the CIAG. The Committee was asked to approve the Clinical Audit Plan for 2025/26.

Rhiannon Beaumont-Wood asked if there is a system to consider medical devices auditing within the Clinical Audit Plan. Andy Swinburn advised it was not contained in the Plan and was monitored separately by a different area within the Clinical Team in the Trust. Following discussion, the Committee approved the Clinical Audit Plan for 2025/26 and noted the update given regarding the progress against the 2024/25 Clinical Audit Plan, within the associated Tracker.

RESOLVED: The Committee APPROVED the Clinical Audit Plan for 2025/26 and NOTED the Action Tracker update against the Clinical Audit Plan for quarter three of 2024/25.

15/25 ANNUAL INFECTION PREVENTION CONTROL SERVICE REPORT – 2023/24

Liam Williams advised that the report provided an overview of the current challenges facing the Infection Prevention and Control (IPC) Team and outlined the Strategic Plan for service enhancement during the 2025-26 financial year.

Over the past year, the IPC Team has navigated several challenges influenced by factors such as workforce changes, leadership transitions, staffing shortages, and a reduction in training opportunities.

Penny Durrant highlighted several points:

1. The report indicated improved compliance with hand hygiene, Personal Protection Equipment (PPE) use, and environmental cleaning, though there was still room for improvement.
2. There has been significant collaboration with internal and external partners, including health and safety, occupational health, Public Health Wales, and national IPC leads.
3. There were challenges in Respiratory Protection Equipment (RPE) provision which were being addressed, and the work was nearing completion.
4. Strengthened governance with policy reviews and updates was ongoing, and there was a focus on improving risk management and training standardisation.
5. A comprehensive IPC training program was being developed in collaboration with training colleagues to align staff competencies with national standards.
6. A Board Assurance Framework was being formalised to enhance policy compliance, accountability, and performance reporting.
7. There were ongoing efforts to recruit into key IPC positions to ensure service stability and continued collaboration across the Trust. There was a push to champion Infection Prevention Control (IPC) quality leads within operational teams and comprehensive IPC training programs aligned with national standards.

Liam Williams emphasised the significant work completed in the Respiratory Protective Equipment (RPE), highlighting the rollout of Powered Air Purifying Respirators (PAPR) across most of Wales and the expansion into the Southeast as soon as it becomes available. Jonny Sammut noted there were efforts to identify digital audit tools and potential collaboration with other services to mitigate funding risks.

RESOLVED: The Committee received the 2023/23 Annual Infection and Prevention report.

16/25 INTERNAL AUDIT REPORT: PATIENT EXPERIENCE COMMUNITY INVOLVEMENT

Liam Williams explained that the Patient Experience and Community Involvement (PECI) Report provided the Committee with a clear and comprehensive view of the Trust's efforts to embed public engagement into its governance and operational structures.

The report gave a reasonable assurance opinion, which reflected the progress made in PECI while highlighting areas for further improvement.

Leanne Hawker noted the launch of the new People's Experience Framework, which aimed to strengthen the duty to promote listening and learning from patient feedback, aligning with several regulations and acts.

Additionally, the PECI Team's Work Plan will be refined to align more closely with operational priorities and transformation goals. This includes introducing a population

health-based approach to analysing feedback and reporting variations in outcomes across Wales.

The Committee held a discussion which focused on the importance of building on the foundations laid and continuing to improve the PECI involvement in the delivery of the Trust's services.

RESOLVED: The Committee NOTED the Internal Audit outcomes, recommendations, management responses, and next steps.

17/25 AUDIT TRACKER 2.0 DECEMBER 2024 (Q3)

Trish Mills explained that the report provided the Committee with the current position with respect to management actions for audits within the purview of the Quality, Experience and Patient Safety Committee (QuEST).

Of those internal audit recommendations relevant to this Committee, two have been closed in quarter of a total of eleven (18%). There were five recommendations which have had a change in date proposed (marked in blue). There were two open actions on their third revised date: action 604 (Pain Management internal audit) and action 683 (Electronic Patient Clinical Records (ePCR) Clinical Compliance internal audit).

In terms of the external audits relevant to this Committee, none have been closed in quarter of a total of three. One of the external audit actions has a new revised date proposed (marked in blue) taking it to the third revised date; 139 National Review of Patient Flow – A Journey Through The Stroke Pathway.

RESOLVED: The Committee:

(1) Noted there were no Internal Audits and Audit Wales reviews within their remit
(2) Monitored management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

18/25 POLICIES FOR APPROVAL/NOTING

The following policies were presented the Committee for approval:

1. Safeguarding Children and Adults at Risk of Harm Policy;
2. Violence Against Women, Domestic Abuse and Sexual Violence 'Ask and Act' Policy.

The Committee acknowledged that the policies had been through internal governance processes and consultation and through Executive Leadership Team. There were no issues and the policies were approved, as presented.

RESOLVED: The Safeguarding Children and Adults at Risk of Harm and the Violence Against Women, Domestic Abuse and Sexual Violence 'Ask and Act' policies were approved.

19/25 COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

The Committee Priorities and Cycle of Business Monitoring Report was received.

RESOLVED: The Committee noted the update.

20/25 KEY MESSAGES FOR THE BOARD

These would be articulated on the Committee's Highlight report.

RESOLVED: The Committee noted that the key messages for the Board would be articulated through the Committee highlight report

21/25 REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

Bethan Evans summarised the decisions and actions as follows:

1. Clinical Transformation Model: The QIA discussion was moved to a Closed session for further work.
2. Committee Effectiveness Review: Conducted differently this time, with feedback to be emailed for the Draft Annual Report and priorities for 25/26. Amendments to the Terms of Reference were also agreed upon.
3. Patient Story: Provoked discussions on digital accessibility improvements, with Jonny Sammut tasked to develop further.
4. People and Culture Committee: They will monitor progress on accessibility, especially for deaf people and others with barriers.
5. Quality Governance Review: Agreed to take forward conversations offline to improve governance.
6. Duty of Quality Implementation Plan: A closure report will be brought back to the next meeting as a consent item.
7. Datix Recovery and Improvement Plan: Jonny Sammut to update Jayne Beeslee, with ELT reviewing timelines. It will return to the Committee if significant risks emerge.
8. PTR Report: New format welcomed, with a focus on supporting wider system decommissioning work.
9. Cancelling of Calls: Further work to be done outside the Committee, with feedback to be provided later.
10. Clinical Audit Plan for 25/26: Approved, recognising the need for flexibility.
11. Policies Approved:
    - Safeguarding Children and Adults at Risk of Harm Policy
    - Violence Against Women, Domestic Abuse, and Sexual Violence 'Ask and Act' Policy

Reflections:

The time allocations for items throughout the meeting were challenging, however the difficulty of managing such a comprehensive agenda was acknowledged. The Chair was commended for effectively conducting the meeting. Related to this point, there was consideration of how the meeting arrangements could be adjusted to allow for a more comfortable flow, including where it could be helpful to have pre-meeting discussions on more technical matters.

Rhiannon Beaumont-Wood, Non-Executive Director on the Trust Board, was welcomed to her first meeting of the committee. Additionally, there were several observers ranging from internal Trust staff, Health Improvement Wales, Internal Audit, and NHS Wales Joint Commissioning Committee (JCC) colleagues for the risk discussions.

The Committee acknowledged the work of Kevin Webb, Head of Clinical Intelligence and Assurance, a valued member of the WAST Team who is retiring in the coming weeks. Kevin Webb has been instrumental in the Trust's clinical audit work and a note of thanks was recorded for all his contributions.

Date of Next meeting: 9 May 2025

Meeting concluded at 15:30

CONFIRMED MINUTES OF THE PEOPLE AND CULTURE COMMITTEE MEETING (OPEN SESSION) HELD AT CARDIFF MRD AND REMOTELY VIA MICROSOFT TEAMS ON 18 FEBRUARY 2025

Chair: Ceri Jackson

Members:

Ceri Jackson	Non-Executive Director and Chair (MRD)
Bethan Evans	Non-Executive Director (virtual)
Hayley Hutchings	Non-Executive Director (virtual)
Hannah Rowan	Non-Executive Director (virtual)

Prescribed Attendees:

Lee Brooks	Executive Director of Operations (virtual)
Alex Crawford	Assistant Director of Planning and Transformation (virtual)
Christian Fox	Trade Union Partner (MRD)
Estelle Hitchon	Director of Partnerships and Engagement (MRD)
Carl Kneeshaw	Director of People (MRD)
Angela Lewis	Director of Culture Change (MRD)
Trish Mills	Director of Corporate Governance/Board Secretary (MRD)
Lizzie O'Shea	Freedom to Speak up Lead Guardian (MRD)
Andy Swinburn	Executive Director of Paramedicine (virtual)
Chris Turley	Executive Director of Finance and Corporate Resources (virtual)
Damon Turner	Trade Union Partner (virtual)
Marcus Viggers	Trade Union Partner (MRD)

Attendees:

Rhiannon Beaumont-Wood	Non-Executive Director (virtual)
Mark Churchill	Ambulance Care Assistant (MRD)
Kat Cobley	Head of Inclusion and Engagement (virtual)
Sarah Davies	People and Culture Directorate Business Manager (virtual)
Dr Catherine Goodwin	Assistant Director Inclusion, Culture and Wellbeing (MRD)

Caroline Jones	Corporate Governance Officer (virtual)
Fflur Jones	Audit Wales (virtual)
Osian Lloyd	Head of Internal Audit (virtual)
Sara Mills	Head of Culture and OD (virtual)
Alex Payne	Corporate Governance Manager (MRD)
Liz Rogers	Deputy Director of People and Culture Directorate (MRD)
Liam Williams	Executive Director of Quality and Nursing (virtual)

Apologies:

Julie Boalch	Assistant Director of Corporate Governance and Risk
Tim Cahalane	Trade Union Representative
Jo Kelso	Head of Workforce Education & Development
Mark Marsden	Trade Union Partner

121/24 **WELCOME AND APOLOGIES FOR ABSENCE**

The Chair opened the meeting of the People and Culture Committee by welcoming everyone and introduced Hayley Hutchings and Rhiannon Beaumont-Wood, recently appointed Non-Executive Directors attending; Hayley as a member of the Committee and Rhiannon as part of her induction. She also welcomed Mark Churchill who was attending for the Staff Story agenda item.

122/24 **DECLARATIONS OF INTEREST**

No new declarations were made in addition to the standing declarations which were already noted on the Trust Register of interests.

RESOLVED: That no new declarations were received.

123/24 **MINUTES OF PREVIOUS MEETING, ACTION LOG AND HIGHLIGHT REPORT**

The Minutes of the Open meeting held on 14 November 2024 were considered and agreed as a correct record.

Action 69/24 - *To include in the next report (partnerships and engagement), outcomes and impacts using examples in terms of qualitative feedback as an overall partnership piece. Further discussion with the Chair, and Trish Mills to consider which data should be captured.* The action was discussed and it was agreed that further discussion would be held regarding reporting of partnerships and engagement

that are outside the remit of this committee, potentially with a view to taking that directly to the board. The action remained open.

Action97/24 – *Angela Lewis agreed to ensure that change management principles and techniques are embedded in the leadership work being done, particularly through change and ensuring that change management is at the heart of leadership development*. Our WAST Way featured on the agenda and the action was closed.

Action 101/24 – *Chris Turley noted the mixed messaging in fire safety reporting in the People and Culture Metrics report and the Health& Safety report. One being highlighted as improving area and one flagged as red indicating a need for action. He agreed to take the lead with Fire Safety and the need for improvements and potential issue re data quality and ESR figures.* The figures reported were both correct as the timing of the reporting periods for each were different. A detailed annual fire safety update paper had been to Finance & Performance Committee. Additionally, Chris Turley highlighted that Fire Safety compliance training was just below 80%. The Committee were content with the level of assurance provided and the action was closed.

Members noted the highlight report from the meeting held on 14 November 2024 and had no further comments.

RESOLVED: That the

1) **Minutes of the meeting held on 14 November 2024 were approved; and**
2) **Actions 97/24 and 101/24 were both closed and action 69/24 remained open as set out above; and**
3) **The highlight report from the 14 November 2024 meeting was noted.**

124/24 DIRECTOR UPDATE

Angie Lewis highlighted several areas of the report which included excitement around the upcoming International Women's Day on March 11, where both Hayley Jones-Dunne and Kat Cobley would be attending an event at the House of Lords, hosted by Dame Tanni Grey-Thompson.

Angie flagged the people networks and the work that Laura Stephens had been involved with in terms of spotlights and culture change events. There were now 161 culture champions of whom 68% were from operational areas. Sara Mills expanded on Laura's work by explaining how Laura has been visiting stations and having conversations with

colleagues and promoting staff networks and initiatives. Sara emphasised the importance of going out to colleagues rather than expecting colleagues to come forward, and thanked Laura for her efforts and the EMS and Ambulance Care colleagues for welcoming her.

Angie Lewis praised Catherine Goodwin for presenting at the Tackling Workplace Sexual Harassment in the public sector conferences, supported by Welsh Government. Hannah Rowan expressed her appreciation for Catherine's work and commented on positive feedback she had received from another Board about how interesting and helpful the presentation had been.

Catherine Goodwin's work was recognised and a sexual safety training programme pilot for operational colleagues will start in March.

Carl Kneeshaw spoke of the development of a coaching award linked to the emergency ambulance practitioner development pathway, aimed at professionalising the service and ensuring continuous development across the Trust.

He referenced the recruitment of essential skills tutors within education development, which would support colleagues in literacy, numeracy, and digital skills, enhancing their employability and career progression within the Trust. He emphasised the alignment of these initiatives with the workforce plan agreed last year, focusing on continuous development and strengthening the employee offer.

He mentioned the moving on process which looked at people's experience at work. This would be discussed in more detail later in the agenda.

Lastly, the job evaluation improvements were noted, ensuring that job descriptions and adverts were able to be progressed in a timely manner.

Andy Swinburn praised the investment in the skills tutors, noting that WAST excelled in providing our people with a range of additional skills.

Hannah raised her concern about shift overruns with anecdotal feedback suggesting that progress that had been made was not felt on the frontline and queried what was being done to communicate any improvements to colleagues.

Lee responded by confirming that this would be included in the outputs from the Welsh Ambulance Services Partnership Team (WASPT) to the

organisation, acknowledging that the general theme was one of containment, meaning the situation was neither worse nor improved. This was considered a degree of success given the Winter period. Lee went on to say that an agreement with TU Partners to conduct a series of task & finish groups in March/April had been agreed. The aim of the groups was to explore additional steps to further reduce shift overruns, conceding that most of the issues were outside the Trust's control.

Ceri provided some of her reflections from the paper which included:

- the positive light on the Equality, Diversity and Inclusion work and its progress;
- welcoming the climbing over 100 places in the workforce employer index; and
- celebrating the 225 applications for flexible working.

Angie Lewis indicated that whilst the improvement in the workplace employer index was a positive sign of progress, there was still room for improvement. She emphasised that the external accreditations and recognitions, such as the disability confidence commitment and the carers' confidence, were deliberate efforts to hold the organisation accountable and to seek external help to improve further. Angie committed to providing additional context on where the Trust stands overall in the index at the next meeting.

RESOLVED: That

1) **The positive progress being made, visible in the Director Update, was noted; and**
2) **Angie Lewis agreed to provide additional context on the Workforce Employer Index relating to the Trust's position in the index.**

125/24 OPERATIONS QUARTERLY REPORT

Lee Brooks began by expressing his condolences to the friends, family and colleagues of Jason Jones and Carl Merritt who had passed away recently.

He also congratulated Jerry Adams, a Community First Responder, who had recently been awarded his MBE at Buckingham Palace.

Lee Brooks highlighted several key points for Committee Members:

- The initiation of the E-timesheet workshop and its alignment with the migration of GRS to a cloud-based solution which was scheduled for next year.

- The conclusion of changes within EMS Co-ordination, including the introduction of new roles and the single allocator model, which faced challenges during the Winter, but was now showing positive feedback from staff.

- Collaboration between the operational, medical and clinical teams to improve clinical supervision for Advanced Paramedic Practitioners (APP), and the inclusion of prescribing for all Band 7 APPs was highlighted.

- The progression of palliative care paramedics, including the potential for advanced practice and external financial support.

- Discussions were ongoing with Trade Union Partners to agree on the rules of engagement for the next roster review, accepting the learning opportunities from previous experiences.

- The joint efforts of Ambulance Care and EMS Coordination to ensure Urgent Care Staff adhered to their scope of practice, with high compliance rates, was praised. Opportunities for clinical supervision in Ambulance Care was mentioned.

Members were content with the comprehensive report and no queries were raised.

RESOLVED: That the Operations progress was noted.

126/24 **STAFF STORY – Mark Churchill**

Mark Churchill has been a WAST employee for the past 10 years; he shared his career journey and experiences. Before joining the Trust, Mark had a diverse career, including 33 years with South Wales Police, where he developed skills in communication, investigation, and community engagement. He also worked for a drug and alcohol charity and as an investigator for the Office of National Statistics. These roles equipped him with valuable skills in dealing with people, building trust, and handling complex situations.

In his current role, Mark works in Ambulance Care, primarily transporting vulnerable and elderly patients to their medical appointments, including those in dementia units, dialysis units, and oncology. He emphasised the importance of building relationships with patients, providing social support, and ensuring their safety and comfort.

He highlighted the dedication of his colleagues and their commitment to treating patients with dignity and respect.

Mark also discussed areas for improvement within the Trust, particularly around communication and planning. He mentioned that staff often felt their suggestions for improvement were not heard or acted upon, leading to frustration. He suggested that localising planning could improve efficiency and reduce stress for both staff and patients. Mark also called for better integration of diversity training into mandatory training sessions to ensure all staff understood acceptable behaviour and practices.

Angie Lewis expressed her appreciation for Mark Churchill's openness and honesty in sharing his story. She acknowledged the positive aspects of his narrative, particularly highlighting the value of his extensive previous experience and how it contributed to his current role. Angie also noted the importance of Mark's feedback on training and communication, emphasising the need to connect and make training more accessible to colleagues. She thanked Mark for his contributions and for being candid about areas for improvement.

Bethan Evans thanked Mark Churchill for joining the committee and sharing his story, appreciating his honesty and transparency. She acknowledged the positive aspects of his work, particularly the relationships built with patients. Bethan noted that some of Mark's points resonated with her from her visit to Hawthorn station. She recognised the challenges in communication within a geographically dispersed organisation and asked Mark what one change would make the most significant difference in helping staff feel more appreciated and valued.

Mark Churchill responded to Bethan Evans by stating that there was not a single "golden nugget" to fix everything, but rather a combination of small improvements. He emphasised the importance of communication and local planning. Mark highlighted that staff often find the planning unrealistic and unachievable, leading to frustration. He suggested that

localising planning could significantly help staff and improve the overall service.

Hannah Rowan thanked Mark Churchill for his focus on what could be improved and stressed the importance of learning from those who knew the job well. She reflected on the specific issues Mark mentioned, such as inaccurate timings from hospitals and planning not being aligned with road conditions. Hannah highlighted the importance of addressing specific problems that make the job more difficult and worsen the patient experience. She expressed curiosity about how these issues were being taken forward.

Marcus Viggers appreciated Mark's balanced feedback, but noted that in the EMS and clinical directorates, staff ideas were often listened to and implemented if valid. However, he acknowledged that this level of engagement might not be present in Ambulance Care, currently.

Lee Brooks responded by emphasising the significant advancements made in Ambulance Care, referencing Mark Harris's recent presentation at the Trust Board. He highlighted the progress since the McClellan review of 2013, noting that the idea of devolving back to Health Boards was no longer discussed, which was a testament to the progress made. Lee acknowledged Mark Churchill's perception and thanked him for his honesty. He pointed out the structural differences between Ambulance Care and EMS, noting that Ambulance Care Managers handled larger teams and had less capacity compared to their EMS counterparts. Lee mentioned ongoing efforts to introduce clinical oversight for ACA staff, which could offer new career paths. He also addressed the planning issue, cautioning against creating a divide between field staff and control room staff.

RESOLVED: Mark Churchill's story was well received and the improvements suggested were noted.

Staff Story Diagram – Ela Lewis

The Staff Story Diagram from the previous meeting was received for information and was noted.

127/24 **OUR WAST WAY**

Angie Lewis explained that Our WAST Way was a key piece of work in culture change and invited Sara Mills to share her presentation with the Committee.

Sara Mills provided an update on the progress of the WAST Way project, emphasising its importance in driving cultural change within the organisation.

Sara focused on the vision and progress which aimed to articulate what good leadership looked like at different levels within the Trust, promoting a culture of compassion, inclusive and connected leadership. Three core leadership principles were developed,

- Care
- Value Everyone
- Connect

The project included structured development opportunities aligned with the principles to support leaders and managers at various career stages and create a more engaged, motivated and productive workforce.

Sara emphasised the link between staff experience and patient experience, noting that the culture within the organisation could significantly impact how staff interacted with each other and with patients.

Members were able to share their views, with Estelle Hitchon expressing concern about the environment that created poor managers and questioned whether the recruitment process focussed enough on disposition rather than just qualifications. She highlighted the pressure on middle management and suggested this could lead to poor behaviour. Andy Swinburn spoke of the importance of professionalising leadership as a skill set, noting that both disposition and qualifications were necessary for effective leadership.

Bethan asked how the Trust planned to measure performance against the leadership behaviours and how line managers would be trained to respond positively and constructively to 360 feedback.
Andy Swinburn responded by saying both attitude and disposition skills were crucial for effective leadership and that the Trust could implement specific metrics together with regular evaluations, which may include feedback from 360 reviews, appraisals and direct observations. He also

suggested providing training programmes which focussed on both technical and soft skills required for effective leadership.

Hannah reflected on the importance of addressing specific issues raised by staff and ensuring the Trust took steps to improve the work environment.

Angie Lewis summarised the discussion by emphasising the importance of the leadership behaviours and principles in driving cultural change within the organisation. She highlighted the need for clear leadership behaviours and structured development opportunities as key drivers for achieving true cultural change. She also acknowledged the rich insights and questions raised and mentioned the importance of continuous learning and improvement based on the feedback received.

RESOLVED: That the Committee

1) **took assurance from the update provided on the WAST Way;**
2) **commented on and received the content of the update; and**
3) **committed to the role in this agenda.**

128/24 CULTURAL THEMES AND TRENDS REPORT

Liz Rogers provided an overview of the key data related to employee relations, turnover, and moving on interviews for the period from July to December 2024. Key points included:

- 63 new disciplinary cases, a significant increase compared to the same period last year.
- 18 requests for respect & resolution (R&R) cases, a slight decrease from the previous year.
- The average duration for a case to be closed was 33 days, a significant improvement from previous averages.
- Fast track cases saw a 18% increase, with 14 cases during the period.
- Complex cases, particularly those involving sexual safety concerns, took longer to resolve, with an average of 209 days.
- The average duration for cases involving police investigations was 122 days.

There was a significant increase in the number of cases resolved through informal action, such as training and development or informal conversations.

Liam Williams raised a point about the importance of ensuring that local resolution genuinely led to the cultural change the Trust was seeking. He emphasised the need for confidence that local resolution not only addressed the immediate issue but also contributed to a true cultural shift, preventing the recurrence of similar issues.

Liz Rogers discussed the feedback from the moving on interview pilot data, highlighting the depth of information now available through the new process, which went live across the Trust in January. Key points included:

- The new process included a digital trigger and reminder for managers to conduct interviews or for leavers to complete the questionnaire.
- The data provided insights into reasons for leaving, levels of satisfaction with workplace relationships, recognition, and whether thoughts and ideas were heard.
- There were differences in feedback based on gender, with significantly more female leavers than male leavers.

The data also covered areas such as career progression, coaching, and mentoring opportunities.

Angie Lewis discussed the Speaking Up Safely data, emphasising its importance as the first meaningful insight available to the committee. Key points included:

- 65 concerns were raised in the last six months, with a notable increase in October during the Speaking Up Safely month and its promotion at CEO Roadshows.
- The number of anonymous concerns decreased after rapport was built with those reporting a concern by Lizzie O'Shea.
- 63% of the concerns were related to incivility.
- Many concerns were resolved at a local level or by senior leaders, which aligned with the vision of addressing issues at the most appropriate level.

There was a focus on understanding and mitigating detriment experienced by individuals who came forward with concerns.

RESOLVED: That the Committee

1) **accepted and noted the report and presentation deck;**

2) **noted the rollout of Moving on Conversations across the organisation with future updates to be received through the Cultural Themes and Trends report; and**
3) **noted the Speaking Up Safely case volumes identified in the report.**

129/24 **COMPASSIONATE PRACTICES UPDATE AND ACTION PLAN (Compassionate Practices Deep Dive)**

Liz Rogers provided an update on the compassionate practices, highlighting the following points:

- The journey began in 2022, inspired by work from Aneurin Bevan University Health Board.
- 224 colleagues have been trained in compassionate practices, with more to follow.
- 70 colleagues have received investigating officer training, and additional training sessions on misogyny and sexual safety have been conducted.
- An internal audit identified four actions, most of which were completed, with some still in progress.
- An external evaluation by a university in Austria was underway, analysing quantitative and qualitative data to assess the effectiveness of the initiatives.

The focus was on embedding compassionate practices across all managerial activities, not just disciplinary processes, to create a consistent and supportive work environment.

Members welcomed the update and no queries were raised.

RESOLVED: The Committee

1) **confirmed assurance on the progress against the audit actions; and**
2) **noted the progress against the action plan.**

130/24 **PEOPLE AND CULTURE PLAN METRICS UPDATE AND WORKFORCE SCORECARD**

Angie Lewis provided an update on the People and Culture Metrics, focusing on the following points:

- The inclusion of safeguarding data for the first time, reflecting the work done with Liam William's team on behaviours and sexual safety concerns. The transparency in reporting 45 open safeguarding cases, including elements of sexual misconduct was a crucial step towards addressing these issues and ensuring accountability.
- People networks are thriving, with a significant number of participants leading to better communication, collaboration and morale.

Providing updates on change management showed a commitment to continuous improvement and adaptation. This helped in keeping everyone informed and aligned with the Trust's goals.

Angie discussed the review of People and Culture Metrics, highlighting the following recommendations:

- It is proposed to continue alternating between qualitative and quantitative metrics.
- The categorisation of metrics under the three Cs will be maintained: culture, capacity, and capability, linked to the People and Culture Plan.
- The current quantitative measures will be maintained while adding safeguarding and speaking up safety metrics.
- Reporting will continue spotlighting specific issues during the qualitative reporting.

Angie Lewis reiterated the importance of equality, diversity, and inclusion as a golden thread through the People and Culture work. She highlighted key priorities for the upcoming year, including the Clinical Model Transformation Programme, and sought feedback on whether any important areas were missing from the priorities list.

Angie Lewis highlighted the importance of the metrics in understanding the impact of initiatives and ensuring that the Trust was moving in the right direction. Angie also mentioned the importance of evaluating the effectiveness of actions and continuing to build on the work done so far.

Members queried what good would look like in 2028. The response highlighted the vision for 2028, emphasising the importance of understanding what tangible difference would be seen and how the Trust would feel and operate differently. Angie Lewis confirmed that the

team were actively considering and planning for the long term visions referencing previous discussions and materials.

Angie Lewis also confirmed that progress would be measured through employee relations, speaking up and other activities. It was noted that these measures would eventually stabilise and drop, indicating progress.

RESOLVED: That the Committee

1) **received and commented on the progress to date;**
2) **supported the recommendations made in relation to metrics; and**
3) **supported the proposed priority focus areas for the 2025-28 IMTP.**

130a/24 MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT (MIQPR)

Alex Crawford presented the MIQPR for December 2024/ January 2025 and pointed out the following key areas:

- During the winter period, hours lost to handover increased, which was a significant factor affecting staff experience. However, during peak periods, the Trust was able to produce above 95% of the required hours, reaching 97% at peak times.
- The abstraction rates were slightly below the benchmark of 30%, primarily driven by annual leave rather than sickness. Sickness rates showed a downward trend, with January figures at 8.12%, still above the target but improving.
- Stress and anxiety continued to be the leading causes of sickness, with a notable increase in short-term sickness during December. Long-term sickness trends showed some improvement.
- The flu vaccination uptake was 28.4%.
- There was significant progress in the Clinical Model Transformation (CMT) programme, particularly for corporate staff and operational staff in senior roles. Workshops in January helped reflect on the pace of the programme and adjust it to maintain momentum without causing burnout.
- The issue of shift overruns was addressed earlier in the meeting, so it was not elaborated on further in this report.

- Performance Appraisal and Development Review (PADR) completion rates increased but were still not at the desired level. Mandatory training compliance was above target.

Overall, the report highlighted key performance metrics, trends in sickness and abstraction rates, progress in the CMT programme, and the importance of maintaining a balanced pace to avoid staff burnout.

Ceri Jackson queried the figures relating to applications received which stated that 714 of the 1248 received were from underrepresented groups. The figure was an error and would be corrected in the next report.

RESOLVED: That

1) **the MIQPR report was considered, and the Committee took assurance from the update given; and**
2) **Alex Crawford would revisit the number of applications received from underrepresented groups and ensure this was updated in the next report.**

131/24 INTERNAL AUDIT REPORT: RESOURCING POLICY

Lee Brooks acknowledged that the limited assurance audit was anticipated and had to a certain extent been expected. The committee was informed that the primary issue was the outdated resourcing policy, which required a holistic refresh. The team has committed to addressing this in the upcoming year, working with Trade Union Partners to meet the timeline set out in the management response, aiming for completion by October.

Lee emphasised the significant amount of work required to review and republish the resourcing policy, but was committed to achieve this. It was recognised there was a need to develop departmental focused standard operating procedures to separate policy from procedure.

Damon Turner highlighted that within the policy the main issues raised by members, included overruns, and TOIL, which were significant concerns for their members.

Actions to address recommendations include ongoing oversight and monitoring of working time regulations, establishing a reporting mechanism using the senior operations team, and developing departmental standard operating procedures.

Bethan Evans noted there were significant variances in working time breaches across different areas, with the southeast showing the highest number of 11-hour breaches. A detailed analysis report was planned to understand and address these variances. Lee Brooks agreed to provide a report for Committee once the findings were known.

RESOLVED: That the Resourcing Policy audit was received and noted the commitment to progress a refreshed policy.

132/24 WASPT HIGHLIGHT REPORT – JANUARY 2025

Christian Fox mentioned that WAST had been invited to deliver a session at the annual Ambulance Leadership Forum (ALF) conference next month, to talk about WAST's experience, learning and activities of building respectful and cohesive relationships. TU Partners were asked to feed back to the Committee at the next meeting on this.

A Social Partnership Conference was due to be held in March to look at how to build relationships and move forward following a recommendation from an earlier ACAS report. Staff were working together to present key aspects of partnership working at the conference. Liz Rogers had been organising the Social Partnership Conference with preparations well underway for guest speakers and internal speakers from the Trust being finalised.

Health boards are working with WASPT to provide the necessary electrical infrastructure for the new Dyson fans purchased to reduce exposure to diesel fumes for members.

Christian mentioned ongoing issues with members being unable to take TOIL, linked to delays at hospitals. A task and finish group has been set up to address these issues and find a way forward.

Christian briefly mentioned that they were starting to look at planning for Christmas, although it was still early in the year.

RESOLVED: That the

1) **detail contained within the report was noted; and**
2) **TU representatives would provide feedback to the Committee on their experience at the ALF conference.**

133/24 **INTERNAL AUDIT REPORT: EXPOSURE TO FUMES**

The internal audit provided reasonable assurance across the areas of work. Management actions have been confirmed, and several had progressed since the report was completed.

It was recognised that progress has been made in securing and rolling out Dyson fans for heating to address temperate weather conditions.

Efforts were underway to secure a master class with an expert public health consultant to further address the issue.

Liam Williams acknowledged the challenges in ensuring compliance with mitigation measures. The Health and Safety team, Operations team, and Trade Union Partners were all involved in this effort.

RESOLVED: That the exposure to fumes internal audit report was received.

134/24 **ANNUAL EFFECTIVENESS REVIEW 2024/25**

Trish Mills presented the annual effectiveness review, stressing that they provided a valuable chance for the committee to collectively assess its effectiveness.
Estelle mentioned the need to triangulate the information received in the Committee with what was seen at Board level and during Non-Executive visits.

Sara Mills stressed the importance of connecting metrics to the specific issues the committee aimed to address. She proposed that metrics should be linked to particular cultural themes or issues, such as social partnership and leadership and management, to offer a clearer direction and focus. Sara also mentioned that rather than using all available metrics, it would be more effective to associate specific metrics with particular projects, like "Our WAST Way," to provide a more focused evaluation and clearer narrative.

Catherine Goodwin voiced her discomfort with including Respect & Resolution (R&R) disciplinary cases and suspensions under the Speaking Safely metrics. She stressed that speaking up safely covered a broader range of issues, such as raising concerns about patient safety, and should be considered separately from disciplinary matters.

Liam Williams emphasised the need to distinguish between reporting specific incidents where staff did not feel safe under the Speaking Up

Safely initiative and the general reporting of patient safety incidents through the Datix system. He pointed out that most patient safety incidents were reported through the Putting Things Right team and stressed that these two reporting routes should remain separate to prevent confusion.

Angie Lewis recognised that much of the reporting on equality, diversity, and inclusion was statutory and mandatory. She suggested that there should be more focus on visible indicators such as sick absence, discipline, grievance, and R&R metrics, and emphasised that these should be reported separately from the Speaking Up Safely metrics.

Ceri Jackson stressed the importance of triangulating the Monthly Integrated Quality Performance Report (MIQPR) metrics with other reports to provide context. She noted that while the MIQPR included many relevant metrics, it was essential to link them to the broader context of the People and Culture Committee's work. Ceri also mentioned the need for the MIQPR to be more tailored to the Committee's needs, while recognising the challenge of ensuring that the context from other parts of the report was not lost.

Trish Mills discussed the importance of concentrating on the strategic direction and the long-term impact of the Committee's work. She suggested that the committee should shift its focus from merely monitoring the implementation of plans to evaluating their outcomes and impact. Trish highlighted the need to ensure that the metrics and reporting provided to the Committee were aligned with the strategic objectives, offering a clear line of sight to the desired outcomes. Additionally, she emphasised the importance of triangulating metrics and ensuring that the Committee received reports that linked various elements together, providing a comprehensive view of the Trust's progress.

Carl Kneeshaw explained that the skills mix was part of the broader strategic workforce plan, emphasising that having the right people in the right place at the right time was crucial for determining the skills mix, which was an operational aspect of the plan. He highlighted that workforce planning involved analysing the strategic workforce plan, identifying what was needed, and implementing the requirements back into the model to ensure the Trust had the appropriate skills mix to meet its needs.

Chris Turley endorsed the inclusion of the skills mix in the Committee's considerations, noting the importance of capturing the broader context of both clinical and non-clinical elements, even while focusing on specific parts of the business. He mentioned that incorporating the skills mix would help address the broader capacity perspective and ensure that the committee's focus aligned with the Trust's overall objectives.

Lee Brooks supported the inclusion of volunteers in the Committee's considerations, emphasising that volunteers were an integral part of the organisation, much like paid staff, and should be included in the People and Culture Committee's remit. However, he expressed caution regarding the inclusion of the skills mix, noting the potential for overlap with other committees such as Quest and Finance and Performance. Lee highlighted the importance of avoiding duplication and confusion when addressing the skills mix from both clinical and budgetary perspectives.

Trish observed that the Committee had not received standalone reports on leadership and management development and succession planning until the current meeting, where the "Our WAST Way" was presented. She suggested considering changes in the wording around the capability section to better reflect the committee's focus and responsibilities.

Trish also raised the possibility of including additional elements under capability, such as HEIW commissioning, registration and revalidation, learning and development, and assurance on the armed forces covenant. There was a discussion on whether to include assurance around DBS and driving licence checks, but it was noted that these were transactional and managed by Shared Services. The discussion also touched on whether to specifically highlight the skills mix, but it was noted that this fell under the strategic workforce plan and was more operational. Additionally, it was suggested to include volunteers in the capability section, as they are considered part of the Trust.

A discussion was facilitated as outlined above to consider what changes and improvements could be made to the Committee's operations. The draft Annual Report was reviewed, however the final Report for submission to the Audit, Risk and Assurance Committee, and the revised Terms of Reference for 2025/26, would be circulated for approval by Chair's Action after the meeting.

RESOLVED: That

1) **Committee discussed its remit in line with the terms of reference;**

2) **Members evaluated the cycle of business and proposed potential changes and improvements;**
3) **The draft Annual Report was reviewed; and**
4) **The final Annual Report and revised Terms of Reference for 2025/26 would be circulated for approval by Chair's Action.**

135/24 **RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK**

Trish mentioned that the risk management report was not a fresh set of risks for the Committee because it had been seen at the Board previously. She was discussing with Julie about potentially changing the cycle to better align with the committees.

Trish highlighted the four top risks, noting that two were rated at 20 (sickness and reputation).

Risk 160 - High absence rates;

Risk 163 - Maintaining Effective & Strong TU Partnerships;

Risk 201 - Reputation;

Risk 558 - Deterioration of staff health and wellbeing.

Trish pointed out that the Trade Union relationship risk had reduced to a score of 12.

The health and well-being of staff risk remained unchanged, with new mitigations and actions updated.

Ceri Jackson expressed concern about taking assurance on the items listed in the risk report because the information might be outdated or inaccurate due to the timing of the report. She noted that the end of March is only six weeks away, and it is important to ensure that the deadlines are met.

Trish assured members that all risks have had reviews, and there were new mitigations and actions updated. The risks were coming to the Executive Leadership Team for further review.

Trish suggested that if the timing of the report could not be aligned, the report should include a summary of any significant updates or issues that needed attention. This would ensure that the committee was aware of the most current and critical information, even if the full report was slightly outdated.

Carl also provided assurance that the team had been working on updating the risks and actions, and the next iteration of the report would show completed or removed actions, as well as any additional

ones that come on stream. He mentioned that the updated report would be presented to the Board, providing more accurate and current information.

RESOLVED: That

1) **The report was considered and discussed; and**
2) **Future reports where reporting was out of alignment to meetings, an updated position would be provided in the SBAR.**

136/24 **DEEP DIVE ON RISK 160 (High Absence Rates): Managing Attendance**

Liz provided a detailed presentation on the deep dive into managing absences risk by way of a presentation. She highlighted the comparison of sickness absence data from the last quarter of 2024 against 2023, noting the trends and patterns observed, noting that the general trajectory of sickness was downward, which was positive.

She identified areas with higher levels of sickness absence, specifically in integrated care and EMS, and discussed potential drivers for these increases.

Liz outlined the actions planned in response to these challenges, emphasising the importance of targeted interventions and ongoing monitoring to mitigate the impact of high absence rates.

She also mentioned the national position of ambulance services, comparing their sickness absence rates to provide context and benchmarks.

Additionally, Liz spoke to the performance of corporate service teams, noting that some teams showed very small to zero absences in the last five months, while others experienced increases due to significant workloads and ongoing changes.

She shared a case study from Swansea and Neath, where the introduction of welfare pods led to a consistent reduction in sickness absence and positive feedback from staff regarding stress levels and mental health.

Estelle Hitchon raised a question about the calculation of sickness absences, specifically comparing WAST's method to that of West Midlands Ambulance Service. She noted that WAST counts all days in the week as sick days if someone is off for their shifts and not back for

the following days, whereas West Midlands only counts the working days. Estelle questioned whether this method was right, wrong, or indifferent, as it seemed to her that it might be skewing the data.

Carl Kneeshaw agreed to review how sickness was recorded to ensure alignment with other UK ambulance services; noting that West Midlands recorded their data differently.

RESOLVED: That

1) **the contents of the presentation were noted; and**
2) **Carl Kneeshaw agreed to review how sickness was reported in line with other UK ambulance services.**

137/24 AUDIT TRACKER Q3 2024/25 REPORTING

Trish Mills discussed the audit tracker, pointing out that the current format was a long spreadsheet, and that work was ongoing to developing more intelligent reporting. She highlighted that 17% of the actions were closed, with three more pending confirmation of evidence. Additionally, over 40% of the actions had moved dates, but she assured members that there was robust challenge and confirmation when dates were moved. Trish emphasised that the goal was to avoid moving dates unless absolutely necessary and to ensure that high-priority recommendations were addressed promptly.

Trish Mills asked the committee to endorse the approach of closing the outstanding actions from the Trade Union Release Time audit, acknowledging that they may not be closed in the originally envisaged manner but ensuring that the risks were mitigated.

Ceri Jackson mentioned that at the Audit Committee, it was agreed that for items on their third revised date, the responsible Director would be invited to provide an update. This process ensured accountability and transparency for actions that had been delayed multiple times.

RESOLVED: That

1) **the new Internal Audits and Audit Wales reviews within the remit were received and reviewed;**
2) **the management actions to address recommendations in the Audit Tracker be monitored; and**
3) **the update provided in respect of the two audit actions relating to Trade Union Release Time were received and considered and confirmed a closed position.**

138/24 **POLICIES FOR APPROVAL**

The Committee recognised that the policies listed below had all been through the appropriate route and were approved by Committee.

Occupational Health Policy
Recruitment and Selection Policy
Occupational Immunisation Policy
Equality Impact Assessment Policy
Bank Worker Policy

RESOLVED: That the five policies listed above were approved.

139/24 **CONSENT ITEM – Not discussed in the meeting**

Committee Cycle of Business Monitoring Report & Committee Priorities.

140/24 **CONSENT ITEM – Not discussed in the meeting**

Welsh Ambulance Services Partnership Team (WASPT) Minutes of the meeting held on the 15 November 2024.

141/24 **REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS**

Reflections on the meeting were that the discussion regarding Our WAST Way was of particular importance given its role in leadership and management development and in driving cultural change. The approach taken to the facilitation of the committee effectiveness review was commended. The focus on more strategic as opposed to transactional matters of business was acknowledged, and Members felt that the hybrid approach worked well.

142/24 **ANY OTHER BUSINESS**

Nothing raised.

143/24 **DATE OF NEXT MEETING**

The next meeting is scheduled for the 15 May 2025.

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

MINUTES OF THE OPEN MEETING OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST HELD ON THURSDAY 6 MARCH 2025 IN CARDIFF MRD AND VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Ceri Jackson	Non-Executive Director and Vice Chair of the Trust Board

IN ATTENDANCE:

Julie Boalch	Assistant Director of Corporate Governance and Risk
Judith Bryce	Assistant Director of Operations (Left after |Item 08/25)
David Butler	Audit Wales (Left during Item 03/25)
Jonathan Chippendale	Assistant Director of Clinical Development (Item 03/25 only)
Christian Fox	Trade Union Partner
Fflur Jones	Audit Wales
Wendy Herbert	Assistant Director of Quality and Nursing
Osian Lloyd	Head of Internal Audit, NWSSP
Trish Mills	Director of Corporate Governance/Board Secretary
Carl Kneeshaw	Director of People
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Jessica Price	Head of Financial Accounting
Felicity Quance	Internal Audit
Ed Roberts	Interim Deputy Director of Finance
Yvonne Thomas	Audit Wales (Left after Item 08/25)
Aled Williams	Assistant Director of Digital (Item 03/25 only)
Carl Window	Local Counter Fraud Manager

APOLOGIES:

Rhiannon Beaumont-Wood	Non-Executive Director
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

01/25 PROCEDURAL MATTERS

The Chair welcomed all to the meeting noting the apologies of Rhiannon Beaumont-Wood, Chris Turley, Damon Turner, and Liam Williams.

Minutes: The Minutes of the Audit, Risk and Assurance Committee (ARAC) meeting held on 21 November 2024 were approved.

Action Log: Action 55/24: *The Committee sought an indicative timeline regarding the completion of the Digital Systems report. It was agreed this would be followed up and communicated to the Committee.* Fflur Jones advised it was likely the Digital Systems report will be presented to ARAC in June. Action Closed.

Action 59/24: *The Committee will adopt the policy by way of a Chair's Action post-meeting as it was not available on Ibabs. All-Wales Procedure for the Recovery of Overpayments - Chairs Action on 2 December 2024*. This action was agreed for closure.

Action 56/24b *In the Overtime Controls Internal Audit report, objective 2.18 reflects the workforce as being EMT Band 4 Paramedics, this needs to state EMT Band 5 and it was asked that this will be updated to reflect the change*. The Business Management Team have been tasked with engaging with Audit Colleagues with the request to amend the report narrative to reflect the correct wording. This action was agreed for closure.

Declarations of Interest: No other declarations of interest were added to those already on the register.

Chair's Action: The Committee was asked to Ratify the decision made by Chair's Action to adopt the All-Wales Procedure for the Recovery of Overpayments on the 02 December 2024. Trish Mills provided an explanation in terms of the timing of the Chair's action. Alex Payne further advised that one of the documents was omitted from iBabs in error and subsequently required a Chair's action in order to formalise the matter.

Committee AAA Report: November 2024: The Committee AAA report dated 21 November was received.

RESOLVED: The Committee:

(1) Noted the apologies of Rhiannon Beaumont-Wood, Chris Turley, Damon Turner, and Liam Williams.
(2) Approved the Minutes of 21 November 2024.
(3) Noted there were no further declarations of interests recorded other than those listed on the Register of Interests.
(4) Noted the update on the actions as described.

(5) Ratified the decision made by Chair's Action to adopt the All-Wales Procedure for the Recovery of Overpayments on the 02 December 2024.

02/25 COMMITTEE EFFECTIVENESS REVIEW AND REVIEW OF ANNUAL COMMITTEE PRIORITIES

Trish Mills thanked the team for their hard work on the committee effectiveness review. The approach this year involved assessing effectiveness throughout the year rather than waiting for an end-of-year review.

The review included input from auditors to ensure comprehensive feedback. The National Audit Office (NAO) questionnaire was completed, highlighting three major themes and four or five recommendations for the committee to consider. The committee was asked to provide feedback on the NAO questionnaire responses and to identify priorities for the upcoming year.

Trish emphasised the need to consider changes to the terms of reference, reporting, and overall operation of the committee.

Trish discussed the process of committee referrals, noting that while there was a provision for escalations from other committees, it was not frequently utilised. She stressed the importance of making committee chairs and Non-Executive Directors aware of the opportunity to refer items to the ARAC. This could include issues related to audit recommendations that were off track. Trish suggested that more awareness and discussion in committees about what might be escalated to ARAC could be beneficial.

Trish asked the Committee to consider potential changes to the terms of reference, report formats, and the overall operation of the committee. Specific focus areas included the skill mix, induction processes, and the length and volume of meeting papers.

The Committee was encouraged to provide feedback on what worked well and what could be improved, either during the meeting or via the chat function.

The Committee discussed the importance of all members and attendees making valuable contributions. It was noted that the culture of the meeting allowed for open and respectful discussion, with members feeling comfortable to contribute. There was a suggestion to use iBabs for pre- and post-meeting comments to enhance engagement.

Peter Curran raised the issue of internal audit reports sometimes being reviewed by other committees before ARAC due to timing. He questioned whether ARAC should review both the original report and the feedback from the other committee to ensure thorough scrutiny. Trish agreed that if a report has been to another committee, it should come to ARAC with the committee's comments for additional scrutiny. There was a consensus that ARAC should challenge both positive and negative audit outcomes.

The Committee discussed the length of meetings, noting that while the current length was generally sufficient, it was important to ensure meetings do not become too long, which could impact the quality of discussion. There was a suggestion to consider splitting longer meetings over two mornings if necessary.

The Committee briefly touched on the need for a comprehensive induction process for new members, especially given the technical nature of the committee's work.

Ceri Jackson mentioned she did not have an induction when she joined the committee. She emphasised the importance of continuous learning, especially regarding regulations or changes, to ensure that committee members who were not professionals in the area have the necessary knowledge and skills for effective scrutiny.

Following Ceri Jackson's comments on the lack of induction, Trish acknowledged that no committee-specific induction had been provided and highlighted the identified gap. Trish mentioned that a paper on this topic would be discussed later and agreed with the need for a comprehensive induction programme. Trish also noted that the induction should cover various areas such as finance, audit, and structured assessment, and should be available to all prescribed attendees to ensure full contribution. Trish invited members to suggest specific areas for development to be included in the induction programme.

Christian Fox shared his experience as a relatively new senior team representative, mentioning that he initially found the content overwhelming. He appreciated the support from Trish, Julie, and Alex, which helped clarify what he needed to read and understand. Christian also expressed concern about the amount of time he should dedicate to reading and understanding the materials but noted that the support received made it easier.

Carl Kneeshaw mentioned attending the NHS Wales board development programme alongside two newly appointed NEDs. They found the program insightful, covering governance, board structure, financial sustainability, and organisational operations within NHS Wales. Carl appreciated the remote format but felt it was a missed opportunity for building networks.

Overall, the discussion focused on the need for a structured induction programme, continuous learning opportunities, and fostering a supportive culture for committee members.

Ceri Jackson mentioned that the committee has a good balance of skills, especially with the presence of internal and external auditors. She also raised a concern about the significant challenge around diversity when considering skill mix and committee membership, emphasising the importance of addressing this issue.

RESOLVED:

(1) Members assessed whether the committee's remit, as outlined in its terms of reference, remained appropriate for 2025/26. Consideration was given to any necessary amendments, additions, or removals, areas that might be better addressed by another committee, or changes to membership.

(2) Members evaluated the cycle of business included in this pack. Reflecting on the hallmarks of effective assurance reporting, members were asked to propose potential improvements to enhance the strength and efficiency of assurance processes for the committee.

(3) Members considered the responses to the NAO questionnaire and advised of any alterations.

(4) Members reviewed the draft Annual Report and provided comments ahead of it being finalised for the May committee meeting.

03/25 INTERNAL AUDIT REPORTS

Osian Lloyd gave an update on the Internal Audit Progress Report and on the 2024/25 Internal Audit Plan, with the Committee noting that the plan remained on track. Osian added there were no proposed changes in respect of the Plan.

He added that in respect of Key Performance Indicator returns these had improved in terms of compliance, but there was still room for improvement. Trish Mills added that she and Osian have worked extensively to clarify the start of the 15-day period for report submissions, incorporating this into the handbook. Osian and his team have been instrumental in providing draft orders and setting clear deadlines. They escalate any issues as deadlines approach. Trish added that her and Osian met monthly to review reports, track progress, and address issues with directors.

The Committee also recognised that some actions required coordination among multiple executives, making them more complex than those with a single executive lead.

Trish Mills added that the current escalation process involved direct conversations with the relevant director. Should issues persist, a more structured escalation process with specific timelines would be implemented.

Several Internal Audit reports being presented:

<u>Vehicle Accident Management – Limited Assurance</u>
The purpose of this audit was to assess the management of accidents relating to Trust vehicles, and the mitigating actions being taken to reduce the rate of occurrence. Two of the five objectives (policies were in place and drivers undertake appropriate driver training courses) received reasonable assurance, three received limited assurance.

The audit assessed the management of vehicle accidents and the mitigation actions in place. Key areas for improvement include developing formal guidance and checklists for consistent investigations, maintaining a central repository for driver assessments and training, and ensuring evidence of third-party damage was collected.
Significant discrepancies were found between incidents recorded in Datix (63) and Fleetwave (796), highlighting the need for better alignment and reporting practices. The audit emphasised the importance of using Fleetwave's reporting functionality to identify themes and trends.

Management accepted the findings and provided reasonable responses to address the issues. The committee were advised that a task and finish group will be set up to implement the recommendations with a focus on improving processes. Assurances were provided that that group will have oversight from the Senior Operations Team. The audit highlighted the financial impact of vehicle accidents and the importance of timely reporting to access CCTV footage and contest legal claims.

Judith Bryce welcomed the audit which has been a valuable opportunity to improve processes and foster a culture of learning from vehicle accidents. The audit highlighted discrepancies between Fleetwave and Datix, and it was important to recognise that not all discrepancies were intentional. Some may be due to staff being unaware of vehicle damage, and Fleetwave's detailed reporting can document every minor incident, which might not always be detected or reported by the crew.

<u>Exposure to fumes – Reasonable Assurance</u>
The purpose of this audit was to evaluate the actions being taken by the Trust to ensure the health and wellbeing of staff exposed to fumes as a result of delays in handovers of care at hospital. The Quality, Patient Experience and Safety Committee (QuEST) reviewed this audit at their February meeting. The three objectives were all assessed as being reasonable assurance.

There was a noted decrease in reported incidents from 47 to 29 during the audit period. Improvements required included refining guidance on using shorelines, ensuring compliance with workplace exposure limits, and updating risk assessments for high-risk Emergency Departments (ED).

Management has accepted the recommendations and provided responses to address the issues. Wendy Herbert added that significant work has already been done to mitigate the actions identified, with many actions completed.

Ceri Jackson added that the report was discussed at the People and Culture Committee (PCC), highlighting compliance issues and the importance of ongoing work to address them. The discussion at PCC also highlighted the importance of ongoing efforts to ensure staff safety and the positive steps already taken to address the audit findings.

Patient Experience and Community Involvement – Reasonable Assurance
The purpose of this audit was to provide assurance on compliance with the Health and Social Care Quality Engagement Act and alignment with the Trust's Integrated Medium Term Plan (IMTP). QUEST reviewed this audit at their February meeting. Many actions have already been completed or were on track, except for the complex data protection impact assessment related to SMS text messaging for 999.

Ceri Jackson stressed it was important that the Board were mindful of feedback from the public particularly that which was relevant to the Trust's long-term strategy.

Rollout of Penthrox – Reasonable Assurance
The purpose of this audit was to assess the impact of the rollout of Penthrox on patients and staff, following the recent announcement that it can be administered by ambulance crews and Community First Responders. Of the four objectives of this audit, one was assessed as being substantial, two as reasonable and one as limited assurance. QUEST will receive a medicines management report in May 2025 dealing with some of the actions.

Management accepted the recommendations and provided responses to address the issues. Jonathan Chippendale outlined there was a balance between security and accessibility for Penthrox, adding there were plans to revisit training modules and access protocols.

Judith Bryce added there were significant benefits this initiative has brought to volunteers. By addressing the issue of prolonged waiting times and the inability to provide pain relief, this has made a real difference in their ability to perform their duties effectively. Judith added that the Trust was the first UK ambulance Trust to roll out this solution to volunteers. Additionally, the environmental impact of reducing Entonox use was an important benefit. Penthrox's rollout not only supported volunteers but also contributed positively to the Trust's environmental goals by minimising greenhouse gas emissions.

Ceri Jackson queried if the carbon footprint impact was being captured and were there any indicators being taken to the Finance and Performance Committee (FPC). It was agreed that in terms of reporting medical gases, Ed Roberts advised this was reported through the Decarbonisation Action Plan. In terms of the metrics being reported to FPC he agreed to investigate further and provide an update for the next ARAC meeting.

111 Digital Operations – Substantial Assurance
The purpose of this audit was to assess whether the digital operation of 111 is safe and effective, with mitigation plans in place for any weaknesses identified and tracked to resolution. The Finance and Performance Committee reviewed this audit and reported it to the board in its January 2025 AAA report. Members commended the team on the audit which provided substantial assurance across all objectives.

The audit assessed the safety and effectiveness of the digital operations of the 111 system, which replaced the previous Salus system. Despite the rapid implementation, the system's performance and security were maintained. Regular review meetings between the Trust and the supplier were noted, ensuring appropriate performance and issue resolution.

Aled Williams added that the collaborative effort between digital, 111, and operations teams was as a key factor in the successful rollout. Ed Roberts added that the new system was implemented at a significantly lower cost compared to the Salus system, resulting in considerable financial savings for the Welsh Government and the Trust.

Energy Management – Substantial Assurance

The purpose of this audit was to determine the adequacy of, and operational compliance with, the established systems for the management and control of energy consumption within the Trust and considered other supporting regulatory and procedural requirements. Five of the eight objectives were assessed as substantial and the remaining three as reasonable. The Finance and Performance Committee will review this audit at its March meeting.

The Committee noted that detailed monitoring reports were used to inform decisions, and renewable energy schemes have been implemented to improve energy efficiency. Three medium-priority findings were raised, including the need for enhanced automation of approvals, reducing estimated reads, and removing non-A-rated small appliances. The audit concluded with substantial assurance, noting that energy use is well monitored and controlled. The Trust's active management of key issues and the implementation of renewable energy schemes were highlighted as positive steps.

The Committee noted that the Trust was the only UK ambulance service to have ISO accreditation in this area, reflecting the significant work done by the Estates team.

2025/26 Internal Audit Plan

Osian Lloyd presented the 2025/26 Internal Audit Plan for approval. The Committee was assured the plan aligned to the principal risks facing the Trust. The schedule of audits was listed as follows:

- Risk Management & Assurance
- Welsh language standards
- Follow Up Action Tracker
- Budget setting
- Clinical equipment
- Clinical Model Transformation (CMT) programme management
- Integrated Medium Term Plan (IMTP) Development process
- Remote clinical support
- Cymru High Acuity Response Unit (CHARU)

- Manchester Arena Inquiry (MAI)
- Capacity management plan (Ambulance Care)
- High risk records policy
- Data management practices/devolved data
- Emerging technology adoption
- Business continuity
- Organisational change policy
- Mandatory in-service training (MIST)
- Job evaluation
- Capital Provision: scope(s) to be confirmed.
- Estates assurance: fire safety

Judith Bryce added there had been significant progress in addressing the recommendations from the Manchester Arena inquiry. Governance arrangements had been set up and 46 out of 50 internal recommendations had been completed.

The Committee approved the 2025/26 Internal Audit Plan.

RESOLVED: The Committee:

(1) Noted the following Internal Audit reports: Vehicle Accident Management, Exposure to Fumes, Patient Experience and Community Involvement, Roll out of Penthrox , 111 Digital Operations and Energy Management.

(2) Approved the 2025/26 Internal Audit Plan.

04/25 AUDIT WALES REPORTS

Annual Audit Wales Report 2024/25

The Annual Audit Wales Report for 2024/25 was received. Fflur Jones added that the annual audit report summarised all the pieces of work completed throughout the year, including accounts work, the Cost Savings Arrangements review, Quality Governance Follow Up audit, and the Structured Assessment. All these pieces of work have been through clearance and considered by the Committee in year. The Committee were assured that the remaining pieces of work would be completed in year as planned.

Outline Audit Plan 2025/26.

The Committee were advised that the schedule of audits included:

- Audit of financial statements work.
- Structured assessment, incorporating a deeper dive into estates management.
- Ambulance Care local project work.

Yvonne Thomas added that the fee for the audit work has increased by 1.7% on average to cover inflationary costs. The detailed audit plan will be worked on between now and the end of April and presented to the May committee. The opinion on the accounts will be

issued by the end of June and a meeting was scheduled with the Auditor General to sign off the accounts on 27 June 2025.

Audit Wales Quality Governance Follow-up Report

The Committee acknowledged that the report was received by the Quality, Safety, and Patient Experience Committee (QUEST) at their February meeting and was included in its AAA report. Fflur Jones added that three of the previous eight recommendations from the 2022 review had been fully implemented. These included monitoring clinical audits, improving the process around board member visits, and implementing the Joint Investigations Framework. However, four recommendations were not considered as complete (which had been marked as on the tracker), including reaching targets for Personal Appraisal Development Review (PADR), addressing the mortality review backlog, and reporting to QUEST. In addition, further recommendations were made to ensure the Quality Strategy was achievable within available resources and to detail the necessary funding. The management responses to the new recommendations were considered positive and comprehensive, and the approach to revised actions for the previously closed recommendations was commended.

Trish Mills commented that significant strides have been taken in tracking audit recommendations, with a stronger focus on ensuring closure. Over the last 18 months, you've shifted to a more assurance-focused approach for closing audit recommendations, which was previously limited by capacity. Moving forward, the areas addressed in the current report should close properly, and internal audits will help ensure this.

Wendy Herbert added that the COVID-19 pandemic significantly impacted the completion of certain actions, as priorities shifted to address the immediate crisis.

RESOLVED: The Committee Received the Audit Wales update report.

05/25 RISK MANAGEMENT REPORT

Julie Boalch presented the report and provided assurance against the Risk Management Transformation Programme noting the progress made to date with the Board in the development of a suite of risk appetite statements aligned to the Trust's six strategic objectives. Members moted that an update on the programme's direction of travel and timelines will be presented at the next meeting, acknowledging this was a two to three-year project.

Julie gave further specific updates against the principal risk management activity in Quarter including the increase in score of Risk 260 (cyber security) to 20. This risk will be considered in a closed session of the Finance & Performance Committee due to the sensitive nature of the mitigating actions which impact on the achievement of target score.

Julie further added that work continued on the 'manage and monitor' approach to Risks 223 (*the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) to streamline the internal and external factors of both risks, through a Workshop Approach.

Judith Bryce added that the Workshop Approach aimed to make the risks related to handover delays and patient safety more meaningful and actionable was a positive step forward.

Following a query in terms of engagement in addressing these system-wide risks. Julie Boalch commented that colleagues were committed to viewing these risks from a system-wide perspective, these risks were now the highest scoring on the Joint Commissiong Committee (JCC) register, which helps in gaining system-wide engagement and attention. There was a strong willingness to collaborate, raise the profile of these risks, and work on mitigations to minimise harm.

RESOLVED: Members considered and discussed the contents of the report and:

(1) Noted the progress of the Risk Management Transformation Programme: specifically, the development of risk appetite statements.
(2) Noted the update on the 2024/25 Risk Management Internal Audit Review.
(3) Noted the next steps in relation to a digital risk management solution.
(4) Noted the ongoing repositioning of Risks 223 and 224.
(5) Noted the increase in score for Risk 260 from 15 (3x5) 20 (4x5). The detail will be discussed in Closed Session of Finance & Performance Committee.
(6) Received assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.
(7) Noted the ratings and mitigating actions for each principal risk.

06/25 AUDIT TRACKER 2.0 – DECEMBER 2024 (Q3)

Trish Mills updated the Committee on the revised Audit Tracker from the Q3 2024/25 reporting period, including the current position with respect to closure of actions on their third and final date that were reported to the committee in Q2, with all on track for closure in Q4 as expected. The Committee noted the significant number (68) of actions which were due for closure in Q4.

There continues to be good engagement with Directorates on the revised Tracker 2.0 for Quarter 3 that has resulted in 31 of a total 113 (27%) open internal audit actions being closed in quarter, this figure is down from the 37% reported in Quarter 4.

Two actions from the 2022/23 'Quality Governance Review' Internal Audit remain partially complete and will remain on the tracker until replaced by more up-to-date actions, as agreed with Audit Wales. In addition, an action from the 2023/24 Workforce Planning Arrangements Internal Audit has been marked part-complete, with a revised date of March 2025.

Trish Mills ensured that committees were effectively tracking and closing off actions within the quarter. The revised risk reporting schedule aligned with board and committee cycles, providing up-to-date information. However, the tracker can be cumbersome, especially for committees with many actions. The focus was on changing behaviours to improve tracking and closure of actions. Older actions were being addressed, and there was support from internal audit to set realistic timelines. The new format should make the process easier and more effective.

Members discussed the reporting headlines agreed in September 2023, with a focus on using Power BI to provide more accessible and informative reports. They also considered moving from three revised dates to two, with the aim of improving accountability and ensuring realistic timelines were set from the outset. This proposal will be taken back to the Executive Leadership Team for further discussion by Trish Mills.

RESOLVED: The Committee:

(1) Received assurance that the management actions for the audits within the purview of this Committee and overall were being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale.

(2) Noted that the actions against the Cyber-Security and Technical Resilience internal audit will be received in closed session.

07/25 2024/25 ANNUAL ACCOUNTS REPORT

Ed Roberts provided an update with respect to arrangements and timetables for the 2024/25 audited accounts and annual report. Key headlines were:

1. Audit Wales (AW) proposed an average fee increase of 1.7% for 2025/26 due to unavoidable inflationary pressures.

2. At the time of writing, Welsh Government (WG) were yet to provide the final year-end timetable, but the draft year-end timetable proposes audit certification deadline of 30th June 2025 compared to 15th July 2024 certification for 2023/24.

3. At the time of writing, AW have provided the draft Outline Audit Plan 2025 and have advised the Detailed Audit Plan 2025 will be provided in readiness for the May ARAC meeting.

4. '*Audit enquiries of those charged with governance and management*' was yet to be received from AW and will therefore be circulated later.

RESOLVED: The update was noted.

08/25 2024/25 ANNUAL FILINGS SCHEDULE

Alex Payne presented the reported and noted that the Annual Filings timetable has been drafted based on the draft Manual for Accounts (MfA), therefore the schedule was subject to change as the final MfA was yet to be received. The Committee should note that the deadline / certification date for the 2024-25 filing was 30 June 2025; which was earlier than the 2022-23 and 2023-24 filing. The Finance Team will maintain a work programme for the production of the accounts.

RESOLVED: The Committee:

(1) Approved the Annual Filings 2024-25 schedule; and
(2) Noted that circulation of the draft reports for review and comment by email will be completed as set out in the table in paragraph 13.

09/25 INTEGRATED GOVERNANCE PROGRAMME: THE DYNAMIC INTEGRATED SYSTEM OF GOVERNANCE AND OVERSIGHT

The committee were introduced to the Integrated Governance Programme by Trish Mills. The aim was to replicate good governance principles from the board and committee level throughout the entire organisation, ensuring a flow of assurance from floor to board.

The committee noted the mapping of governance structures, which would serve as the 'single source of truth' for the Trust, and a baseline for the Quality and Performance Management Framework. The programme included tiering principles setting out the rules of establishment and operating arrangements to streamline processes.

Trish added that the programme was a two to three-year initiative, with the next steps including the development of a handbook and further refinement of the governance structures. The programme will form a priority for the committee in 2025/26 and the details of the year's deliverables and desired outcomes will be discussed in May.

Ceri Jackson suggested emphasising the strategic and operational governance context in the summary paper and questioned whether the Trust could further streamline meetings and groups. Trish Mills acknowledged these points and mentioned ongoing efforts to

ensure efficiency and effectiveness, including an effectiveness review of the Clinical Quality Governance Group. Members expressed support for the programme, highlighting its potential to improve clarity, consistency, and confidence in governance processes.

RESOLVED: The Committee:

(1) Received assurance on the integrated mapping of governance forums at Annex 1 and Annexures 1a to 1e.
(2) Considered the tiering principles at Annex 2
(3) Noted the next steps for the programme.

10/25 POLICY REPORT

Lisa Trounce provided an update on the progress made in policy compliance, noting an increase from 14% in July 2023 to 46% currently. She noted that a meeting with the Assistant Director's Leadership Team was scheduled to reprioritise the remaining policies, which will enable more robust performance reporting from Q1 onwards. It was noted that going forward a biannual report would be presented to the committee.

Ceri Jackson raised a question about the decision-making process for determining whether a document should be a policy or a standard operating procedure (SOP). Lisa explained that the policy group ensures these discussions were held with Trade Union partners and other stakeholders before deciding. The goal was to ensure that procedural documents were appropriately categorised.

Trish Mills noted that the next piece of work being undertaken would focus on ensuring that policies drive audit and monitoring processes effectively. This includes embedding policies within directorate groups and ensuring that they are part of everyday governance. Trish suggested that this work would likely start in 2026-2027.

RESOLVED: The Committee:

(1) Received assurance on the progress to bring the Trust's policies up to date.
(2) Endorsed the future work plans for the remained of the work.

11/25 QUEST COMMITTEE HIGHLIGHT REPORT: CLINICAL AUDIT PLAN 2025/26

Trish Mills provided noted that Clinical Audit Plan for 2025/26 had been approved at the last Quality, Patient Experience and Safety Committee meeting, and was presented to the Audit, Risk and Assurance Committee for assurance, in line with its terms of reference.

RESOLVED: The report was received for assurance and the update was noted.

12/25 LOSSES AND SPECIAL PAYMENTS – 1 APRIL 2024 to 31 JANUARY 2025

Ed Roberts presented the losses and special payments report which covered the period 1 April to 31 January 2025. The total amount of special payments and losses was just over £500K after reimbursements from the Welsh Risk Pool. The damages figure in this period amounted to £126K.

RESOLVED: The Losses and Special Payments Report for the period 1 April 2024 to 31 January 2025 was received.

13/25 COMMITTEE INDUCTION

The proposed induction programme was set out, with the template committee induction document which will be adapted for each committee ahead of implementation. The committee was asked to provide feedback on the proposed framework, endorse the ARAC-specific arrangements, and support its implementation by the Corporate Governance Team.

Peter Curran found the PowerPoint pack comprehensive and helpful, with no additional comments. Ceri Jackson praised the clarity and excellence of the work, emphasising the importance of a supportive environment for continuous learning and clarity on roles and responsibilities.

The discussion concluded with an acknowledgment of the need for continuous improvement and support for committee members.

RESOLVED: The Committee received the proposed committee induction programme, endorsed the ARAC specific induction arrangements, and noted that the Corporate Governance Team will implement the arrangements as proposed.

14/25 AMENDMENTS TO STANDING ORDERS AND STANDING ORDERS NON-COMPLIANCE REPORT

Trish Mills explained that the changes to the standing orders, were minor and mostly involved updates to titles with no material impact on the Trust.

The committee reviewed and endorsed the amendments to the Standing Orders Main Document and the Scheme of Reservation and Delegation of Powers for approval by the Trust Board in March and noted the position with the non-compliance issues.

RESOLVED: The Committee:

(1) Reviewed and endorsed the amendments to the Standing Orders Main Document and the Scheme of Reservation and Delegation of Powers for approval by the Trust Board in March; and

(2) Noted the position with non-compliance against Standing Orders and mitigating actions taken regarding the non-compliance of Standing Orders reported to the Board in February 2025 regarding the approval of a contract award.

15/25 ALL WALES AUDIT COMMITTEE CHAIRS MEETING HELD ON 10 DECEMBER 2024

The committee heard that the All-Wales Audit Committee Chairs met in December at which three focus areas were discussed. They were the management of audit actions via audit trackers, supporting systems used for risk management activity and counter fraud measures. The Chair reflected that the Trust was performing well in these areas.

RESOLVED: The update was noted.

16/25 COMMITTEE PRIORITIES & CYCLE MONITORING REPORT

Trish Mills added there were no matters to escalate to ARAC from the Cycle of Business.

RESOLVED: The Committee Noted the update on the Cycle of Business Monitoring Report for the Committee.

17/25 IMPACT ASSESSMENTS

The report was presented for information.

RESOLVED: The report was received for information.

18/25 REFLECTIONS AND SUMMARY OF ACTIONS

Peter Curran highlighted the extensive ground covered during the meeting and the high quality of both written and verbal presentations. He recognised the constructive challenge and support among participants, ensuring inclusivity and understanding of roles.

Ceri Jackson noted the effectiveness of the hybrid meeting format and the high standard of papers, which facilitated appropriate scrutiny and assurance.

Trish Mills reflected on the broader remit of the committee around assurance and the importance of the integrated governance program. Trish appreciated the time given to discuss broader assurance pieces and the contributions from her team. She encouraged attendees to provide any additional feedback via chat or e mail.

Meeting concluded at 13:52

Date of next meeting: 1 May 2025

MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 18 MARCH 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 (Left at item 23/25)

IN ATTENDANCE:

Hugh Bennet	Assistant Director, Commissioning and Performance
Alexander Crawford	Assistant Director of Planning and Transformation (Item 22/25 only)
Mark Harris	Assistant Director of Operations
Wendy Herbert	Assistant Director of Quality and Nursing
Estelle Hitchon	Director of Partnerships and Engagement (joined for 22/25 and 23/25)
Carl Kneeshaw	Director of People (Left at item 23/25)
Osian Lloyd	Head of Internal Audit
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Item 22/25 only)
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer (Left after Item 23/25)
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Edward Roberts	Interim Assistant Director of Finance
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner

APOLOGIES:

Lee Brooks	Executive Director of Operations
Liam Williams	Executive Director of Quality and Nursing

14/25 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 January 2025 were considered by the Committee and confirmed as a correct record.

Action Log: Action number 04/25: *Further detail and clarity was sought on the context and rationale of the strategic intent and integration of the financial sustainability programme with broader strategic objectives, potentially involving Angie Lewis for historical context and alignment with the IMTP.* It was agreed an update would be provided to the Chair by Carl Kneeshaw. A meeting has now been arranged, and it was agreed that this item could be annotated as closed.

Committee Highlight report – 16 January 2025
The Committee highlight report dated 16 January 2025 was received.

RESOLVED: The

(1) Minutes of the meeting held on 16 January 2025 were confirmed as a correct record.
(2) Action log was considered and updated as described above.
(3) Committee highlight report dated 16 January 2025 was received.

15/25 COMMITTEE EFFECTIVENESS REVIEW

Trish Mills provided the committee with a PowerPoint presentation which looked at the Committee Effectiveness Review and drew attention to specific areas as follows:

It was noted that the committee terms of reference contained details of the Strategic Direction and Delivery, and that the committee oversees the long-term strategy (2030 delivering excellence) and various aligned plans, including the digital plan and vehicle procurement strategy.

Trish highlighted the importance of aligning the committee's purpose to health and care quality standards and strategic objectives. She suggested combining and reorganising the terms of reference to reduce duplication and provide clarity.

The Integrated Medium-Term Plan (IMTP) was monitored as the delivery vehicle for the strategy and plans. The committee holds a central overview of all plans, including their links and expiration dates. The commercial plan will be included due to the new head of commercial.

The finance section included monitoring against the annual plan, in-year monitoring, risks, and Welsh Government reporting. Monthly reporting and Welsh Government Monitoring reports were standard and necessary.

Trish Mills suggested attaching PIRs to the business cases that have been approved, with the understanding that there might be a period before the PIR was ready, depending on when the return on investment or the value of the investment can be seen.

Trish proposed removing the item about monitoring progress on a range of development and capital projects from the terms of reference. She suggested that large key developments over £500,000 would be monitored through the strategic transformation board governance and the IMTP.

Trish clarified that the monitoring of the capital programme would still be included in the finance section, ensuring updates on capital projects and any issues such as delays or procurement challenges.

In terms of performance, Hugh Bennett noted the importance of focusing on key performance indicators (KPIs) that were relevant and already in the Monthly Integrated Quality and Performance Report (MIQPR). He suggested instead of reviewing all external performance indicators, the committee should concentrate on the main ones that were significant. Hugh also mentioned the possibility of providing a link to the latest published AQIs (Ambulance Quality Indicators) for reference.

Trish Mills discussed the quality and performance management framework, noting its importance for the committee. She advised that the framework was being refreshed and that it was crucial for providing assurance on the value of outcomes produced. Trish also highlighted the need to monitor progress on KPIs at the board level, to avoid overwhelming the committee with too many metrics.

Jonny Sammut expressed support for the idea of moving digital discussions to a separate committee. He added that conversations around digital were becoming deeper and more frequent, with rapid changes in legislation.

Trish Mills updated the committee on the proposition which sat under the Fleet, estates and Environmental area, to consolidate these under an infrastructure section.

Members also discussed the potential for adjusting committee meeting frequency and the quorum requirement for Non-Executive Directors.

At the conclusion of the presentation Members took part in a Mentimeter quiz. Trish Mills added there was an open invitation to the chairs of the other committees to attend the 1 May ARAC meeting and welcomed any further comments the quiz.

RESOLVED: The Committee:

(1) Assessed whether the committee's remit, as outlined in the presentation and in its terms of reference, remained appropriate for 2025/26. Consideration was given to any desired amendments, additions (such as commercial/business development), or removals, as well as any areas that might be better addressed by another committee.

(2) Evaluated the cycle of business and reflected on the hallmarks of effective assurance reporting. Members proposed potential improvements to enhance the strength and efficiency of assurance processes for the committee, including any individual reports.

(3) Took part in a short Mentimeter quiz during the meeting to answer the following questions:

- **(a) What would help you as report writers/reviewers/receivers of assurance**
- **(b) What works well in this committee**
- **(c) What improvements could we make in this committee**

(4) Reviewed the draft Annual Report and provided any comments ahead of it being finalised and circulated for email approval by Chair's Action.

16/25 FINANCIAL POSITION FOR MONTH TEN AND MONTH ELEVEN 2024/25

Chris Turley gave a presentation on the financial position of the Trust as at month Eleven.

1. The financial position has been broadly stable for several months, with a forecast to land at a break-even position. The Trust was reporting a small revenue surplus £42K for month 10. In line with the financial plans that support the Integrated Medium Term Plan (IMTP), gross savings of £5.924m have been achieved in month 10 against a target of £5.531m.

2. Month 11 was a continued reported revenue underspend against budget of £0.042m In line with the financial savings plans that supported the IMTP.

3. Gross savings of £6.317m have been achieved against a year-to-date target of £5.975m (these included income generation schemes) hence an over achievement of £0.342m. The capital programme continued to be closely monitored as the Trust moved towards the end of the financial year, with a focus on ensuring minimal variation against the Welsh Government set Capital Expenditure Limit (CEL) by the end of the month / year end.

4. The financial risks for the current year have been managed effectively, with no significant risks remaining for the next two weeks. The Trust was confident in its ability to manage any remaining risks and achieve the break-even position.

Peter Curran queried, in terms of the year-end accounting, particularly regarding depreciation, whether there would be any actions taken to accelerate depreciation that would impact the budget either positively or negatively. Chris Turley explained that the depreciation estimates assumed that the full capital allocation will be spent within the year. While there were slight changes in what the capital was being spent on, these changes do not significantly affect the asset lines compared to previous estimates.

RESOLVED: That the Finance and Performance Committee:

(1) Noted and gained assurance in relation to the Month 10 revenue financial position and performance of the Trust as at 31 January 2025.
(2) Noted the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust.
(3) Noted the brief capital programme update for 2024/25, and
(4) Noted the Month 10 Welsh Government (WG) monitoring returns submission included within *Appendices 1 – 2* (as required by WG).

17/25 INTEGRATED MEDIUM TERM PLAN DELIVERY/ASSURANCE - PROGRESS UPDATE 2024/27

Hugh Bennett explained the report was the interim Q4 2024/25 position. He provided an update on the Integrated Medium Term Plan (IMTP) delivery and assurance, focusing on the following points:

1. The update covered the clinical model transformation programme, progress on other IMTP deliverables, and the Cabinet Secretary's priorities.
2. The assessment of IMTP deliverables was both quantitative and qualitative, using a traffic light system used for assessment which included additional indicators like yellow for cautionary and blue for complete.

Hugh highlighted there were no red indicators, but Remote Integrated Care was marked as yellow (cautionary) due to capacity issues.

1. Health Transport: This was marked as cautionary, needing a more strategic vision from Commissioners and the addressing of capacity management.
2. Change Management: Marked as cautionary due to concerns about the volume and work and the pace of change which was significant.
3. Excellent Clinical Leadership: Marked as cautionary or amber, reflecting the need for associated clinical supervision to catch up with changes.
4. Non Emergency Patient Transport Services (NEPTS) Re-Rostering: This was marked as amber, indicating significant change for 450 staff, with potential for increased patient journeys but facing engagement issues.
5. Discharge and Transfer Service: Marked as amber due to lack of traction with Health Boards. Hugh highlighted the need for a more coordinated and standardised national discharge and transfer service in Wales, rather than having fragmented services.
6. Consultant Connect: This required more prioritisation due to the pace of change in integrated care.

7. Quality Improvement Hub: This had been delayed due to funding but was expected to be complete next year.

8. Civica: The Trust was progressing with the requirement for a data protection assessment.

9. Income Generation: This had been delayed due to unsuccessful appointment of the Head of Commercial position.

10. Strategic Board Assurance Framework (BAF): This was annotated as cautionary but was expected to be completed in the current quarter.

The significant drop in 111 patient survey data was raised by the committee given satisfaction levels have dropped from 88% to 49% and further detail was requested as to the reasons. It was agreed that Hugh Bennett would investigate further and provide details at the next meeting.

The challenges in recruiting to the Head of Commercial position were discussed, with the job description now undergoing a review with plans to re-advertise in the coming weeks.

The committee held a discussion in terms of staff morale and concerns were raised about the pace and change fatigue and the impact of that on staff. Members noted that the changes have introduced new ways of working and emphasised the need to ensure staff well-being and manage the pace of change. In response to the discussion and concerns regarding the impact of the pace of changes over the last year to staff it was agreed to refer to the People and Culture Committee (PCC) to seek assurance on the ways in which morale, wellbeing and support are a focus in the change management programmes in place to support delivery of the IMTP and provide an update back to the FPC.

In terms of the NEPTS roster review Mark Harris outlined significant changes were being implemented which will require extensive engagement work to guide people through these changes.

RESOLVED: The Committee:

(1) Noted the progress in identifying 'what good looks like' through the continuing development of high level outcomes measures.
(2) Noted the CMT programme progress update.
(3) Noted the confirmed Directorate-led IMTP interim position for Q4.
(4) Noted the update against the Cabinet Secretary's priorities set out in the 2024-27 planning framework.

18/25 QUALITY AND PERFORMANCE MANAGEMENT FRAMEWORK – REFRESH

Hugh Bennett provided an overview of the Quality and Performance Management Framework (QPMF) refresh report, highlighting the following key points:

1. The framework was evolving rather than undergoing a complete overhaul, as the current framework sets a high standard.
2. The previous internal audit provided reasonable assurance on the framework but limited assurance on delivery, primarily due to capacity issues within the team. The focus now was on completing what has been started.
3. Organisationally, the top of the organisation was strong in terms of assurance mechanisms, but there was variation in practice across directorates.
4. The framework emphasises self-assessment and reflective practice, allowing directorates to determine what they need to do based on organisational requirements.
5. The framework supports the statutory Duty of Quality, serving as the quality policy of the Trust.
6. A new organisational requirement has been added to strengthen evaluation processes

Bethan Evans expressed her support for the QPMF, welcoming the stronger focus on quality, which was crucial for evidencing the Duty of Quality.

Trish Mills added that the Quality and Performance Management Steering Group reported into the Executive Leadership Team.

The committee were content to endorse the QPMF for Board approval.

RESOLVED: The Finance and Performance Committee endorsed the re-fresh of the Quality and Performance Management Framework for Board approval:

19/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Hugh Bennett presented the report and drew out the following key points:

1. Call Abandonment Rate for 111: The rate was 14.8% in December, higher than the target of 5%, but better than previous winters. It stabilised at 8.2% in January and 10.1% in February.

2. P1 Times: Performance was very good, but P2 and P3 times have dipped due to increased demand deflected to clinicians linked to changes in the 999 system.

3. Call Handling 999: This was generally stable, but the 95th percentile was over one minute in December and 33 seconds in February.

4. Red Performance: The recent announcement by the Cabinet Secretary was the main corrective action, and future categorisation of clinical response models will be considered.

5. Clinical Indicators: Good performance on clinical bundles, but stroke call-to-door times were too long. Harm levels remained high, and patient cancellations were dropping due to early intervention by clinical navigators.

6. National Reportable Incidents (NRIs) / Concerns Response: the Trust reported six NRI's to the NHS Executive in January 2025, slightly more than December 2024 (three) and

25 serious patient safety incidents were referred to Health Boards under the Joint Investigation Framework.

7. In February 2025, 5,342 patients cancelled their ambulance (this figure excludes patients who refused treatment), and the Trust was unable to send an ambulance due to the application of the Clinical Safety Plan to approximately 63 callers. Both of these figures were a significant reduction in December 2024 and January 2025 levels.

8. Hours Produced: The Trust produced 127,833 Ambulance Response unit hours in January 2025 and delivered an emergency ambulance unit hours production (UHP) of 97%, achieving the 95% target.

9. Concerns: This was stable at 73% in January and 64% in February, which was good given the winter context.

10. Production and Abstractions: There was good production and low abstractions through winter, but handover issues were affecting overall performance.

11. Sickness Absence: the Trust's overall sickness percentage was 8.46% in January 2025, a decrease on the 8.69% recorded in December 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 8% is above the 2023/24 IMTP ambition of 6%.

12. Cymru High Acuity response (CHARU): The Trust achieved a 91% CHARU Unit Hours Production (UHP) in February 2025 and is now seeking to close the remain gap through the recruitment of fully qualified paramedics.

Peter Curran questioned why the metric "average jobs per shift" was positioned under the value category as opposed to the partnership system contribution category. Hugh explained that it was under that category as it was connected to the handover delays.

RESOLVED: The committee received the December 2024/January 2025 update and the unverified December 2024 Integrated Quality and Performance Report and noted that it provided sufficient assurance for the committee against progress against the performance indicators.

20/25 DIGITAL REPORTING

Jonny Sammut updated the committee on the following areas:

1. The Clinical Model Transformation programme requires significant input from various Digital teams. These requirements were not known at the time of writing of the Digital Plan and so many of the pre-agreed priorities and timelines for 24/25 were now paused or at risk.
2. Recruitment has been successful, with new posts filled in the Information and Data Services team and ICT team, including senior posts.
3. Progress on the digital transformation and innovation programme was going well, with the creation of an innovation lab to foster digital ideas and problem-solving.

4. Uptime measures for systems have been near perfect, achieving 99.999% uptime, which translated to less than 40 minutes of downtime across the year.
5. The Information and Data Services team continue to face high demand, with turnaround times now around 30 days.
6. The Non Emergency Patient Transport Services (NEPTS) cancellation two-way SMS functionality has been launched, allowing patients to cancel and rearrange appointments via text message.

Jonny also mentioned specific progress on IMTP projects, including the purchase of drones and the completion of scoping work for the Infection, Prevention and Control audit tool.

Trish Mills discussed the presentation of information in reports, specifically highlighting the new format that included highlights, low lights, and red flags.

The responses were positive, with committee members indicating that the format was effective and helpful., and the consensus was that the structured format was beneficial for quickly assimilating information and identifying key points.

RESOLVED: The committee noted the contents of the Digital Report and the trends in metrics presented.

21/25 INFORMATION GOVERNANCE REPORTING

Jonny Sammut presented the report and drew the committee's attention the following points:

1. Information Governance (IG) mandatory training was below the new 85% target, with around 340 people needed to meet this requirement. This shortfall may impact future research participation due to non-compliance with IG toolkit standards.
2. The Trust has recently recruited to the full-time Data Protection Officer role, with an existing member of staff having been appointed. Additionally, the Head of Compliance and Assurance role has been filled internally to bolster freedom of information responses.
3. The Information Governance Toolkit improvement plan was progressing with all items having been achieved save for the mandatory training target.
4. In terms of records management, the Trust was working to migrate paper records held by Denbighshire Country Council to Vantage Point House in Cwmbran.

In terms of Freedom of Information (FoI) compliance rates Trish Mills outlined the challenges involved meeting the required target, as one request could contain several other questions within it and may also require cross directorate engagement.

Damon Turner asked if there were any trends or specific areas where the compliance with the information governance training was lacking. Jonny explained that the IG training compliance issue was primarily within the operations department, which has the highest volume of staff. He mentioned that the training course was initially on the Electronic Staff register (ESR)

platform, which had feedback about the time it took to complete. To address this, the course was moved to the LMS365 platform for a quicker completion process.

RESOLVED: The committee noted the update on information governance for the period December 2024 to February 2025.

22/25 IMTP 2025/28 INCLUDING FINANCIAL PLAN FOR 2025/26

Rachel Marsh gave the committee a PowerPoint presentation and drew their attention to the following areas:

1. It was important to ensure the plan aligned with the long-term strategy of the Trust.
2. There was a need for the plan to be ambitious yet deliverable, considering the Trust's capacity and resources.
3. In terms of the Financial Plan, Rachel stressed the importance of having a credible and sustainable financial plan underpinning the IMTP.
4. The plan should appropriately account for patient outcomes and staff well-being, ensuring that both were prioritised.
5. Rachel mentioned the need for the plan to address risks appropriately, ensuring that potential challenges were identified and mitigated.
6. There were key differences and innovations in the plan this year due to the implementation of several major initiatives, such as the clinical model transformation programme, the development of a new vision for health transport and ambulance care services, and the introduction of virtual assistants and symptom checkers for digital advice.
7. Rachel highlighted the importance of engaging with stakeholders, including the public, Health Boards, and staff, to ensure the plan was comprehensive and inclusive.
8. Rachel also introduced a visual representation of metrics to measure progress towards strategic objectives, focusing on patient care and staff well-being.
9. In the next few months, a vision statement and business case will be finalised and agreed upon with WG and Commissioners. Starting on 1 July 2025, a new system for measuring emergency response will be implemented. This system will focus on "purple arrest" and "red emergency" categories.
10. By the end of this year, a single integrated team of remote clinicians will be established. This team will be supported by a larger number of Community Welfare Responders and enhanced by remote monitoring and technological capabilities.
11. There will be a continued investment, albeit at a reduced rate compared to previous years, in various alternative on-scene response options such as Advanced Paramedic Practitioners, palliative care, mental health services, and falls.

12. In terms of our people, work was focussed around three main areas: culture, capacity, and capability. One of the key priorities included the WAST way, which was the leadership and management development framework with the aim of developing and enabling leaders in every part of the Trust to work better with their teams.

13. A new handover group, clinically led, was being established to quickly identify and implement actions to reduce handover delays.

In summary, Rachel concluded that the plan was ambitious and aimed for significant transformation, but it was not without risks, particularly financial and collaborative challenges. The plan itself was very clear on what was currently assumed as income and funding to support the Trust's estimated expenditure in 2025/26 and what savings were currently required and assessed as being deliverable.

The risk that further savings may be required in year by the Joint Commissioning Committee (JCC) was discussed in some detail, both in relation to the timing of the request and the potential impact on service delivery, patient safety, and performance.

Bethan Evans expressed strong support for the plan, describing it as ambitious and potentially transformational. She acknowledged the substantial risks involved, particularly the significant efficiency targets of £8.5 million. Rachel acknowledged that while there was increased emphasis from the Cabinet Secretary, WG officials, NHS executive officials, and NHS leadership board, she remained slightly anxious about the outcomes.

Peter Curran expressed concerns about the ambitious nature of the IMTP 25-28 plan, highlighting the substantial efficiency targets of £8.5 million. Rachel added that while the current plan remained as is, any further savings or income reductions would require Board discussions to understand risks and implications before making decisions.

Financial Plan for 2025/26

Chris Turley updated the committee on the following points:

1. The financial plan included a 1.77% uplift from the Health Board's allocation, amounting to approximately £5.2 million. This does not cover the full-year effect of everything put in place this year, including the EMT band 5 impacts.
2. The plan required significant savings, with an £8.5 million savings target necessary to achieve a break-even position. There was confidence in delivering around £6.5 million of the required savings, with ongoing work to identify the remaining £2 million.
3. The plan includes detailed estimates of cost and income movements, inflationary pressures, and other cost pressures for the next year.
4. There was a risk associated with the JCC's financial position, which may require further savings discussions.

Chris highlighted that any further savings or income reduction would need to be discussed and agreed upon by the Trust Board, considering the implications and risks involved.

Chris Turley explained that the financial plan presented was balanced, but it did not include any additional savings beyond the current stretched value of £8.5 million. Chris stated that it was highly unlikely that anything beyond the current plan will be achievable in 2025-2026 without significant impacts on resources, capacity, service delivery, patient safety, and performance.

Jayne Beeslee acknowledged the significant efforts of the Executive Leadership Team and other teams in developing the plan. Additionally, she stressed the importance of the revenue budget, and the assumptions made, particularly those dependent on Welsh Government funding.

Trish Mills stressed the importance of the Equality Impact Assessment (EQIA) that accompanied the IMTP. She noted that it was a crucial part of the Board's role to review and consider the EQIA when approving the IMTP.

RESOLVED: The Committee:

(1) Noted the progress made in developing this year's IMTP.
(2) Advised of any further assurance required during the final stages of the planning cycle.
(3) Endorsed the IMTP, including the financial plan for 2025/26 for submission to Trust Board for approval at its meeting on 27 March 2025, subject to any final editing.
(4) Endorsed the EQIA for the Board's review.

23/25 WELLBEING OBJECTIVES

Estelle Hitchon provided an overview of the well-being objectives, noting their long-term nature and alignment with the ethos of the Well-being of Future Generations Act. She mentioned that the objectives were designed to reflect the Trust's contribution to the act's goals. The revised wellbeing objective were as follows:

Objective One: A Socially Responsible and Inclusive Employer

Objective Two: An Innovative and Sustainable Organisation

Objective Three: A Pro-active, Accessible and Equitable Care Provider

Estelle highlighted the Trust's proactive approach, noting that they have been working in the spirit of the act since its inception in 2015. She also mentioned the establishment of a task and finish group involving colleagues and Trade Union partners to develop these objectives.

The committee endorsed the proposed revised objectives, with Estelle adding that the objectives need to be published by 31 March 2025.

RESOLVED: The Committee:

(1) Noted the process of setting the wellbeing objectives, including the feedback received through the process of staff and public engagement and the response made to that feedback.

(2) Endorsed the proposed revised objectives (subject to any additional feedback and amendment) for onward submission to the Board at its March 27, 2025 meeting and thereafter, subject to agreement, their publication by March 31, 2025.

24/25 INITIAL 2025/26 REVENUE BUDGET

Chris Turley presented the initial 2025/26 Revenue Budget Setting Paper and drew attention to the following areas:

1. The budget was based on the financial plan, which included an £8.5 million savings requirement to achieve a balanced budget. This budget will be set assuming the delivery of these savings, even though the final £2 million was still being worked on.
2. The budget included assumptions for the cost of the pay award in 2025-2026 and the additional National Insurance (NI) employers' costs from April 2025, which were expected to be funded by Welsh Government. The NI uplift has been included in the budget with an assumed income stream to support it.
3. The budget reflected the need to balance the financial plan, with detailed breakdowns provided for divisional and directorate budgets. Discussions with individual directors will take place in Q1 to finalise these budgets.

Chris added that the budget was presented as balanced, but there were risks and assumptions that need to be managed throughout the year. The committee endorsed the budget paper for approval by the Board on 27 March 2025.

RESOLVED: Members endorsed the initial 2025/26 revenue budget, building on the WAST Financial Plan included in the IMTP and recommended it for onward approval at Trust Board on 27 March 2025.

25/25 INTERNAL AUDIT REPORT: VEHICLE ACCIDENT MANAGEMENT

The vehicle accident management internal audit was presented. This limited assurance report was discussed at length at the Audit, Risk and Assurance Committee (ARAC) on 6 March, with both this committee and ARAC assured that the actions proposed were reasonable.

1. The audit was initially scoped to review vehicle accident management from a financial sustainability perspective but was expanded to include operational aspects.
2. The audit resulted in a limited assurance rating, primarily due to issues in the operations directorate related to the reporting and management of vehicle accidents.

3. It was found that the cost of vehicle accidents to the Trust was low, and the Trust was better positioned to defend claims due to the use of cameras and GPS tracking.

4. The limited assurance was mainly due to the lack of reporting of incidents when they occur and the identification of damage during routine maintenance or inspections.

5. Management actions have been agreed to address the findings, with a focus on improving reporting and management processes.

26/25 AUDIT TRACKER

The Q3 audit tracker was produced with no escalations reported. Those committee related actions on their third and final date were discussed at ARAC in November 2024 and March 2025 and should be closed in Q4.

The report noted that nearly 70 actions were due this quarter, and new reporting practices have been agreed upon to streamline the process.

A discussion was planned with ELT to consider whether to have two dates instead of three for action closures.

RESOLVED: The Committee:

(1) Received the Finance and Performance Committee extract of the Audit Tracker reporting the position at of 27 December 2024; and

(2) Monitored management actions to address recommendations in the Audit Tracker, and associated updates provided, noting any revised dates for actions (in blue).

27/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

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

1. The cyber risk has been moved to the closed session due to the need for expanded actions and confidentiality.

2. All risks have undergone their quarterly review, with no changes in score except for the cyber risk.

3. There were discussions about potentially reducing the number of dates for risk actions from three to two, which will be taken to the ELT for further consideration.

4. Trish suggested that the two major risks, 223 and 224, which have been brought into multiple committees, might no longer need to be reviewed by this committee and the People and Culture Committee, as the Board and the Audit, Risk and Assurance Committee (ARAC) already cover them extensively.

Trish emphasised the importance of focusing on the risks relevant to this committee and considering the strategic Board Assurance Framework in future reviews.

The committee decided that risks 223 and 224, which were currently reviewed by the Board ARAC, will no longer be brought to this committee. This decision was made to avoid duplication and ensure that the committee focused on risks directly relevant to its scope.

Damon Turner suggested that it might be useful to have some staff, particularly Trade Union (TU) input, on the scoring of risks. Trish Mills explained that the risk management process was executive-owned and underwent executive oversight through, the Assistant Directors Leadership Team (ADLT), and ELT before reaching committees where TU colleagues could raise concerns.

Wendy Herbert noted the relevance of risks 223 and 224 to the FPC; while these risks were well-rehearsed in the Quest committee, there was a performance risk associated with them due to patient harm and safety elements resulting from handover delays.

RESOLVED: The Committee noted the contents of the report.

28/25 COMMITTEE PRIORITIES AND CYCLE MONITORING REPORT

Members received the Committee Cycle of Business Monitoring Report and Committee Priorities update with no escalations for the Board. It was noted that the Value Based Healthcare item had been deferred for a second time to the May meeting of the committee.

RESOLVED: The Committee received the report.

29/25 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

Members reflected that the agenda and business was managed well, with sufficient time for each item which ensured comprehensive discussions. There was a focus on quality of information which provides good assurance. Additionally, members acknowledged the need to focus the committee's attention on relevant risks and minimising duplication where business was received at other committees.

Meeting concluded at 14:20

Date of Next Meeting: 20 May 2025

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee (JCC)

Dyddiad y Cyfarfod / Date of Meeting	18/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Jacqui Maunder – Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Stacey Taylor - JCC Interim Chief Commissioner
Noddwr yr Adroddiad / Report Sponsor	Stacey Taylor JCC Interim Chief Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards	April 2025	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer (CEO) Members of the Joint Committee with a summary of the key issues considered by the Joint Commissioning Committee (JCC) at its public meeting on 18 March 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee is set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

3. HIGHLIGHT REPORT

(Links to reports highlighted March 2025 - NHS Wales Joint Commissioning Committee)

Status	Update
Alert / Escalate	• The Joint Commissioning Committee Foundation Plan 2025-2026 was **approved** in readiness for inclusion in Health Board Integrated Medium Term Plans (IMTPs) and submission to Welsh Government by 31 March 2025 with the following conditions: ○ Develop an executive summary, ○ Include an acknowledgment of the level of risk including provider risk that this plan is highlighting, ○ Establish robust accountability process to monitor the delivery of the plan, ○ Recognise the on-going conversations with providers around deliverability and savings targets that could impact on the plan, ○ Acknowledge the limited capacity to undertake the transformation programmes identified within the Plan and the collaboration required from Health Boards in delivery; and ○ Representations with Welsh Government on the position in relation to non-recurrent funding that could impact on the plan. • **Positron Emission Tomography Emission Centre (PETIC) (prostate-specific membrane antigen (PSMA) PET Scan -** An urgent piece of work to be undertaken to identify how scan capacity can be identified and be prioritised according to clinical need and responsibility for health equity. Wider piece of work on equity of access will feature as transformation piece of work detailed in the approved foundation plan.
Advise	• The Chair confirmed that Huw George, Deputy CEO and Executive Director of Operations and Finance at Public Health Wales (PHW), will be the Interim Chief Commissioner from 1 April 2025 for 12 months. He will start in shadow form on a part-time for two days a week during March and become full-time on 1 April 2025 at which point he will hold Accountable Officer status for the

Status	Update
	JCC. Stacey Taylor will continue as the current Interim Chief Commissioner until 1 April 2026. • An update was received from the Interim Chief Commissioner: ○ **Quarter 4 Progress & Future Priorities**: Work continues under transition to establish 'routine business' for the JCC. Priorities included finalising and implementing the final organisational structure and developing the Foundational Annual Plan for 2025/26 for approval, ○ Work on finalising and implementing the Scheme of Delegation, ○ Key achievements were highlighted; and ○ Next developments include securing Public Health expertise, completion of internal reviews for Traumatic Stress Wales (TSW) and the Welsh Kidney Network (WKN). • Members received reports from each of the three Commissioning Directors: • Update from the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups. Members noted: ○ Work on the new Mother and Baby Unit (MBU) in Chester had commenced with a provisional operational date of October 2025; and ○ The review of TSW service had concluded, and discussions are ongoing to consider the recommendations. Further discussions would take place related to the future strategy of the Mental Health portfolio at the April JCC Strategy Session. Members **approved** the establishment of an NHS Wales Continuing Healthcare (CHC) Cooperation Programme subject to funding from WG being secured and assurance to the Chief Commissioner that there is a plan and resilience in place to establish as a co-operation forum. • Update from the Director of Commissioning for Ambulance and 111 provided updates on: ○ The judgment in relation to the judicial review of the JCC decision to develop the Emergency Medical Retrieval and Transfer Services (EMRTS) was anticipated by end of March 2025,

Status	Update
	○ Pending the outcome of the judicial review further work on the delivery of Recommendation 4 - the bespoke road-based service was paused, ○ During March 2025, the JCC will meet with Health Board representatives in stakeholder workshops to review and discuss the recommendations within the WAST Manchester Arena Inquiry report, ○ Welsh Government are establishing a new clinically-led 'national ambulance patient handover improvement implementation group'. This work will be a key enabler in supporting the JCC to reduce risks and improve productivity in emergency ambulance services; and ○ A verbal update was provided on the Health and Social Care Committee's recommendations on emergency ambulance response targets. The long-term vision for Non-Emergency Patient Transport Services (NEPTS) 'The Future Vision' was approved. • The update from the Director of Commissioning for Specialised Services included: ○ An update on the work of the Specialised Services Collaborative Commissioning Group, ○ With the planned care funding from the Welsh Government (WG), Swansea Bay University Health Board (SBUHB) aims to meet the 104-week target for Plastic Surgery patients by the end of March 2025. However, maintaining this target through 2025/26 may be challenging without additional funding above the contract baseline, ○ Capacity gaps in outreach plastic surgery services in north Wales (now in escalation), ○ Obesity surgery waiting times; and ○ Neonatal and Paediatric Intensive Care services remain at an escalated risk level. • **Strategic Planning (Foundation Annual Plan 2025/26)**: ○ NHS Wales Planning guidance highlighted a 1.77% budget uplift with a 2% efficiency savings target, ○ Highlighted the importance of collaboration and prioritisation of resources,

Status	Update
	○ Key priorities include urgent care and planned care recovery, ○ Early estimates suggest the JCC will require between 5.5%-6.4% financial growth requirement, ○ The substantial cost drivers such as inflationary pressures, increased demand and NICE technology approvals were highlighted, ○ The Foundation Plan for 2025/26 was approved subject to caveats (see Alert Section above); and ○ A JCC strategy workshop will be dedicated to support the work to develop the JCC long term strategy and the IMTP for 2026/2029.
Assure	• **Governance & Risk Management**: ○ Updated financial delegated limits were approved for the new Interim Chief Commissioner with effect from 1 April 2025, ○ The Risk register was received, with each of the risks assigned to one of the sub-committees for monitoring and scrutiny, ○ The Corporate Governance Report was received which provided the timeline for approval of the Annual Governance Statement (AGS). Details on the approach to the Committee Effectiveness was provided and the forward plan of Business was presented; and ○ Members noted that the Health Board Standing Orders (and subsequently JCC Standing Orders) would be updated to reflect the recently issued WHC which reduced the timescale for publication of board papers to 5 clear working days.
Inform	• The Committee received the Month 10 Finance Report and the Month 9 Performance Report, • The Committee received the following assurance reports: ▪ CTMUHB Audit and Risk Committee Assurance Report, ▪ Quality Safety and Outcomes Sub-Committee, ▪ Planning Performance & Finance Sub-Committee, ▪ Individual Patient Funding Request (IPFR) Panel assurance report; and ▪ Welsh Kidney Network Board (WKN) assurance report.
Appendices	None

Status	Update

Note that an "in committee" meeting was also held. A formal update will be given to the next public JCC meeting on 20 May 2025 under the Corporate Governance report.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality Reduce Duplication Improve Equality and Population Health Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below: A More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
	If more than one applies please list below: Learning, improvement and research Whole systems perspective Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Efficient All of the domains of quality apply
	If more than one applies please list below: Effective; equitable; person centred; timely and safe
	No - Not Applicable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

ACRONYMS BUSTER

ABBREVIATION	TERM
AAA	Alert, Assure, Advise Report
ACA1/2	Ambulance Care Assistant
ADLT	Assistant Directors' Leadership Team
AfC	Agenda for Change
AGM	Annual General Meeting
AMR	Antimicrobial Resistance
APC	Academic Partnership Committee
APPs	Advanced Paramedic Practitioners
AQIs	Ambulance Quality Indicators
ARAC	Audit, Risk and Assurance Committee
BAF	Board Assurance Framework
CAS	Clinical Assessment System
CASC	Chief Ambulance Services Commissioner
CC	Charity Committee
CCC	Clinical Contact Centres
CFRs	Community First Responders
CHARU	Cymru High Acuity Response Unit
CIAT	Clinical Intelligence and Assurance Team
COPI	Control of Patient Information Regulations
COSHH	Control of Substances Hazardous to Health
CPD	Continual Professional Development
CPR	Cardiopulmonary Resuscitation
CRR	Corporate Risk Register
CQGG	Clinical Quality Governance Group
CSD	Clinical Support Desk
DAP	Decarbonisation Action Plan
CTP	Clinical Transformation Programme
EASC	Emergency Ambulance Services Committee
EDs	Emergency Departments
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
ELT	Executive Leadership Team

ACRONYMS BUSTER

ABBREVIATION	TERM
ePCR	Electronic Patient Care Record
EPRR	Emergency Preparedness Resilience and Response
ESR	Electronic Staff Record
HART	Hazardous Area Response Team
HIW	Health Inspectorate Wales
FPC	Finance and Performance Committee
FReM	Government Financial Reporting Manual
FTE	Full-time Equivalent
HSE	Health and Safety Executive
ICAP	Integrated Commissioning Action Plan
ICO	Information Commissioner's Office
IMTP	Integrated Medium-Term Plan
IPC	Infection Prevention Control
IRP	Incident Response Plan
JCC	Joint Commissioning Committee
JESIP	Joint Emergency Services Interoperability Principles
JIF	Joint Investigations Framework
JOL	Joint Organisational Learning
LCFS	Local Counter Fraud Service
LRF	Local Resilience Forum/Fora
MACA	Military Aid to Civil Authorities
MAI	Manchester Arena Inquiry
MDS	Minimum Data Set
MIQPR	Monthly Integrated Quality and Performance Report
NEPTS	Non-Emergency Patient Transport Service
NHSDW	NHS Direct Wales
NQP	Newly Qualified Paramedic
NRIs	National Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
PADRs	Performance and Development Reviews
PCC	People and Culture Committee
PECI	Patient Experience and Community Involvement

ACRONYMS BUSTER

ABBREVIATION	TERM
PPE	Personal Protective Equipment
PSOW	Public Service Ombudsman for Wales
QIA	Quality Impact Assessment
QMG	Quality Management Group
QuEST	Quality, Patient Experience and Safety Committee
Q1, Q2, Q3, Q4	Quarter (of the financial year)
RC	Remuneration Committee
REAP	Resource Escalation Action Plan
RRB	Regional Partnership Boards
RIF	Regional Integration Fund
ROSC	Return of spontaneous circulation from cardiac arrest
SDECs	Same Day Emergency Care Centres
SI	Statutory Instrument
SORT	Specialist Operational Response Team
STB	Strategic Transformation Board
STEMI	ST segment elevation myocardial infarction
The Trust	Welsh Ambulance Services NHS Trust
TRiM	Trauma and Risk Management
UCS	Urgent Care Service
UTS	University Trust Status
WASPT	Welsh Ambulance Services Partnership Team
WHSCC	Welsh Health Specialised Services Committee
WTEs	Whole-time equivalents