

Bundle Finance and Performance PUBLIC 19 May 2026

Agenda attachments

Item 00 FPC Agenda 19 May 2026 – Public

- 0 09:30 – OPENING ITEMS
- 1 Chair's Welcome, Apologies and Quorum
- 2 Declarations of Interest
 - Item 02 Board Member Register of Interests – 29 April 2026
- 3 Minutes of the last meeting: 17 March 2026
 - Item 03 PUBLIC FPC Minutes 17 March 2026 draft
- 4 Action Log & Matters Arising
 - Item 04 Action Log (Public) FPC
- 4.1 AAA Highlight Report – 17 March 2026
 - Item 04.1 Finance and Performance Committee Highlight AAA Report PUBLIC 17 March 2026
- 4.2 FOR APPROVAL, ASSURANCE AND DISCUSSION
- 5 09:35 – Quarterly operations update Q4 2025/26
 - Item 05 Operations Quarterly Report Q4 2025–2026 – FINAL
- 6 09:50 – Internal Audit Report – Capacity Management Plan (Ambulance Care)
 - Item 06 Internal Audit Report Capacity Management Plan
 - Item 06 Annex 1 Capacity Management Plan Final IA Report 170426
- 7 10:00 – Rurality, including overruns
 - Item 07 Rurality (incl Overruns)
 - Item 07 Appendix 1 Rurality
- 8 10:20 – Financial Report for Month 12 – 2025/26 and Financial Position for Month 1 – 2026/27
Please note documents in Reading Room:
 - *Month 12 2025–26 WAST Monitoring Return*
 - *WAST Month 12 2025–26 Day 9*
 - Item 08 Finance Report Month 12 25–26 Final
- 9 10:35 – Commercial Plan
 - Item 09 Commercial Plan Cover
 - Item 09 Commercial Plan 2026–28
- 9.1 10:55 – COMFORT BREAK
- 10 11:10 – Integrated Medium Term Plan (IMTP) Year End 2025–26
 - Item 10 FPC_IMTP 2025_26 Q4 Progress & Assurance Paper_May 2026 V0.1 DRAFT
 - Item 10 Appendix 1 – CMT Workstream & Project Highlight Reports Q4
 - Item 10 Appendix 2 – IMTP Delivery Assurance Report Q4 Mar 26
 - Item 10 Appendix 3_IMTP What Good Looks Like Performance Update Q4 25 26
 - Item 10 Appendix 4 – IMTP Ministerial Priorities Assessment End of 25–26 Q4 Assessment
 - Item 10 Appendix 5 – Strategic Objectives Plans on a Page 26–29
- 11 11:25 – Monthly Integrated Quality Performance Report
 - Item 11 MIQPR SBARN March April 2026
 - Item 11 Annex 1 MIQPR FPC March April 2026
- 12 11:45 – Digital Reporting May 2026
 - Item 12 Digital Reporting May 2026
 - Item 12 Appendix 1 – Digital Reporting May 2026 – Metrics

- 13 11:55 – Information Governance Report
Item 13 Information Governance Reporting May 26
- 13.1 12:05 – Information Governance Toolkit
Item 13.1 IG Toolkit Status Outcome Report
Item 13.1 Appendix 1 IG Toolkit Full Submission Report
- 14 12:10 – Risk Management Report
Please note document in Reading Room:
– BAF 070526 – FPC Extract
Item 14 Risk Management Report
- 15 12:20 – Audit Tracker 2025–26 Q4 Reporting
Item 15 Audit Tracker 25–26 Q4 (Jan–Mar26) Updates
- 15.1 CONSENT ITEMS
- 15.2 12:30 – CLOSING ITEMS
- 16 Reflections
- 17 Any Other Business
- 18 Date & Time of the next meeting: 21 July 2026

Length of Meeting: 03:05		Agenda Status: AGREED [PUBLIC] FINANCE AND PERFORMANCE COMMITTEE - 19 MAY 2026						Deadline for Papers: 08 May 2026	
Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc
OPENING ITEMS									
09:30	00:05	1	Chair's Welcome, Apologies and Quorum	Verbal	Information	Standing	n/a	Chair	n/a
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a
		3	Minutes of the last meeting held on 17 March 2026	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair	n/a
		4.1	Committee AAA Highlight Report 17 March 2026	Paper	Discussion	Standing	n/a	Chair	Trish Mills
FOR APPROVAL, ASSURANCE AND DISCUSSION									
09:35	00:15	5	Operations Quarterly Report Q4 2025/26	Paper	Assurance	CoB	Ops	Lee Brooks	Judith Bryce Toni-Marie Norman
09:50	00:10	6	Internal Audit Report - Capacity Management Plan (Ambulance Care)	Paper	Assurance	CoB	Gov	Lee Brooks	Osian Lloyd, Lisa Trounce, AnnaMaria Williams
10:00	00:20	7	Rurality, including overruns	Paper	Assurance	Forward Planner	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Melanie O'Connor
10:20	00:15	8	Financial Performance at Month 12 - 2025/26 Financial Position for Month 1 - 2026/27	Paper Presentation	Assurance	CoB	FinCor	Chris Turley	Ed Roberts
10:35	00:20	9	Commercial Plan	Paper	Endorsement	Forward Planner	SPP	Rachel Marsh	Matt Dugdale
10:55	00:15	COMFORT BREAK							
11:10	00:15	10	Integrated Medium Term Plan (IMTP) Year End 2025-26	Paper	Assurance	CoB	SPP	Rachel Marsh	James Houston
11:25	00:20	11	Monthly Integrated Quality Performance Report (MIQPR) March/April 2026	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Melanie O'Connor
11:45	00:10	12	Digital Reporting May 2026	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
11:55	00:10	13	Information Governance Progress Report	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
12:05	00:05	13.1	Information Governance Toolkit	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
12:10	00:10	14	Risk Management Report	Paper	Assurance	CoB	Gov	Julie Boalch	n/a
12:20	00:10	15	Audit Tracker 2025-26 Q4 (Jan to Mar 26) Reporting	Paper	Approval	CoB	Gov	Trish Mills [Julie Boalch]	Lisa Trounce
CONSENT ITEMS The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so. There were no consent items									
CLOSING ITEMS									
12:30	00:05	16	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a
		17	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a
		18	Date & Time of the next meeting: 21 July 2026	Verbal	Information	Standing	n/a	Chair	n/a
12:35	03:05	CLOSE							

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Chair and Non-Executive Director
Julie Boalch	Assistant Director of Corporate Governance and Risk
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital
Lee Brooks	Executive Director of Operations
Chris Turley	Director of Finance and Corporate Resources

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
AHMAD, Umar Afthab	Non-Executive Director * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	GP Partner at Plains View Surgery, Nottingham	Financial Interest	2014		
		Primary Care Network Clinical Director for Arrow Health, Nottingham	Financial Interest	2019		
		Non-executive Director (appointed company director) for Primary Integrated Community Services Ltd, Nottingham and small shareholder [Company number 08763136]	Financial Interest	2023 and 2016		
		Owner and company director of Travel Jab Guru Ltd – online medical travel advice [Company number 14685908]	Financial Interest	2023		
		Local Medical Committee Member	Financial Interest	2019		
		Nottingham Integrated Care Board Cardiovascular Disease and Stroke Prevention Clinical Design Authority Lead	Financial Interest	2025		
		Associate Non-executive Director Nottinghamshire University Hospital Trust (non-voting member of the board)	Financial Interest	2024		
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		08-Feb-26
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	Non-Executive Director * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	Executive Director of Operations	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
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		
		Chair - Taff Housing Association	Any Other Interest	17 July 2025		
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303]	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	Chair of Trust Board and Non-Executive Director * Chair of Remuneration Committee	Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Group Chair of South Central Ambulance Service NHS Foundation Trust and South East Coast Ambulance Service NHS Foundation Trust	Normal	27 March 2026		
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	Non-Executive Director * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		

	Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
	Company Director - Springfield Property Lettings Ltd	Directorships	16 August 2022		
	Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
	Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
	Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
	Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
	[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	Directorships	12 March 2020		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
EVANS, Bethan [continued]	Non-Executive Director * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	Directorships	27 April 2022		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncoel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
HITCHON, Estelle	Director of Partnerships and Engagement	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
HUTCHINGS, Hayley	Non-Executive Director * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025		
		Consultant Advisor to the FASAR Trial, Nottingham Trent University	Financial Interest	25 March 2026		
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	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
KNEESHAW, Carl	Director of People	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	Director of Culture Change	Nil Declaration				
MARSH, Rachel	Executive Director of Strategy, Planning and Performance	Nil Declaration				
MILLS, Patricia (Trish)	Director of Corporate Governance/ Board Secretary	Nil Declaration				
PARRY, Hugh	Trade Union Partner	Nil Declaration				
ROBERTS, Edward	Interim Finance Director (from 09 September 2025)	Nil Declaration				
ROWAN, Hannah	Non-Executive Director * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
SAMMUT, Jonathan (Jonny)	Director of Digital Services [appointed 26.09.2023]	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 2026	
SWINBURN, Andrew (Andy)	Executive Director of Paramedicine	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	Executive Director of Finance and Corporate Resources	Nil Declaration				
TURNER, Damon	Trade Union Partner	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Date Left Trust
WILLIAMS, Liam	Executive Director of Quality and Nursing [from 01 August 2022]	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		
WOOD, Emma	Chief Executive (from 01 October 2025)	Chartered Fellow of CIPD (Chartered Institute of Personnel and Development)	Non-Financial Professional	2000		
		External Moderator for HR Masters modules for University West of England	Financial Interest	September 2024	21 January 2026	
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025		
		Part-time Yoga Teacher at Burnham Swim and Sports Academy Leisure Centre	Financial Interest	July 2025		
		Sub/Relief Yoga Teacher at Omni Studio, Worle, North Somerset	Financial Interest	04 April 2026		



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MINUTES OF THE MEETING OF THE PUBLIC FINANCE AND PERFORMANCE COMMITTEE HELD ON 17 MARCH 2026 IN THE CARDIFF MRD AND VIA TEAMS

Meeting started at 09:30

MEMBERS:

Jayne Beeslee	Non-Executive Director and Chair
Peter Curran	Non-Executive Director
Bethan Evans	Non-Executive Director

PRESCRIBED ATTENDEES:

Matthew Dugdale	Director of Commercial Development
Carl Kneeshaw	Director of People
Rachel Marsh	Executive Director of Strategy, Planning & Performance (From item 13)
Trish Mills	Director of Corporate Governance/Board Secretary
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

ATTENDEES:

Nathan Couch	Audit Wales (<i>observing for item 11</i>)
Keith Dorrington	Assistant Director Digital (<i>deputising for Jonny Sammut</i>)
James Houston	Assistant Director for Planning and Transformation
Osian Lloyd	Head of Internal Audit, NWSSP
Alex Payne	Corporate Governance Manager
Ed Roberts	Interim Assistant Director of Finance (<i>deputising for Chris Turley</i>)
Sonia Thompson	Assistant Director of Operations (<i>deputising for Lee Brooks</i>)

APOLOGIES:

Lee Brooks	Executive Director of Operations
Hugh Parry	Trade Union Partner
Jonny Sammut	Director of Digital
Chris Turley	Executive Director of Finance and Corporate Resources



OPENING ITEMS

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

- 1.1 Apologies were received as set out above. Quorum was confirmed.
- 1.2 Adjustments to the timing of agenda items were discussed and it was noted that item 12, Rurality, had been deferred to the next meeting.

2. DECLARATIONS OF INTEREST

- 2.1 There were no other declarations recorded.

3. MINUTES OF PREVIOUS MEETING 20 JANUARY 2026

- 3.1 The minutes of the public meeting of the Finance and Performance Committee held on 20 January 2026 were received and approved.

4. ACTION LOG AND MATTERS ARISING

- 4.1.1 The Action Log was reviewed and discussed with updates added to the log.

4.1 AAA HIGHLIGHT REPORT 20 JANUARY 2026

- 4.1.2 The AAA Highlight Report from the meeting held on 20 January 2026 was noted.

ITEMS FOR ASSURANCE, DISCUSSION OR APPROVAL

The numbering of items in the minutes do not match the agenda numbering, due to items being presented non-sequentially at the meeting.

5. FINANCIAL REPORT MONTH 10, 2025/26 FINANCIAL POSITION FOR MONTH 11, 2025/26

The papers for this item in relation to the financial performance at month 10, 2025/26 are in the committee pack in iBabs and on the Trust's website, therefore detail of the content is not repeated here.



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- 5.1 Ed Roberts presented an overview of the Month 11 financial position, key assumptions and risks, confirming that the Trust was reporting an underspend of £100,000 against budget, with a small planned in month overspend. The capital plan remains on track and there was a slight overachievement of £27,000 against the savings target. The Public Sector Pay Policy is on track with 98.4% of non-NHS invoices paid within 30 days against a target of 95%. There has been accelerated expenditure from Trust Reserves due to rebasing of balance sheet provisions through the year which has been offset against planned expenditure.
- 5.2 There has been movement of finance and corporate resources in relation to the removal of the Welsh Risk Pool costs, a small overspend against general losses and a shortfall on interest receivable, due to cash balances being lower at certain times of the year. Work is ongoing with Welsh Government and the Joint Commissioning Committee to ensure this does not reoccur in the next financial year. Recurrent savings have been underachieved in-year while nonrecurrent schemes have been overachieved, with work to increase recurrent savings and reduce non-recurrent savings ongoing.
- 5.3 The Trust is on track to deliver its savings targets across all budgets, with all cost pressures mitigated and all risks now removed due to assurance that the Trust will be able to deliver its forecasted financial position by 31 March.
- 5.4 The committee received an update on the Welsh Government "Grip and Control" checklist, with Ed Roberts confirming that many of the measures outlined within it already form part of the Trust's routine financial management and assurance processes. Ed advised that the checklist would be reviewed in detail at a future meeting of the Financial Sustainability Programme Board to ensure that all required controls are fully captured and that no gaps exist.
- 5.5 The committee discussed the appropriate governance route for the Grip and Control work as well as the need to avoid duplicating work between committees and streamlining the reporting pathway, noting that elements of the checklist relate to broader organisational controls that may be more appropriately overseen by the Audit and Risk Assurance Committee (ARAC).
- 5.6 Trish Mills, Ed Roberts and Carl Kneeshaw took an action to review the Grip and Control checklist following its assessment by the Financial Sustainability Programme Board, and to provide a recommendation on the most appropriate governance route to ensure the board is properly assured without duplication within the Trust's governance framework.



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- 5.7 Ed Roberts gave an update on the Month 11 capital programme, confirming that delivery remained on track with only minor slippage in some schemes, largely due to seasonal factors such as weather. Assurance was given that the capital position was monitored daily and there is confidence that the Trust will fully deliver the capital programme against the approved capital expenditure limit.
- 5.8 Peter Curran congratulated the finance team on their effective financial management and sought assurance on whether the large volume of capital spend appearing towards year end carried any risk of underspend or potential clawback from Welsh Government. Confirmation was given that there was no risk of this happening, with all items tracked daily, and year-end spend managed. Substantial capital activity had already been completed, sighted and signed off, and current progress, pipeline deliveries and receipting activity gave strong assurance that the yearend capital programme will be fully achieved.
- 5.9 Members discussed the need to continue tight management of the capital programme will be needed next year and noted emerging geopolitical impacts on non-pay inflation, particularly fuel costs, which had already increased in-year and were identified as a material risk for 2026-027, requiring close monitoring through financial planning and in-year oversight.

The committee:

- **Noted and gained assurance in relation to the Month 10 revenue financial position and performance of the Trust as at 31 January 2026.**
- **Noted the delivery of the 2025-26 savings plan, and the context of this within the overall financial position of the Trust.**
- **Noted the capital programme for 2025-26 and the Month 10 Welsh Government monitoring return submission (as required by Welsh Government).**

6. INTERNAL AUDIT REPORT BUDGET SETTING [REASONABLE ASSURANCE]

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

- 6.1 The committee took assurance from the Internal Audit report on budget setting, which provided a reasonable assurance opinion. Ed Roberts thanked the Internal Audit team for their thorough work and engagement. It was noted that many of the audit recommendations were in progress.
- 6.2 As Chair of ARAC, Peter Curran welcomed the report's findings and confirmed that the discussion at ARAC had been positive, highlighting the



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strong alignment between budget and actual performance which showed confidence in the robustness of the Trust's approach to budget setting.

- 6.3 Osian Lloyd added that similar reviews had been undertaken across several NHS Wales organisations and that a summary thematic report drawing together learning and good practice would be issued later in the year.

The committee received and took assurance from the Budget Setting Internal Audit report and from the discussion at the meeting of the ARAC on 2 March 2026.

7. FINANCIAL SUSTAINABILITY REPORT

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

- 7.1 Carl Kneeshaw provided an update on the Financial Sustainability Programme, noting that the intensive focus on savings development has slowed progress on some longer-term financial sustainability actions.
- 7.2 Matt Dugdale updated on the Trust's commercial activities, confirming that the Commercial Plan has now been significantly developed and endorsed by the Commercial Steering Group. The plan will shortly undergo wider engagement and will be presented for approval to the Finance and Performance Committee in May 2026. Matt highlighted progress on strengthening the capacity to support commercial activity, with funding for the Applications Development Team and a Business Development Manager roles having been approved.
- 7.3 Trish Mills reflected on the recent meetings of the Commercial Steering Group, noting that the discussions now taking place are substantially different in tone and depth compared to earlier stages of the commercial programme. The Trust now has an agreed open risk appetite for delivering exceptional value and a keen risk appetite for innovation, which is helping to shape thinking about commercial opportunities and organisational tolerance.

8. INTEGRATED MEDIUM-TERM PLAN (IMTP) DELIVERY/ASSURANCE UPDATE 2025/26

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



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- 8.1 The committee was assured that previous feedback provided by members has been acted upon, with future reporting reorganised to align deliverables with the Trust's strategic objectives, giving clearer Board level sight of progress against strategic priorities.
- 8.2 Progress continues across Clinical Model Transformation (CMT) workstreams, including the establishment of a Benefits Realisation Steering Group and an upcoming workshop to articulate benefits associated with the programme. The CMT Internal Audit review (below) provided reasonable assurance, which was a positive outcome. The Health Transport workstream remains amber, and this workstream is likely to be paused next year to enable focus on a new Non-Emergency Patient Transport Service (NEPTS) improvement programme.
- 8.3 Members sought assurance regarding the six red-rated items, asking whether Welsh Government would be content with their deferral and whether the organisation had sufficient capacity to carry them into next year. James Houston confirmed that the prioritisation process for 2026–27 has been undertaken with directorate involvement to ensure the new plan is realistic, deliverable and within organisational capacity, and that the forthcoming Q4 report will provide clear evidence and justification to support the Welsh Government submission. It was confirmed that roll-overs are expected within three-year rolling IMTPs and are aligned with Welsh Government expectations.
- 8.4 The Chair asked for clarification on the prioritisation of the IMTP deliverables and whether a critical path had been identified, seeking assurance that the dependencies and sequencing had been examined, so that committee members could clearly understand the plan's key focus areas. The committee were assured that a clear roadmap is already in place and that further refinement will continue as part of ongoing planning. Members were assured that the significant reduction in planned deliverables and ongoing prioritisation means the revised plan is deliverable within available capacity.
- 8.5 The Chair queried the presentation of yellow-rated items, noting that the narrative did not always explain the reason for this status. James agreed an action for future reporting to ensure that all yellow-rated IMTP deliverables in future assurance reports include a brief narrative explaining the reason for the caution rating (e.g., delays, capacity constraints, dependencies, or other issues), rather than using generic wording such as "no change." This will aid the committee to understand the nature of the caution rating and distinguish these items more clearly from green deliverables.



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9. **INTERNAL AUDIT REPORT: CMT PROGRAMME MANAGEMENT [REASONABLE ASSURANCE]**

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

- 9.1 The committee received the Internal Audit report on programme management for the Clinical Model Transformation (CMT) programme, which gave a reasonable assurance opinion. The committee were assured that actions to strengthen governance arrangements were progressing for many of the improvement areas highlighted. As Chair of ARAC, Peter Curran confirmed that the audit had been well received at the Committee.
- 9.2 During discussion, an action for James Houston was agreed for the Project Definition Document (PDD) for the CMT programme to be circulated to Non-Executive Directors in line with the Internal Audit recommendation. It was noted that this was the only outstanding recommendation

The committee received and took assurance from the CMT Programme Management Internal Audit report and from the discussion at the meeting of ARAC on 02 March 2026.

10. **MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR)**

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

- 10.1 James Houston provided the MIQPR update for January and February and outlined key performance movements across 999, 111, emergency response and NEPTS. A refreshed MIQPR format is expected to begin reporting from Q1 2026/27, with further iterative improvements planned over the following 6 to 12 months.
- 10.2 The Chair sought clarity on the timeline for the revised MIQPR and how information would be routed from committees to the board, emphasising the need for a clear flow of assurance, ensuring each committee receives the indicators relevant to its remit to avoid duplication or gaps in reporting. Trish Mills gave assurance that this alignment work is underway, with meetings scheduled between herself, Rachel Marsh, committee chairs and committee executive leads to map committee metrics alongside digital and information governance indicators, to the most appropriate governance route. The intention is to create consistent, streamlined and strategically aligned reporting approach across committees, improving clarity and reducing unnecessary papers as the new MIQPR arrangements embed.



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11. **DIGITAL REPORTING MARCH 2026**

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

11.1 Keith Dorrington introduced the digital update and highlighted continuing pressure on digital capacity alongside strong progress across several areas.

11.2 Members discussed ongoing capacity pressures within Digital Services, particularly due to work supporting CMT and CAD (computer aided dispatch) priorities. Members also discussed the paused 111 digital front end, recognising its linkage to the 2026/27 budget position and the current assumption of no further investment, emphasising the need for a clear impact assessment of not progressing this work, to support evidence-based decisions and inform forthcoming budget considerations.

The committee acknowledged the contents of the paper and were assured on the progress of the Digital Plan activities, IMTP commitments and CMT involvement of the Digital Directorate teams.

12. **INFORMATION GOVERNANCE REPORTING MARCH 2026**

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

12.1 Keith Dorrington presented the Information Governance (IG) update, highlighting an escalation relating to the Paxton DPIA issue, and confirming that an action plan had now been developed to resolve the associated risks. There has been continued strong performance in core IG compliance areas with the IG Toolkit score maintained at 90% and mandatory IG training compliance at 91%, exceeding the 85% target. Progress on policy development has been made.

12.2 Members discussed the data breach involving electronic patient care record data loss, discovered in January 2026 and received confirmation and assurance that the matter had been fully reviewed, that mitigation was underway, and that the situation was being managed in line with information governance requirements. Members were advised that patient survey recommendations from the Information Commissioner's Office have been considered, and the adoption of SMS-based methods for collecting patient experience feedback has been discussed.



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The committee considered the contents of the paper and determined they provide assurance on the progress of the Trust's Information Governance arrangements and related specialist activities for Data Quality, Records Management, Freedom of Information requests and Information Security.

13. INTEGRATED MEDIUM-TERM PLAN (IMTP) 2026-2029 INCLUDING FINANCIAL PLAN 2026-27

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

13.1 Rachel Marsh presented the draft 2026–29 IMTP, highlighting that the plan reflects extensive engagement across the organisation and a significant reduction in deliverables, reduced from 160 to 47, to ensure clarity of focus and deliverability. Further work will be required to ensure activity removed from the central IMTP is appropriately managed within directorate business-as-usual processes. The plan is framed around the Trust's six strategic objectives and supported by a detailed mapping exercise that aligns the deliverables to commissioning intentions, the Well-being of Future Generations Act, and other statutory and strategic drivers. Rachel confirmed that the financial plan underpinning the IMTP is currently based on achieving £9 million in savings for 2026–27, and that this remains subject to refinement as the financial position evolves. Members were assured that engagement had been strong with leaders, staff and partners throughout development, and supported by two Board development sessions that enabled appropriate shaping of the plan.

13.2 Rachel updated the committee on feedback from the Joint Commissioning Committee (JCC) that she had attended that day, confirming that while some partners queried whether the Trust should seek further savings to support wider system pressures, the overall response was supportive and commissioners appeared content with the Trust's proposed £9m savings requirement, while signalling an expectation of increased scrutiny in future years.

13.3 Peter Curran referred to the four areas where further investment is not being proposed and asked whether work has been done on impact assessments, if there are any immediate implications that the committee should be aware of and how this will be communicated to stakeholders so that they have clarity on this. Assurance was given that each decision had been made through a process of prioritisation, with each area requiring system-wide solutions rather than local investment alone. It is likely that digital front-end development will progress at system level because Welsh Government has asked for funding to be released to support this work



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across Wales. Clarification was given that impact assessments are not ordinarily produced for areas not being progressed, although it was confirmed that a Quality Impact Assessment (QIA) had already been completed for the skills-mix review to look at what it would mean for patient care.

- 13.4 The Chair emphasised the importance of having a clear and consistent approach for assessing and articulating the impact and associated risks of stopping or deferring work, both for internal assurance and for external scrutiny, and how this will be communicated. Carl Kneeshaw confirmed that a comprehensive stakeholder engagement plan is already in place to support communication around the decisions not to progress certain areas in the IMTP. Carl highlighted that he is engaged in discussions with system-level partners, including through the new HEIW strategic workforce group, to ensure a coordinated national approach to managing the wider workforce implications. He advised that, once a formal decision is signed off, the organisation has a clear plan for how and when communication will be issued, ensuring that stakeholder expectations are managed effectively and reputational risk is mitigated.
- 13.5 The Committee were assured that confirmation has been received regarding the 2026–27 pay award being fully funded by Welsh Government and this formed the basis for the financial modelling within the IMTP and the revenue budget paper. The Trust is undertaking detailed process-mapping work against the current PTR regulations, with a full gap analysis planned for April.
- 13.6 The Chair welcomed the structure of the IMTP, highlighting the importance of ensuring the revised set of deliverables is clearly aligned to the Trust's six strategic objectives, requesting that this is made clear in reporting. She asked whether the Trust's agreed risk appetite could also be woven through this alignment to strengthen the connection between objectives, deliverables and organisational tolerance and suggested further refinement of the "plan on a page" to make it more accessible and focused on strategic objectives, key deliverables and critical dependencies for committee oversight. The Chair received assurance that all 'plans on a page' for each strategic objective have now been completed and future iterations of the IMTP will present deliverables clearly grouped under the six objectives.
- 13.7 Peter Curran asked for assurance about the assumptions made in the budget regarding non-pay inflation, given the current geopolitical situation. Ed Roberts acknowledged that the Trust is already experiencing upward pressure on costs and steps have been taken to mitigate wider inflationary risks, with no further Welsh Government funding expected for this. The



Committee received assurance that trends are being monitored closely and the assumptions within the budget are the best available based on current intelligence, with recognition that there remains a degree of residual risk.

The committee:

- **Noted progress made in developing the 2026-29 IMTP**
- **Endorsed the draft IMTP and financial plan for submission to Trust Board for its meeting on 26 March 2026.**

14. WAST INITIAL REVENUE BUDGET 2026-27

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

14.1 The committee received the revenue budget for the forthcoming financial year, with confirmation given that it had been developed in full alignment with the financial assumptions set out in the IMTP 2026-2028. Ed Roberts explained that the starting point for the budget was a roll-forward of the current year's position, with all non-recurrent income and expenditure removed, and the 1.11% uplift from the Joint Commissioning Committee applied, on the expectation that this will be passed through Health Boards in the usual way. The impact of the Welsh Risk Pool adjustment from the current year has been factored in appropriately, with the related recurrent cost pressures now built into the base budget. The Trust will need to deliver £9 million in savings to achieve a breakeven position in 2026–27 based on current modelling.

14.2 Peter Curran asked for clarification on when the committee would receive the full capital budget for next year, noting that the IMTP includes only a high-level position and querying whether a more detailed capital plan would be brought. Ed confirmed that the full capital budget will be brought for committee and board approval as part of the May reporting cycle.

The committee endorsed the initial 2026/27 revenue budget, consistent with the financial plan contained within the IMTP 2026-2028, and recommended it for onward approval at Trust Board on 26 March 2026

15. RURALITY

This item was deferred to the May 2026 meeting.



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16. COMMITTEE ANNUAL REPORT 2025-26 AND CYCLE OF BUSINESS 2026-27

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

- 16.1 Meetings have been scheduled with the chairs and committee executive leads of the Finance and Performance Committee, Quality, Patient Experience and Safety Committee, and People and Culture Committee to refine the suite of performance metrics that should be reported into each committee, recognising that this work will likely lead to changes in the Cycle of Business during the year.
- 16.2 An action was agreed for Trish Mills to update the Committee Annual Report to correct the priorities section, which currently reflects last year's priorities in error, and to amend the noted inconsistencies (including clarification of committee membership and footnote references). The updated version will then be circulated to members for information before the report is submitted to ARAC and the Trust Board.

The committee approved the draft cycle of business for 2026/27 and endorsed the draft committee Annual Report 2025-26, subject to the changes agreed.

17. RISK MANAGEMENT REPORT

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

- 17.1 The committee received the risk management report, and Trish Mills highlighted that the cadence of the Business Assurance Framework (BAF) review is quarterly, whereas the committee meets bi-monthly; meaning the timing of this report often results in the Committee seeing limited movement. Trish suggested the cycle of business be adjusted so that risk reports align with the risk review cycle, improving the usefulness of the assurance provided.
- 17.3 Members were advised that a number of actions had been closed and would appropriately move into the strengthened controls section in the next reporting period, improving clarity and demonstrating improved maturity of risk management.
- 17.4 The committee discussed Risk 542 *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* and that it may no



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longer be appropriate to be a standalone risk, given similar pressures emerging across multiple statutory and regulatory requirements.

- 17.5 An action was taken for Trish Mills to review the framing of the decarbonisation risk and bring a proposal to the Finance and Performance Committee in May on whether this should remain a standalone risk or be reframed as a broader statutory/regulatory compliance risk, to include an indicative timeline for this work.

The committee considered the contents of the report including the controls in place against the risks and the actions described to further mitigate the risks.

18. AUDIT TRACKER 2025-26 Q3 REPORTING

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

- 18.1 The committee received the Audit Tracker report, with Trish Mills noting that the reduced closure rate this quarter was not directly comparable with previous periods due to the differing nature and volume of actions. Trish explained that the Governance Team had recently reviewed how audit action assurance could be strengthened and that future reporting would shift away from numerical closure updates towards clearer visibility of underlying risk mitigation, particularly where actions have slipped or been deferred.
- 18.2 The committee sought assurance that the new approach would enable better understanding of where risks remain and supported the proposed direction of travel, noting that a refreshed, more risk-focused reporting model would be brought forward through the Audit, Risk and Assurance Committee before being adopted across Committees.
- 18.3 With respect to actions related to the ICT contract management audit, the committee discussed the need for improved visibility and oversight of all high-value contracts across the organisation, to ensure consistent governance standards. Trish confirmed that work is underway to create a central register and that future Committee reports will highlight contracts above £500,000 due for renewal.
- 18.4 Osian Lloyd noted that a wider All-Wales contract management audit has generated further recommendations, with many actions managed by Shared Services Procurement. The ICT audit forms part of this broader national effort to strengthen contract management.



The committee received assurance on the monitoring of management actions to address recommendations in the tracker and noted the updates provided to the Audit, Risk and Assurance Committee relating to the Technical Resilience, ICT Contract Management, and Vehicle Accident Management.

19. CCTV AND SURVEILLANCE SYSTEMS POLICY

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

19.1 The committee considered the policy presented for approval, with Trish Mills confirming it had completed the necessary governance checks and that an Equality Impact Assessment had been completed.

19.2 The Chair queried whether the current approach, where operational policies routinely come to Finance and Performance Committee for approval, was proportionate or whether a more streamlined approval pathway would be more appropriate. Trish Mills advised that a policy-transformation programme is planned, including a full review of the approvals process, policy format and quality-assurance steps, and confirmed that proposals for a revised approvals framework will be taken through the Audit, Risk and Assurance Committee, after which only policies with material strategic, governance or financial implications would come to Committees for endorsement prior to board approval.

The committee approved and adopted the updated CCTV and Surveillance Systems Policy.

CONSENT ITEMS

20. COMMITTEE CYCLE OF BUSINESS MONITORING AND PRIORITIES UPDATE MARCH 2026

20.1 The committee noted the Cycle of Business Monitoring Report 2025/26.

CLOSING ITEMS

21. REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS



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21.1 Trish acknowledged the committee's scrutiny and the importance of ensuring that policy approval processes add value rather than administrative burden. She recognised that the committee members' detailed reading and feedback demonstrate strong governance.

22. ANY OTHER BUSINESS

22.1 There was no other business discussed.

23. DATE AND TIME OF THE NEXT MEETING

23.1 The next meeting will be held on 19 May 2026 at 9:30am.

MEETING CLOSE: 12.19

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

Action	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
7/170326	17 March 2026	(7) Finance Report Month 10, 2025/26 and Financial Position for Month 11, 2025/26	Grip and control checklist review/governance route: Trish, Ed, and Carl to review the grip and control checklist following its assessment by the Financial Sustainability Programme Board, and to provide a recommendation on the most appropriate governance route (whether that be the FPC, ARAC, or both) to ensure the Board is properly assured without duplication within the Trust's governance framework.	Trish Mills, Ed Roberts, Carl Kneeshaw	21 July 2026	<u>Update 11 May 2026</u> Richard Baxter advised that this is on the Financial Sustainability Programme Board agenda for discussion at the June meeting, following conversations between Trish Mills, Carl Kneeshaw and Chris Turley. A recommendation will come back to FPC following the June FSP meeting.	Open
10/170326	17 March 2026	(10) Integrated Medium Term Plan (IMTP) Delivery /Assurance Update 2026-29	Update for future IMTP assurance reporting: Ensure that all yellow-rated IMTP deliverables in future assurance reports include a brief narrative explaining the reason for the caution rating (e.g., delays, capacity constraints, dependencies, or other issues), rather than using generic wording such as "no change." This will aid the committee to understand the nature of the caution rating and distinguish these items more clearly from green deliverables.	James Houston	19 May 2026	<u>Update 11 May 2026</u> James Houston advised that this action was specific to the CMT progress table included within the IMTP assurance report and has been considered as part of the Q4 report so can be completed. The IMTP performance reports will look different from Q1 onwards so this will be fully resolved.	Open
11/170326	17 March 2026	(11) Internal Audit Report: CMT Programme Management	Distribution of the Project Definition Document (PDD): For the Project Definition Document (PDD) for the Clinical Model Transformation (CMT) programme to be circulated to Non-Executive Directors and the Finance & Performance Committee, in line with the Internal Audit recommendation. This was highlighted during the discussion by Trish, who noted that circulation of the PDD was the one outstanding action referenced in the audit report.	James Houston	19 May 2026	<u>AW Update 11 May 2026</u> PDD was sent to NEDs on 31 March 2026 and to FPC on 20 April 2026. Action status updated to complete.	Complete
16/170326	17 March 2026	(16) Committee Annual Report 2025/26 and Cycle of Business 2026/27	Updates required to the committee annual report for 25/26: An action was agreed for Trish to update the Committee Annual Report to correct the priorities section, which currently reflects last year's priorities, and to amend the noted inconsistencies (including clarification of committee membership and footnote references). The updated version will then be circulated to members for information before the report is submitted to ARAC and the Trust Board.	Trish Mills (Alex Payne)	1 April 2026	<u>Update 8 May 2026</u> AP advised that the updates were completed and the final version went to ARAC on 28 April for endorsement, prior to Trust Board approval. Action status updated to complete.	Complete
17/170326	17 March 2026	(17) Risk Management Report	Review of risk ID 542 (Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan): It was agreed to be necessary to review the framing of the decarbonisation risk and bring back a proposal on whether it should remain a standalone risk or be reframed as a broader statutory/regulatory compliance risk, including an indicative timeline for this work. It was proposed that this position be discussed/clarified and brought back to the committee for May 2026.	Trish Mills (Julie Boalch)	19 May 2026	<u>Update post 17 March 2026</u> Action added to the planner for the May 2026 meeting. <u>Update 11 May 2026</u> Julie Boalch advised that it was agreed this will be a standalone risk, given the mitigations and action plans associated with it. Work is ongoing on what this will look like and what is possible with the resources available.	Complete



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FINANCE AND PERFORMANCE COMMITTEE HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. The papers for these meetings can be found by following this [link](#) to the Committee page on the Trust website.

Trust Board Meeting Date	26 March 2026
Committee Meeting Date	17 March 2026
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

IMTP 2026-29 (including financial plan 2026/27) and Initial Revenue Budget for 2026/27

1. Members considered the draft IMTP against key questions, including alignment with the Trust's long-term strategy, balance between ambition and deliverability, and the robustness of the supporting financial plan. Members also reflected on impacts on patients and workforce wellbeing, the identification and mitigation of risks, and the strength of engagement with leaders, staff and partners during development.
2. The Committee received assurance that the IMTP has been streamlined to 47 focused priorities, representing a deliberate shift towards a more realistic and deliverable plan aligned to organisational capacity and Welsh Government expectations. Members discussed areas not being progressed in 2026/27, noting the need for clear rationale, appropriate impact assessments and careful communication, and sought further clarity on risks, mitigations and stakeholder messaging.
3. Members were assured that engagement had been strong throughout development, supported by two Board development sessions that enabled appropriate shaping of the plan. The JCC is currently content with the IMTP assumptions and financial plan, with no changes required at this stage, although increased scrutiny of priorities, financial choices and efficiencies is anticipated over the coming year.
4. The Committee discussed refining the plan-on-a-page to ensure it is a concise, high-level reference focused on strategic objectives, key deliverables and critical dependencies, alongside more detailed versions required for Welsh Government assurance.



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5. Members discussed rising non-pay inflation, particularly fuel and energy costs, noting that pressures are already being felt in-year. It was confirmed that no additional Welsh Government funding is expected and that inflation risk will need to be managed through contingency, efficiencies and tight financial control.
6. Following consideration of the above, the IMTP 2026–29, including the 2026/27 financial plan and initial revenue budget, was endorsed and is recommended to the Board for approval.

ADVISE

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

7. The **CCTV and Surveillance Systems Policy** was approved.
8. Members **reflected** positively on the quality of scrutiny and engagement, noting that thorough preparation strengthened assurance and decision-making. There was support for moving towards more streamlined, strategic reporting and a review of committee cadence to reduce duplication, with feedback to continue being shared with the Chair to support ongoing improvement.

ASSURE

(Detail here assurance items the Committee receives)

Financial Position and Financial Sustainability

9. The committee received the detailed financial position for month 10, and a presentation on month 11 2025/26 given the timing for the close of month 11 and this meeting. The detail of the paper is not included here as it will be with the board papers, but board may wish to note:
 - Welsh Government grip and control guidance will initially be taken through the financial sustainability programme to review the checklist, with confirmation of the most appropriate committee to provide board assurance reported back to this meeting. Members were confident that many of the issues raised in that guidance are already in place in the Trust.
 - assurance was provided on projected year end spend on capital
 - while the 2025 to 2026 savings target had been met, delivery was heavily reliant on non-recurrent measures, with recurrent savings underachieving, reinforcing the need to strengthen recurrent savings in light of the significant financial challenge anticipated in 2026 to 2027
 - members discussed emerging geopolitical impacts on non-pay inflation, particularly fuel costs, which had already increased in-year and were identified as a material risk for 2026 to 2027, requiring close monitoring through financial planning and in-year oversight
10. The Committee received and took assurance from the Internal Audit Report on Budget Setting that provided a reasonable assurance rating.



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11. The Committee noted progress in the Financial Sustainability Programme, with momentum temporarily focused on the substantial organisational effort required to develop and agree the 2026/27 savings targets. Significant engagement had taken place across directorates, supported by finance, and work was underway to assess the quality, and equality impacts of savings schemes. The service review had progressed, with proposals refined into a smaller number of meaningful actions aligned to IMTP priorities, and non-viable items closed.
12. The Committee noted significant progress in the development of the commercial plan which is scheduled to be brought to the May committee for endorsement. Members welcomed the pace of development, the strengthening of supporting infrastructure, and the intention to use the May meeting to provide deeper assurance on delivery and arrangements.

Integrated Medium Term Plan 2025/26 Delivery Assurance

13. The Committee received and took assurance from the Integrated Medium Term Plan (IMTP) mid-point Q4 Assurance Report that will also be reported to board. Future reporting will align to strategic objectives rather than directorate deliverables. The Committee discussed whether rolling forward IMTP deliverables into the next planning cycle would be acceptable to Welsh Government and manageable within organisational capacity. It was confirmed that roll-overs are expected within three-year rolling IMTPs and are aligned with Welsh Government expectations, particularly given the emphasis on reprioritisation in a no-investment year. Members were assured that the significant reduction in planned deliverables and ongoing prioritisation means the revised plan is deliverable within available capacity.
14. The Committee received the reasonable assurance Internal Audit Report on the Clinical Model Transformation Programme Management which demonstrated the strength of the programme governance applied to what is a complex and wide ranging programme.

Performance Metrics

15. The MIQPR for January/February 2026 was reviewed and will also be presented to the board. Members noted progress to refresh the MIQPR following Board feedback, with a revised report expected at the next Trust Board and intended to form the basis of reporting from Q1. In parallel, committee-specific performance reports are being developed to provide focused, relevant indicators aligned to each committee's remit, supported by bespoke digital and information governance packs. Members agreed that future reporting should be predominantly strategic, with concise regulatory and compliance assurance, to improve clarity, focus and effectiveness of Board and Committee scrutiny.
16. The Digital KPIs relating to data and analytics, ICT systems, digital services, projects & programmes, and details on the progress against the Digital Plan were noted. Members discussed ongoing capacity pressures within IDS, particularly due to work supporting clinical model transformation and CAD (computer aided dispatch) priorities. Members discussed the paused 111 digital front end, recognising its linkage to the 2026/27 budget position and the current assumption of no further investment. The Committee emphasised the need for a clear impact assessment of not progressing this work, to support evidence-based decisions and inform forthcoming budget consideration (see the alert section above).



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17. The Information Governance report included strong overall compliance and evidence of key risks being actively managed. A significant electronic patient care record data loss incident was discussed, with containment measures in place. Members were assured by the minimal patient risk, and recovery work underway with the supplier. Members noted improving progress on previously delayed areas, including CCTV DPIA completion and EPCR compliance following resourcing improvements, and were assured that lessons learned and FOI performance continue to be monitored.

Governance Reports

18. The committee suggested some revisions to the draft 2025/26 annual report and the 2026/27 cycle of business to enable subsequent approval. The audit tracker for Q3 was received with no escalations to the board. The committee's cycle of business monitoring report was received with no escalations to board.

RISKS

The committee received the **Risk and Board Assurance Framework report** noting that this was a similar paper as it received in January given the cadence of formal quarterly updates to the risks. Assurance was provided that risks had been reviewed by owners, and the committee could expect closed actions moving into controls in the next reporting period.

Members noted that progress to reframe the decarbonisation risk into a manage and monitor approach has been slower than intended, and there was a shared view that the current scoring does not feel proportionate when considered alongside other principal risks. In the context of the Trust's challenging financial position and constrained resourcing, it was agreed that further consideration is needed as to whether the risk should be retained, reframed or consolidated. The May paper will therefore take a broader view of how decarbonisation sits within the overall risk landscape, recognising that it is one of a number of areas where financial and workforce capacity may increase the Trust's exposure to statutory and regulatory compliance risks, and that a more coherent and proportionate approach is required within the BAF.

COMMITTEE AGENDA FOR MEETING

IMTP 2026-29 including financial plan 2026/27	WAST initial revenue budget 2026/27	Financial position M10 and M11 2025/26
Financial sustainability report	Internal audit – budget setting	IMTP Delivery/assurance update
Internal audit - CMT programme management	MIQPR	Digital reporting March 2026
Information Governance	Committee annual report 2025/26	Risk management report
Audit tracker Q3	CCTV and surveillance policy	



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COMMITTEE ATTENDANCE						
Name	20 May 2025	21 Jul 2025	16 Sep 2025	18 Nov 2025 ¹	20 Jan 2026	17 Mar 2026
Jayne Beeslee (Chair)						
Bethan Evans					Colin Dennis	
Peter Curran			²			
Chris Turley			Ed Roberts	Ed Roberts		Ed Roberts
Rachel Marsh	Hugh Bennett	Hugh Bennett	Estelle Hitchon	Hugh Bennett	Hugh Bennett	From 10.30 ³
Lee Brooks				Judith Bryce		Sonia Thompson
Liam Williams	Wendy Herbert	Wendy Herbert				
Carl Kneeshaw						
Jonny Sammut			From 1022			Keith Dorrington
Trish Mills						
Hugh Parry				⁴		
Damon Turner						
Matt Dugdale						

	Attended
	Deputy attended
	Apologies received
	No longer member

¹ Emma Wood, Chief Executive Officer joined for this meeting.

² Peter Curran left the meeting at 10.25. Rhiannon Beaumon-Wood joined at 10.30 and was counted towards quorum.

³ James Houston deputising until 10.30

⁴ Left for items 6 and 7



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OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2025-26 Q4 (January – March 2026)

The Committees are informed this report is now structured according to the new Operations Directorate Assistant Director of Operations portfolios. This has resulted in five portfolios reducing to four to support the creation of the new Deputy Director of Operations role. An appointment to this position has been made following the recruiter supported process and a start date will be confirmed shortly. Paul Underwood has accepted an offer and is to join WAST from Aneurin Bevan University Health Board where he has been the General Manager, Urgent Care for the last six years. Paul has extensive experience across health (including ambulance) as well as in the private and third sectors.

The structure of this report shall be reviewed following Paul's induction to the organisation and Directorate.

National Operations & Support

General Update

Putting Things Right Recovery Plan

As part of the broader Trust wide PTR recovery plan, Operations Quality has met the trajectory set for overdue complaints at the end of March, ensuring complaint responses are proportionate to enable timely completion within required timeframes/targets. The department closed the recovery plan on trajectory with only 4 complaints overdue the PTR Tier 1 target, down from 88 in October 2026.

Accredited Centre of Excellence (ACE) for MPDS

Work has commenced on the 20 points of accreditation for re-accreditation as an ACE for MPDS, due in December 2026. Operations Quality is working closely with the International Academies of Emergency Dispatch (IAED) on re-accreditation activities. The Trust has been an ACE for MPDS since 2017. ACE not only provides assurance that the Trust provides high quality 999 call taking to internal and external stakeholders but also provides several other benefits including call handler certification and recertification costs, access to IAED college courses, software versions and updates, and client support. To achieve ACE, the Trust needs

to meet the required standard of 999 call compliance from random audit (approximately 350 calls a month) including achieving under 7% non-compliant calls. Random call compliance is well within the IAED set criteria and has been for the past 12-months, putting the Trust in a strong position for re-accreditation.

Resource Department Culture Review

A programme of work is underway focussed on the culture in the Resource department. A listening exercise and poll was undertaken in December 2025 and in March 2026, we brought all Resource teams together for the first time as a follow up exercise to review the themes (attached at Appendix A), commence the development of a team charter and agree next steps. Feedback from the day was positive and we will continue to work with the OD team to develop an action plan and next steps.

Coordination & Integrated Care

Challenges

Abstractions

Sickness related abstractions within EMSC continue to present challenges. Work is underway with People Services and Service Managers to develop a formal action plan, alongside a coordinated programme led by Locality Managers to ensure a consistent approach across all sites.

EMSC coordination continues to maintain a safe and effective service, with mitigation measures in place to manage abstraction levels.

111 Clinical Performance

Clinical performance within the 111 service continues to experience pressures. A comprehensive deep-dive review is currently underway, led collaboratively by the Operational Delivery Unit data analysis team, the Head of Service, Integrated Care and Integrated Care Operational colleagues. This review aims to fully understand the underlying drivers of performance challenges and to identify opportunities for improvement across clinical processes, workforce deployment, and service efficiency. Findings and recommended actions will be shared once the analysis is complete.

Clinical Navigator TEAMS® Video Functionality

This enhancement to Remote Clinical Support went live on 10 March 2026, strengthening clinical decision-making, patient safety and access to appropriate pathways and outcomes.

The service is available to WAST responders on scene, enabling real-time visual review of the patient's clinical presentation and context by senior clinical colleagues within the EMS Co-ordination Centres. Subject to patient consent, this is delivered via one-way video, complementing existing telephone-based clinical navigator support and enhancing remote clinical assessment when advice is requested.

Integrated Care First Line Organisational Change Process (OCP)

The Organisational Change Process (OCP) has now been fully completed, with interviews for the newly established positions concluding in early February 2026. Successful candidates have been identified, and preparatory work is well underway to support the transition into the new structure.

Work continues on the development of Standard Operating Procedures (SOPs), associated training materials, and updated rosters to ensure clarity of roles, consistency of practice, and operational readiness across all impacted functions.

Targeted engagement is ongoing with affected staff, including secondees returning to their substantive posts, to ensure they receive the necessary information, guidance, and support required for a smooth transition into the revised arrangements. To safeguard service continuity and minimise disruption, the transition will be delivered using a phased, tiered implementation approach. This will allow teams to embed new processes gradually and ensure any emerging issues can be addressed promptly.

111 Roster Review

Roadshows to support survey engagement were held across Wales from 12 to 15 January. Survey closed on 8 February with an approximate 65% response rate, representing staff across call handlers, clinicians and varying contract lengths. The suite of rosters has been agreed between, staff, Trade Union Partners and the project team. Briefing Sessions for manager to carry out detailed 1-to-1's with all staff to share the roster lines and to agree choices will be carried out in the coming weeks. The allocation rule set has been agreed in partnership so that in the event of over-subscription to an individual line then a fair and equitable process will be followed. It is anticipated that rosters will be placed onto GRS in the coming weeks with a phased implementation to commence on 1st June 2026.

General Update

LifeX C3 Interface

The LifeX–C3 interface went live on 7 January 2026, enabling Response Coordinators to manage radio operations directly within C3 CAD, reducing the need to use a separate system and supporting more efficient crew and call management.

Key benefits:

- Radio integrated in C3, reducing system switching.
- Simplified radio traffic handling to improve operational efficiency.
- Clearer prioritisation of Priority Request to Speak via on-screen indicators.
- Improved Shift Manager oversight for monitoring and call clearing.
- Quicker group calls to a callsign (no directory search/scrolling).
- Visible identification of monitored talk groups.

Section 136 Patients

A new call process and AQM questionnaire were introduced to record section 136 requests from police for transporting mental health patients. This process will improve data on the volume of these calls and provide evidence to support the 'Right Care Right Person' agenda with police forces.

C3 Pre-Alert Functionality Update

Pre-alerts for RCS0 (ineffective breathing) calls will no longer appear immediately on the Clinical Navigators queue. Instead, these calls will only show up once fully coded and confirmed as RCS0. This change boosts accuracy, which allows Clinical Navigators to concentrate on relevant incidents, and increases clinician capacity by ensuring urgent cases get immediate responses. It also improves efficiency in allocating clinical resources for appropriate calls.

Paramount Pro QA Upgrade

The International Academies of Emergency Dispatch (IAED) mandates that each user or service routinely updates the Medical Priority Dispatch System (MPDS) (the 999-call prioritisation system used by WAST) to the latest version, typically on a biannual basis. This ensures adherence to best practice and consistency. Additionally, agencies certified as

Accredited Centres of Excellence (ACE), including WAST, are required to implement the most recent MPDS version within one year of its release.

These upgrades are clinically imperative to maintain compatibility with other UK Ambulance Trusts, particularly when exchanging calls electronically across services. Accurate matching and translation of clinical dispatch codes, whether MPDS or Pathways, is vital to safeguard patient safety.

We can report that an upgrade was carried out on 10 February 2026. During the Clinical Model Transformation, the Trust experienced delays deploying updates as focus shifted to support key operational changes. Alert to the potential for risk the Operations Quality Team, EMSC, and other stakeholders collaborated to ensure all necessary updates were given priority attention in early 2026. Consequently, the Trust is now nationally aligned.

The upgrade also provided an opportunity to review the CHARU and CFR Code Set. The upgrade also provided an opportunity to review the CHARU and CFR Code Set.

Comprehensive training was delivered to all EMSC staff in advance of this upgrade.

CAD Upgrade

Several improvements were made following the CAD upgrades to the following areas:

- MAIT (Multiagency Incident Transfer)
- Escalation Functionality within CAD
- Changes to CFR / CWR Allocation Process
- Call Escalation via LowCode
- P1–P4 Back-Up Requests – CAD System Change

Staff Relocation to Matrix

Thanet House served as the work base for more than 150 staff, in addition to varying numbers of bank staff and GP Hub personnel. Following assessment, the aging facility at Thanet House was deemed no longer fit for purpose, prompting the decision to move services to a modern, more suitable environment that supports the Trust's long-term operational needs.

Colleagues previously based at Thanet House have now been successfully relocated to the Matrix site in Swansea, in line with the Trust's strategic aspirations for future service delivery. Building works at the Matrix site completed at the end of January 2026, enabling relocation activity to begin on 4 February 2026. All staff have now transitioned to the new site, ensuring continuity of service and improved facilities for teams supporting patient care.

Falls Desk Trial

To best utilise the funding provided by Welsh Government there was a short term expansion of the Falls Desk service to offer improved support at night. Stronger daytime coverage and new night-time services offered greater clinical assistance and more consistent decision-making throughout extended hours. During the night period (Dec-March), the desk managed 673 patients, with only 322 requiring ambulance conveyance. (48%). From February 2 to March 31, 2026, a pilot program tested the APPNAV intervention for Falls and Frailty patients who were at risk of worsening conditions or repeat visits. The funding allocations for 2026/27 does not support continuation of night shift cover, but this will be continually evaluated. Beyond these calls, APPNAVs performed standard APPNAV tasks, concentrating on falls and frailty, and coordinated community and urgent care to prevent unneeded ED escalation.

A pilot from 2 February to 31 March 2026 tested the APPNAV intervention for Falls and Frailty patients at risk of deterioration or repeat attendance. Beyond these calls, FAPPNAVs performed standard APPNAV tasks, concentrating on falls and frailty, and coordinated community and urgent care to prevent unneeded ED escalation.

In its first three months, the Falls Desk handled 2,370 incidents and provided early clinical advice in nearly 2,000 cases. Through new remote guidance, 415 patients (18%) were safely helped up, and over 70% were assisted off the floor within two hours, lowering risks associated with long periods of immobility. Patients who received remote assistance had balanced clinical outcomes: 31% were safely managed via Consult and Close pathways, while the rest were almost evenly divided between those transported and those not transported. This shows that early clinical assessment can safely reduce unnecessary transport without increasing risk in a group that needed intervention.

Falls Responder utilisation rose from 52% to 62.5%. Daytime usage is still higher than overnight, mainly due to resource availability.

Following our evaluation of 2025/26 funding has been confirmed to continue the Falls Desk via Welsh Government for 2026/27. However, there is no line of sight to direct funding beyond this financial year so we will need to develop a plan in-year.

Respiratory Desk Trial

An Integrated Care Respiratory Desk was trialled from 4 to 18 February 2026 to test a focussed respiratory assessment point within Integrated Care, enabling earlier identification

of patients suitable for management through community respiratory pathways, SPoA services, or other non-ambulance options. This approach aimed to support more effective use of WAST resources and strengthen collaboration with community teams increasingly able to manage higher-risk respiratory patients at home when appropriate.

Clinicians involved in the trial received additional respiratory-specific training and were supported throughout by the Specialist Respiratory Lead to ensure a consistent, high-quality assessment approach. During the trial, the Respiratory Desk clinician primarily triaged MPDS code 06D02 (difficulty speaking between breaths) directly from the Clinical Support Desk queue and operated between 06:30 and 18:30, Monday to Sunday.

The trial is currently being evaluated, with results expected by the end of the quarter.

Single Clinician Queue

Technical development of the Single Clinical CAD Module is progressing well, with the module now installed in the Training system and currently undergoing configuration to ensure operational readiness. Training packages are being developed in parallel, with delivery sessions scheduled from late March to mid-April. Engagement sessions will begin in early March, followed by dedicated Q&A opportunities to support staff understanding and preparedness. Work also continues with Health Boards to confirm Remote Worker access arrangements.

Alongside this, development of Standard Operating Procedures and associated processes is underway, including detailed plans to maintain business continuity in the event of any service interruptions. Overall, all workstreams remain on track and aligned with the planned Go-Live date of 21 April.

Emergency Operations

Challenges

TOIL Allocation

A pilot scheme was agreed in Partnership which saw a monitored approach to TOIL allocation with an overwhelming 'can do' approach to allowing staff to utilise TOIL. The benefits of this will see the Trust TOIL balance reduce appropriately and importantly improve staff wellbeing by enabling time off when needed to rest and recuperate.

Throughout the months of December, January & February a TOIL approval rate of over 80% has been observed. During regular TOIL project meetings, the reasons for decline have been

scrutinised and the overwhelming reason for declined TOIL requests was due to low UHP and therefore to protect safe levels of local resource availability.

March sees the last month of the pilot, and a final meeting is scheduled at which there will be a determination as to how we adopt the process as BAU, and importantly how we monitor the figures going forward. A final pilot meeting will take place at the beginning of May which will review the whole period and moving forward a monthly Toil scrutiny meeting will be held, working in partnership with TUs and chaired by Emergency Operations Head of Service.

SORT Uplift

Preparations for the SORT uplift training are progressing well, with proactive collaboration from EMS teams to optimise staff abstraction while safeguarding UHP. Communication around cross-charge arrangements are ongoing to support the FSP framework. We are currently at 222 SORT members with a recruitment plan in place to deliver 290 by end of September 2026; no training will be undertaken through the 6-week school summer holidays due to high abstractions. SORT staff on duty between 0600-0200 are being recorded and reported on the daily risk huddles with a mechanism being developed to provide assurance and identify themes and trends.

Specialist Operations Vehicles

The fleet department advised they were on course to deliver enhanced operational capability, with the planned acquisition of five additional SORT crew carriers and five replacement HART vehicles scheduled for completion by the end of the financial year. Conversations are ongoing with fleet to identify delivery dates.

Continuity 2 Rollout

The Continuity 2 training programme continues to advance, with the majority of Trust-wide departments either having completed training or confirming dates. A minor delay is anticipated, with six departments outstanding, the EPRR team is actively pursuing engagement and will escalate through SOT channels should timely cooperation not be forthcoming.

IMTP

APP Roster Review

The APP Roster review deliverable is progressing well with all Health Boards providing OMDA with key local information. OMDA are interpreting this information and applying into their algorithms and methodology to use Optima Predict to provide vital APP demand data. The output from OMDA will include recommended rotas including all local APP rotations (i.e.,

Primary Care, APP Navigator etc). Based upon this information local APP roster design will take place in partnership and full APP involvement.

Increasing Capacity in Rural Areas

The actions of the Task & Finish Group have progressed and made some local impacts in supporting local individuals in preparing for readiness to apply for EMT roles. As an IMTP deliverable this subject has now demonstrated assurance, so it has formally been closed. However, this workstream is seen as requiring constant focus to have maintain operational capacity, so the Task & Finish Group members have agreed to terminate T&F Group but re-establish itself as an ongoing working group have a constant overview of the rural position. The recommendation that the working group will continue to liaise closely with the workforce team and work through a series of long, medium and short term actions to improve and sustain rural capacity.

General Update

Mandatory In-Service Training (MIST)

Mandatory In-Service Training (MIST) compliance continues to show positive progress across EMS. In 2025/26, EMS is closing the year at 93.66% compliance, with the remaining gaps largely understood and managed. Processes are underway regarding a small number of colleagues who did not complete their training as expected. All other outstanding cases relate to staff who do not currently require assessment, such as those on long-term sickness or maternity leave, and these will be addressed through return-to-work arrangements. For 2026/27, early engagement has been strong, with 69% of EMS staff and 68% of ACA staff booked onto MIST as at 8 April, following the introduction of self-booking. Managers are now allocating sessions where required, with the expectation that all staff will be booked by the end of May. The first MIST session commenced on 14 April, marking the formal start of delivery for the new year. It is expected this revised and trade union approach to planning will reduce the number of mop-up/additional training requirements placed on our training colleagues.

Ambulance Care

Challenges

Financial Saving Plan

The organisation faces a significant operational and financial challenge arising from the discontinuation of last year's additional funding that heavily supported Discharge & Transfer

capacity, winter resilience, and delivery against key performance targets. This temporary funding has been critical in reducing cancellations, stabilising flow, and maintaining service performance during peak pressure periods.

While discussions with Commissioners are continuing, we do not yet have confirmed agreement for next year's plans or funding arrangements. This creates some uncertainty for operational planning, particularly as the additional discharge and transfer capacity, and the Capacity Management Plan (CMP) support that has helped reduce cancellations, are currently due to conclude on 31 March.

Without continued investment, our ability to meet forecast demand, sustain patient flow, and protect performance, especially through high-pressure periods, will be significantly constrained. The loss of this capacity will also place increased strain on core services, with likely implications for handover delays, staff workload, and overall system resilience. This year our IMTP includes the NEPTS Improvement Programme which will ensure we are maximising our approach to capacity.

IMTP

NEPTS Roster Review

The roster review process is progressing as planned. Working Party 3 has now been completed, and there will be a six-week period before Working Party 4 convenes. The six-week gap between Working Parties provides sufficient time for teams to make any final adjustments to their submissions ahead of the final review. During this interval, staff groups have been tasked with refining and finalising two roster options for consideration. These two options will be formally presented at Working Party 4, which will mark the final stage of the design phase.

A two-week voting period will then take place, led and overseen by union representatives to ensure transparency, fairness, and independence in the selection process. Staff will vote for their preferred roster, and the option receiving the majority support will become the final agreed roster.

Subject to completion of the voting process and any subsequent implementation planning, the new rosters are expected to go live in Q2.

General Update

Cleric Patient Application

The development of the new Cleric patient app is progressing well and is now approaching final completion. This application is designed to significantly improve the patient experience by allowing users to:

- Receive real-time vehicle location and journey status updates
- Mark themselves as ready for collection
- Book, manage, or cancel journeys directly through the app

Implementation timeline has been impacted by extended governance requirements. Specifically, the approval of the Data Protection Impact Assessment (DPIA) which has taken longer than anticipated.

The implementation timeline has been delayed due to a requirement to complete a wider WAST DPIA related to the MDVS tracking on all current vehicles which is linked with an out of date WAST privacy policy . An amended version of the app, without the real time vehicle location, is being developed with CLERIC with a phased implementation date targeted for June.

Culture Review

Following the completion of the externally led Culture Review earlier this year, the NEPTS management team has continued to progress the next phase of work. The findings and recommendations were shared with staff, and since then we have met with the Culture Team and local management groups to develop a structured action plan directly aligned to the review's recommendations.

A number of improvements are already underway, including:

- Standardisation of the three-week induction programme for all new JCC staff, ensuring a consistent and supportive introduction to the service.
- Targeted ad-hoc training, including focused support on making difficult calls, handling cancellations, and other challenging communication scenarios.
- Additional recommendations from the review have been incorporated into a wider improvement plan, which teams are now actively working through.

This work will continue throughout the year, with regular updates to staff as actions are completed and further improvements are implemented.

Discharge and Transfer

The Discharge and Transfer process is now fully embedded into business as usual, with booking behaviours consistently aligning to the expectations set by Welsh Government. Sites are demonstrating much stronger discipline around advance bookings, resulting in smoother planning, fewer late changes and a more reliable approach to managing demand.

This has strengthened operational predictability and improved the overall flow of patients through the system.

We have now also implemented a live Discharge and Transfer Dashboard, providing site leads and operational teams with real-time visibility of their bookings. This has already streamlined late activity and enabled quicker intervention when issues arise. The dashboard is now used daily at the national 11:00hrs Health Board huddle, where it has been extremely well received, offering a clear picture that supports patient flow across the system.

Fleet Replacement

A total of 65 new large Peugeot Boxer vehicles are scheduled for fleet deployment by the end of Quarter 4, accompanied by an additional 13 smaller NEPTS multi-use replacement vehicles to further enhance operational capacity and readiness

Pan Directorate Updates

Financial Savings

The Operations Directorate has developed a Financial Savings Plan for 2026/27 to deliver £4.337 of savings, representing 1.8% of its overall budget. The plan builds on a strong track record of delivering required savings and sets out a combination of schemes already identified through Senior Leadership Team planning, alongside further workstreams being developed through the Operations Financial Savings Group (OFSG). The majority of schemes are intended to be recurrent, supporting longer-term financial sustainability.

Governance arrangements have been established through the OFSG to provide oversight, scrutiny and assurance of delivery. Each savings scheme has clear ownership, delivery actions and phasing assumptions, with performance monitored at scheme level. Monthly monitoring will align with end-of-month finance reporting, enabling early identification of under- or over-delivery and timely mitigation where required.

While there is confidence in the overall direction of travel, a small residual delivery and phasing risk remains. This will continue to be actively managed through ongoing scrutiny, identification of alternative schemes where necessary, and a strong focus on maximising recurrent savings. Regular assurance updates will be provided to senior leadership and executive leadership to maintain visibility of progress, risks and mitigating actions throughout the financial year.

Datix Backlog

Progress against the Datix Backlog Action Plan continues to be positive, with 41 actions currently identified across all Operations service areas and Quality, Safety and Patient Experience Directorate. Of these, 15 actions have been completed and 18 are actively progressing.

Since backlog recovery work commenced in September 2025, a total of 1,389 historic incidents have been closed, representing a 43% reduction from the original 3,205 cases, some of which dated back to 2021/22. Variances identified within the current reporting data are being reviewed with the Trust Datix Lead to confirm the accurate position.

From September 2025, services have reported 2,416 new incidents and closed 1,408 of them, achieving a 58% closure rate. Notably, 69% of these new incidents closed, were closed within 30 days, indicating encouraging improvements in compliance and timeliness.

Quality and Support Days

Quality and Support Days were delivered across Operations throughout January and February on the following dates:

- Integrated Care: 14 January and 11 February
- EMS Operations, EMS Coordination and Ambulance Care: 15 January and 12 February

Across both months, a total of 969 MS Forms were completed. Feedback themes were as follows:

January – Christmas and New Year Period:

Feedback focused on operational and staff-experience matters relating to the festive period, including:

- Christmas period cover
- Christmas dinners
- Voucher scheme
- Self-rostering

February:

Feedback centred on key workforce and compliance topics:

- Sexual harassment
- CPD training and compliance
- E-Learning (EMS Coordination only)

Operations Managers are currently engaging with local teams who have expressed interest in implementing self-rostering for the upcoming festive period. February results will also be reviewed by local management teams during March.

APPENDIX A – Resource Department Culture Themes



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



Resourcing Team Listening Exercise

Theme Summary

How we treat and interact with each other

- Teamwork, humour and pride in the service are clear strengths.
- Cultural experiences differ, some colleagues feel excluded or unable to speak up.
- Everyone can help build a more inclusive culture by noticing who's left out and encouraging positive behaviours.



How we experience leadership and management



- Many people experience their managers as supportive valuing regular check-ins and team meetings.
- Leadership can feel inconsistent across sites, with unclear decisions, formal or fragmented communication and avoided difficult conversations.
- Everyone can strengthen the culture by communicating clearly, giving constructive feedback and supporting one another, regardless of role.

How we communicate and feel heard

- People generally feel comfortable sharing ideas and staying connected through natural, informal communication.
- Feedback doesn't always lead to visible action, leaving some unsure whether their voice matters and sometimes creating tension.
- Everyone can support better communication by checking understanding, sharing information and raising ideas constructively.



How our workload, systems and pressures affect us



- There is a strong can-do attitude, with teams pulling together under pressure and committed to delivering quality work.
- However, uneven workloads, duplicated systems and deprioritised meetings create frustration and leave little time for improvement.
- Teams can help by raising issues early, sharing ideas, supporting one another and collaborating on small, achievable improvements.

How trust and fairness feel in our hybrid ways of working

- Employees value flexible hybrid work, in-person collaboration and the trust to manage their own time.
- Challenges arise from inconsistent hybrid experiences, perceptions of monitoring or autonomy and assumptions about productivity, creating tension and mistrust.
- Focusing on contributions rather than work location and challenging unhelpful assumptions can improve trust and collaboration.



How supported, included and able to grow we feel



- Peer support and care within the team are strong, especially during busy or pressured times.
- Challenges include inconsistent access to wellbeing support, uneven development opportunities and managers needing more guidance on complex people issues, affecting morale and retention.
- Fostering an inclusive environment, offering support, mentoring, and creative development opportunities can improve confidence, growth and team wellbeing.

Thank you for your honesty, engagement and commitment - let's continue improving together.....



OUR WAST WAY
HOW WE LEAD TO BE OUR BEST





GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
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Welsh Ambulance Services
University NHS Trust

Agenda Item No. 6

REPORT TITLE

Internal Audit Report – Capacity Management Plan

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Lee Brooks, Executive Director of Operations
Author(s) of report	AnnaMaria Williams, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The purpose of this audit was to provide assurance that the capacity management plan (CMP) is being applied appropriately, with consistent decision-making and clear communication of outcomes to patients.
2. Audit, Risk and Assurance Committee recognised that the CMP is operating in an exceptionally pressured environment where demand routinely exceeds capacity. Strong



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operational foundations are in place, including clear guidance, training, scripts and dashboards.

3. One high-priority finding related to the need for greater consistency, transparency and audit trail in decision-making, particularly around journey cancellations and prioritisation. Discussion highlighted the lack of objective thresholds, limited recording of rationale within systems, and the absence of systematic analysis of ineligible patients, appeals and downstream patient impact, compounded by eligibility criteria set nationally and not reviewed for many years.
4. Members recognised the significant impact on patients and staff, including potential disproportionate effects, while taking assurance that management actions are appropriate and realistic, albeit dependent on system changes and funding.
5. Overall, ARAC was assured that the CMP is functioning as intended within current constraints, with further work required to strengthen learning, assurance and patient impact visibility.

RECOMMENDATION(S)

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

The Committee is requested to note the report.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

The Committee is requested to receive the following:

Annex 1 Capacity Management Plan Final Internal Audit Report



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Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
28 April 2026	Audit, Risk and Assurance Committee

Capacity Management Plan

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

Contents

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

WAS-2526-11

January - March 2026

16 April 2026

28 April 2026

Lee Brooks, Executive Director of Operations

Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To provide assurance that the Capacity Management Plan (CMP) is being applied appropriately, with consistent decision-making and clear communication of outcomes to patients.

Overview

Non-Emergency Patient Transport Services (NEPTS) provide essential transport for individuals across Wales who are unable, for medical reasons, to travel independently to and from healthcare appointments at clinics, hospitals, and day centres.

Eligibility is determined through a Patient Needs Assessment (PNA) conducted by NEPTS, in accordance with criteria set out by Welsh Government guidance (Welsh Health Circular 2007/005). The CMP is designed to be activated when demand exceeds available capacity; however, as has been widely reported in the Trust, these circumstances occur on a regular basis. As a result, the CMP continues to present considerable operational challenges, with an average of 500 journeys across Wales cancelled each week due to demand exceeding available capacity. As a consequence, patients who would ordinarily be eligible for transport under the WHC are often advised that transport cannot be provided.

The CMP establishes a structured framework for NEPTS to respond effectively when demand pressures arise. In light of increasing demand for NEPTS, the Trust has revised the CMP to enhance its ability to manage journey requests and ensure that eligible patients are appropriately prioritised.

Audit Opinion

We have concluded **reasonable** assurance on this area. The Trust has established a strong foundation of controls to support the appropriate application of the CMP. Clear and comprehensive guidance is in place to direct the management of non-emergency patient transport requests and the operation of the CMP. This is supported by a well-structured training programme that combines classroom-based learning, system-specific instruction, supervised practice and ongoing support to ensure staff are equipped to perform their roles effectively.

System-driven controls at the booking stage are in place with the embedded PNA ensuring eligibility decisions are made consistently and in accordance with defined criteria. Standardised scripts are used to ensure transparency and clarity for patients when communicating eligibility outcomes, with a review process in place should decisions be challenged.

The Trust has established arrangements for capturing and analysing NEPTS performance information. The Cleric system is used to record core datasets, and a well-developed Power BI dashboard that enables detailed trend analysis, supports informed operational oversight, and strengthens assurance over CMP activity. In consideration of this data, the Trust may benefit from reviewing its booking methodology, with consideration given to basing bookings on capacity available at the time of the journey requirement rather than two days in advance.

The matters requiring management attention include:

- The CMP could be strengthened by further clarifying key activation triggers, cancellation criteria and prioritisation rules, including the use of more measurable thresholds.
- There is no central repository to record and retain training records.
- NEPTS does not record or monitor ineligible PNA outcomes, limiting visibility of refusals, trends, and unmet need.
- The Cleric system does not provide functionality to record the rationale for journey-planning decisions and CMP activation, limiting the audit trail and reducing transparency of prioritisation decisions.
- Eligibility appeals are not tracked or analysed, resulting in limited oversight of trends, outcomes and areas for learning and process improvement.
- There is no systematic method for capturing patient-reported impacts, creating a gap in understanding the real-world consequences of cancellations.

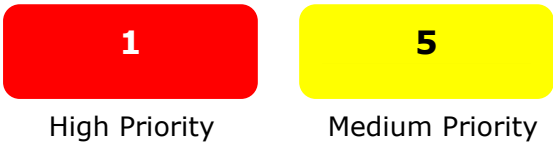
We note that a separate journey booking process used by healthcare professionals operates differently from the standard patient-initiated pathway. As the majority of these bookings are not normally subject to CMP cancellation procedures, we have not reviewed this process as part of the audit.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

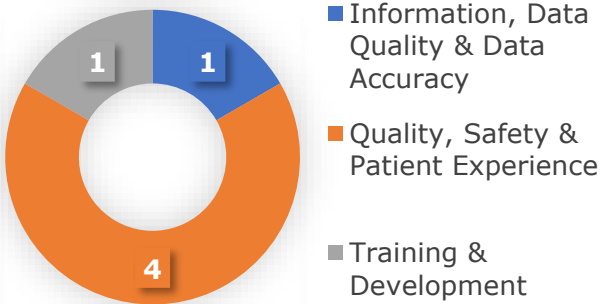
Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There is clear and documented guidance in place regarding the management of non-emergency patient transport requests, and application of the Capacity Management Plan.	3	Reasonable
2	Appropriate training is provided to staff responsible for processing transport requests.	1	Reasonable
3	The Capacity Management Plan is implemented consistently, and decisions relating to transport requests are made in accordance with established procedures.	2,3,4	Limited
4	Decisions are communicated effectively to patients and/or their representatives; with a defined process for patients to request a review of eligibility where transport requests have been declined.	4,5	Reasonable
5	Mechanisms are in place to capture and analyse performance information, such as journey cancellations, and to evaluate the impact of these on patients and their care, with reporting to appropriate forums both internally and externally.	4,6	Reasonable

Management Actions



Themes



Risk Types

- Public Perception & Reputational Risk
- Quality or Safety Issues
- Legal & Regulatory Non-Compliance

At a Glance – Non-Emergency Patient Transport Services Activity

NEPTS Activity Overview

The following table sets out the scale of NEPTS activity ¹ and the pressure on capacity, highlighting the volume of journeys that cannot be delivered and are therefore cancelled under the Capacity Management Plan (CMP).

Metric	October 2025	November 2025	December 2025
Total Journeys booked ²	66,751	61,402	70,086
Total Journeys completed ²	57,728	53,219	55,452
Total cancellations (all causes ³, excluding CMP)	6,336	5,581	12,514
CMP cancellations	2,687	2,602	2,120
% of demand	4.03%	4.24%	3.02%
Average journeys cancelled per week under CMP	607	607	488

¹ This data has been extracted from a Cleric system report that includes all NEPTS activity during the period October to December 2025

² The values presented reflect the total number of NEPTS journeys, with each individual movement counted separately. This means that an inward journey and an outward journey are recorded as two distinct journeys (noting that the majority of bookings involve transporting a patient both to and from their appointment). Consequently, where transport is cancelled under the Capacity Management Plan (CMP), both legs of the journey are recorded as separate cancellations. This approach provides an accurate representation of overall service activity and the scale of capacity pressures experienced across the system.

³ Other cancellation causes (as per Cleric) include, but are not limited to, cancellation by family/friend/patient; patient is deceased; patient has Covid-19; patient is in hospital; patient has access to own transport; treatment has finished early; poor weather conditions; and bank holiday suspensions.

Capacity Management Plan Activation Frequency

The following table sets out the number of days that the Capacity Management Plan (CMP) was activated ¹.

Month	Days in month (Monday - Friday)	Days that the CMP was activated
October 2025	23	23
November 2025	20	20
December 2025	23	22

Findings & Agreed Action Plan

Objective 1: There is clear and documented guidance in place regarding the management of non-emergency patient transport requests, and application of the Capacity Management Plan.	Reasonable
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The Trust’s Capacity Management Plan (CMP) is a comprehensive and well-documented framework governing the management of non-emergency patient transport during periods of operational pressure. The approved CMP (last reviewed May 2023) sets out clear eligibility and prioritisation criteria, defined booking processes, and an established decision review mechanism (see Appendix A). The CMP is aligned with the statutory eligibility requirements set out in WHC (2007) 005 through the Patient Needs Assessment (PNA) process. Although England updated its equivalent criteria in 2022, the Welsh eligibility criteria has not been reviewed as originally intended (12 months post publication as cited in the circular). We recognise that responsibility for undertaking this review sits outside the Trust.

While several operational thresholds are clearly defined within the CMP, such as the booking cut-off time, communication requirements, and approval steps for cancellation categories, key elements would benefit from the inclusion of more measurable and objective triggers. It is recognised that some flexibility is necessary to ensure that available resources are utilised in the most effective way, however, the activation trigger for initiating CMP escalation remains qualitative; defined simply as demand exceeding available resources without numerical thresholds to support consistent or auditable decision-making **(see Key Finding 3)**.

Similarly, prioritisation within cancellation categories does not incorporate objective criteria or risk-based scoring, and certain journey cancellation triggers rely on subjective concepts such as having a “high level of confidence” that a journey can be accommodated. These gaps reduce clarity and introduce scope for inconsistent interpretation during periods of operational pressure.

The Trust has developed a structured training programme for call handlers, day controllers and journey planners, incorporating a blend of classroom-based induction, system-specific learning, supervised practice, and ongoing support.

The Cleric system is used to manage the patient journeys. New starters receive formal system training supported by detailed Cleric user guides, access to a training account with mock scenarios, shadowing of experienced colleagues, and a buddy arrangement to aid transition to live activity. Opportunities to further enhance this induction framework has been identified by the Trust. Managers review completion of training checklists and determine readiness for independent work, with additional support available following initial sign-off. Recent system interface changes have also prompted Trust-wide refresher training.

During our site visit to Vantage Point House (VPH), and acknowledging that practices may vary across sites, we noted that training records are not consistently captured or retained (see **Key Finding 1**). ESR reflects only mandatory ESR-based modules; module-specific checklists are not routinely uploaded to individual staff files, limiting the ability to evidence staff competence, training compliance, and alignment to CMP/SOP requirements.

The service has identified training gaps, and an updated training framework is currently in development to address areas such as managing difficult situations and mandatory vehicle familiarisation. However, no defined process has yet been established to systematically record and maintain these training activities (see **Key Finding 1**).

Key Findings		Risk & Impact	Agreed Management Action
1	Recording and Retention of Training Documentation Training records are not consistently captured or stored across the service. ESR only reflects mandatory ESR-based modules. The module-specific training checklists (intended to evidence completion of system training, induction components and role-specific competencies) are not routinely uploaded to individual staff files. As a result, the Trust cannot reliably demonstrate that staff have completed the required training, nor provide assurance over competence, compliance with CMP/SOP requirements, or the consistency of training delivered across teams. Although we recognise the Trust is developing its training provision, such lacks a process to ensure training is consistently recorded and maintained.	Variability in decision-making across regions or staff could result in inequitable access to transport services.	Agreed Action: 1. A central training records framework will be developed defining mandatory modules (to consider ESR based), system-specific training, induction requirements and role-specific competencies; with recording of completed training on such mandated. 2. Periodic assurance checks will be undertaken to ensure that required training has been completed and records are maintained consistently. 3. Quarterly training compliance reports will form part of the Ambulance Care Quality Dashboard, which will be reported to Ambulance Care Formal and Quality Management Group. Expected Evidence of Implementation: 1. Approved training records framework and storage protocol. 2. Evidence of the training records being uploaded. 3. Inclusion of training compliance within the Ambulance Care Quality Dashboard.

Key Findings		Risk & Impact	Agreed Management Action
		Medium Priority	Officer: Karl Hughes: Head of Service, Ambulance Care Coordination
	Theme: Training & Development	Control Operation	Target Implementation Date: 31 March 2027

Objective 3: The Capacity Management Plan is implemented consistently, and decisions relating to transport requests are made in accordance with established procedures.

Limited

Journey booking

System-driven controls operate effectively at the booking stage for the telephone requests received. The Patient Needs Assessment (PNA) is embedded within the system and requires completion of all mandatory questions aligned to the eligibility criteria outlined in WHC 2007/005 before a booking can proceed. Walkthrough and call-monitoring testing, undertaken at the NEPTS contact centre during a site visit to VPH, confirmed that call handlers follow the scripted PNA and make eligibility decisions based solely on defined criteria.

Although the system-controls at the booking stage are functioning effectively, there is no mechanism to record or monitor patients deemed ineligible. This limits the Service's ability to monitor refusals, identify demand patterns, or detect inconsistencies in the interpretation of eligibility criteria (**see Key Finding 2**).

Journey planning and CMP activation

Decision-making during journey planning and activation of the CMP is significantly more variable. Although high-level prioritisation principles exist, (first renal and oncology patients, followed by seven mobility categories in order of priority i.e. stretcher patient, wheelchair user), journey planners can exercise considerable discretion when allocating resources, placing journeys on the unallocated list for 'on the day allocation', or selecting those for CMP cancellation (**see Key Finding 3**).

It is acknowledged that a certain degree of flexibility within the journey-planning process is both necessary and appropriate. The dynamic nature of demand, variations in patient mobility needs, journey distances, geographical challenges, and operational disruptions require planners to apply professional judgement to maximise the use of available resources. This human element, such as sequencing journeys based on proximity, anticipating late cancellations, or adapting to changes in staffing or vehicle availability, are an integral element to achieving operational efficiency. As such, some variation in practice is expected and reflects the practical reality of managing a complex, high-volume transport service within variable capacity constraints.

The service has developed a journey-planning checklist to aid planners in implementing the CMP consistently. However, based on practices observed at VPH, the tool is not routinely used in practice. In addition, the system does not provide functionality to record the rationale underpinning planning decisions, thereby limiting the service's ability to respond effectively should a patient dispute the decision or requests further review (**see Key Finding 4**).

Walkthrough testing confirmed that CMP cancellations are documented on the system using the standard code "CMP – No resource at planning." However, no additional narrative is captured to explain why certain journeys were allocated resources, and why others were cancelled, or how planners determined which cases should be placed on the unallocated list. The absence of documented reasoning for selecting lower-priority journeys for cancellation once capacity is exhausted limits transparency and auditability.

Monitoring consistency

Mechanisms for monitoring consistency of CMP application are inherently limited, particularly given that CMP activation occurs daily as demand exceeds capacity. Daily variation in demand patterns, mobility requirements, journey distances, individual planner discretion, and differences between health boards means that full consistency is neither expected nor feasible, and a degree of variation is appropriate within such a dynamic environment. Within these constraints, the service has implemented proportionate measures to monitor CMP usage, (see *objective 5* for further details). While these mechanisms cannot eliminate variability, they do offer meaningful visibility of CMP activity.

CMP activity data provided by the Trust further demonstrates an underlying degree of consistency across health boards. Despite the absence of documented rationale for individual decisions, lower-mobility categories (e.g., C3 – Own Wheelchair and C1– Walking Case) consistently account for the highest proportion of CMP cancellations.

Key Findings		Risk & Impact	Agreed Management Action
2	Visibility of Eligibility Screening Outcomes and Incomplete Monitoring of Ineligible Patients Despite effective front-end system controls for determining patient eligibility for transport, the service has no mechanism to record or monitor patients deemed ineligible following the PNA. Ineligible outcomes are not retained within the patient record, and no dataset exists to track refusals, reasons for refusal, or trends over time. This gap limits the ability of management to monitor the volume and nature of ineligible requests, assess whether eligibility criteria are being interpreted consistently, or identify potential training needs or quality issues. It also restricts visibility of demand that does not convert into bookings, reducing the Service's ability to understand unmet need.	Variability in decision-making across regions or staff could result in inequitable access to transport services.	Agreed Action: 1. A proposal will be developed that provides functionality within the Cleric system to record ineligible outcomes, the reasons for such, any advice provided to the patient and whether an appeal was made. Implementation will be subject to the identification of additional funding as required. 2. Monthly data analysis and reporting of the above dataset will be undertaken to identify, for example, trends or recurring reasons for ineligibility, potential inconsistencies in decision making, training needs for call handlers, levels of unmet need/demand not converting into bookings etc.
		Medium Priority	Expected Evidence of Implementation: 1. Recording mechanisms embedded in the system and in active use. An approved proposal for the implementation of ineligible patient recording. 2. Implementation, subject to identification of funding, to deliver above proposal. 3. Defined database for monitoring ineligible outcomes; and actions / training improvements based on trends identified. 4. Reporting of output from database as part of the Ambulance Care Quality Dashboard reported to Ambulance Care Formal and Quality Management Group.
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Karl Hughes: Head of Service, Ambulance Care Coordination Target Implementation Date: 31 March 2027
3	CMP Triggers While a Capacity Management Plan (CMP) exists, key triggers and prioritisation rules are not defined in measurable terms, relying instead on qualitative judgement; increasing the risk of	Inconsistent decision-making may undermine assurance over fair	Agreed Action: 1. Quantifiable CMP triggers will be developed; and these will replace/supplement qualitative descriptors to ensure consistent activation of capacity responses.

Key Findings		Risk & Impact	Agreed Management Action
	inconsistent decision-making during periods of capacity pressure.	and robust journey prioritisation and cancellations.	Expected Evidence of Implementation: 1. Updated CMP with measurable triggers and prioritisation rules.
		Medium Priority	Officer: Karl Hughes: Head of Service, Ambulance Care Coordination Target Implementation Date: 31 March 2027
	Theme: Quality, Safety & Patient Experience	Control Operation	
4	Audit Trail for Journey Planning and CMP Activation Decision Supporting tools, such as the journey-planning checklist, are not routinely used and the system records only high-level cancellation codes without capturing the rationale behind planning decisions (e.g., why journeys are allocated, deferred or cancelled). insufficient documentation reduces transparency, limits auditability and increases the risk of inconsistent decision-making during periods of capacity pressure.	Undocumented decision-making may undermine assurance over fair and robust journey prioritisation and cancellations.	Agreed Action: 1. The routine use of supporting tools, including the journey-planning checklist, to ensure consistent planning practice will be mandated. 2. A proposal will be developed to enhance the recording on the Cleric system of cancellation and planning codes to capture the rationale behind decisions. Implementation will be subject to the identification of additional funding as required. 3. Inclusion within the NEPTS Quality Dashboard of period audits of CMP decision making.
			Expected Evidence of Implementation: 1. Communication of the mandatory use of the journey-planning checklist. 2. An approved proposal for the recording of Cleric system codes. 3. Updated Cleric system codes implemented and in use. Implementation, subject to identification of funding, to deliver above proposal. 4. CMP decision-making audit outcomes included within Quality Dashboard and reported to Ambulance Care Formal and Quality Management Group.
		High Priority	Officer: Karl Hughes: Head of Service, Ambulance Care Coordination Target Implementation Date: 31 March 2027
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 4: Decisions are communicated effectively to patients and/or their representatives; with a defined process for patients to request a review of eligibility where transport requests have been declined.

Reasonable

Eligibility decisions

The service has established structured and consistent processes for communicating eligibility decisions to patients at the point of booking. Standardised scripts are used by call handlers when advising patients who do not meet the eligibility criteria outlined in the PNA, and observations of calls further demonstrated compliance with these scripts. Patients who disagree with an eligibility decision are informed of their right to request a review, and a defined review process is in place. Appeals are logged in the non-eligible review log and escalated to a supervisor, who re-assesses the call recording and, where appropriate, undertakes a re-review of the PNA using the extended criteria set out in the CMP SOP.

Whilst the eligibility review process is clearly communicated, the service does not monitor the number or nature of appeals submitted. There are no mechanisms in place to track appeal trends, analyse outcomes, or identify learning opportunities (**see Key Finding 5**).

CMP cancellations

CMP cancellations are applied as a last resort, at short notice, and only once all feasible options to accommodate the journey have been exhausted. As with eligibility decisions, cancellations under the CMP are communicated using standardised scripts and delivered consistently by Journey Coordination Centre staff. Patients are notified by telephone at least one working day before travel. Where patients do not answer, voicemail messages are left, and although patients are not explicitly offered a call-back, they may contact the main NEPTS contact centre to discuss the decision.

Despite the use of standard scripts, the communication to patients does not include a detailed explanation of the rationale behind CMP cancellations or articulate the application of prioritisation principles that underpin CMP decision-making (**see Key Finding 4**). In contrast to eligibility decisions, no formal review or appeal mechanism exists for patients whose journeys are cancelled under CMP. Given the time-critical nature of same-day and next-day planning, there is no practical window for a review to be undertaken without further delaying or disrupting journey allocation. Patients are instead signposted to the Trust's Putting Things Right process should they wish to raise concerns.

Key Findings		Risk & Impact	Agreed Management Action
5	Monitoring and Oversight of Eligibility Appeals While the eligibility review process is clearly communicated to patients and consistently applied by call handlers, the service does not maintain any mechanism to monitor the number, nature, or outcomes of appeals submitted following an eligibility decision. There is no systematic tracking of how often eligibility decisions are challenged, whether particular themes or misunderstandings recur, or whether communication practices could be strengthened in response to patient feedback. Without this oversight, the service lacks visibility of trends, learning opportunities, and signs of process failure or inconsistency, limiting the Trust's ability to assess how effective its communication approach is.	Poor communication of decisions to patients and lack of clarity on review processes may increase dissatisfaction and complaints.	Agreed Action: 1. A SOP will be created for documenting and categorising appeals to ensure consistent recording by call handlers and reviewing officers. 2. A process will be developed to capture all appeals received. Details to be recorded will include reason for appeal, outcome (upheld/overturned). 3. Regular thematic analysis will be completed monthly and presented to the NEPTS weekly huddle and Quality Management Group to identify trends or recurring themes; areas where communication of guidance may need strengthening; indicators of inconsistencies in the eligibility assessment process. 4. Findings of the analysis will be reported routinely through the NEPTS Quality Dashboard and reported to Ambulance Care Formal and Quality Management Group.
			Expected Evidence of Implementation: 1. SOP approved and implemented. 2. Centralised appeal logging mechanism in use. 3. Thematic analysis report presented to the relevant NEPTS weekly huddle and Quality Management Group and documented improvements / actions arising from identified trends.
	Theme: Quality, Safety & Patient Experience	Medium Priority Control Operation	Officer: Karl Hughes: Head of Service, Ambulance Care Coordination Target Implementation Date: 31 March 2027

Objective 5: Mechanisms are in place to capture and analyse performance information, such as journey cancellations, and to evaluate the impact of these on patients and their care, with reporting to appropriate forums both internally and externally.

Reasonable

The Trust has implemented a range of mechanisms to capture and analyse performance information relating to NEPTS activity, cancellations and CMP usage. At an operational level, the system records core datasets such as journey identifiers, patient mobility categories, booking and cancellation timestamps, and CMP-related triggers. CMP cancellations are consistently recorded using the standard code "CMP – No Resource at Planning," and the CMP trigger log provides meaningful insight into cancellation volumes, regional variation, and the mobility groups most affected. This information is further analysed through the dedicated Power BI Quality Dashboard, which is used routinely within weekly team meetings and the monthly NEPTS Formal Ambulance Care meetings to review trends, identify inconsistencies, and inform operational planning. In consideration of this data, the Trust may benefit from reviewing its booking methodology, with consideration given to basing bookings on capacity available at the time of the journey requirement rather than two days in advance.

While the system captures what has been cancelled and when, it does not record the decision-making rationale underpinning cancellations or journey-planning choices (refer to *objectives 3 & 4*; and **Key Finding 4**). This limits the completeness of the audit trail and constrains the ability to evaluate whether CMP has been applied consistently and in line with prioritisation principles. Similarly, although cancellation trends can be analysed accurately, the Trust currently lacks the capability to assess the downstream impact of cancellations on patient care.

NEPTS systems do not interface with health board clinical or appointment systems, meaning the service cannot determine whether a cancelled journey resulted in a missed or delayed appointment, or whether alternative arrangements were made, thereby limiting the Trust's understanding of patient impact (**see Key Finding 6**). There are currently no alternative mechanisms by which to gather or analyse such feedback. However, at the date of audit fieldwork, we note that a Civica survey was being developed to automatically contact patients affected by CMP cancellations and capture self-reported impacts. While this is a positive development, the functionality is not yet in place. This gap is reflected in wider patient experience data, where high satisfaction among transported patients contrasts with significant complaints relating to cancellations and unmet need.

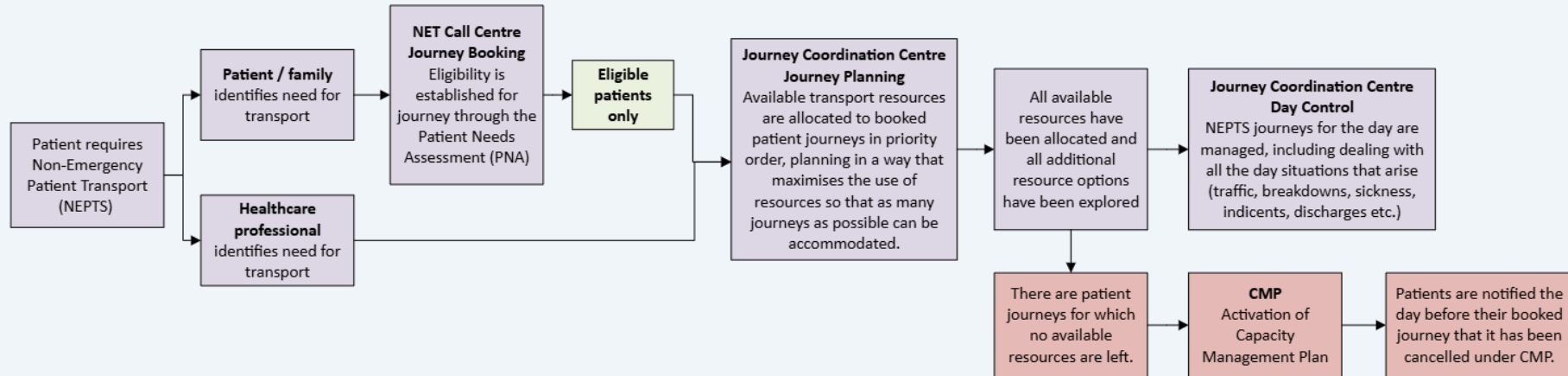
Oversight mechanisms are otherwise well embedded. The Monthly Integrated Quality and Performance Report (MIQPR) provides consistent reporting, including timeliness of renal and oncology journeys, NEPTS completed journeys, and CMP cancellations, to the Executive Leadership Team, the Quality, Patient Experience and Safety Committee (QUEST), the Finance and Performance Committee, and the Trust Board. Quarterly operational reports and bi-annual Patient Experience and Community Involvement reports further enhance triangulation. Externally, structured reporting to the Delivery Assurance Group (DAG), Commissioning Assurance Group (CAG) and the NHS Wales Joint Commissioning Committee (JCC) provides transparent system-level visibility of pressures, risks, activity and emerging issues.

Key Findings		Risk & Impact	Agreed Management Action
6	Ability to Assess the Impact of Cancellations on Patient Care The Trust lacks the ability to assess the downstream impact of cancelled NEPTS journeys on patient care. NEPTS systems do not interface with Health Board clinical or appointment systems, so the service cannot confirm whether cancelled journeys led to missed or delayed appointments, whether alternative arrangements were made, or whether cancellations affected treatment or wellbeing. As a result, understanding of patient impact is limited to internal operational data and feedback from patients who received transport. A Civica survey is being developed to automatically contact patients whose journeys are cancelled under CMP and capture self-reported impacts; however, this mechanism is not yet implemented.	High cancellation rates or delays in transport could lead to missed appointments, delayed treatment, and adverse health outcomes.	Agreed Action: 1. The Civica patient impact survey will be explored (subject to Data Protection Impact Assessment) to gather patient feedback on journeys cancelled under CMP. If feasible, survey content will capture missed/delayed appointments, treatment impact, alternative arrangements made and any patient wellbeing issues. 2. We will introduce a process whereby the enhanced service hub will, as part of their routine operations, review any enhanced CMP cancellations (e.g. oncology, renal). 3. Subject to an effective survey, responses will be collated and analysed integrating findings into performance reporting to identify patterns, risks and high-impact cancellation types. 4. Quarterly reporting to Ambulance Care Formal and Quality Management Group providing patient impact insight to support service improvement and strategic planning.
			Expected Evidence of Implementation: 1. Civica impact survey implemented and functioning. 2. Enhanced Service Hub review process in place. 3. Interim manual process documented and in operation. 4. Defined analysis and reporting process approved. 5. Quarterly reporting to Ambulance Care Formal and Quality Management Group.
	Theme: Quality, Safety & Patient Experience	Medium Priority Control Operation	Officer: Karl Hughes: Head of Service, Ambulance Care Coordination Target Implementation Date: 31 March 2027

Appendix A: Non-Emergency Patient Transport Services Process Map

Patient Transport Booking Through to Capacity Management Plan Cancellation

The process map was developed through walkthrough testing undertaken at Vantage Point House during the course of audit fieldwork.



Appendix B: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Agenda Item No.

7

REPORT TITLE

Rurality (including Overruns)

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh, Executive Director, Strategy, Planning & Performance
Author(s) of report	Hugh Bennett, Assistant Director, Commissioning & Performance

PURPOSE OF REPORT

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



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REPORT SUMMARY:

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

1. The 2024/25 IMTP included a deliverable on improving rural capacity. This was carried over into 2025/26. Rurality was also a potential line of enquiry at the recent Public Accountability Meeting and continues to be a key line of inquiry for the commissioners.
2. There is evidence of a public perception of an inequity of service between rural and urban areas. Similarly, there is a staff perception of overruns particularly affecting more rural stations.
3. The slide deck at Appendix 1 defines rurality, looks at urban v rural performance, overruns urban and rural and the findings of the Rurality Task & Finish Group, set up to look at the rural offer and respond to the IMTP deliverable. This was discussed in detail at the ELT meeting on the 18 March 2026.
4. The analysis identifies that old Red (immediately life threatening) and new Purple (Arrest) and Red (Emerg) response time performance are worse in rural areas, compared to urban, however, it also clearly indicates that performance for old Amber and new Orange (Now) is better in rural areas, compared to urban areas. The fundamental reason for this is that given the sparser population and demand in rural areas, it requires more resource to try and hit the 6 to 8-minute range. Whilst the resource is not sufficient (at current levels of handover), the higher level of resource means that for less time dependent incidents, performance is better.
5. The analysis also indicates that the spend per head of population is materially higher in rural areas than urban areas.
6. High level patient safety data, does not indicate that patients are less safe in rural areas, however, the Trust is currently improving its patient harm reporting and improving its ability to drill into and interrogate Datix data, so this will be kept under review.
7. For overruns, an initial comparison of three health boards, does indicate longer times for rural areas. Collaborative work is ongoing with our Trade Union Partners via the Dispatch Framework Steering Group to find and test innovative ways to reduce overruns for our people; however, it must be noted that there is a limit to what the Trust can do to mitigate the impact of handover lost hours.
8. The Rural Capacity Task & Finish Group identified that recruitment and retention in rural areas, can be more problematic, although this is not universal across rural areas, with some having good levels of staff in post to establishment. The main finding of the task & finish group is that the 2023 Demand & Capacity Review indicated that with transformation (as per the CMT Programme) and lower levels of handover lost hours (W45), there should be sufficient capacity in rural areas to deliver appropriate levels of response times, but that a



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more flexible approach may be required to rural roster design to recruit and retain staff in rural stations. This action will now be taken forward by the Trust at a local level.

9. The application of W45 remains the key solution for rural performance times and overruns, with the realisation of benefits from the CMT Programme and productivity gains identified in the IMTP also being also key.

RECOMMENDATION(S)

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

Committee is requested to:

1. Discuss the analysis on rural v urban contained in the slides at Appendix 1, including the information on overruns.
2. Note the action to work on flexing roster design in more rural stations to encourage recruitment and retention but note that the application of W45 is the key solution.
3. Any change in the level of required rural performance or model to achieve this, would be a decision for the Joint Commissioning Committee.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

The Finance and Performance Committee is requested to receive the following:

1. Appendix: Rurality, EMS Response / Deep Dive



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [[link to objectives and what good looks like](#)]

☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

n/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [[link to standards](#)]

☒ Safe	☒ Timely	☐ Effective
☐ Efficient	☒ Equitable	☐ Person Centred

Quality Enablers (select all that apply) [[link to standards](#)]

☐ Leadership	☒ Workforce	☐ Culture
☐ Information	☐ Learning Improvement & Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [[link to goals](#)]

☐ A socially responsible and inclusive employer	☐ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☒ n/a	☒ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
18 March 2026	Executive Leadership Team
08 May 2026	Rachel Marsh, Executive Director of Strategy, Planning & Performance

Welsh Ambulance Services University NHS Trust

Rurality

EMS RESPONSE / DEEP DIVE



GIG
CYMRU
NHS
WALES

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

Version 1.0

Released: 17 March 2026 (F&P)

by Commissioning & Performance Team



Large parts of **mid and West Wales** are defined as **rural**.

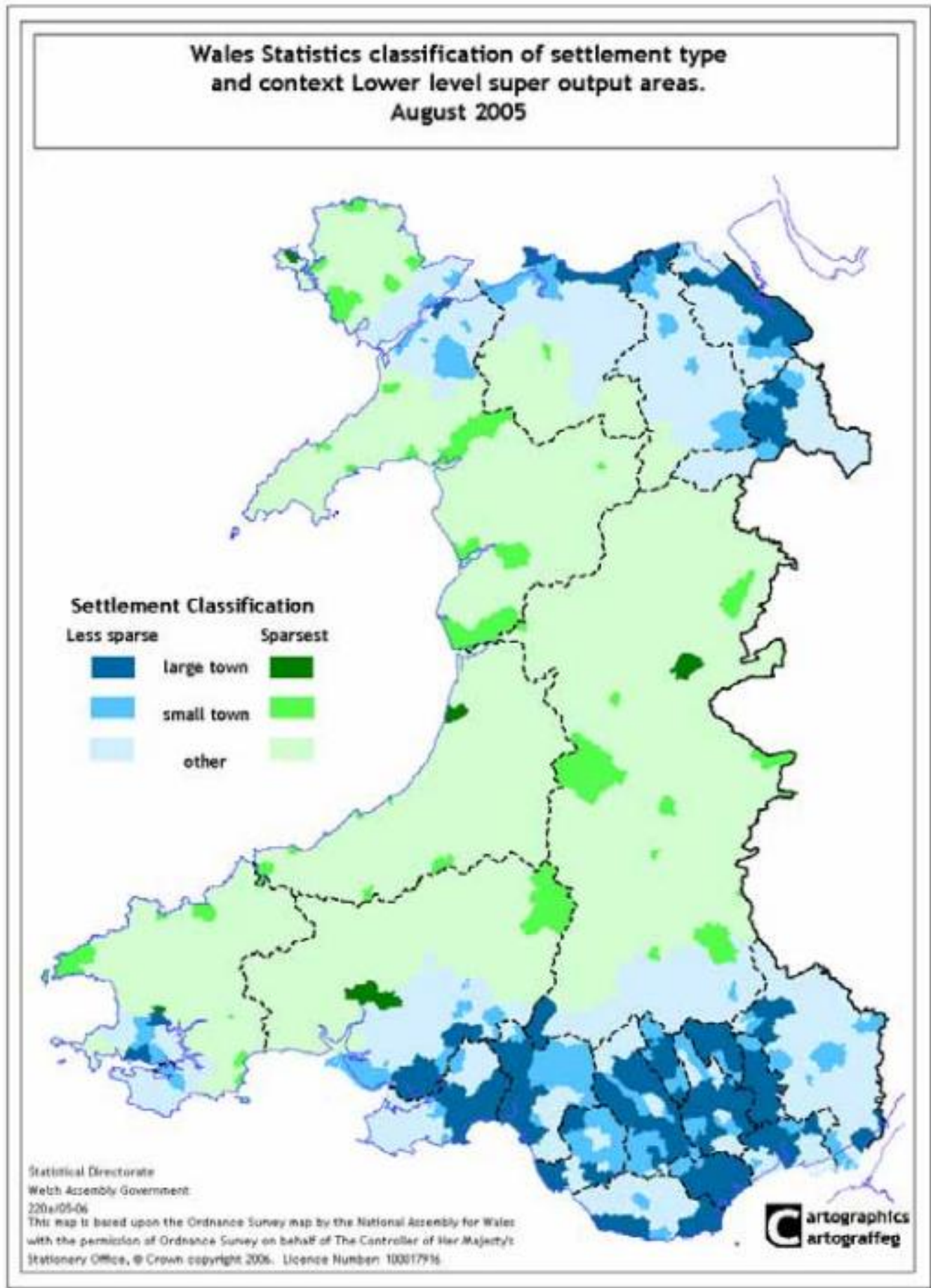
The Trust's EMS Response **rosters** are **designed to deliver an equitable** level of performance (at a health board level) across Wales.

But the rosters are designed to cope with **6,000 hours** of handover lost hours, **not the +15,000** average in 2025/26.

The **Trust spends significantly more per head of population in rural areas** on emergency response than in urban settings – the sparsity of demand and longer response times are factored into the rosters.

Any decision to focus on performance at a more local level or change of approach is a decision for the Joint Commissioning Committee.

The **main message** from these slides is the continuing need to **reduce handover lost hours** and to continue to deliver the **benefits of the CMT Programme**.



Health Board	Locality
AB	Monmouthshire
BC	Gwynedd Isle of Anglesey
HD	Carmarthenshire Ceredigion Pembrokeshire
Powys	North South

The map was used to guide a consideration of rurality during the 2020-2022 EMS Transformation Programme. The table show which ambulance localities are considered rural. WAST is commissioned at a health board level, not at a locality level



Demand & Capacity Review

Final December 21 Position

Performance and Utilisation Summary

2021 Position with Planned Shifts (10% H&T)

Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	8	Mean		90th Percentile			
Abertawe Bro Morgannwg University LHB	77.6%	05:25	81:20	179:34	10:34	224:56	-
Aneurin Bevan LHB	81.1%	05:01	46:29	105:53	09:54	106:42	270:00
Betsi Cadwaladr University LHB	75.6%	05:34	29:57	69:48	11:12	64:43	173:31
Cardiff & Vale University LHB	80.3%	05:29	43:39	122:36	10:02	99:03	315:16
Cwm Taf LHB	75.2%	05:44	36:12	71:05	10:53	80:41	172:35
Hywel Dda LHB	64.0%	06:59	65:25	144:06	15:14	177:25	-
Powys LHB	65.4%	07:06	62:27	141:39	17:02	166:25	-
Wales-wide	76.0%	05:40	49:45	112:29	11:19	123:39	145:25

Final 2021 Position with CTL RRVs (Re-roster planned + relief, 10% H&T)

Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	8	Mean		90th Percentile			
Abertawe Bro Morgannwg University LHB	66.7%	06:56	61:23	171:31	14:11	150:50	-
Aneurin Bevan LHB	66.3%	06:56	30:21	64:14	14:25	62:37	144:42
Betsi Cadwaladr University LHB	69.0%	06:18	21:17	47:26	13:04	45:08	106:03
Cardiff & Vale University LHB	67.9%	06:45	26:47	70:11	13:20	54:36	161:47
Cwm Taf LHB	66.9%	06:43	24:14	42:59	13:19	49:17	91:09
Hywel Dda LHB	65.8%	07:12	48:04	123:55	16:26	111:37	-
Powys LHB	67.9%	06:26	42:48	118:54	15:57	102:13	-
Wales-wide	67.3%	06:46	34:55	85:27	14:06	78:26	80:44

Difference

Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	8	Mean		90th Percentile			
Abertawe Bro Morgannwg University LHB	-10.9%	01:30	- 19:57	- 08:04	03:37	- 74:06	-
Aneurin Bevan LHB	-14.8%	01:54	- 16:08	- 41:39	04:31	- 44:05	- 125:17
Betsi Cadwaladr University LHB	-6.6%	00:44	- 08:40	- 22:22	01:53	- 19:36	- 67:28
Cardiff & Vale University LHB	-12.4%	01:16	- 16:52	- 52:25	03:18	- 44:27	- 153:28
Cwm Taf LHB	-8.3%	00:59	- 11:58	- 28:06	02:25	- 31:25	- 81:26
Hywel Dda LHB	1.9%	00:13	- 17:21	- 20:11	01:12	- 65:48	-
Powys LHB	2.5%	- 00:40	- 19:39	- 22:45	- 01:05	- 64:12	-
Wales-wide	-8.7%	01:05	- 14:50	- 27:01	02:47	- 45:13	- 64:42

Utilisation

CCC Area	EA	RRV	UCS
Central & West	49.3%	33.2%	54.1%
North	53.1%	31.8%	55.7%
South East	61.3%	31.9%	62.3%
Overall	54.1%	32.2%	58.0%

Utilisation

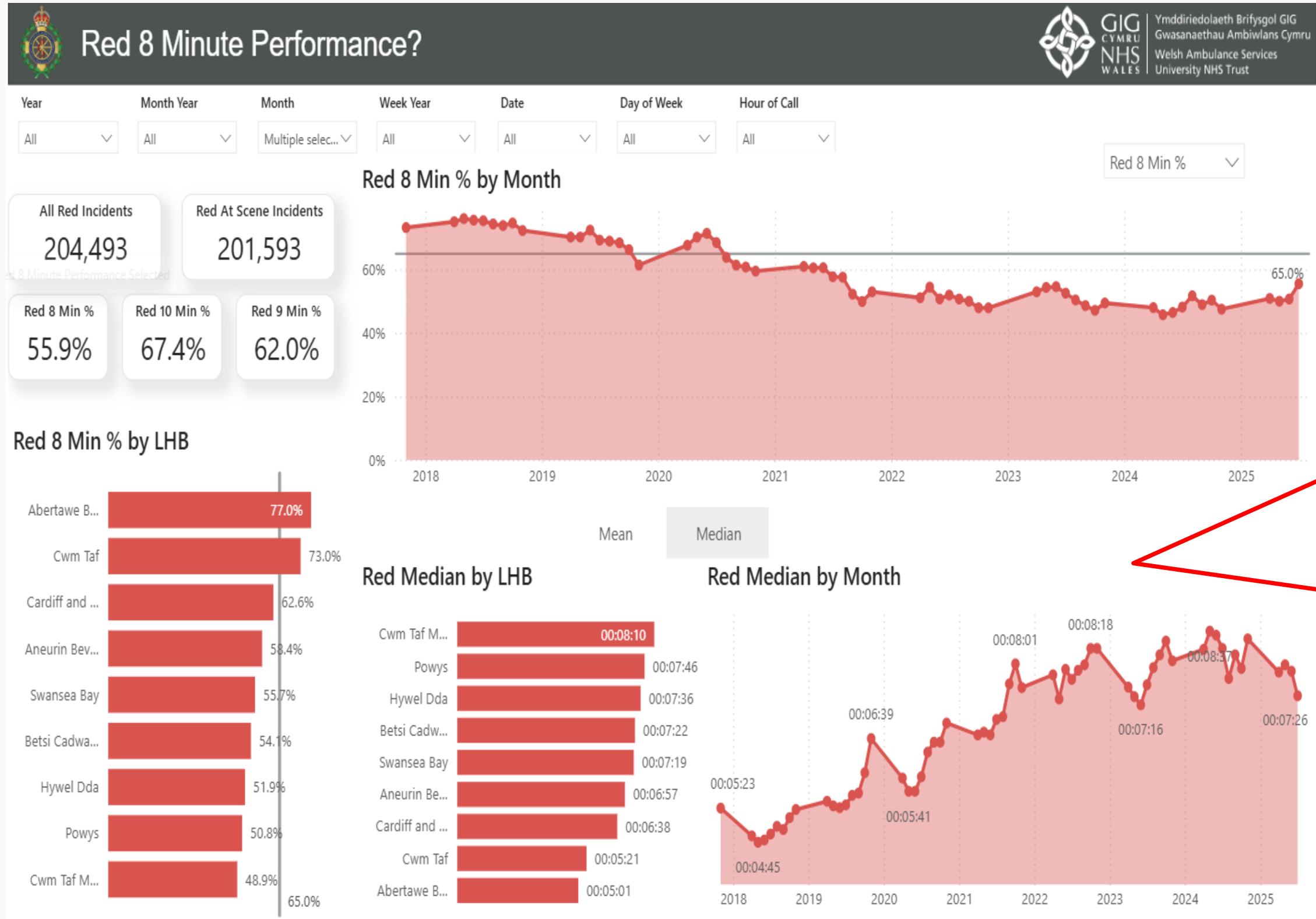
CCC Area	EA	RRV	UCS
Central & West	49.1%	36.1%	52.2%
North	50.6%	33.6%	50.5%
South East	56.4%	38.1%	48.2%
Overall	52.0%	36.4%	50.0%

In 2019 an independent strategic review, led by commissioners, modelled attaining consistent levels of performance across each health board. As a result of the review the Trust received funding to deliver the levels of workforce identified by the review and was required to re-roster every ambulance station across Wales. Both the recruitment and re-rostering were completed in 2022

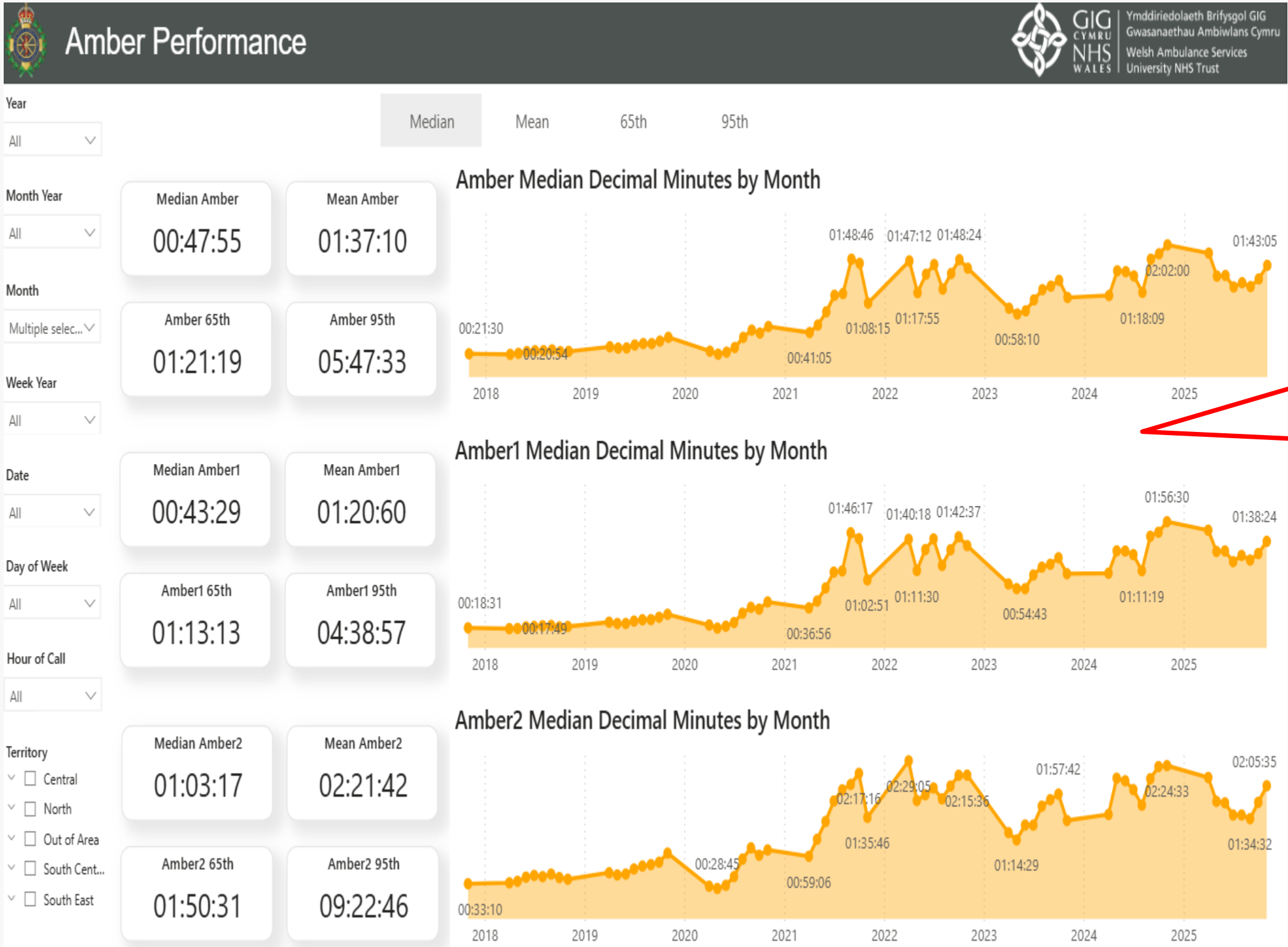




Pan Wales Red



Pan Wales WAST did not consistently achieve the old Red 8-minute target. The graph on the bottom left shows that the more rural areas performed worse than the average. This has traditionally been the case, due to the sparsity of the demand and capacity to respond (reduced by ability to recruit, handover lost hours and urban drift



Median

Mean

65th

95th

Median Amber

00:47:55

Mean Amber

01:37:10

Amber 65th

01:21:19

Amber 95th

05:47:33

Median Amber1

00:43:29

Mean Amber1

01:20:60

Amber1 65th

01:13:13

Amber1 95th

04:38:57

Median Amber2

01:03:17

Mean Amber2

02:21:42

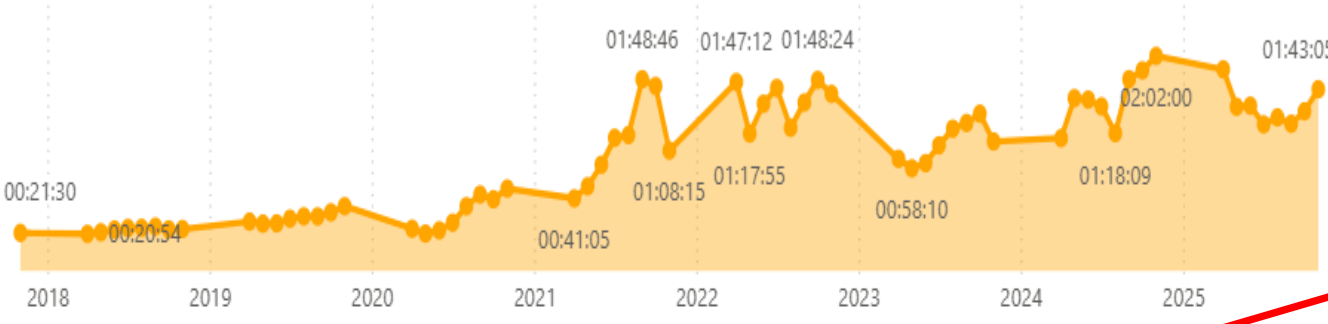
Amber2 65th

01:50:31

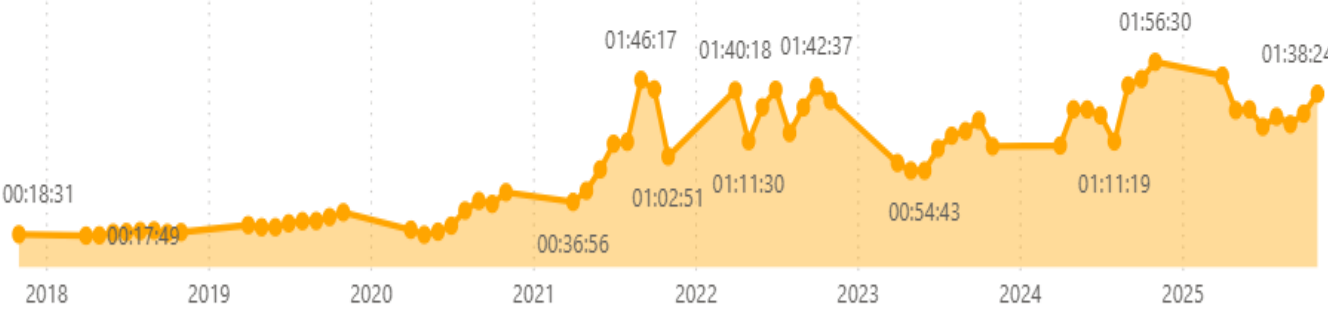
Amber2 95th

09:22:46

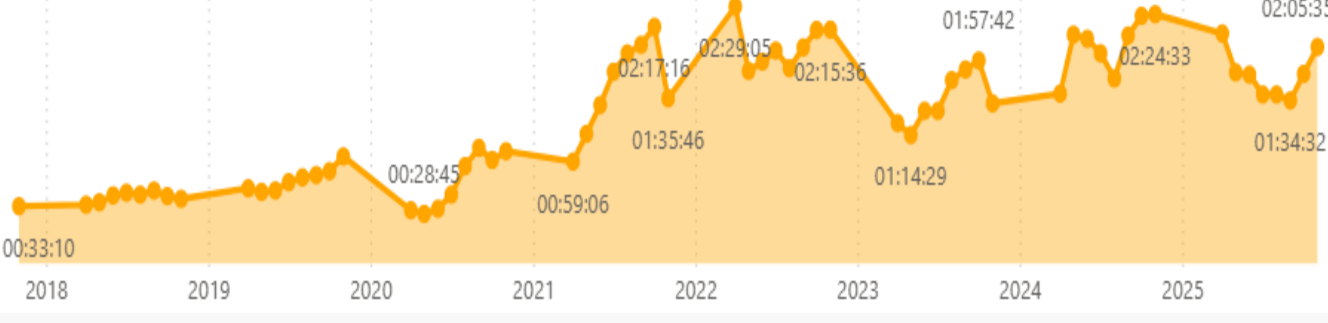
Amber Median Decimal Minutes by Month



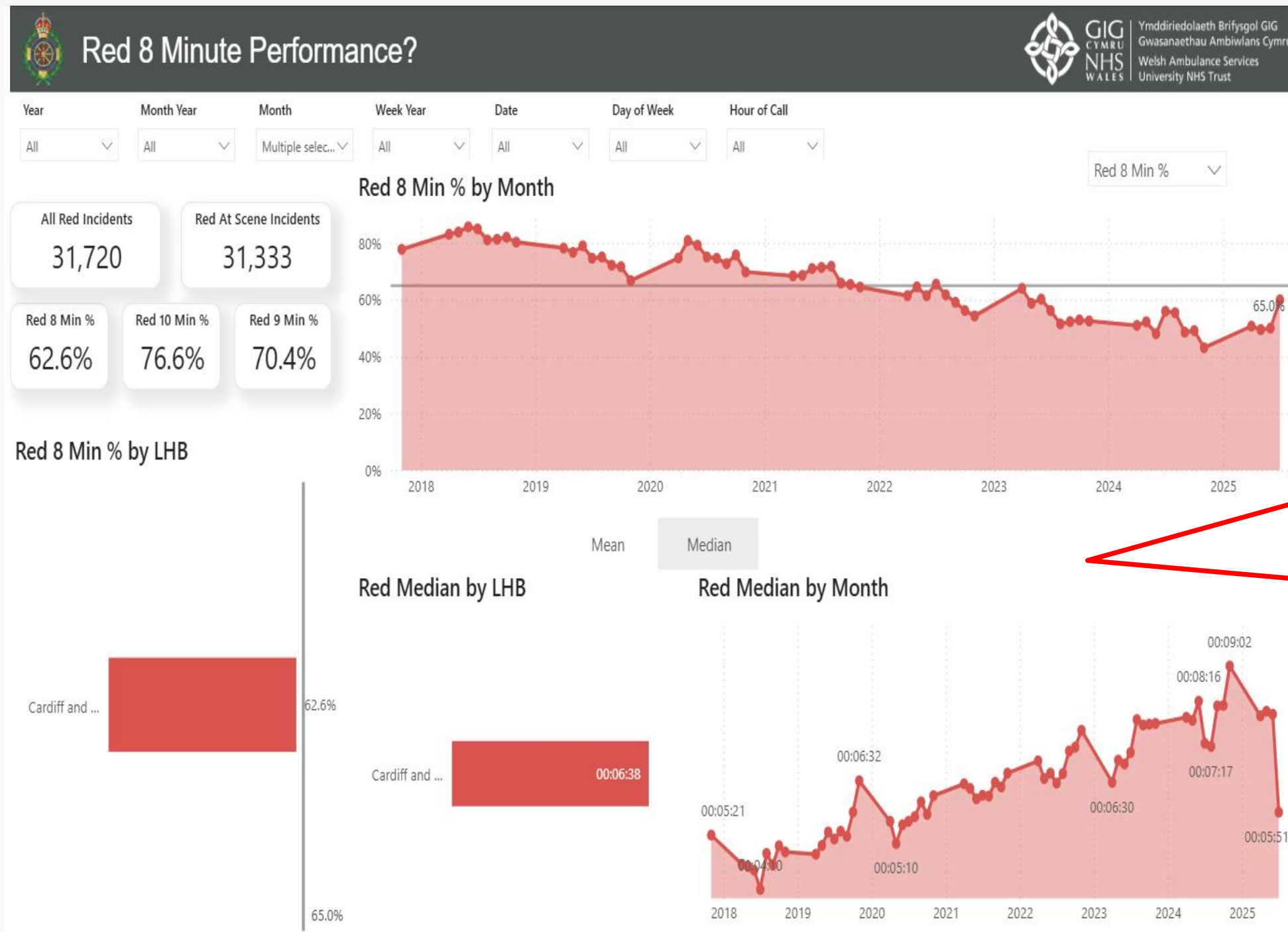
Amber1 Median Decimal Minutes by Month



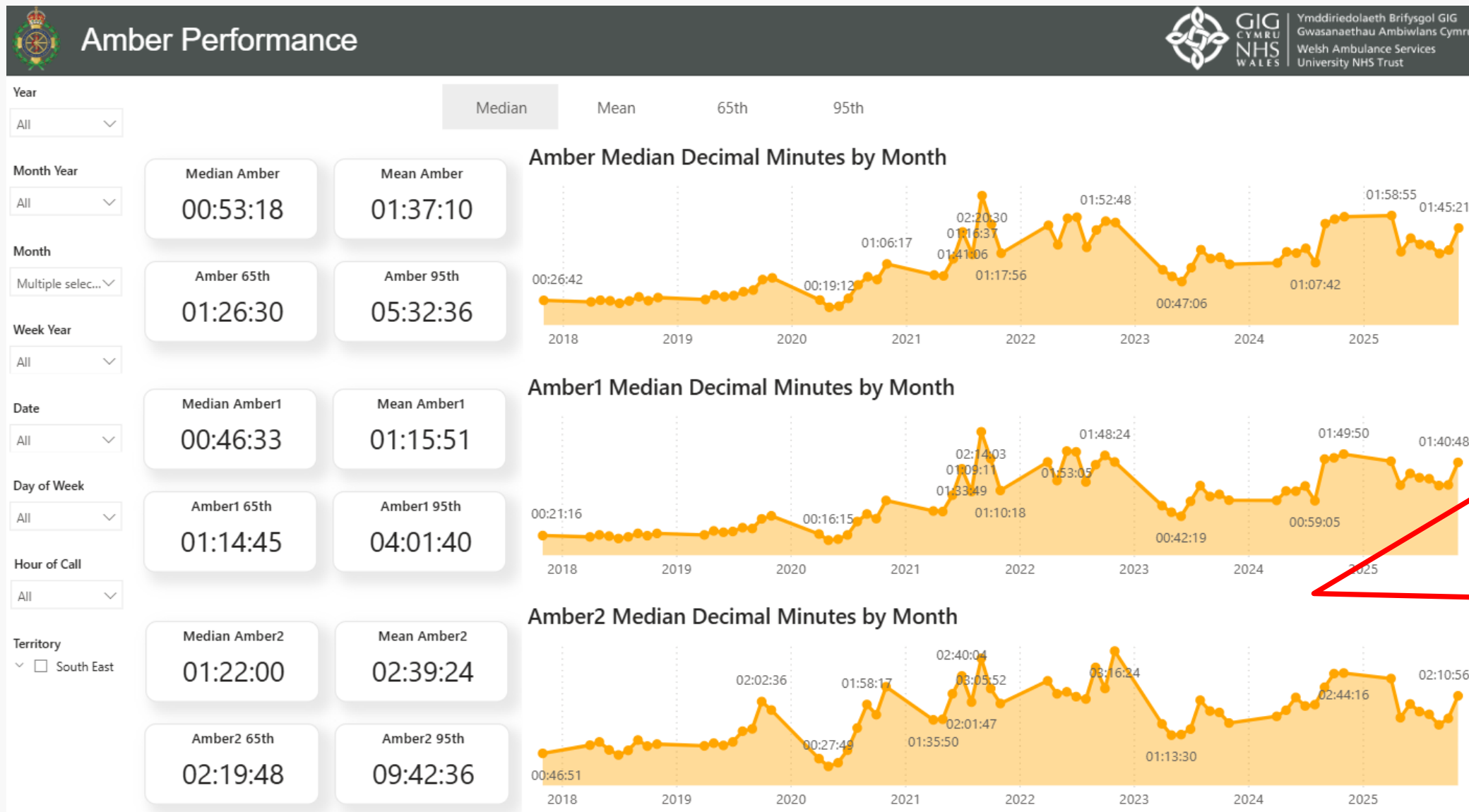
Amber2 Median Decimal Minutes by Month

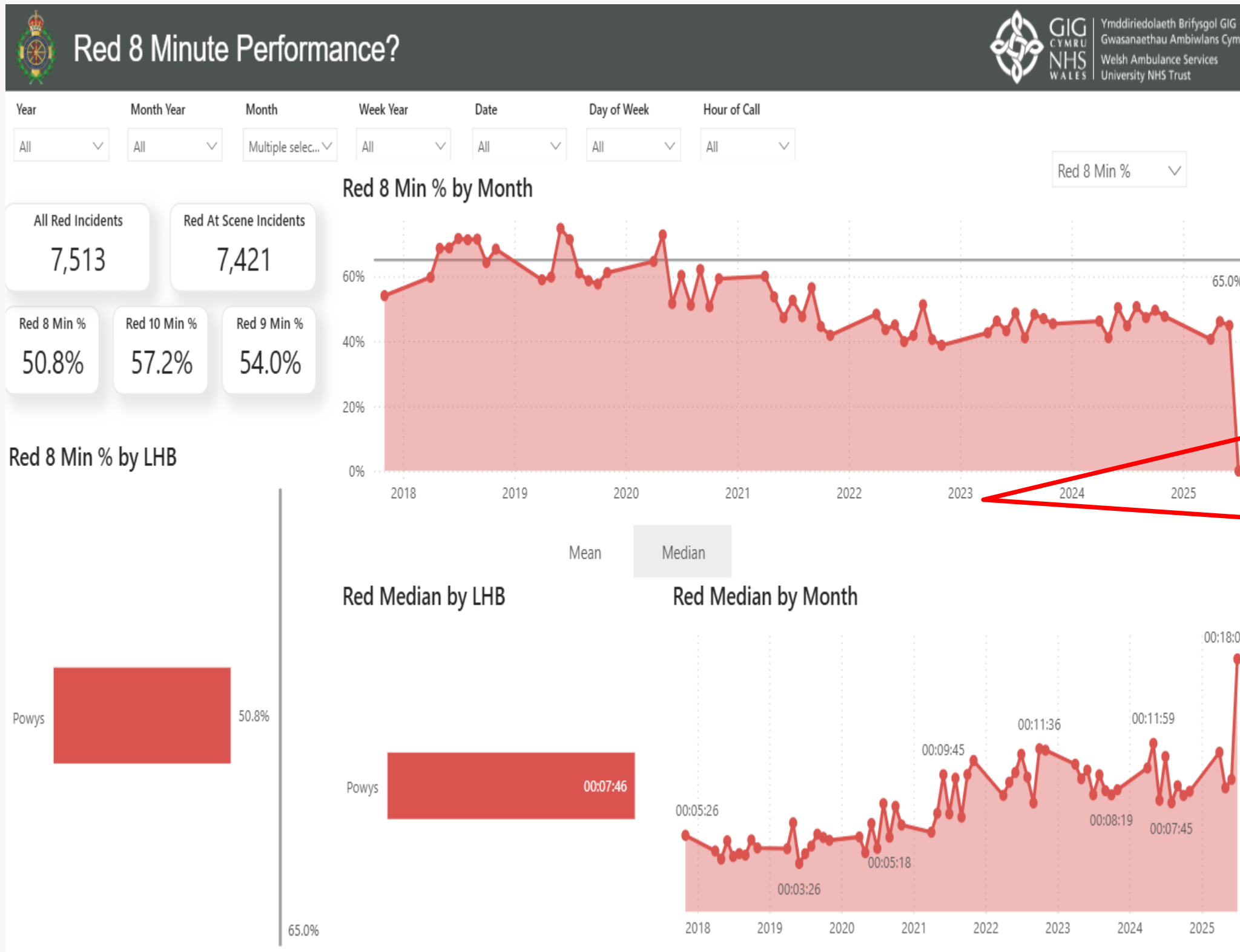


Amber 1 median performance from April-18 to Nov-25 (based on April to November each year) was 43 minutes. This Pan-Wales position will be compared to each locality identified in the first slide

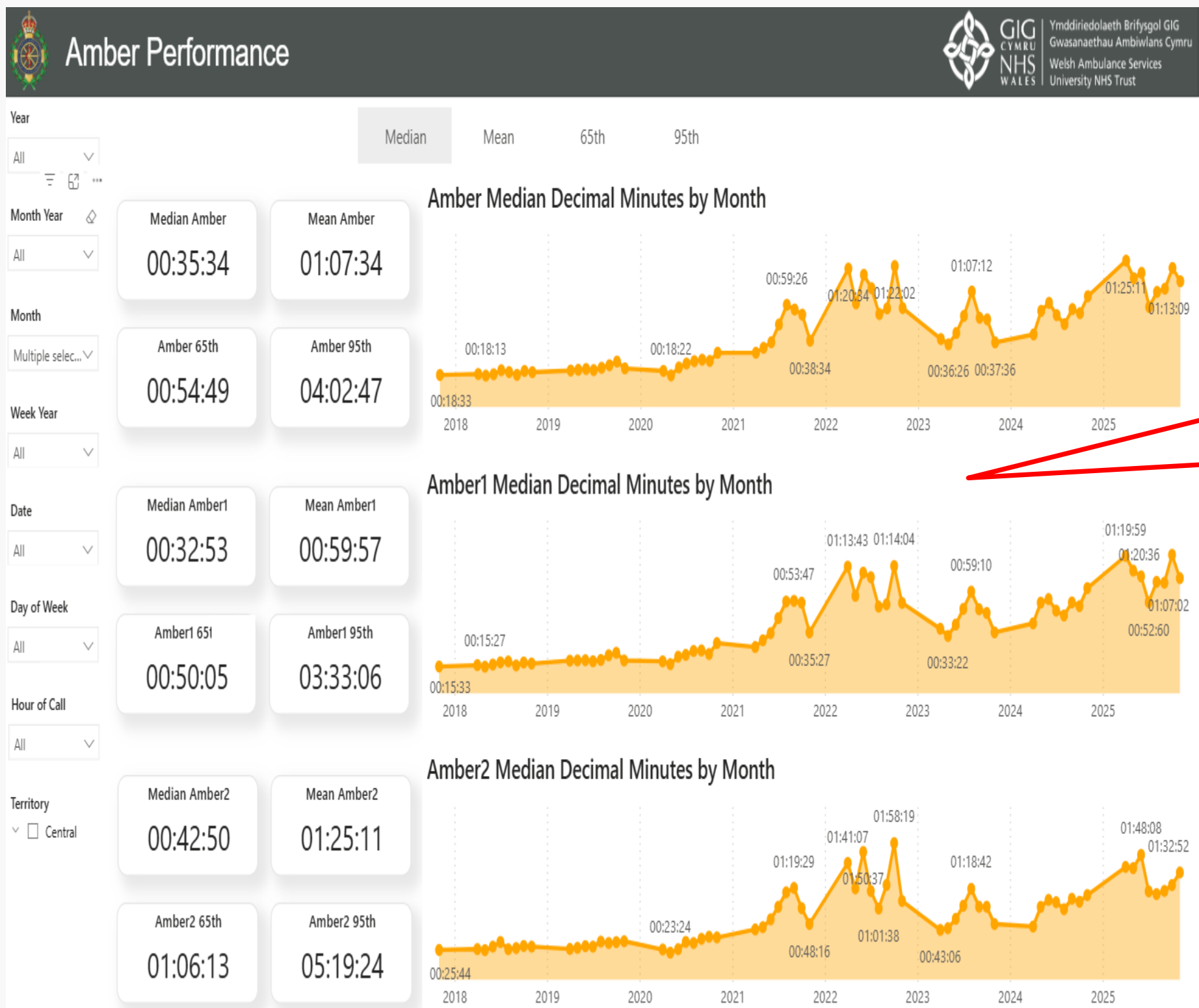


Cardiff & the Vale is the most urban health board. Traditionally it has much better Red performance. The Red 8 minutes for C&V here is 62.6%, compared to 55.9% pan-Wales. This is due to the density of the demand and the shorter travel times that the ambulances have to respond to

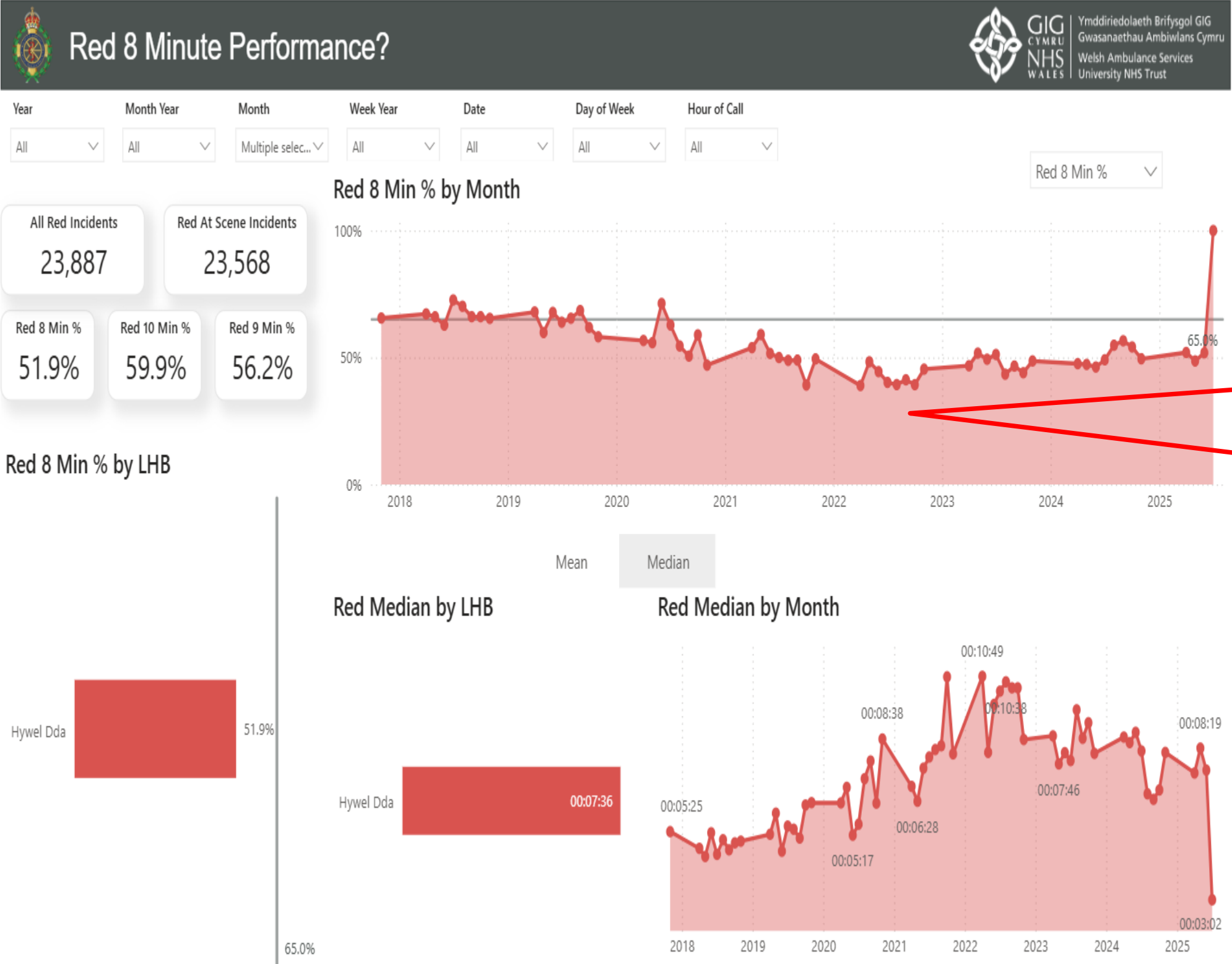




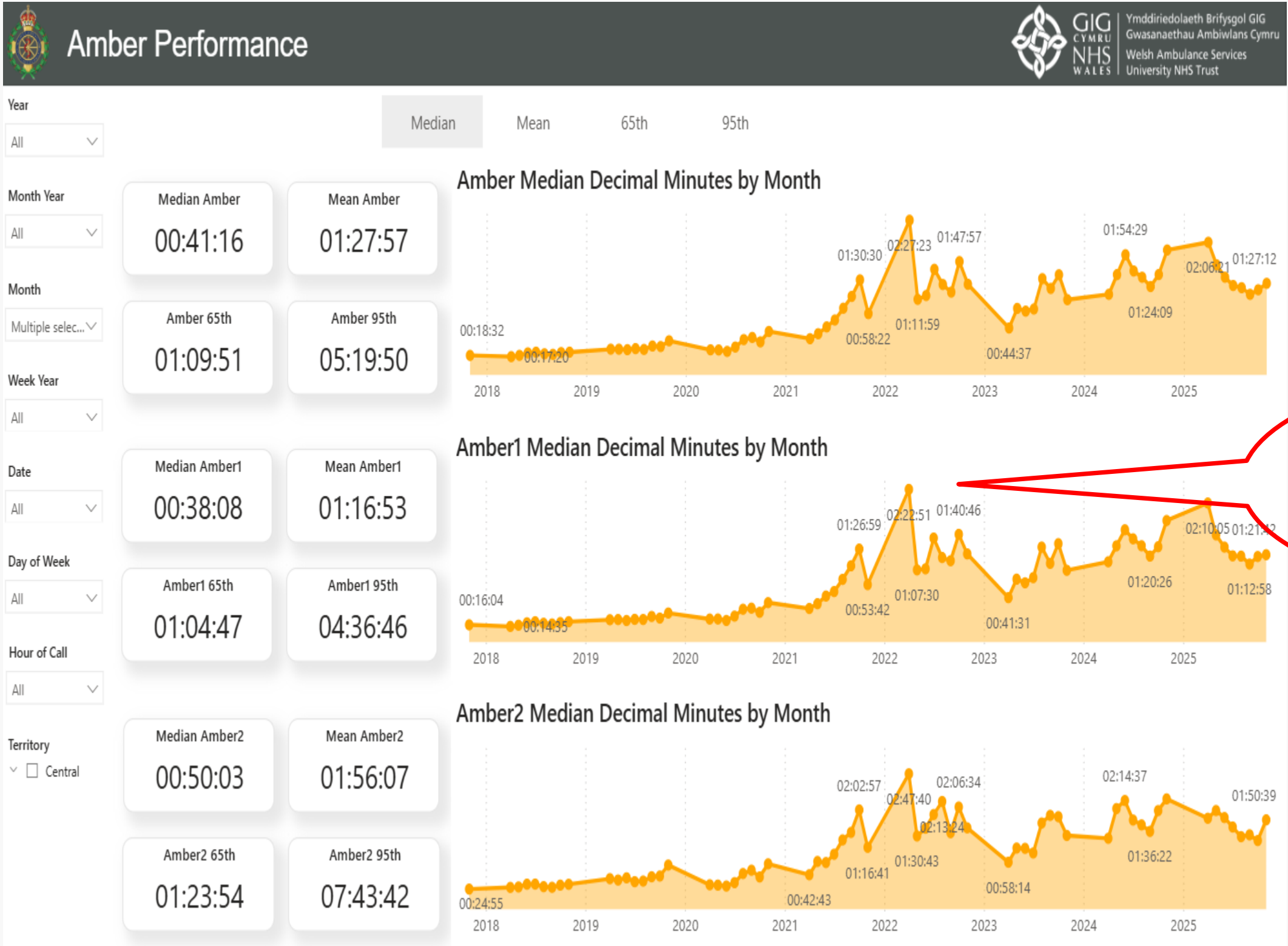
Powys is the most sparsely populated county in England & Wales. Independent benchmarking in 2018 identified that spending per head of population of materially higher in Powys compared to Cardiff (see separate slide). Old Red performance was 51% in Powys, compared to 56% pan-Wales



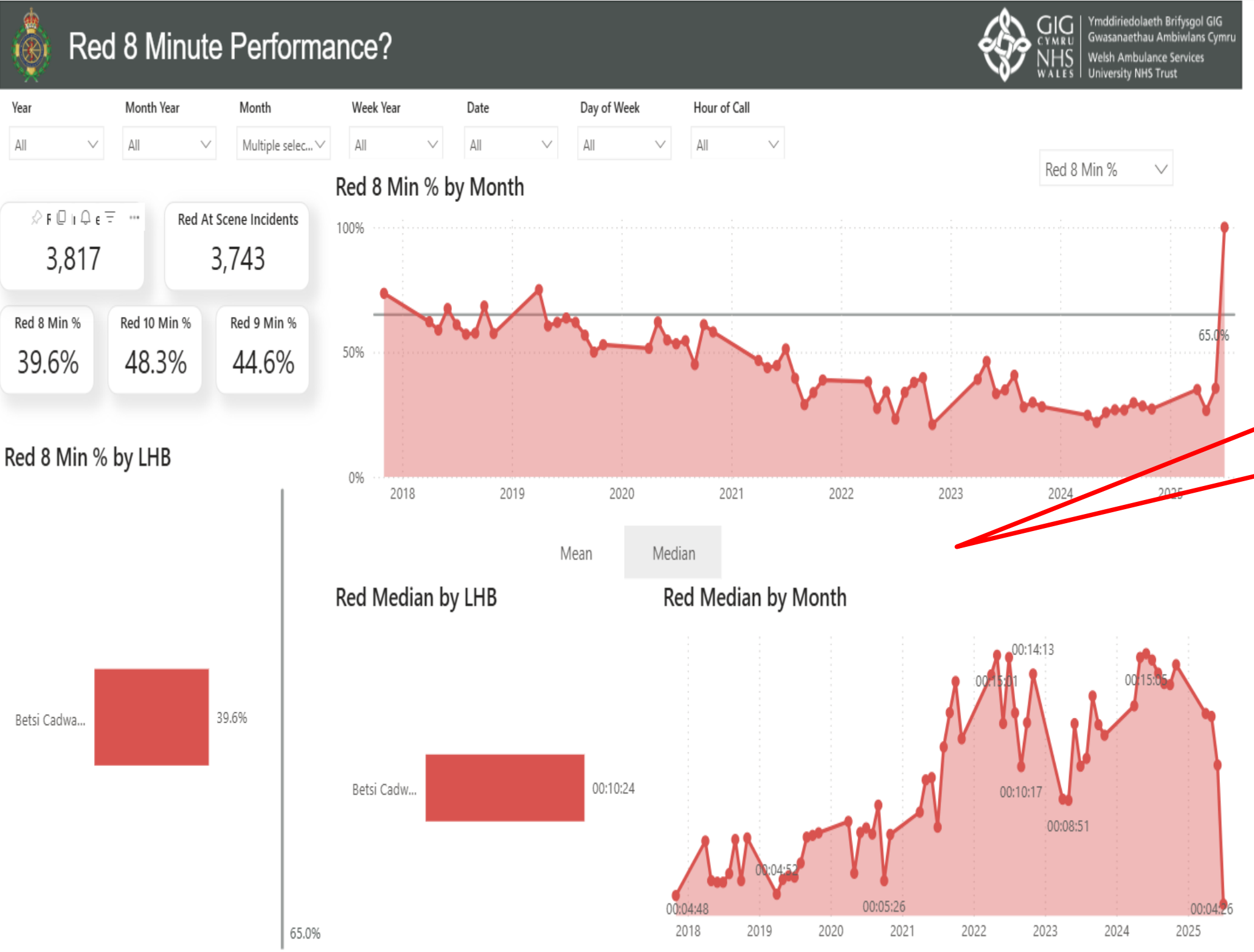
By contrast Powys's Amber 1 performance was always much better than the urban or Pan-Wales average, at 33 minutes compared to 43 minutes Pan-Wales. This is due to the higher spending per head of population



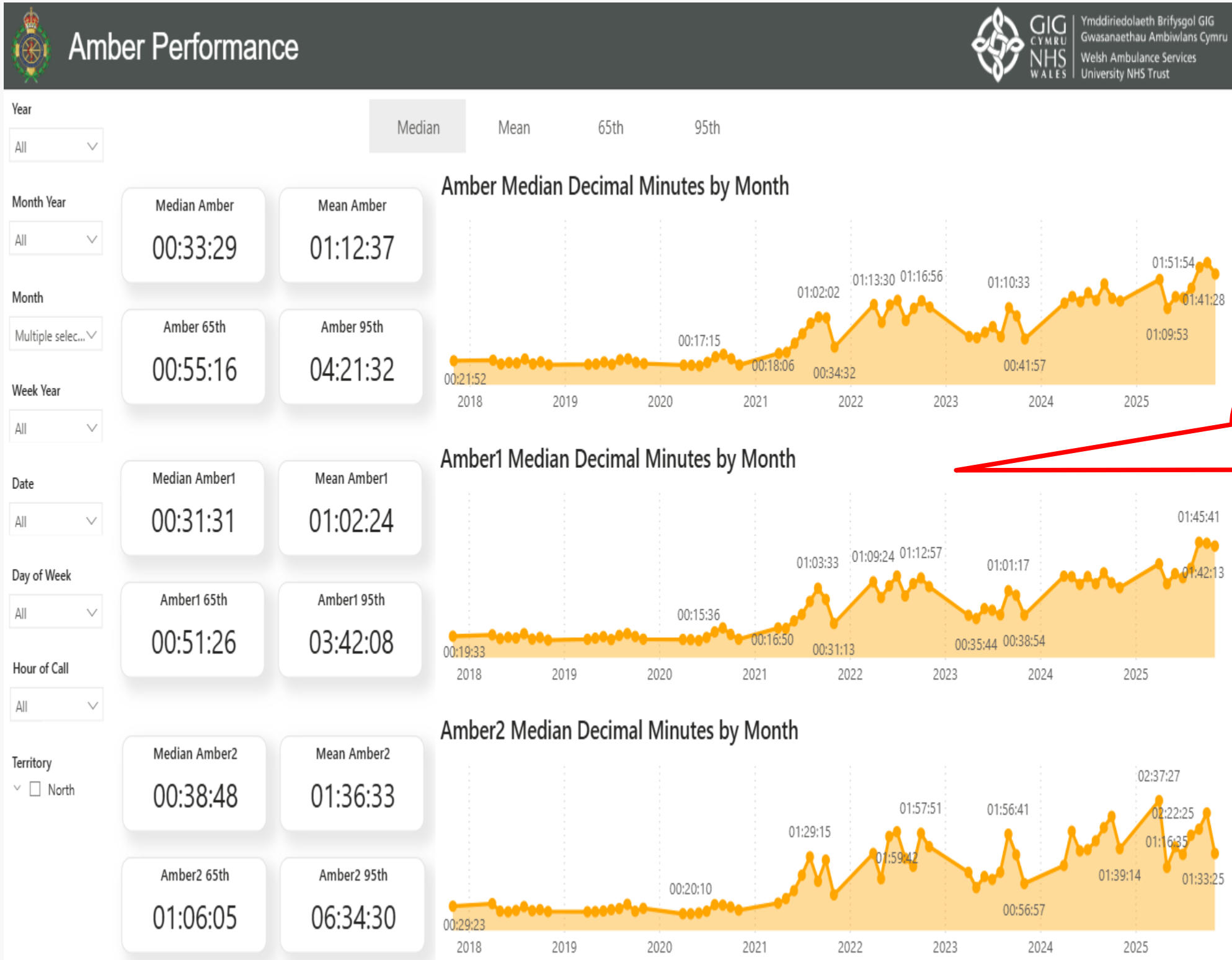
The same worse than average performance on old Red, but better performance on old Amber repeats through the other rural areas. For HD the old Red median was 52%, compared to the 56% pan-Wales median



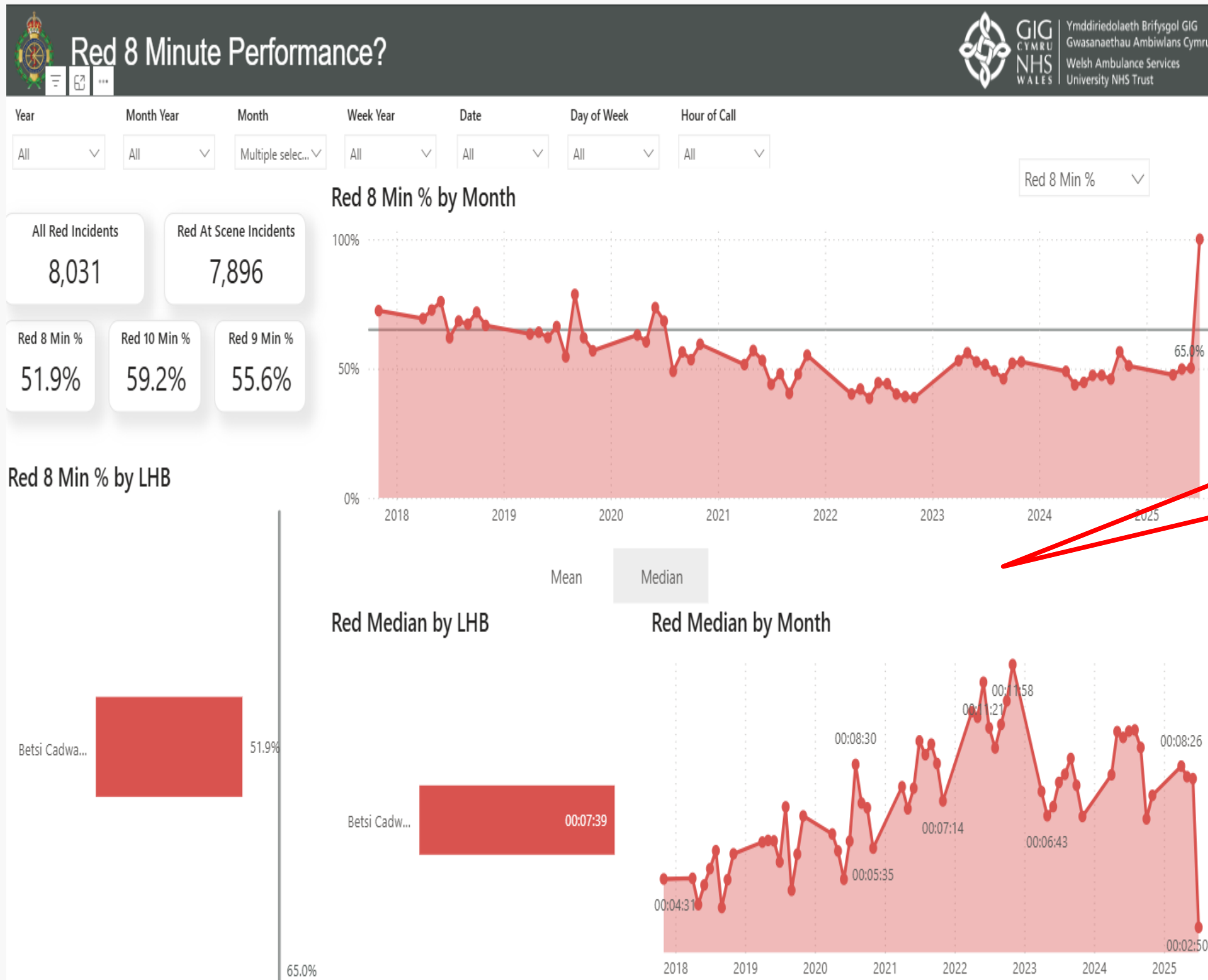
By contract HD's Amber 1 median is materially better than Pan-Wales, at 38 minutes and 43 minutes respectively



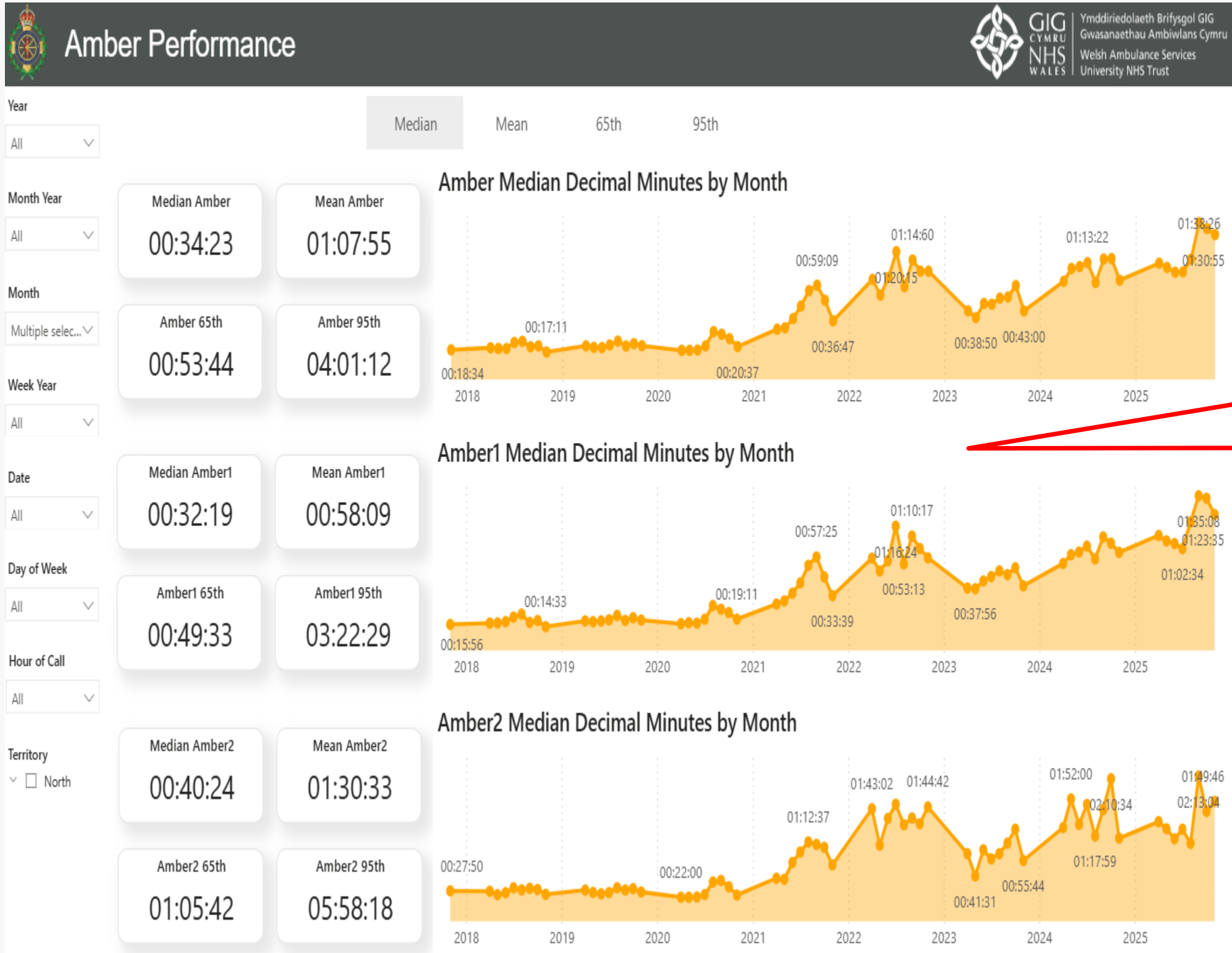
Again, old Red is materially worse than the pan-Wales median in Anglesey at 40%, compared to pan-Wales's 56%



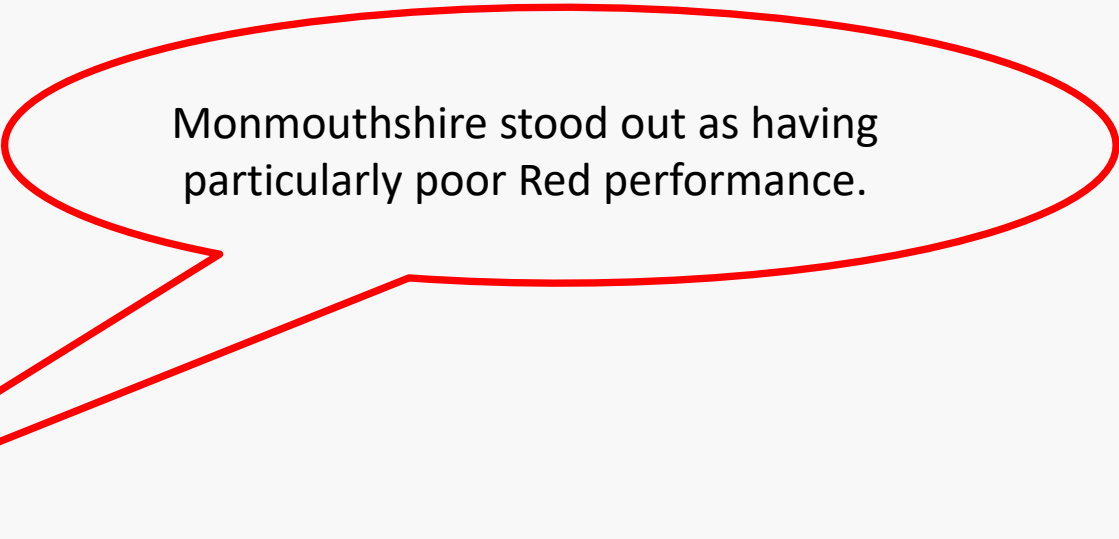
Again, the Amber 1 median is better than the average at 31 minutes, compared to 43 minutes

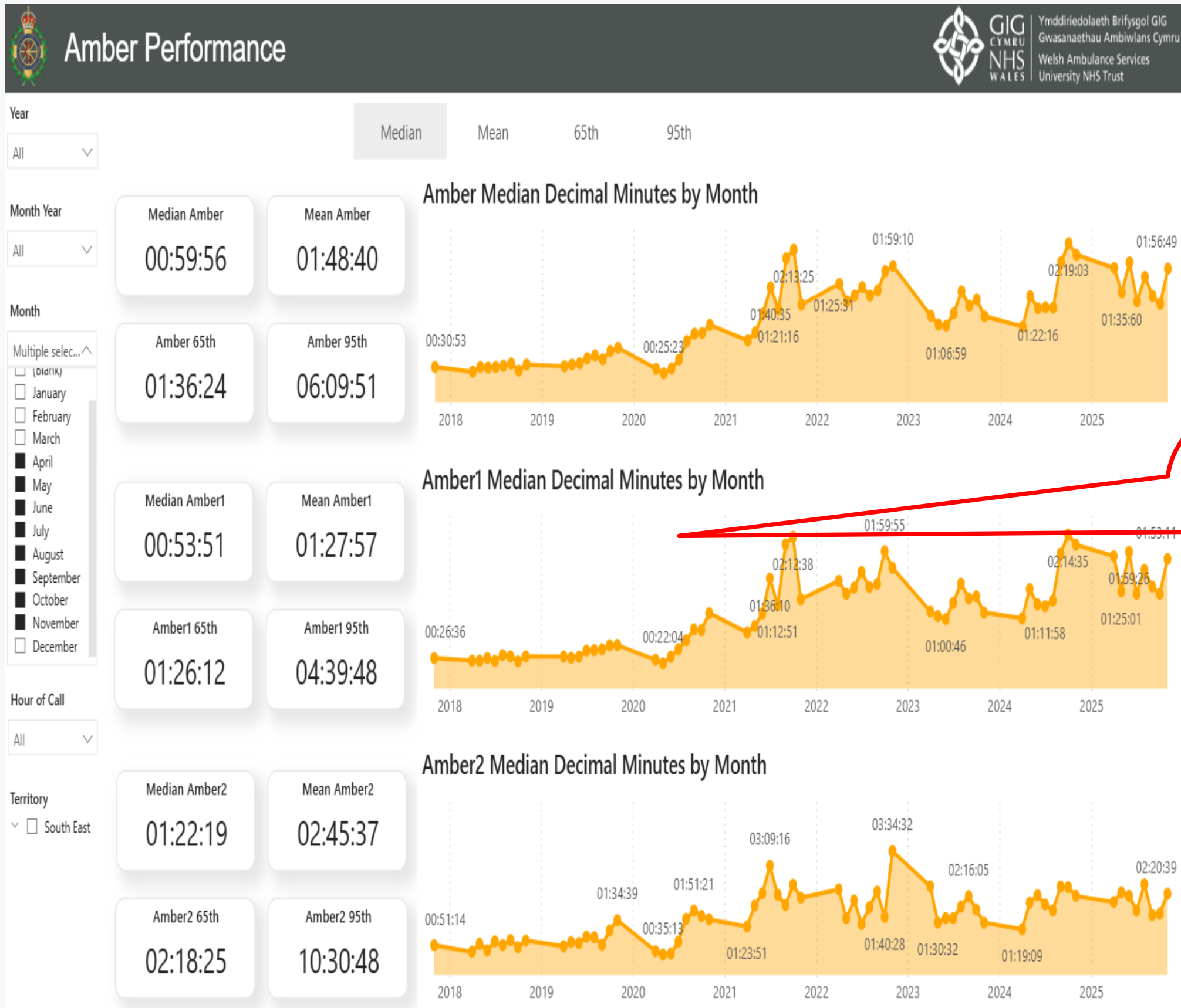


Again, old Red is materially worse than the pan-Wales median in Gwynedd at 51.9%, compared to pan-Wales's 56%



Again, the Amber 1 median is better than the average at 32 minutes, compared to 43 minutes



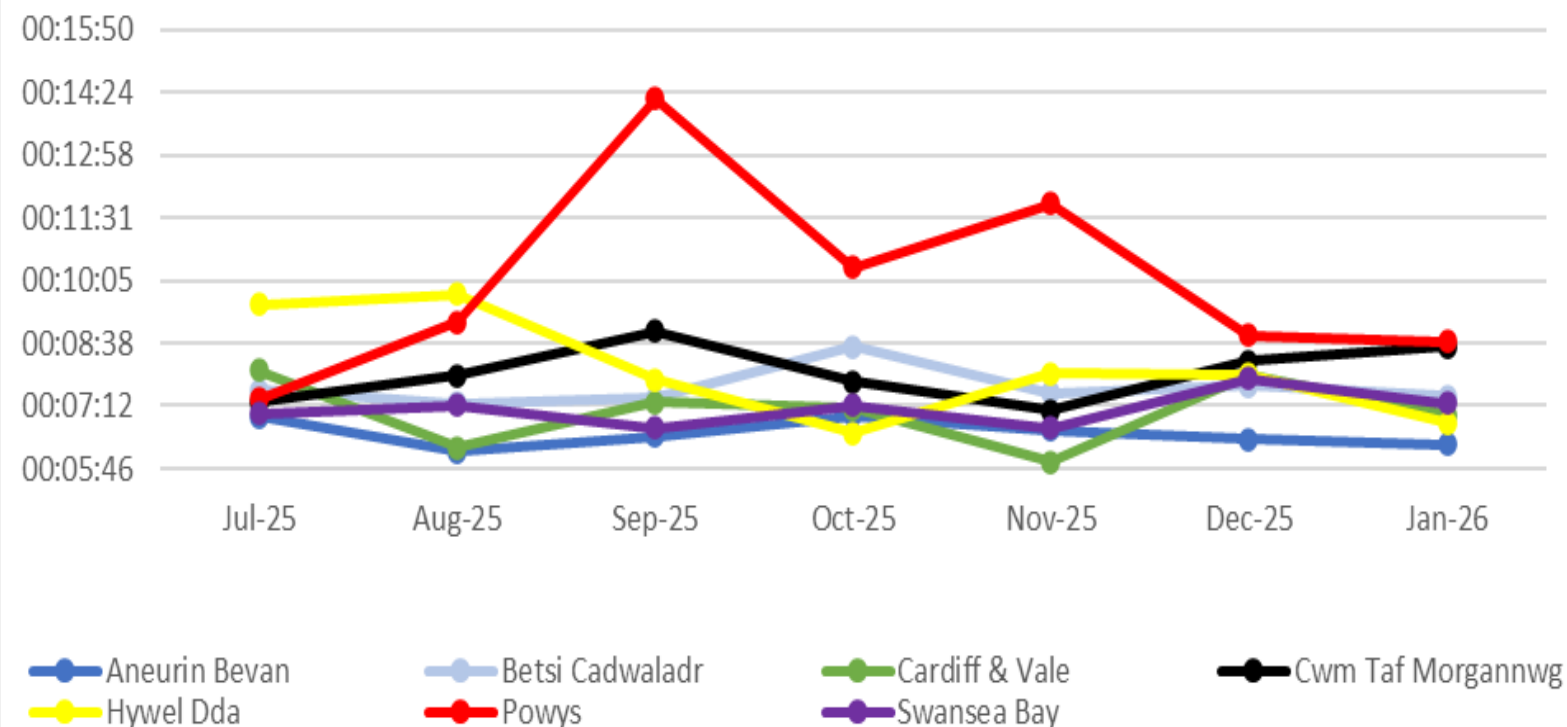


Monmouthshire's Amber 1 performance was much better than its Red performance, with the reasons as previously identified, but was higher at 54 minutes, compared to the pan-Wales median of 43 minutes.

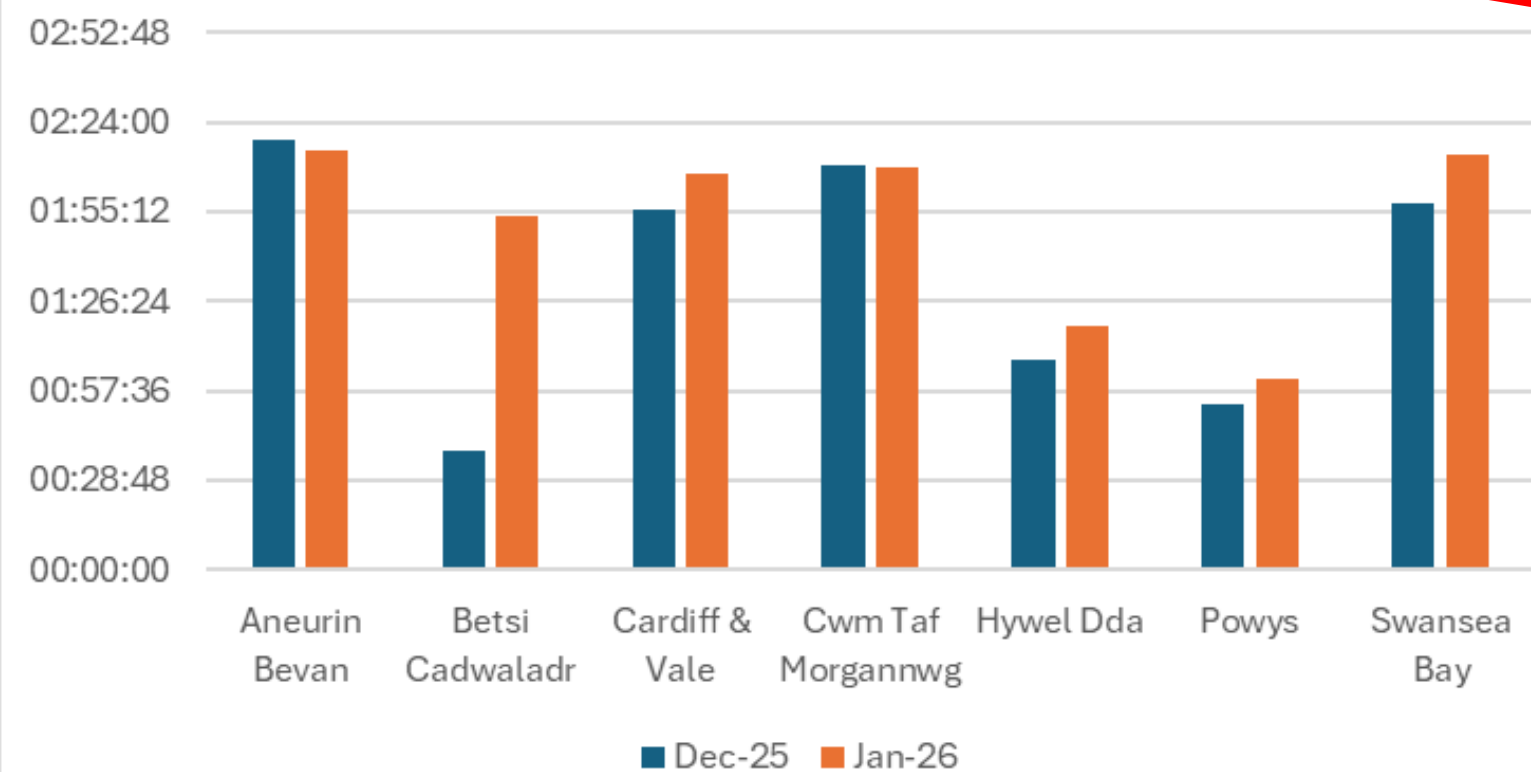
Ambulance Performance Framework



Arrest Median Response Performance by Health Board



Orange Median



In the new Ambulance Performance Framework, the same relationships play out, because whilst the model has changed the underlying issue of chasing sparse demand, now for Arrest rather than old Red, still applies.

But by contrast the higher levels of ambulance resources required to chase the sparse Arrest demand, affect Orange (which is part of what has replaced Amber), and is a large cohort of demand, positively.

Powys is an outlier in the first chart on Arrest median, but Powys, Hywel Dda and Betsi Cadwaladr all perform better in the Orange category.



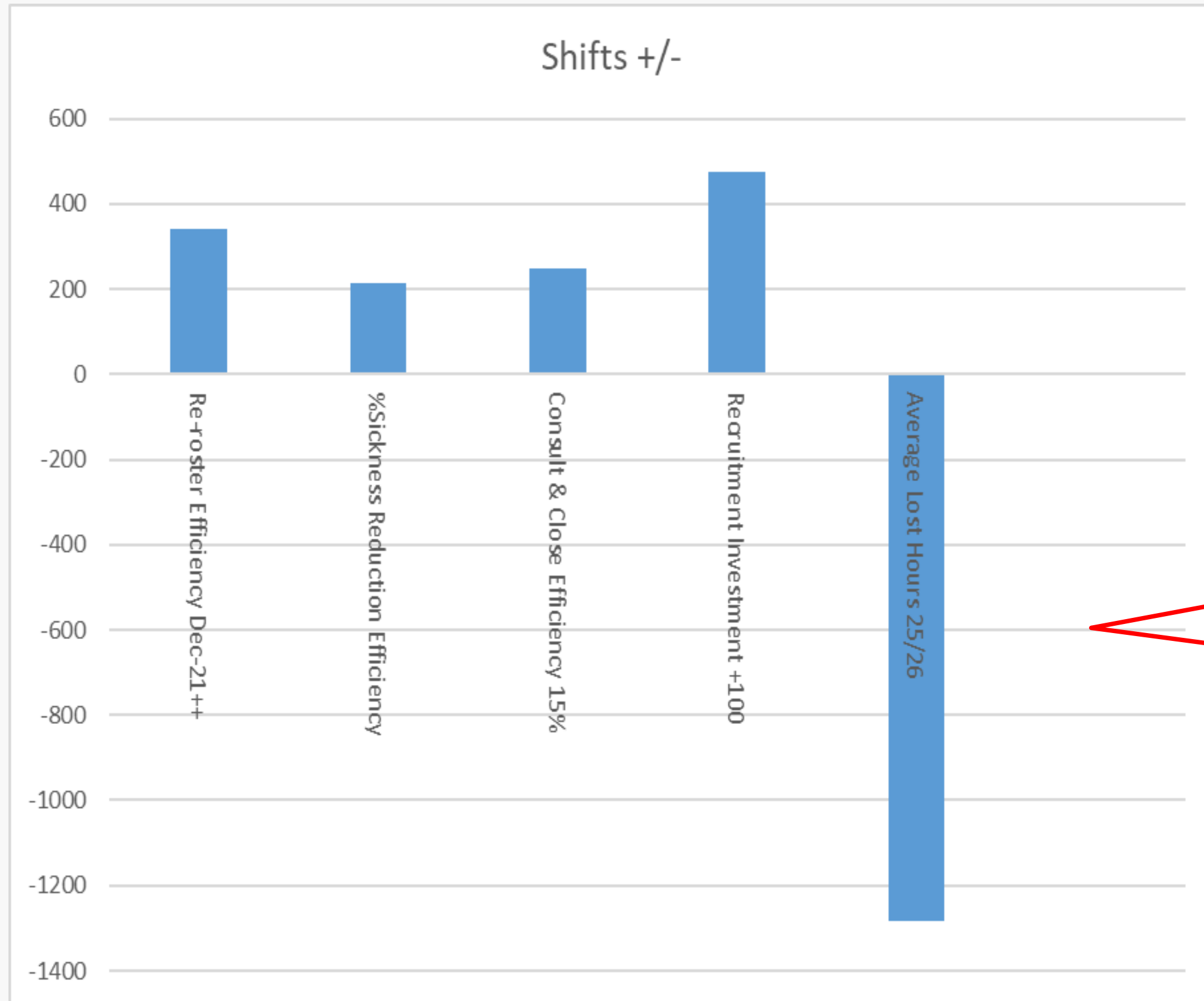
Population Spend / Per Capita

C&V					
Population:	518,269				
Planned Hours per Week					
		EA	CHARU	UCS	Total Hrs
	Cardiff	1,253	168	0	
	Vale	553	0	532	
		1,806	168	532	2,506
Planned Hours per Year					130,663
Planned Annual Hours per Head of Population					0.25

Powys					
Population:	133,200				
Planned Hours per Week					
		EA	CHARU	UCS	Total Hrs
	North Powys	910	84	40	
	South Powys	1,064	168	0	
		1,974	252	40	2,266
Planned Hours per Year					118,149
Planned Annual Hours per Head of Population					0.89

Previous independent benchmarking (almost a decade ago) identified that the Trust spends significantly more per capita in rural areas, compared to urban. These tables are based on the current EMS rosters and provide an updated position. They indicate a similar position, that the EMS resource per head of population is materially higher in rural v urban areas

Impact of Handover Lost Hours



This waterfall chart from a few years ago shows how the efficiencies and investments made in WAST are offset by handover lost hours



Volunteers & Defibs

Health Board	EMR Volunteers
BCU	156
HD	118
P	44
SB	174
AB	91
C&V	44
CTM	43

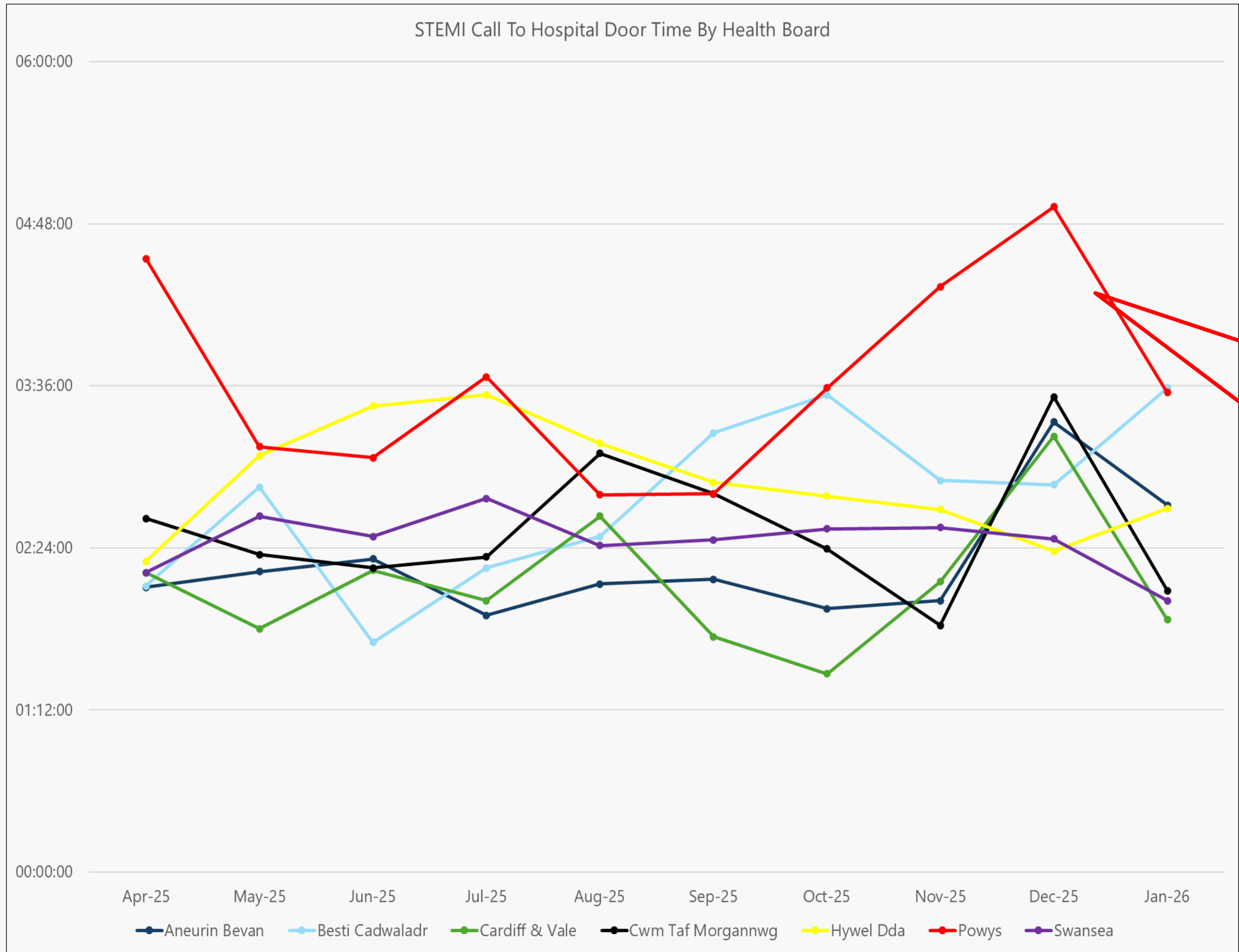
Potentially, the Trust needs more volunteers in more rural locations, but this is not easy to achieve or wholly in the control of the Trust

The Trust has made a **research application** via its Research & Innovation Team to mathematically model the **placement of Defibs** across Wales. Like volunteers, the placement of Defibs has emerged over time and there is an opportunity, linked to the new Arrest category and **chain of survival** work to undertake a research piece on demand data and their placement.

The bid has received a **letter of support from Welsh Government** and is currently at the stage 2 point of the process. The modelling would be undertaken in-house, via the Trust's Data Science & Simulation Specialist, with support from a senior officer.

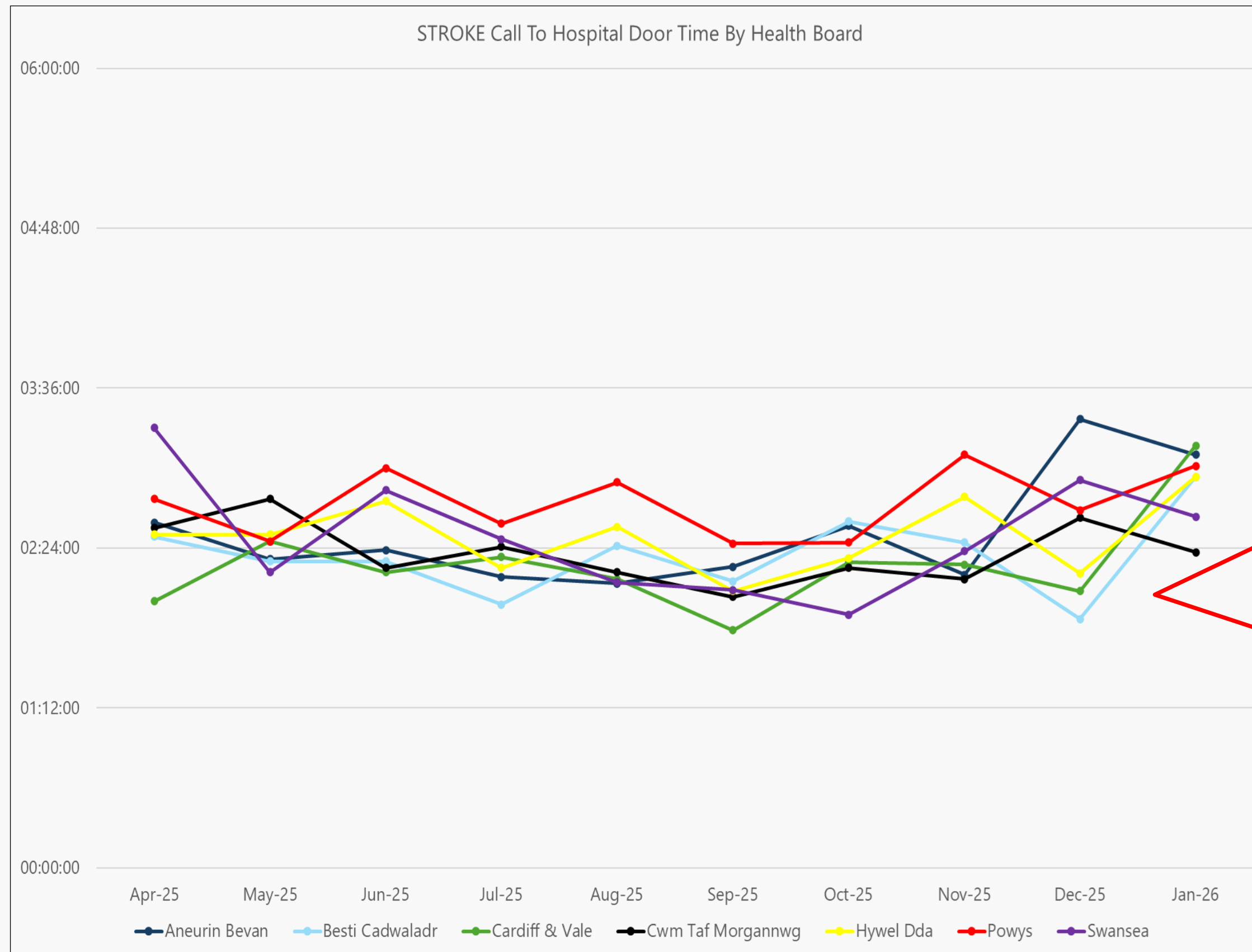


Clinical Indicators



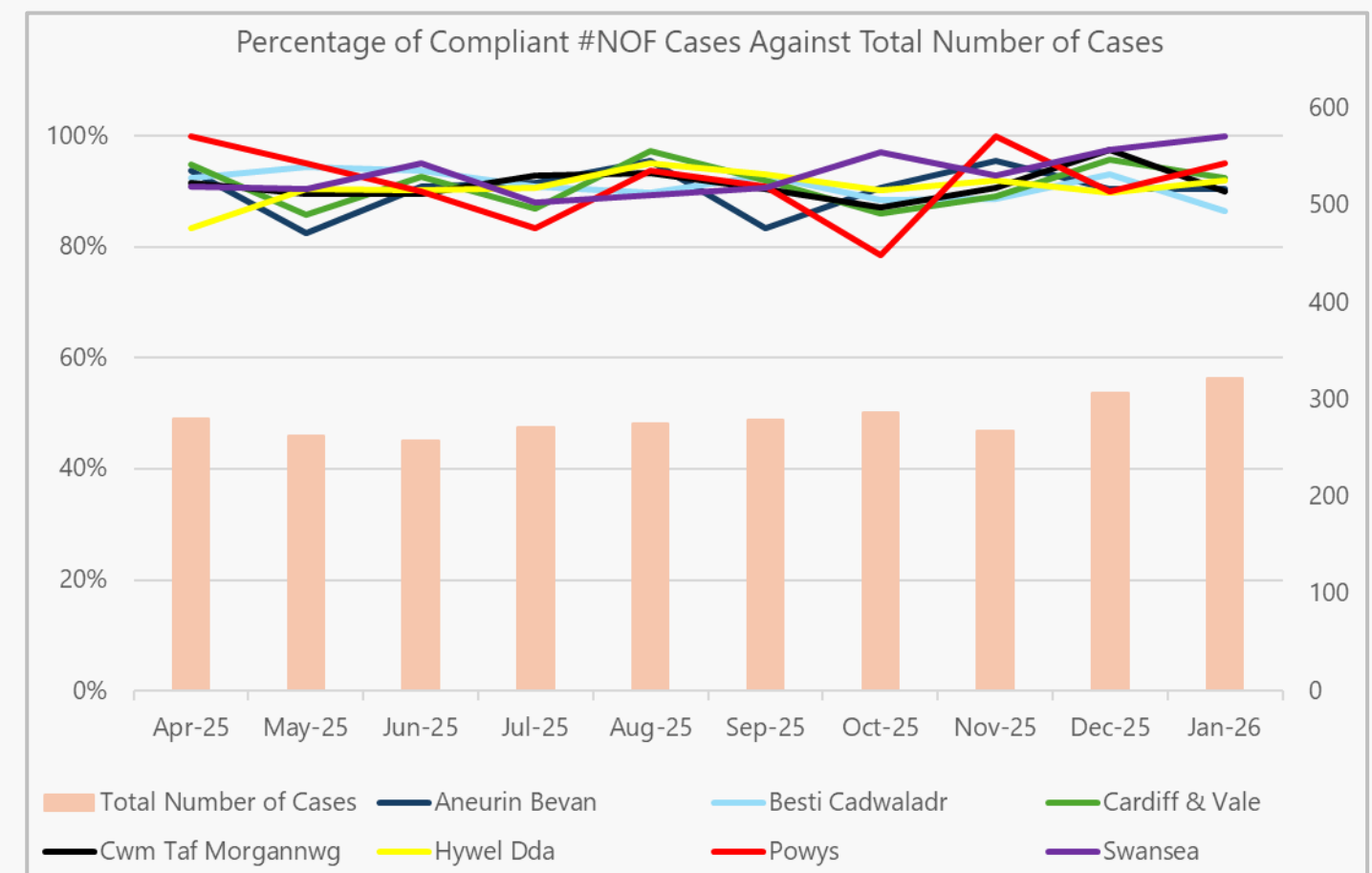
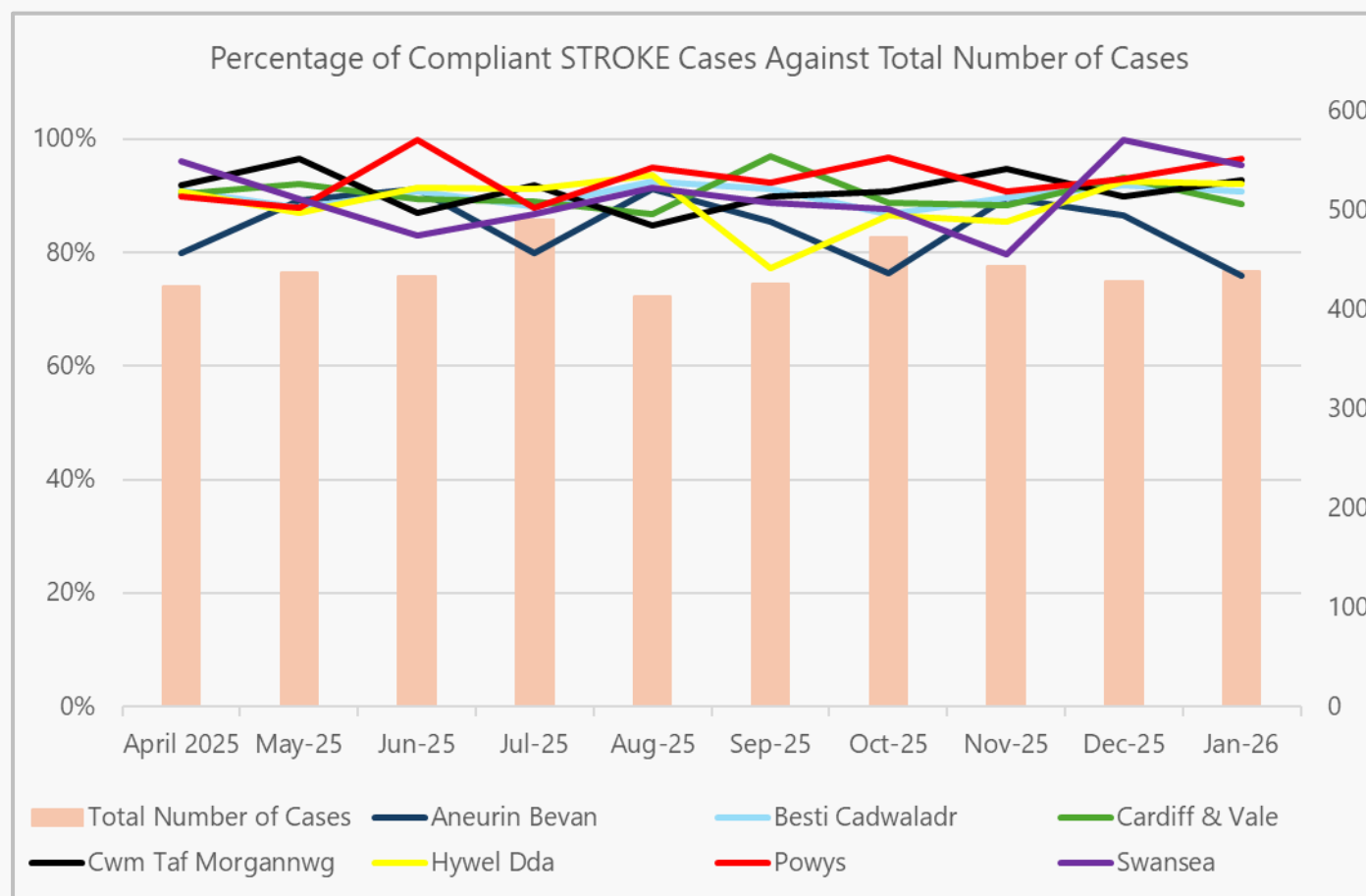
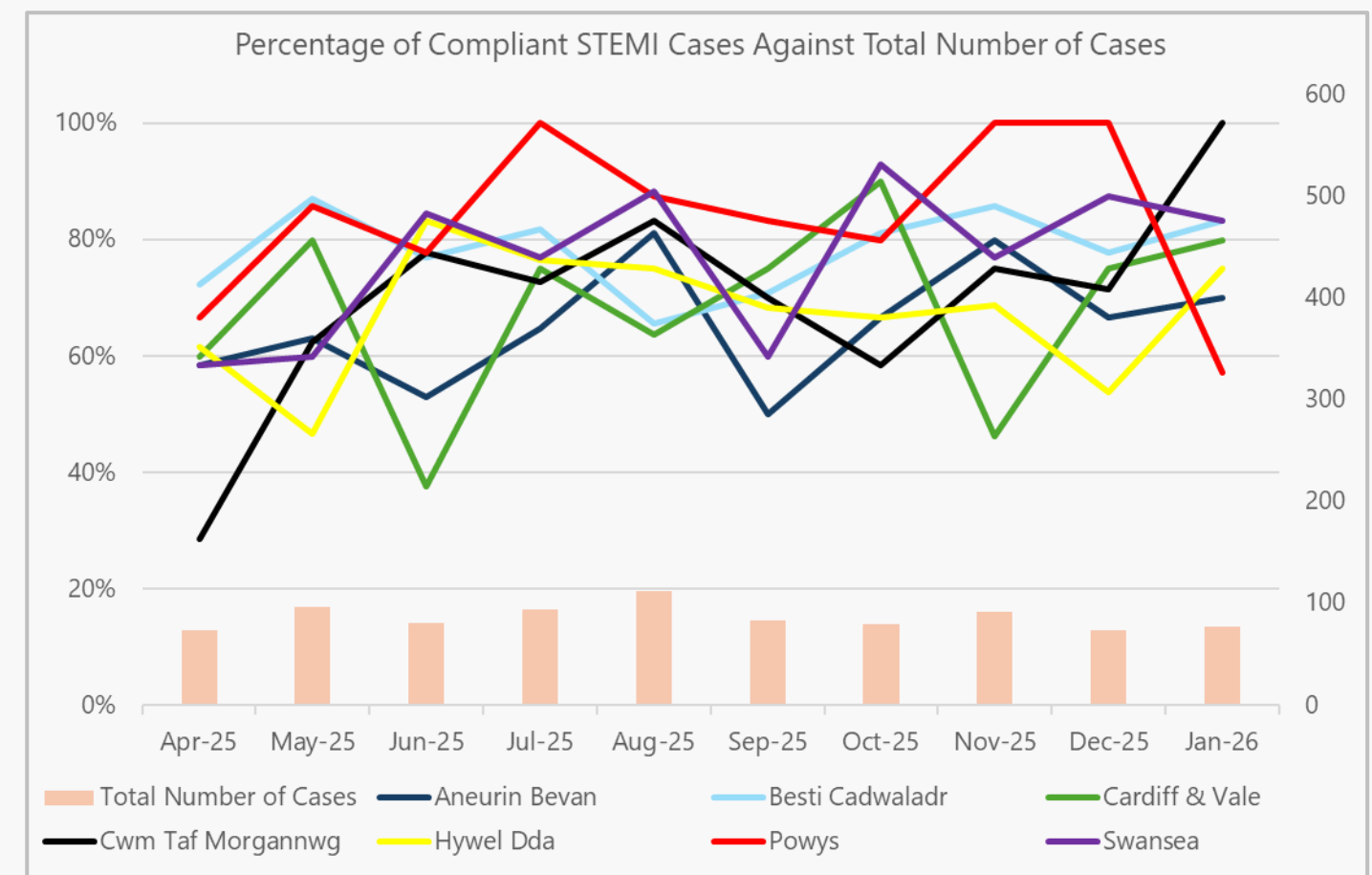
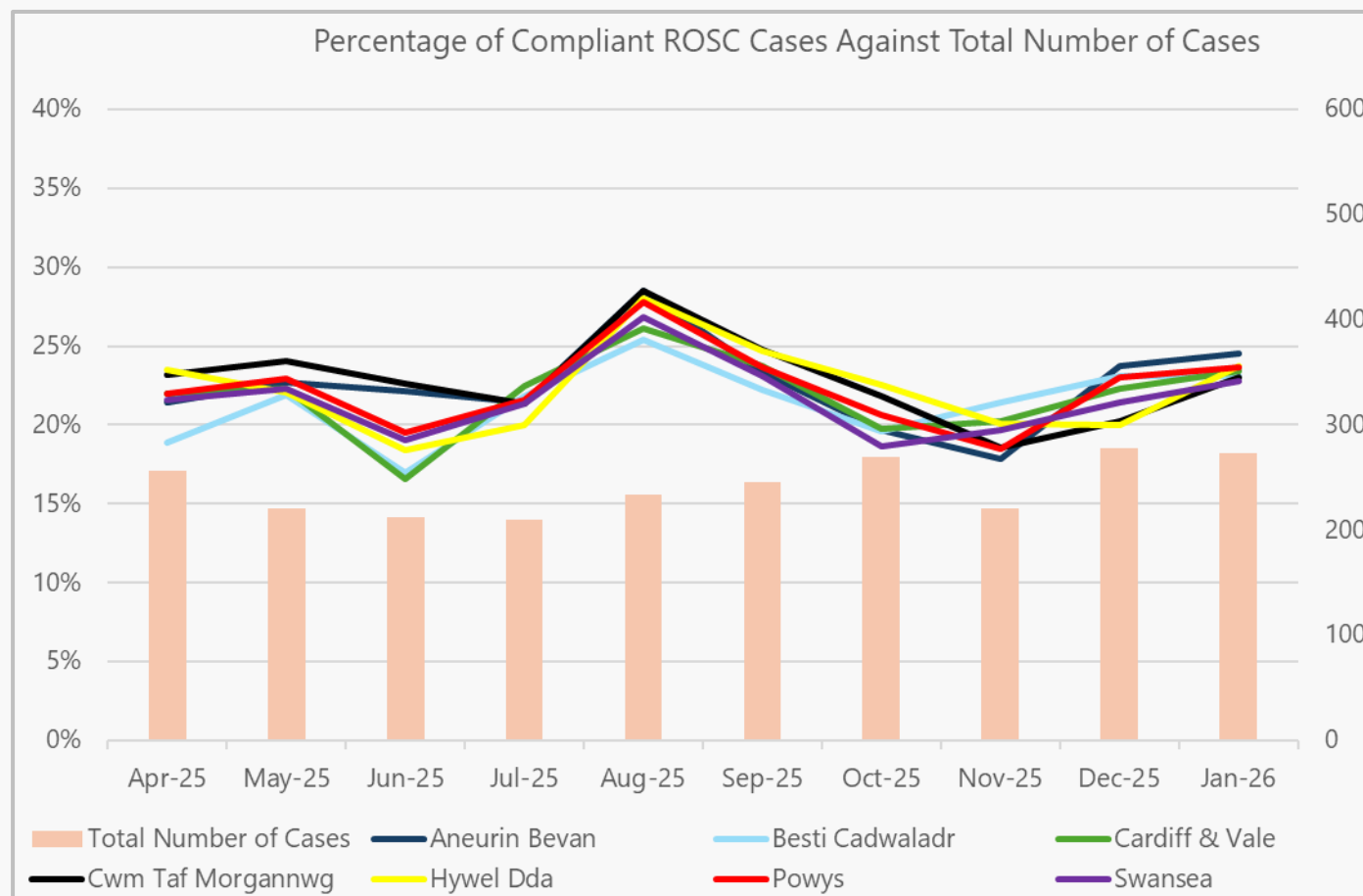
Call to door times can be longer in more rural settings. The key is to reduce handover lost hours to what the rosters are designed to cope with: 6,000 hours not +15,000 hours

Clinical Indicators



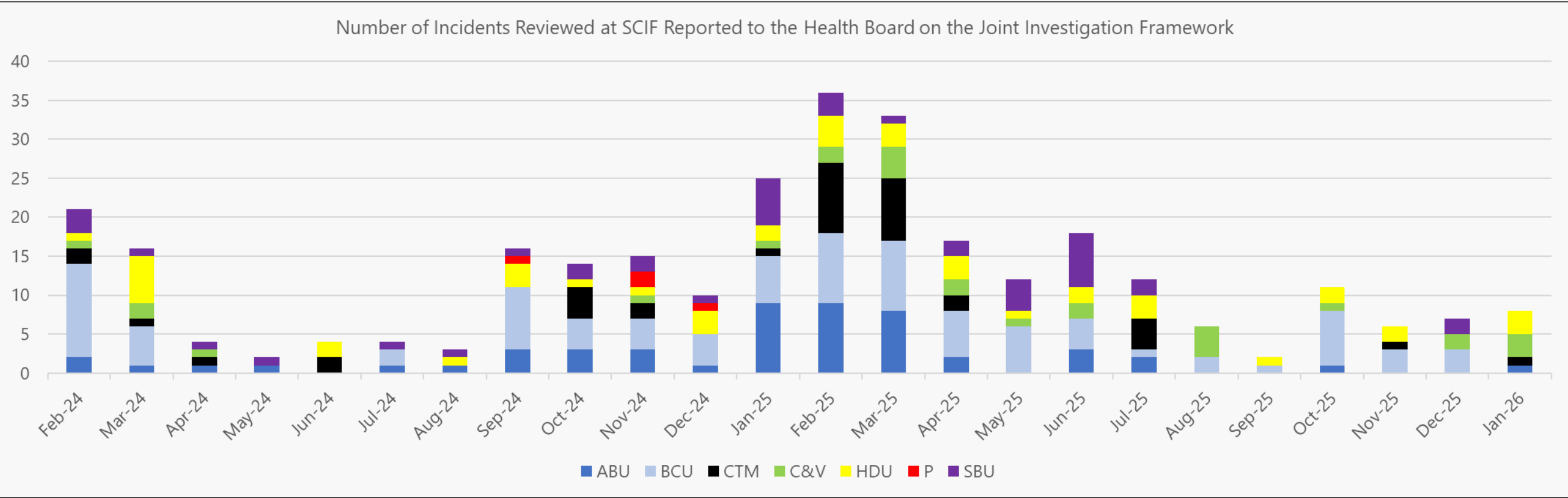
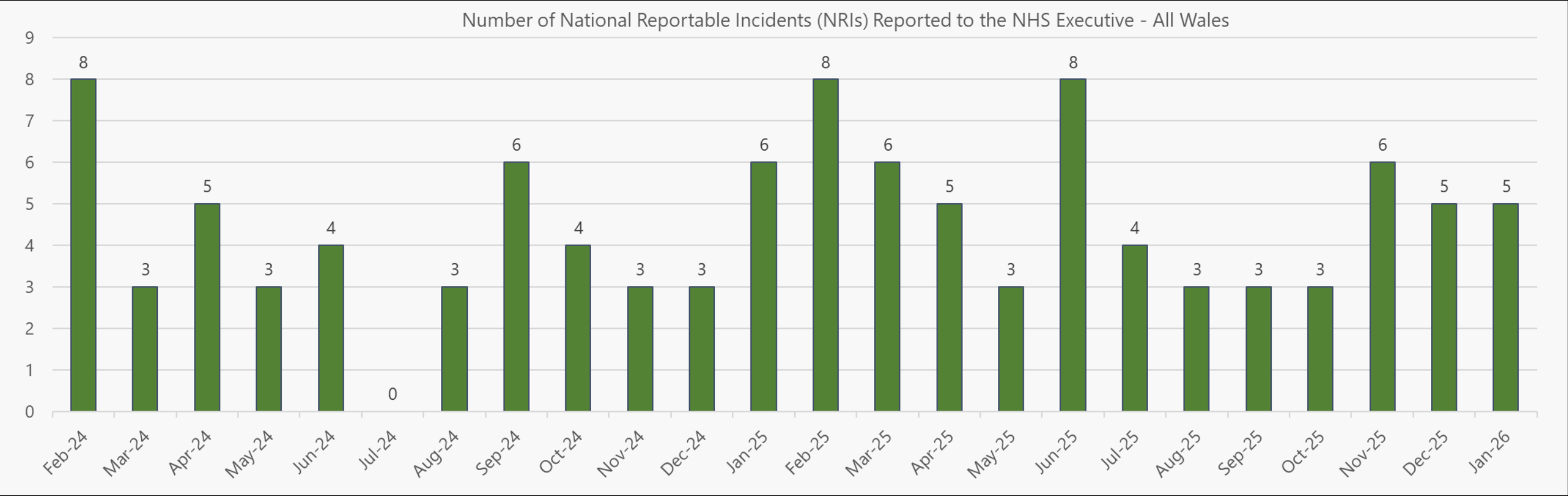
Potential reconfigurations of stroke and STEMI services may lead to longer scene to unit times, but the clinical evidence internationally indicates that getting patients to a higher level of clinical care unit, as offered through a reconfiguration, is key to the right clinical outcome for our patients

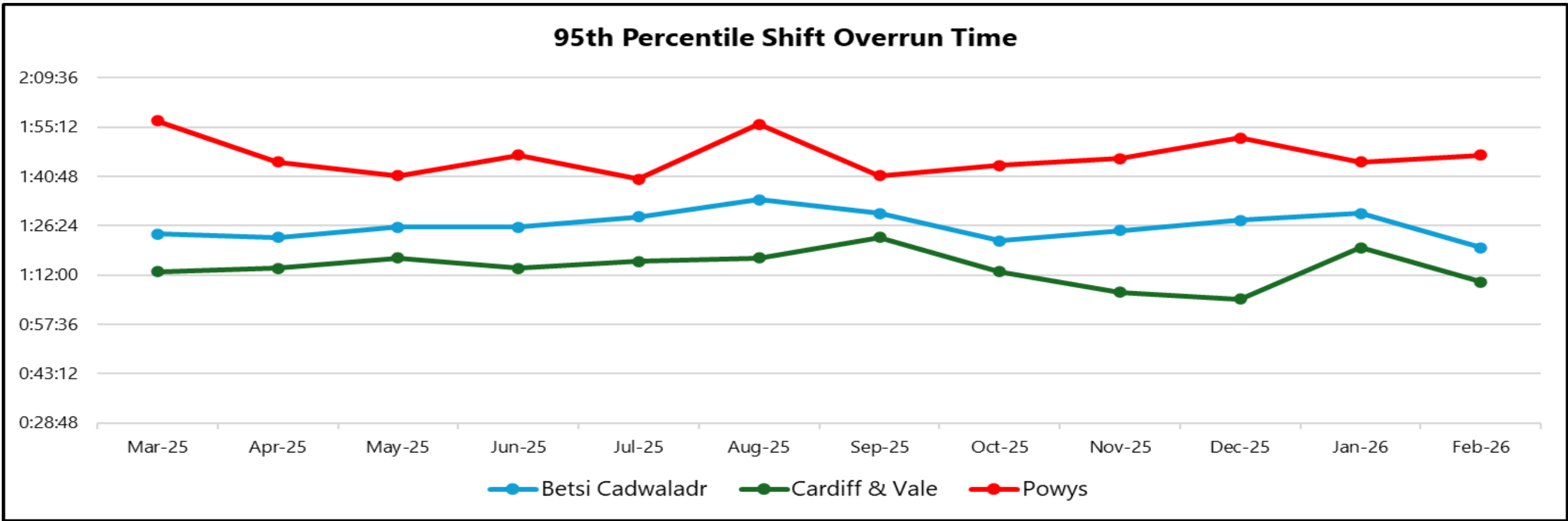
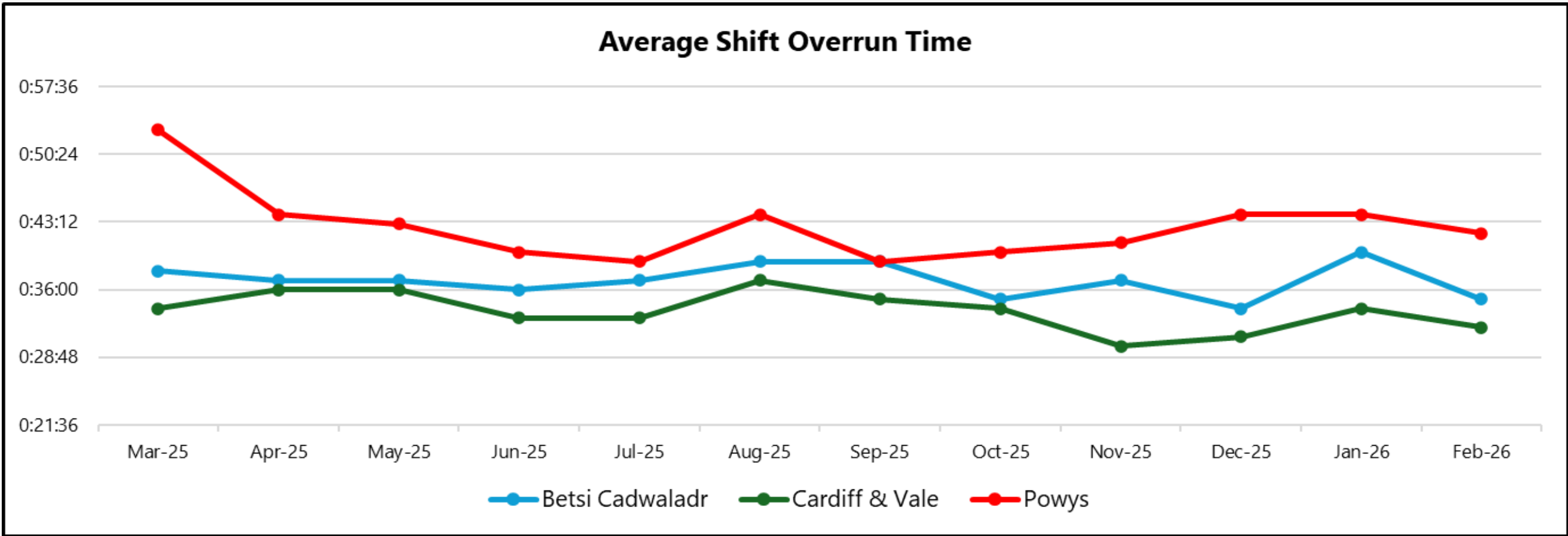
Clinical Indicators





Harm





The following 2024/25 IMTP deliverable was rolled forward into 2025/26:-

Emergency Medical Services - 999			
No.	Year 1 deliverables	Commissioning Intention? Y/N	Commissioning Intentions Ref
Incomplete IMTP 24/25 Deliverables carried over to 25/26			
EMS02 - Improve capacity in Rural areas	Continue to build a sustainable rural capacity by a) reviewing and implementing recruitment strategies b) reviewing demand and capacity 2023 recommendations	Yes	EMS/4

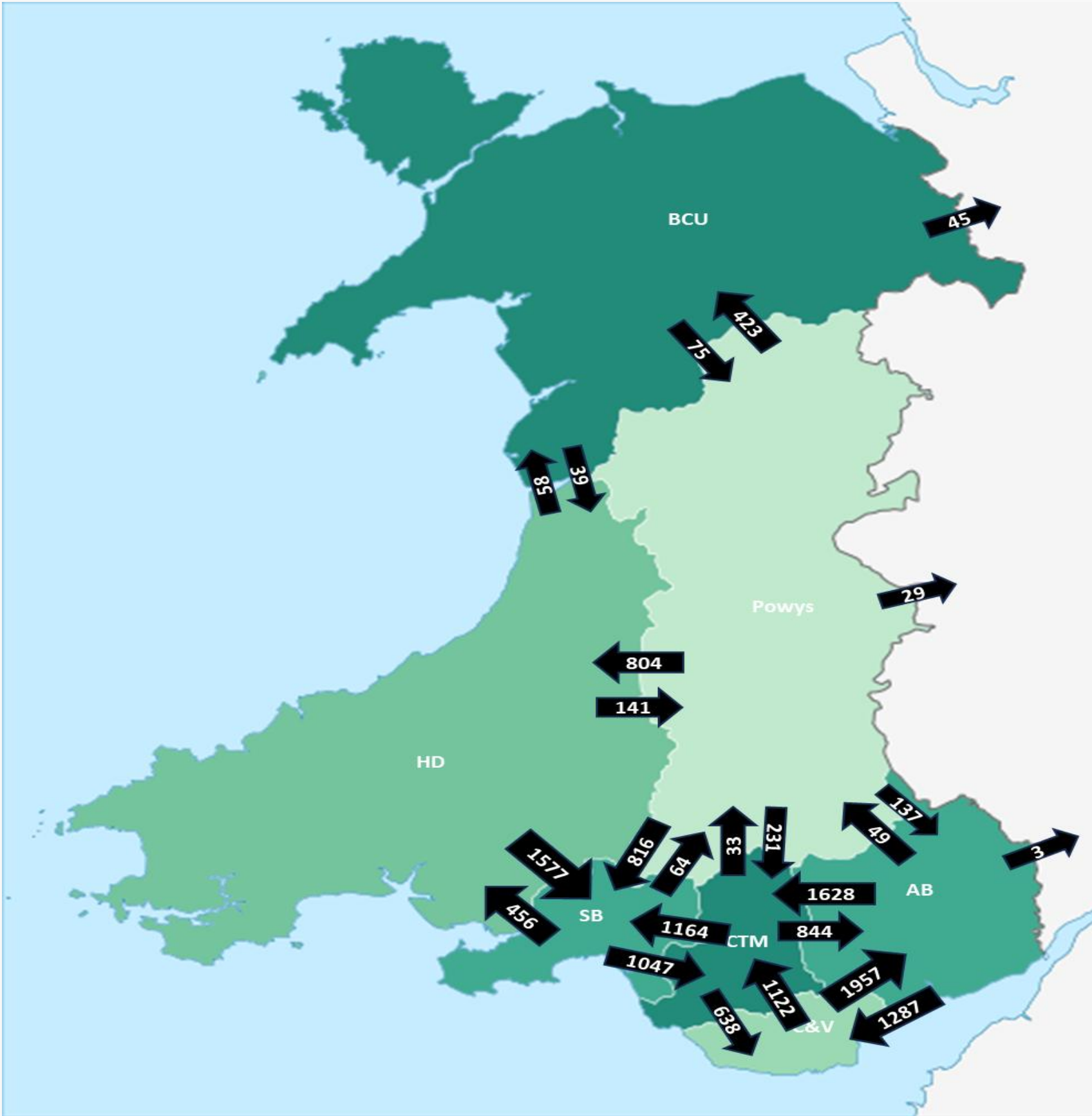
The CEO asked a number of Executives to consider the Trust's rural offer and pick up on this deliverable.

A Task & Finish Group was set up to look at rurality.

Operations Directorate's Senior Leadership Team received a rural capacity report from the task & finish group, at its 03 March 2026 meeting. This report identified the following points:-

1. The independent modelling identified that acceptable levels of performance could be delivered with full transformation and lower handover;
2. The key issue was recruiting and retaining staff on the rosters in the more rural parts of Wales;
3. Because the training for NQPs and EMT/EAP to Paramedic conversion takes place in more urban settings, this does not help recruit local people from rural communities. This is not easy to overcome;
4. The key finding is “**one glove does not fit all**” and that there needs to be an ability to design local rural rosters that are more attractive e.g. EA / CHARU rotational rosters.
5. Any gain from tweaks to the rosters would be marginal gain.

EA Cross Border Response Total Flow Activity – 1st January to 30th November 2023



	Cross Border Flow Totals								
	AB	BCU	C&V	CTM	HD	Powys	SB	OOA	Total
AB		0	1287	1628	0	49	0	3	2967
BCU	0		0	0	39	75	0	12	126
C&V	1957	0		1122	4	0	23	0	3106
CTM	844	0	638		30	33	1164	0	2709
HD	0	58	1	102		141	1577	0	1879
Powys	137	423	0	231	804		816	29	2440
SB	0	0	18	1047	456	64		0	1585
OOA									0
Total	2938	481	1944	4130	1333	362	3580	44	14812



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

Agenda Item No.

8

REPORT TITLE

Financial Performance as at Month 12 – 2025/26

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

1. This paper presents to the Committee the Financial Performance Report of the 2025/26 financial year, the reported position as at Month 12 (March 2026) / year end.



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Welsh Ambulance Services
University NHS Trust

2. The Committee is asked to review, comment, note and receive assurance on the financial outturn position for 2025/26 (**subject to audit**) and ahead of the Trust Board presentation of the 2025/26 accounts in June 2026.
3. Key highlights from the report for the Committee to note are:
 - The Trust is reporting a small revenue underspend/surplus of £0.080m, which is the basis for the draft accounts for the 2025/26 financial year (*subject to audit*);
 - Capital expenditure is fully spent;
 - In line with the financial plans that support the IMTP, gross savings of £8.556m have been achieved against a target of £8.500m;
 - Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.4% for the number, and 98.8% of the value of non-NHS invoices paid within 30 days.

RECOMMENDATION(S)

The Committee is requested to:

1. **Note** and gain **assurance** in relation to the Month 12 revenue financial position and performance of the Trust as at 31st March 2026.
2. **Note** the delivery of the 2025/26 savings plan.
3. **Note** the capital programme for 2025/26.
4. **Note** the Month 12 Welsh Government monitoring return submission (as required by WG).

ADDITIONAL PAPER(S)

The Committee is requested to receive the following:

1. Monitoring return submitted to Welsh Government for month 12 – as required by WG (*in the Reading Room*)
2. Monitoring return letter submitted to Welsh Government for month 12 – as required by WG (*in the Reading Room*)



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

APPROVAL/SCRUTINY ROUTE

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



GIG
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NHS
WALES

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

SITUATION

1. This report provides the Committee with a summary of the revenue financial performance of the Trust as at 31st March 2026 (Month 12 2025/26 and therefore the draft 2025/26 year end position), along with an update on the final 2025/26 capital programme spend, both of which are now part of the draft 2025/26 accounts and therefore ***subject to audit***.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2025/26** (1st April 2025 – 31st March 2026) are that:
 - The cumulative revenue financial position reported is a **small underspend against budget of £0.080m, 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 **£8.556m** have been achieved against a target of **£8.500m**;
 - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 98.4% for the number, and 98.8% 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.

ASSESSMENT

REVENUE FINANCIAL PERFORMANCE – MONTH 12 2025/26

4. The table below presents an overview of the financial position for the period 1st April 2025 to 31st March 2026.



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Revenue Financial Position for the period 1st April - 31st March				
	Annual	Year to date		
	Budget	Budget	Actual	Variance
	£000	£000	£000	£000
Income	-344,348	-344,348	-344,337	11
Expenditure				
Pay	261,780	261,780	258,635	-3,144
Non-pay	62,700	62,700	65,578	2,877
Total pay & non-pay expenditure	324,480	324,480	324,213	-267
Depreciation & Impairments / interest payable & receivable	19,868	19,868	20,044	176
Total	0	0	-80	-80

Income

- Reported Income against the initial budget set to Month 12 shows an underachievement of **£0.011m**.

Pay Costs

- Overall, the total pay variance at Month 12 is an underspend of **£3.144m**.

Non-pay Costs

- The overall non-pay position at Month 12 is an overspend of **£2.877m**. In addition, for reporting purposes Depreciation, Impairment and Interest is excluded from the above figure, which overspent by **£0.176m**, hence the total overspend to budget of **£3.053m**.
- Much of this however was not committed to until the income and, in particular, pay positions were largely known and forecast, within the overall bottom line balanced position and out-turn.

Savings

- As above, the 2025/26 financial plan identifies that a minimum of **£8.500m** of planned savings (including income generation) were required to achieve financial balance in 2025/26, this equates to c.2.7% of the Trust's discretionary income. Of this, **£6.225m** is recurrent and **£2.275m** is deemed non recurrent.
- Month 12 in month performance was, plan of £0.752m and £0.781m achieved, therefore an overachievement of £0.029m (recurrent underachievement of £0.021m and non-recurrent overachievement of £0.050m), as per the below table.



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	Annual Plan £000	In Month			Cumulative			Forecast		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Themes	6,225	562	541	-21	6,225	5,850	-375	6,225	5,850	-375
Non Recurrent Schemes / Themes	2,275	190	240	50	2,275	2,706	431	2,275	2,706	431
Overall Total	8,500	752	781	29	8,500	8,556	56	8,500	8,556	56

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

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

	Annual Plan £000	In Month			Cumulative			Forecast		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Savings (Cash releasing and Cost Avoidance)	8,350	723	777	54	8,350	8,505	155	8,350	8,505	155
Net Income Generation	150	29	4	-25	150	50	-100	150	50	-100
Accountancy Gains	0	0	0	0	0	0	0	0	0	0
Overall Total	8,500	752	781	29	8,500	8,556	56	8,500	8,556	56

12. **Appendix 1** provides the overall detail for Month 12 by theme. This is now further split over recurring and non-recurring schemes.

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 £000	Year to date			
		Budget £000	Actual £000	Variance £000	Tolerance 5% %
Directorate					
Operations Directorate	222,592	222,592	221,039	-1,553	-0.7%
Chief Executive Directorate	2,263	2,263	2,294	31	1.4%
Board Secretary	731	731	754	23	3.2%
Partnerships & Engagement Directorate	656	656	602	-54	-8.3%
Finance and Corporate Resources Directorate	37,703	37,703	38,846	1,144	3.0%
Planning and Performance Directorate	3,164	3,164	3,007	-157	-5.0%
Quality, Safety and Patient Experience Directorate	7,771	7,771	7,629	-143	-1.8%
Digital Directorate	16,413	16,413	16,028	-385	-2.3%
People and Culture	6,503	6,503	6,090	-413	-6.4%
Medical & Clinical Services Directorate	6,524	6,524	6,476	-47	-0.7%
Trust Reserves	574	574	1,110	536	93.4%
Trust Income (mainly JCC)	-304,894	-304,894	-303,955	939	0.3%
Overall Trust Position	0	0	-80	-80	

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

- Most directorates are either underspent or broadly in line with budget plan for Month 12 except for Trust Reserves and Finance and Corporate



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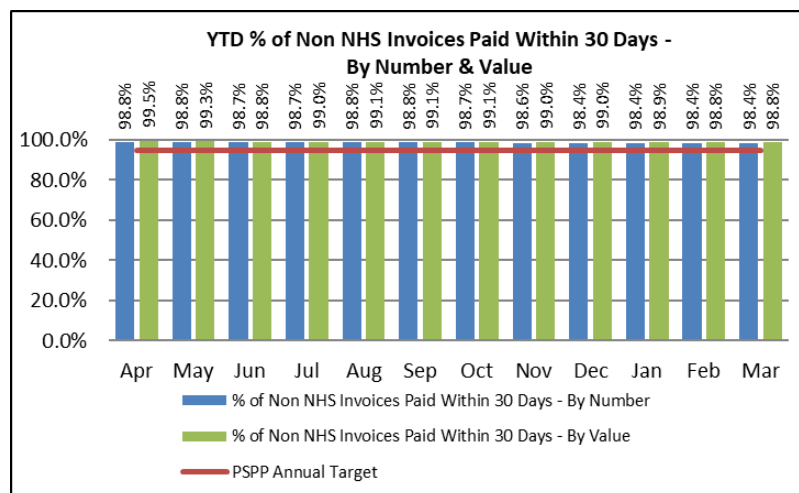
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Resources, where a number of more technical and Trust wide budgets are held.

- Core budgets set for Finance and Corporate Resources at the 2025/26 financial year were balanced, following the reversal of the WRP assumptions the non-pay is overspent due to the following areas:
 - Interest receivable has been lower in year due to a reduction in rate from plan and also lower cash balances during the year.
 - General losses and special payments have been higher than budgeted.
- Trust reserves due to rebasing some balance sheet provisions from 2024/25 for annual leave sold.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

15. Public Sector Payment Policy (PSPP) compliance to Month 12 was **98.4%** against the **95%** WG target set for non-NHS invoices by number and **98.8%** by value.



2025-26 CAPITAL PROGRAMME

16. At Month 12, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2025/26 is **£32.326m**. This includes **£26.378m** of All Wales Approved schemes and **£5.948m** for Discretionary schemes.

17. The Trust achieved the CEL target of **£32.326m**, with a very small underspend against plan of **£0.73** (*subject to audit*). Below is a summary of the year end capital spend across the main headings of the capital plan.



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	Actual £'000	Plan £'000
All Wales Capital Programme:		
Schemes:		
ESMCP - Control Room Solutions	421	421
MDVS	72	72
Special Operational Response Teams (SORT) Enhancement Equipment	290	290
Welsh Ambulance Services NHS Trust – Vehicle Replacement Programme – 2025-26	22,452	22,452
TEF - Infrastructure	300	300
TEF - Decarbonisation	707	707
Replacement PC/Laptops, Server & Switch upgrades - End of Year Digital funding 2025-26	550	550
EA Chassis 26-27 - End of Year funding 2025-26	1,290	1,290
Voice Conference & Voice Recorders Upgrade - End of Year Digital Funding 2025-26	296	296
Sub Total	26,378	26,378
Discretionary:		
I.T.	1,149	1,149
Equipment	250	250
Statutory Compliance	0	0
Estates	4,507	4,507
Other	42	42
Unallocated Discretionary Capital	0	0
Sub Total	5,948	5,948
Total Funding from WG	32,326	32,326

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.

2025/26 YEAR END ACCOUNTS AND AUDIT

19. Finalisation of the Accounts and audit work continues in respect of the 2025/26 Trust Annual Accounts. The draft accounts were submitted to WG and Audit Wales, as per the issued guidance, on 1st May 2026, with the audited accounts to be presented to Audit Committee on 23rd June 2026 ahead of seeking final approval of these at Trust Board on 25th June 2026.
20. The 2025/26 year-end audit will again be conducted virtually, maximising the use of technology and building on the experiences of the previous 6 years' audits.



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RECOMMENDATION

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

NEXT STEPS

- 22. Monitor the ongoing revenue and capital as we move into 2026/27 the year, linking in with key stakeholders, to ensure delivery to plan.
- 23. Continue to closely monitor risks and ensure plans are developed to ensure the Trust can meet its statutory duties.



Appendix 1

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

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 25-26

Reporting Month

12

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprentice Income	50	4	4	0	50	50	0	50	50	0
Balance Sheet Flexibility	200	50	100	50	200	150	-50	200	150	-50
Commercialisation Opportunities	100	25	0	-25	100	0	-100	100	0	-100
Disposals	250	35	35	0	250	250	0	250	250	0
End of Shift Overrun	100	8	8	0	100	98	-2	100	98	-2
Fuel	230	15	16	1	230	634	404	230	634	404
Interest Receivable	516	43	26	-17	516	218	-298	516	218	-298
Non Pay Local Schemes - Corporate	914	94	61	-33	914	714	-200	914	714	-200
Non Pay Local Schemes - Operations	650	58	54	-4	650	520	-129	650	520	-129
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	221	228	7	3,140	3,140	0	3,140	3,140	0
Pay Vacancy Management - Corporate	2,275	190	240	50	2,275	2,706	431	2,275	2,706	431
Pay Vacancy Management - Corporate 25-26	75	9	9	0	75	75	0	75	75	0
Totals	8,500	752	781	29	8,500	8,556	56	8,500	8,556	56

Savings Performance by Theme 25-26 - Recurrent

Reporting Month

12

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprentice Income	50	4	4	0	50	50	0	50	50	0
Balance Sheet Flexibility	200	50	100	50	200	150	-50	200	150	-50
Commercialisation Opportunities	100	25	0	-25	100	0	-100	100	0	-100
Disposals	250	35	35	0	250	250	0	250	250	0
End of Shift Overrun	100	8	8	0	100	98	-2	100	98	-2
Fuel	230	15	16	1	230	634	404	230	634	404
Interest Receivable	516	43	26	-17	516	218	-298	516	218	-298
Non Pay Local Schemes - Corporate	914	94	61	-33	914	714	-200	914	714	-200
Non Pay Local Schemes - Operations	650	58	54	-4	650	520	-129	650	520	-129
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	221	228	7	3,140	3,140	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	9	9	0	75	75	0	75	75	0
Totals	6,225	562	541	-21	6,225	5,850	-375	6,225	5,850	-375

Savings Performance by Theme 25-26 - Non Recurrent

Reporting Month

12

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprentice Income	0	0	0	0	0	0	0	0	0	0
Balance Sheet Flexibility	0	0	0	0	0	0	0	0	0	0
Commercialisation Opportunities	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
End of Shift Overrun	0	0	0	0	0	0	0	0	0	0
Fuel	0	0	0	0	0	0	0	0	0	0
Interest Receivable	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Corporate	0	0	0	0	0	0	0	0	0	0
Non Pay Local Schemes - Operations	0	0	0	0	0	0	0	0	0	0
Pay Cost Management (Variable / Net Vacancies) - Operations	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,275	190	240	50	2,275	2,706	431	2,275	2,706	431
Pay Vacancy Management - Corporate 25-26	0	0	0	0	0	0	0	0	0	0
Totals	2,275	190	240	50	2,275	2,706	431	2,275	2,706	431

Please note figures are rounded to the nearest whole number



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Agenda Item No. 9

REPORT TITLE

Commercial Plan 2026-2028

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh, Executive Director for Strategy, Planning and Performance
Author(s) of report	Matt Dugdale, Assistant Director of Commercial Development

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The Welsh Ambulance Services University NHS Trust (WAST) Commercial Plan 2026–2028 sets out a clear, values-driven framework for commercial development as a strategic enabler of improved patient care, organisational resilience and sustainable value creation. It emphasises that commercial activity is not an end in itself, but a means to reinvest in



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services, workforce development and innovation. The plan reflects growing financial pressures and system demand, positioning WAST as an outward-looking, collaborative organisation that leverages its expertise, assets and partnerships to deliver long-term public benefit. Central to the plan is alignment with the Trust's Integrated Medium Term Plan (IMTP) and strategic objectives, particularly innovation, collaboration and delivering exceptional value.

2. The plan defines commercial development as the responsible pursuit of opportunities that create value, strengthen capability and enhance patient outcomes, underpinned by ethical practice and robust governance. It establishes a structured Commercial Development function to move from reactive to proactive opportunity management, focusing on areas such as digital services, data insight, artificial intelligence and scalable service models. Importantly, the Trust commits to not commercialising identifiable patient data and to ensuring all activity meets strict governance, legal and ethical standards. The ambition is to achieve a self-sustaining commercial function by 2027/28 while embedding Value Based Healthcare principles and social value in all decisions.
3. Delivery is organised around three strategic pillars. Firstly, building trusted partnerships across public, private and third sectors to co-develop innovative services aligned to WAST priorities. Secondly, driving innovation and income generation through structured opportunity pipelines, new commercial models (e.g. joint ventures and licensing), and a focus on digital and data-enabled services. Thirdly, creating sustainable organisational capability by developing skills, systems, governance and a culture that enables staff-led innovation and effective commercial delivery. Collectively, these pillars aim to generate sustainable income, strengthen resilience and support reinvestment into patient care and workforce development while maintaining focus on core service delivery.
4. The plan outlines clear benefits for patients, staff and partners. For patients, it aims to improve access, quality and responsiveness of care through innovation, co-design and reinvestment. For staff, it provides clearer routes to develop and scale ideas, supported by training, protected time and innovation frameworks. For partners, it offers transparent and values-led collaboration opportunities focused on shared outcomes and system-wide benefits. This inclusive approach is intended to foster innovation, enhance capability and strengthen system integration across Wales while ensuring commercial activity consistently delivers public value.
5. A robust governance and risk management framework underpins delivery, ensuring commercial activity remains safe, ethical and proportionate. The key risks are actively managed within established governance structures, with a low tolerance for any impact on patient safety or public trust. Success will be measured through a balanced framework including patient outcomes, financial performance, partnership quality, workforce engagement and overall value creation rather than income alone. A detailed delivery plan



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with defined actions, timelines and accountability supports implementation, ensuring commercial development is aligned to organisational capacity and contributes to long-term sustainability and improved care outcomes.

RECOMMENDATION(S)

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

The Finance and Performance Committee is requested to:

1. Endorse the Commercial Plan for 2026-2028.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

The Finance and Performance Committee is requested to receive the following:

1. Commercial Plan 2026-2028.



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [[link to objectives and what good looks like](#)]

☐ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☐ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

N/A

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [[link to standards](#)]

☐ Safe	☐ Timely	☒ Effective
☒ Efficient	☐ Equitable	☐ Person Centred

Quality Enablers (select all that apply) [[link to standards](#)]

☐ Leadership	☐ Workforce	☐ Culture
☒ Information	☐ Learning Improvement & Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [[link to goals](#)]

☐ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☒ n/a	☐ n/a	☒ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☐ No ☒ Yes
If yes, what impact assessment is attached	To follow, pending approval.

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
29/04/2026	Executive Leadership Team



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Commercial Plan

2026-28

Delivering value for WAST.
Delivering value for Wales.



Foreword

From the Executive Director for Strategy, Planning and Performance



I am pleased to present the Welsh Ambulance Services University NHS Trust's Commercial Plan for 2026–2028. This plan sets out how we will take a clear, values-driven and well-governed approach to commercial development, ensuring that commercial activity supports our core purpose as a public service organisation and contributes to better outcomes for the people of Wales.

For WAST, commercial development is not an end in itself. It is a means of creating sustainable value, strengthening organisational capability, supporting innovation and enabling reinvestment in patient care, workforce development and service

improvement. At a time of increasing demand and financial pressure, it is important that we make the best possible use of our expertise, assets, partnerships and ideas.

This plan reflects our ambition to be outward-looking, collaborative and enterprising in the right way. It recognises the opportunities presented by innovation, digital development, data-driven insight and scalable service models, while making clear that all commercial activity must be aligned to our values, strategic objectives and robust governance arrangements.

The Commercial Plan is closely aligned to our wider strategic direction, particularly our objectives on Innovation and Technology, Developing Services in Collaboration, and Delivering Exceptional Value. It provides a practical framework for how we will identify and prioritise opportunities, build trusted partnerships, and develop the capability needed across the organisation to respond effectively and responsibly.

Importantly, this plan is grounded in realism. Commercial development will only be pursued where it is proportionate, value-driven and supported by the right capacity, capability and enabling arrangements across the Trust. This plan is also about creating opportunities for our people. We want colleagues across WAST to feel that commercial development is relevant to them, not as something separate from day-to-day improvement, but as a route through which good ideas can be supported, developed and, where appropriate, scaled for wider benefit. Through this approach, we aim to create clearer routes for innovation, stronger support for staff-led ideas and greater opportunities for reinvestment in training, development and service improvement.

Above all, this plan is about responsible growth in support of public value. It reflects our commitment to improving care, strengthening resilience and delivering long-term benefit for patients, communities and the wider system.

Thank you for taking the time to read our plan. I look forward to working with colleagues, partners and communities to deliver it over the years ahead.

Rachel Marsh

Executive Director of Strategy, Planning and Performance

Introduction

The commercial landscape within the healthcare sector has evolved significantly in recent years, driven by increasing financial pressures, the need for system-wide collaboration, and a growing emphasis on innovation and sustainability. For NHS organisations, commercial development is no longer solely about income generation; it is about creating value, strengthening capability, and forming partnerships that enhance patient care and organisational resilience.

The Welsh Ambulance Services University NHS Trust (WAST), as a critical component of Wales' urgent and emergency care system, is uniquely positioned to harness its expertise, assets and reputation to develop commercial opportunities that are a natural extension of its existing portfolio. Through innovation, collaboration and responsible enterprise, WAST seeks to grow its services in a way that is sustainable, aligned to our values, and supportive of our core mission to deliver high-quality care for the people of Wales.

Commercial development within WAST is not simply a transactional activity; it is a strategic enabler. It is about building trusted partnerships, unlocking new ways of working, and creating mutually beneficial opportunities that balance risk with long-term value, all of which are underpinned by our Delivering Excellence strategic framework. By approaching commercial activity through the lens of value creation, system benefit and ethical practice, we can ensure that income-generating activity directly supports improved outcomes for patients, staff and the wider healthcare system.

The establishment of a dedicated Commercial Development function marks a significant milestone in the Trust's maturity and ambition. As a new team and capability, it provides the focus and structure required to identify opportunities, develop partnerships, and grow organisational confidence in operating within commercial environments. Realising this ambition will require not only strong ideas and partnerships, but also sufficient organisational capability, delivery capacity and enabling support across the Trust. A clear understanding of our current capabilities, assets and areas for development is therefore fundamental to ensuring that our approach is realistic, proportionate and aligned to our Integrated Medium Term Plan (IMTP) priorities.

This Commercial Plan for 2026–2028 sets out how WAST will create sustainable value and organisational capability, build and sustain trusted partnerships, and drive innovation and responsible income-generating activity. It recognises that the healthcare landscape will continue to change at pace, and that, to thrive within it, we must be outward-looking, collaborative and commercially astute. In particular, WAST recognises that some of its most significant future commercial opportunities are likely to arise through digital services, data-driven insight, artificial intelligence, and scalable platforms that extend the reach and impact of our expertise across Wales and beyond.

Over the lifetime of this plan, our ambition is for the Commercial Development function to be progressively developed to achieve financial self-sufficiency by the end of 2027/28 and establish an enduring, well-governed commercial capability for WAST. By 2028, WAST will have a commercial approach that is aligned to the IMTP, enables innovation and partnership working, embeds social value and Value Based Healthcare principles, and generates sustainable value for reinvestment in services for the people of Wales.

What we mean by commercial development

In the context of the Welsh Ambulance Services University NHS Trust (WAST), commercial development is the strategic and responsible pursuit of opportunities that create sustainable value, strengthen organisational capability, and support the delivery of high-quality patient care. It is not solely about generating income, but about using our expertise, assets and relationships in ways that are mutually beneficial, ethically grounded and aligned to our core purpose as a public service organisation.

Commercial development within WAST encompasses innovation, partnership working and income-generating activity that is a natural extension of our existing portfolio and our clinical, operational and educational strengths, maximising our offer and contribution to NHS Wales where we are best placed to deliver value. This includes collaborating with partners across the public, private and third sectors, developing and scaling new services and products, and exploring new delivery models that improve efficiency, resilience and outcomes across the wider health and care system.

As a newly established function, commercial development provides a structured and coordinated approach to identifying, assessing and delivering opportunities. It ensures that activity is strategically aligned, appropriately governed, and balanced against risk, capacity and operational priorities. This approach enables WAST to transition from opportunistic engagement to a proactive, planned and sustainable commercial opportunity pipeline.

In practical terms, this means building the capability to:

- Identify and evaluate commercial opportunities that align with our strategic objectives and values.
- Develop and sustain trusted partnerships based on shared purpose and long-term value.
- Support innovation and the translation of ideas into viable, scalable services and solutions.
- Generate commercial income that can be reinvested to enhance patient care, workforce development and service resilience.

In support of this approach, WAST will not commercialise identifiable patient data. Opportunities involving data, digital or artificial intelligence will only be progressed where they are lawful, ethical, proportionate and aligned to the Trust's information governance, data protection, clinical safety, cybersecurity and AI governance requirements.

Through this lens, commercial development becomes a catalyst for growth, innovation and collaboration, supporting WAST to remain financially sustainable, system-focused and future-ready while continuing to place patients and communities at the heart of everything we do.

Why we need a commercial plan

WAST needs a Commercial Plan to provide a clear, consistent and governed approach to how we identify, develop and deliver commercial opportunities that support our public service purpose. It moves us from ad hoc or reactive activity to a proactive, strategically aligned approach that creates sustainable value, strengthens organisational capability and supports service improvement.

The Commercial Plan is a practical enabler of the Trust's strategic priorities, in particular Strategic Objective 3 (Innovation and Technology), Strategic Objective 4 (Developing Services in Collaboration) and Strategic Objective 6 (Delivering Exceptional Value). Strategic Objective 3 is especially significant to this plan, as many of WAST's most promising commercial opportunities are likely to arise through innovation, digital development, data-driven insight, artificial intelligence and the application of technology to improve services and create scalable models.

Commercial development is explicitly supported by Strategic Objective SO6 – Delivering Exceptional Value, under which the Trust has set an open risk appetite for commercial innovation and responsible growth. WAST will actively seek opportunities that maximise value for service users and stakeholders, including in commercial innovation, the foundational economy and environmental sustainability. The Trust will take calculated risks where this can deliver significant improvement, supported by robust risk management and governance.

The Plan also strengthens how we secure value from public resources through better commercial planning, option appraisal, contract and supplier management, and reinvestment of income into patient care, workforce development, innovation and service resilience. In this way, commercial activity is not an end in itself; it is a means of improving outcomes and building long-term sustainability.

As a named NHS Wales organisation, WAST must act in accordance with the Well-being of Future Generations (Wales) Act 2015, ensuring our plans and decisions contribute to the well-being goals and apply the five ways of working. The Commercial Plan supports this by ensuring commercial activity and partnerships are designed to deliver long-term public value for Wales, including through prevention, collaboration, involvement, integration and a long-term approach.

The Plan is also shaped by the public procurement framework, including the Procurement Act 2023, which places emphasis on value for money, maximising public benefit, transparency and integrity in covered procurement. These principles reinforce WAST's approach to responsible commercial activity and how we design, procure and manage commercial relationships.

For WAST, applying Value Based Healthcare (VBHC) principles in a commercial context means assessing opportunities not only on financial return, but on the wider value they create - outcomes for patients, experience of care, equity of access, workforce benefit, environmental sustainability, and benefit to communities across Wales. This includes demonstrating social value through our partnerships, supply chains and reinvestment decisions, so that commercial activity contributes to better care and wider system benefit. NHS Wales VBHC also emphasises outcomes that matter to patients, equity, reducing unwarranted variation and prudent use of resources, which aligns strongly with this approach.

Commercial development will be pursued in a way that is proportionate and realistic, and WAST will not pursue commercial growth at the expense of safe, effective core service delivery. Prioritisation will

therefore be essential, with opportunities progressed according to strategic fit, value, delivery capacity, risk and readiness. The Trust also recognises that its ability to pursue commercial opportunities will at times be constrained by operational demand, workforce pressures and competing organisational priorities.

The Commercial Plan therefore provides the framework WAST needs to pursue innovation and responsible growth with clear governance, proportionate risk management and a consistent focus on public value.

Our vision for commercial development

THE VISION

To build **trusted** and **innovative** commercial partnerships that strengthen the Welsh Ambulance Service, create sustainable **value**, and enable **reinvestment** in patient **care** and community **well-being** across Wales.

Our vision for Commercial Development reflects the Trust's ambition to be an outward-looking, values-driven and system-focused organisation. It articulates our commitment to building trusted and innovative partnerships that create sustainable value, strengthen organisational capability, and support the reinvestment of resources into patient care and community well-being across Wales. This vision provides a clear and unifying direction for all commercial activity, ensuring that growth, innovation and income generation are pursued in a way that is ethical, collaborative and firmly aligned to the core purpose and strategic priorities of the Welsh Ambulance Services University NHS Trust.

This vision is underpinned by three strategic pillars, which define our commercial objectives:

Pillar 1 | Trusted partnerships

Develop strong, transparent and mutually beneficial relationships across the public, private and third sectors.

Pillar 2 | Innovation and income

Identify and deliver value-driven commercial opportunities that enhance resilience and service capability.

Pillar 3 | Sustainable capability

Build the capacity, skills, systems and culture to assess, prioritise and deliver opportunities robustly.

The following sections set out these strategic objectives in greater detail and describe what they mean for our people, our patients and our partners.

Pillar 1 | Build and sustain trusted partnerships

Delivery Objectives

Under this pillar, the Trust will seek to explore new markets, products and services that leverage WAST's expertise, including digital, data and AI-enabled opportunities, while supporting healthcare innovation across Wales. To deliver our ambitions for the future, it is essential that we develop and maintain strong, transparent and mutually beneficial relationships across the public, private and third sectors, ensuring that all partnerships are aligned with WAST's values, strategic priorities and commitment to high-quality patient care.

How will this be delivered?

- Develop and implement a Commercial Partnerships Framework that sets out how partnerships are identified, developed and governed, prioritising partnerships where WAST's national role, expertise and assets can add the greatest value to NHS Wales.
- Identify and progress opportunities for commercial co-development that align with WAST's values and strategic priorities, for example partnering with a mental health organisation to deliver innovative elements of our mental health response or partnering with a technology provider to accelerate our AI ambitions.
- Design and deliver partner-led innovation programmes focused on our highest-priority challenges, engaging organisations across Wales and beyond to co-create solutions.

Pillar 2 | Drive innovation and commercial income-generating activities

Delivery Objectives

Under this pillar, the Trust will seek to identify and deliver innovative commercial opportunities that enhance WAST's operational resilience and service capability. To ensure sustainable success, this will focus on value-driven opportunities, particularly those arising from digital service models, data and insight, artificial intelligence, scalable platforms, and market developments within the health and social care sector, alongside efficiencies achieved through robust and effective contract management.

How will this be delivered?

- Develop a structured route for consideration of commercial ideas through existing Trust prioritisation and governance arrangements, with clear criteria to assess strategic fit, value, risk, capacity and impact on patient care before progressing to delivery.
- Consider piloting innovative commercial models such as joint ventures, licensing, managed services, or shared services that support innovation, spread best practice, and create sustainable income streams.

Pillar 3 | Create sustainable value and organisational capability

Delivery Objectives

Under this pillar, the Trust will continue to develop a culture of enterprise and innovation, centred on building the internal capacity, capability, skills and systems required to identify, assess, prioritise and deliver commercial opportunities in a robust and sustainable way. Sustainability principles will be embedded throughout all stages of planning and delivery, ensuring that commercial activity supports long-term organisational resilience, responsible growth and alignment with the Trust's values and strategic priorities.

How will this be delivered?

- Encourage staff-led proposals for new services, process improvements, or digital solutions through our ambition to design and deliver a single, aligned ideas management platform. This will be delivered through close working with Quality Improvement, Research and Development, Digital and Charity.
- Conduct regular reviews of projects to ensure they are delivering financial and non-financial benefits.
- Strengthen Board and senior leadership commercial capability through targeted development sessions on commercial models, risk, governance, value-based decision-making and reinvestment, to support confident oversight, constructive challenge and timely decision-making.
- Provide commercial and innovation training for relevant staff, e.g., finance, operational leads, and business managers.
- Establish a live, Trust-wide contract register to oversee and ensure supply-chain value. This will be delivered in partnership with NHS Wales Shared Services Partnership, with the aim of ensuring transparency, efficiency and accountability.
- Implement systems to capture and track commercial activity, project pipelines, and outcomes.
- Ensure commercial and operational planning reflects long-term organisational resilience.

What does this mean for our patient, people and partners?

The plan creates value only when it improves care, supports colleagues and enables purposeful collaboration.

Patients and communities

Improved quality, accessibility and responsiveness of care through trusted partnerships, co-design and reinvestment.

Our people

Clearer routes to bring forward ideas, access support, develop skills and turn improvements into practical change.

Potential partners

A transparent, values-led route to collaborate with a trusted NHS organisation on shared outcomes and system benefit.

What this means for our patients

For patients and communities across Wales, this plan is about improving the quality, accessibility and responsiveness of care. By building and sustaining trusted commercial partnerships, WAST will be able to work with a wider range of organisations to develop and deliver services that better meet the needs of the people we serve. This includes, for example, partnering with technology providers to strengthen digital and artificial intelligence capability, or working with regional and national organisations to strengthen specialist services, such as respiratory care and paediatrics.

Strong, well-governed partnerships enable the sharing of knowledge, expertise and resources, supporting the adoption of best practice, accelerating research and delivering more joined-up care across the system. Central to this approach is the co-design of services and pathways with patients and communities, ensuring that innovation is shaped by lived experience and results in services that are accessible, culturally sensitive and responsive to local need.

Responsible commercial activity and sustainable income generation will ensure financial sustainability and enable reinvestment in new and improved services, technologies and models of care that enhance quality, safety and patient experience. For example, income generated from the Trust's intellectual property can be reinvested to strengthen service capability, reduce unwarranted variation and support more consistent and equitable care. By embedding sustainability principles throughout planning and delivery, the Trust will be better placed to provide resilient, high-quality services that continue to adapt to changing patient and community needs.

How our patients can get involved

- Sharing experiences and feedback on current services, digital tools and patient pathways to help identify priorities for improvement.
- Taking part in engagement activity (e.g. surveys, focus groups, listening events and community conversations) to inform the design of new services or innovations.

- Joining co-design workshops with staff and partners to help shape how commercial partnerships can contribute to new models of care and service improvements.
- Helping test and evaluate new ideas (for example digital tools, information resources or service changes) to ensure they are accessible, safe and meet patient needs.
- Providing feedback on what matters most in how value is measured, so that success is judged not only by financial return but by patient outcomes, experience, equity and wider community benefit.

We will ensure involvement is accessible and meaningful, providing feedback on how views have shaped decisions and service development.

What this means for our people

For our people, this plan is about creating real opportunities to improve services, develop skills and turn good ideas into practical change. It means that commercial activity will not only support the long-term sustainability of the Trust but can also generate income that can be reinvested in our workforce, including staff ideas, improvement initiatives, training and service development across the organisation.

For individual members of staff, this should mean clearer routes to bring forward ideas and greater support to develop them. If a colleague identifies an opportunity to improve a service, develop a new approach, create a training offer, or design a product or solution that could benefit WAST and the wider system, the Trust's ambition is to provide the right support to help take that idea forward.

This includes creating opportunities for staff to access protected time, coaching, advice and development support so that promising ideas can be explored and, where appropriate, developed into tested improvements, new services or commercial products. It also means helping colleagues build skills in areas such as innovation, service development, partnership working, intellectual property and commercial thinking, so that they feel confident and supported throughout the process.

Income generated through ethical and sustainable commercial activity will be reinvested to support workforce development, innovation and service improvement. This includes supporting staff-led ideas to be developed and scaled, improving access to training and development, and strengthening the tools, equipment and digital solutions that help colleagues deliver high-quality care.

Through this approach, the Trust will continue to foster an environment where staff and volunteers are encouraged to contribute ideas, shape improvement and pursue professional growth. Commercial development should therefore feel relevant not only to specialist teams, but to colleagues across the organisation who want to improve services, develop their skills and help create lasting value for patients, communities and WAST.

How our people can get involved

- Sharing ideas for new services, service improvements, training offers, digital tools, partnership opportunities or other initiatives that could create value for patients, communities and the Trust.
- Taking part in innovation and service design activity, including workshops, pilots and improvement projects to help shape and test new approaches.

- Accessing support to develop promising ideas, including guidance, coaching and development opportunities.
- Contributing specialist expertise (clinical, operational, technical, educational or corporate) to the development of proposals, business cases and partnership opportunities.
- Helping to trial, refine and implement new services, products or delivery models in a safe and practical way.

We will support involvement through clear routes for submitting ideas, access to guidance and training, and feedback on how contributions have informed outcomes. Where ideas show strong potential, we will seek to provide appropriate support and development to help colleagues take them forward.

What this means for potential partners

For potential partners, this plan represents an opportunity to collaborate with a trusted, values-driven NHS organisation with a clear strategic intent to innovate, share expertise and create mutual benefit. WAST is strengthening its internal commercial capability and governance to enable transparent, purpose-led and well-managed partnerships that focus on shared outcomes, long-term value and improved health and well-being across Wales.

Through this approach, WAST will actively seek strategic partners who can support the responsible development and use of our knowledge assets and intellectual property, helping to build organisational capability and intellectual capital over the long term. Our commitment is to provide a strong platform for co-design, innovation and sustainable growth, working with partners to develop and deliver solutions that generate meaningful value for our people, our patients and the wider health and care system.

How partners can get involved

- Proposing collaborative opportunities that align with WAST's strategic priorities, including service improvement, innovation, education and training, digital solutions, research, and system resilience.
- Taking part in co-design and discovery activity to help define problems, shape solutions and develop models that are practical, safe and responsive to patient and service needs.
- Partnering on pilot projects and innovation programmes to test and evaluate new approaches, technologies or service models before wider adoption.
- Working with WAST to develop and scale products, services or intellectual property, where there is clear strategic alignment, public benefit and appropriate governance.
- Contributing specialist expertise, technology or capacity to support priority programmes, including clinical innovation, digital transformation, workforce development, estate and fleet solutions, and operational improvement.
- Collaborating on funding, research and development opportunities that enable shared learning, innovation and long-term value creation.

We will provide clear routes for engagement and proportionate governance processes to support transparent, values-led partnership development.

Managing risk and measuring success

Commercial activity will be safe, ethical value-driven and proportionate.

The delivery of the Commercial Plan will be underpinned by a robust and proportionate approach to risk management and clear measures of success. Commercial activity will be pursued in a way that is safe, ethical, value-driven and consistent with the Trust's statutory duties, public service ethos and strategic objectives.

The Trust recognises that, while commercial innovation can support sustainability, capability and wider public benefit, it must be undertaken within clearly defined risk boundaries and with appropriate governance and assurance.

Managing Risk

Commercial activity within a publicly funded healthcare system presents a distinct risk profile. These risks will be actively identified, assessed and managed through the Trust's established risk management framework, including the Board Assurance Framework, the Integrated Medium Term Plan, and the Trust's Risk Appetite Statements.

In line with the Trust's articulated risk appetite:

- The Trust is open to carefully managed commercial innovation where this supports strategic objectives, public value, learning, sustainability and the foundation economy.
- The Trust is keen to lead in innovation and technology, actively seeking and embracing new opportunities.
- The Trust has minimal appetite to take risks that could compromise patient safety, clinical quality, financial probity, statutory compliance, or public trust.

Key areas of risk associated with the Commercial Plan include:

Risk area	Control focus
Strategic and Reputational	The risk that commercial partnerships or activities do not align with the Trust's values, public service ethos, or strategic objectives, potentially undermining public confidence or stakeholder trust. All commercial proposals will therefore be assessed for strategic fit, public benefit and reputational impact prior to approval.
Clinical and Operational	The risk that commercial activity could adversely impact patient safety, quality of care or operational performance if not appropriately governed or integrated. The Trust has a low appetite for risk in this area, and commercial activity will not proceed where it could detract from core clinical priorities or safe service delivery.
Financial	The risk associated with investment decisions, income volatility, cost recovery, and the potential for activities not to deliver anticipated returns or value for money. The Trust's appetite for financial risk remains cautious, with a clear expectation that commercial activity supports long-term sustainability without exposing the organisation to undue financial exposure or subsidy risk.
Legal and Regulatory	The risk of non-compliance with procurement law, subsidy control, competition law, information governance, intellectual property protection,

	and contractual obligations. This includes compliance with data protection law, information governance requirements, DPIA processes, clinical safety standards for digital and AI-enabled solutions, and the appropriate oversight of data and AI-related risk. The Trust has a low tolerance for non-compliance and will ensure appropriate specialist advice and assurance is in place.
Workforce and Capacity Risk	The risk that commercial activity places additional pressure on staff capacity and diverts focus from core services if not carefully planned and resourced. Periods of sustained operational pressure, workforce constraint or competing strategic priorities may limit the Trust's ability to pursue, develop or scale commercial opportunities at the pace envisaged. Commercial activity will therefore be prioritised and phased in line with organisational capacity.
Ethical and Social Value	The risk that commercial decisions do not adequately reflect Value Based Healthcare principles, the Well-being of Future Generations (Wales) Act, equality duties, or the Trust's commitment to social partnership and sustainability. All commercial activity will be assessed for ethical impact, social value and alignment with the Trust's wider public sector responsibilities.

Measuring Success

Success in delivering the Commercial Plan will not be measured solely by financial performance, but by the extent to which commercial activity delivers sustainable value for patients, staff, partners and the wider system. Success will be assessed through a balanced set of indicators including:

- Demonstrable alignment with the Trust's strategic objectives and IMTP priorities
- Delivery of clear public, clinical or system benefit
- Compliance with the Trust's risk appetite and governance requirements
- Evidence that patient safety, quality and core services have not been compromised
- Generation of sustainable value, learning or capability for the Trust and wider NHS in Wales

Additional measures include:

Patient and population impact Demonstrable improvements in quality, safety, access, experience and equity of care resulting from commercially enabled innovation and reinvestment.	Value and sustainability Generation of sustainable, recurrent income and efficiency gains, with clear evidence that commercial activity is delivering value and supporting reinvestment into frontline services, workforce development and service improvement.
Financial performance Measured through a small set of clear indicators, including the value of the commercial opportunity pipeline, the number	Partnership quality The establishment of trusted, long-term partnerships that deliver shared outcomes, innovation and system benefit.

of opportunities progressed to approved business case, income generated, net contribution after costs, and the level of reinvestment into agreed priority areas.

Innovation and capability

Growth in the Trust's ability to develop, prioritise, scale and commercialise innovation, including the effective management of intellectual property and knowledge assets, and the development of the organisational capacity required to respond effectively to commercial opportunities.

Governance and assurance

Strong compliance, transparency and Board assurance, with all commercial activity demonstrably aligned to the Trust's values, statutory duties and Value Based Healthcare principles.

Workforce engagement

Increased staff involvement in innovation and commercial activity, enhanced skills and capability, and a positive impact on recruitment, retention and well-being.

This approach ensures that commercial activity is pursued within the Trust's agreed risk boundaries, supports long term sustainability, and reinforces public confidence in the Trust's stewardship of public resources.

Delivery Plan

General

Objective	Key Actions	Owned By	Timescale
Establish a communications plan to support the delivery of the Commercial Plan 2026-28	Develop, approve and deliver an engagement plan.	Assistant Director of Commercial Development	Q2–Q3 2026/27
Track value and impact	Develop benefits realisation framework including pipeline value, approved business case value, income, net contribution, reinvestment, patient outcomes, workforce benefit and social value	Assistant Director of Commercial Development	Q2 2026
Redesign a single, aligned ideas generation framework	Continue partnership working with QI, Transformation, RD&I, Charity and Digital.	Assistant Director of Commercial Development	Q3 2026/27

Pillar 1 – Build and Sustain Trusted Partnerships

Objective	Key Actions	Owned By	Timescale
Establish a clear and consistent approach to commercial partnerships	Develop and approve a WAST Commercial Partnerships Framework (governance, due diligence, social value, intellectual property ownership and licensing, benefit-sharing, protection of public value, data and information governance, risk allocation, and exit arrangements)	Assistant Director of Commercial Development	Q2–Q3 2026/27
Build a strategic partnership pipeline aligned to Trust priorities	Map priority clinical, digital and system challenges and identify target partner sectors (e.g. tech, mental health, academia, third sector)	Assistant Director of Commercial Development	Q3 2026/27

Develop flagship strategic partnerships	Establish 1–2 anchor partnerships (e.g. AI, mental health response, education/training) with formal MoUs and delivery plans	Assistant Director of Commercial Development	By Q1 2027/28
Embed co-design with patients and communities	Create patient and public involvement (PPI) model for commercial innovation and partnership programmes	Assistant Director of Commercial Development	Q4 2026/27
Launch partner-led innovation programmes	Design and deliver themed open calls around innovation in areas such as urgent care, mental health, workforce and digital.	Assistant Director of Commercial Development	2027–2028

Pillar 2 – Drive Innovation and Commercial Income-Generating Activity

Objective	Key Actions	Owned By	Timescale
Develop a Commercial Income Reinvestment Framework	Set out governance, decision-making criteria, priority reinvestment areas, and reporting arrangements for income/surplus generated through commercial activity.	Assistant Director of Commercial Development	Q1 2026/27
Create a structured commercial opportunity pipeline within existing Trust prioritisation and governance arrangements	Design and implement an ideas triage and approval process aligned to existing Trust prioritisation and governance arrangements, including DOG and DLG oversight where appropriate (strategic fit, value, risk, capacity, governance)	Assistant Director of Commercial Development	Q2–Q3 2026/27
Develop priority income streams	Develop business cases for priority areas (e.g. IP licensing such as CPSS)	Assistant Director of Commercial Development	Q3 2026/27 – Q1 2027/28
Strengthen IP and knowledge asset management	Establish IP register, protection process, ownership principles, benefit-sharing arrangements and commercialisation routes	Assistant Director of Commercial Development	Q3 2026
Pilot innovative commercial models	Test joint ventures, managed services, licensing and partnership delivery models	Assistant Director of Commercial Development	2027/28

Grow sustainable commercial income	Scale successful pilots into recurring income streams	Assistant Director of Commercial Development	2027/28
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Pillar 3 – Create Sustainable Value and Organisational Capability

Objective	Key Actions	Owned By	Timescale
Build internal commercial capability	Develop and deliver a commercial skills and capability framework (IP, contracting, business cases, negotiation, partnership management)	Assistant Director of Commercial Development	Q3 2026/27 – Q1 2027/28
Embed innovation culture	Launch cross directorate staff innovation programme with seed funding established through the Commercial Team	Assistant Director of Commercial Development	2027/28
Implement commercial governance and assurance	Establish and embed governance principles within Commercial Steering Group and Financial Sustainability Programme (risk, ethics, value, social impact, VBHC alignment, information governance, clinical safety and AI assurance)	Assistant Director of Commercial Development	Q1 2026
Improve contract and commercial performance	Implement Trust-wide contract register and commercial assurance process	Assistant Director of Commercial Development	Q4 2026/27
Implement commercial systems	Develop and deploy a CRM / opportunity management tool for opportunities, partners, IP and contracts	Assistant Director of Commercial Development	2027/28
Align commercial and IMTP planning	Integrate commercial opportunity pipeline into annual IMTP and capital planning cycles	Assistant Director of Commercial Development	Annually 2026–2028

Governance and Accountability

Senior Advisors	
Area	Role
Senior Responsible Owner - Commercial Plan & Delivery	Executive Director for Strategy, Planning & Performance
Commercial Development Function	Assistant Director of Commercial Development
Financial Assurance & Reinvestment	Executive Director of Finance and Corporate Resources
Clinical & Patient Safety Alignment	Executive Director of Quality and Nursing
Governance, Legal and Regulatory Framework Alignment	Director of Corporate Governance
Partnership & System Alignment	Director of Partnerships & Engagement
Innovation & Research	Assistant Director of Research, Development and Innovation, Director of Digital
Information Governance, Data and AI Assurance	SIRO, Director of Digital and Director of Corporate Governance



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Agenda Item No.

10

REPORT TITLE

Integrated Medium Term Plan (IMTP) 2025/26 Q4 (End of Year Report)

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh, Executive Director of Strategy, Planning & Performance
Author(s) of report	James Houston, Assistant Director of Planning & Transformation

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The purpose of this paper is to provide the committee with an end of year (Q4) update on progress delivering the 2025/26 Integrated Medium Term Plan (IMTP). This report includes an end of year positional update on the Trust's Clinical Model Transformation Programme (CMT), directorate led IMTP Deliverables, Ministerial Priorities and the IMTP 'What good

looks like' statements. The paper also provides a situational update on the development of the 2026-29 IMTP Deliverables and future reporting arrangements.

RECOMMENDATION(S)

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

Committee is asked to:

- 1. NOTE** progress and the end of year (Q4) position against the 2025/26 IMTP deliverables and future reporting arrangements.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

Appendix 1: CMT Work Stream & Project Highlight Report (Q4)

Appendix 2: IMTP Delivery Assurance Report (Q4)

Appendix 3: IMTP 'What Good Looks Like' end of year progress update (Q4)

Appendix 4: IMTP Ministerial Priorities (Q4)

Appendix 5: IMTP Strategic Objectives Plan on a Page 2026-29



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to objectives and what good looks like\]](#)

☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

N/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [\[link to standards\]](#)

☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred

Quality Enablers (select all that apply) [\[link to standards\]](#)

☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to goals\]](#)

☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
28 th April 2026	Strategic Transformation Board (STB)

SITUATION

1. The purpose of this paper is to provide the committee with an end of year (Q4) update on progress delivering the 2025/26 Integrated Medium Term Plan (IMTP). This report includes an end of year positional update on the Trust's Clinical Model Transformation Programme (CMT), directorate led IMTP Deliverables, Ministerial Priorities and the IMTP 'What good looks like' statements. The paper also provides a situational update on the development of the 2026-29 IMTP Deliverables and future reporting arrangements.

BACKGROUND

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

ASSESSMENT

3. The first section of this report provides an end of year Q4 position on progress against our Clinical Model Transformation (CMT) Programme providing an overview of the key progress reported to the CMT Board on 9 April 2026.

Clinical Model Transformation (CMT) Q4 Progress Report

4. The Clinical Model Transformation (CMT) Programme continues to progress in line with its strategic ambition to transition to an integrated, clinically led Clinical Services Model.
5. Following approval of the **CMT Programme Benefits Realisation Plan** at CMT Board in Jan-26, the majority of foundational documents are now complete, to be reviewed periodically in line with programme changes. These include the **Programme Definition Document** that is due for review in Q1 2026/27.
6. The **Benefits Realisation Steering Group** has initiated, and a **Benefits Realisation Workshop** was held in early April. Themes and priorities were identified, and a plan is now in development to mitigate the key issues discussed on the day through an agreed delivery structure.

7. **Progress** continues in enabling the realisation of identified **benefits**, and IDS are tasked with developing the PowerBI dashboards. A first iteration of the programme dashboard has been developed and was presented to the participants of the workshop for review. The remaining scorecards are in development with approximately two weeks required per scorecard.
8. Work on the **Patient Personas** are now complete. These personas were presented to the Clinical Advisory Group for review and onwards to both CMT Board in Dec-26 and Jan-26 for discussion. Further work was required on the inclusion of additional personas. The Coronial Statement template was also approved at Apr-26 Board.
9. Change Management training was completed in early March 2026. Change principles have also been applied to our existing highlight reporting, with narrative and progress updates now supporting by a number of 'prompt questions' provided by the change leads. These aim to consider the changes from the perspectives of those enacting them.
10. **CMT programme deliverables and narrative** are now complete and included within the final IMTP submission. As noted in the mid-point update, the number of CMT deliverables has now been confirmed as 10, and progress will be reported as a standing item through CMT Board.
11. Following the **CMT Audit** finding of **reasonable assurance**, management actions are now reporting via the programme update into CMT Board. Two of the nine actions have been **completed** ahead of schedule, and the remaining seven remain **on-track** for completion within the proposed timeframes.
12. The table below provides a high-level summary of progress against each CMT work stream and further detail can be found in the CMT highlight report in the appendices.

Table 1: Overview of the CMT Q4 Highlight report

Workstream/Enabling Group	RAG	Notes
Digital Front-End	Green	On Track: Upward trend following Apr-26 Board, remaining deliverable Symptom Checker remaining deliverable rolled over into 2026/27 (Q2)).
Remote Integrated Care	Green	On Track: Successful implementation of the single system for RICS clinicians went live on the 21 st April with 999 Remote and NHS 111 clinicians operating on a single system and queue. Early teething issues following implementation being mitigated following implementation.

Workstream/Enabling Group		RAG	Notes
Urgent Community Response		Yellow	On Track (cautionary status): No change. Status due to requirement of APP Scheduling mitigations (completion of Roster Review and software functionality). No major disruption anticipated at this point, but cautionary status remains.
Emergency Response	<i>Call Flow and Prioritisation</i>	Green	On Track: No change. Closure Report for Call Flow and Rapid Clinical Screening submitted. Health Care Professional (HCP) flows Tests of Change underway, and Communications and Messaging (SMS Functionality) Project on Track
	<i>Out of Hospital Cardiac Arrest</i>	Green	On Track: No change. Additional funding recently received to distribute CPR education to schools.
Health Transport		Closed	Workstream closed , and resource reallocated to Non-Emergency Patient Transport (NEPTS) Improvement Programme
CMT Metrics		Closed	Closed: Closed and outstanding items transferred to Benefits Realisation Steering Group.
Change Management		Amber	Off Track: Downgraded due to delay in number of deliverables - Change Management Plan for 2026/27 is in development and scheduled to go through governance routes and be approved in June. Senior Responsible Officer (SRO) and Executive Role Profile development is in progress but requires wider consultation and discussion prior to adoption. Anticipated downgrade of status to Yellow in June 2026 following approval of the 2026/27 Delivery Plan and broader engagement on new role profiles
Partnerships & Engagement		Green	On Track: No change
CMT Benefits Realisation Steering Group		Green	On Track: Plan in development, proposed structure and membership developed and circulated. Priorities to include Urgent Care Metrics, Orange Now Call Distribution, People Metrics, and Data Linkage.

Clinical Model Transformation (CMT) Year End Progress

Accessing Online Digital Advice

13. Digital Front End has progressed at pace over the last year, procuring the Online Symptom Checkers in Q1, launching Albot in Q2, developing the live agent pilot and WhatsApp integration in Q3, and demonstrating proof-of-concept for the Live Agent in Q4. The Virtual Assistant also received Highly Commended at the inaugural "Excellence in Healthcare Partnership Awards" in February 2026 in the Partnership Team of the Year (HealthTech) category, recognising the successful introduction of Albot.
14. Looking ahead at 2026/27, the Digital Front End (DFE) work stream will focus on final implementation and optimisation. This includes user acceptance testing (UAT) of the Symptom Checkers prior to anticipated Go Live in Q2 2026/27, as well as the evaluation of existing implementations and enhancing functionality

(WhatsApp integration where possible). A new content management system is also expected to be procured by Q4.

Emergency Response

15. The Emergency Response workstream has seen significant change over the last twelve months with the Ambulance Performance Framework now in place in pilot form. Phase One went live in July 2025, with Phase Two following in December. The development of additional functionalities such as text-messaging functionalities and Healthcare Professional call flows were also initiated with early Tests of Change, stakeholder engagement and process mapping undertaken. The Out of Hospital Cardiac Arrest plan has already completed work with GoodSAM responders (surveying outcomes and footprint expansion), as well as expanding into schools following the receipt of additional funding.
16. Delivery over the coming year will aim to refine the model by refining and optimising those additional functions (including the text messaging functionalities and dedicated Healthcare Professional call flows) and embedding the Out of Hospital Cardiac Arrest Action Plan across the education sector and local communities. By the end of 2026/27, the plan hopes to identify suitable locations for distribution of defibrillators, enhanced training provision, and commence a clinical audit.
17. Interim Ambulance Performance Framework evaluations will take place throughout the year, and regular monthly reporting will look to demonstrate improved patient safety, improved patient outcomes, and a better understanding developing demand.

Remote Integrated Care

18. Remote Integrated Care has been closely aligned with the Emergency Response Workstream over the last twelve months, supporting implementation of the Ambulance Performance Framework which included RCS0. The workstream has also completed Tests of Change around remote monitoring and the CPSS Application (Winter Desk) in Q1, completed digital enhancements (Video Consultation) in Q2, refined the Care Planning function and implementation of the Falls Desk in Q3, and began the implementation of the Integrated Queue (Single CAD) in late Q3.
19. The final year of the programme will see RICS develop into a single, coherent service that supports patients to access safe, timely, and appropriate



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care following implementation of the Single CAD in late April 2026. Welsh Clinical Portal integration will follow in Q1 alongside expansion of CPSS. Q2 and Q3 will focus on refining professional practice and development, including standardising training plans, CPD and Clinical Supervision frameworks. It will also look to implement a dedicated Respiratory Desk, following the success of the Falls Desk in late 2025. The year will end with a series of evaluations and identification of opportunities for digital functionality enhancements.

Urgent Community Response (UCR)

20. Year two of the programme saw the Urgent Community Response workstream complete the APP Organisational Change Process (OCP), and subsequent recruitment of Senior APPs (SAPPs) to support clinical supervision. A Falls Response plan was also developed for Falls and Enhanced Falls response models. In December 2025, UCR Scheduling piloted an approach, identifying opportunities for refinement of a preferred model, that is due to be implemented in Year Three. Following a year-long pilot, a decision was also made to step the Mental Health Response Vehicle (MHRV) Pilot down in favour of enhanced remote triage functionality.
21. Consistent community care remains the ambition for Phase Three. The workstream will continue developing its Face-to-Face interventions (Falls Response, Advanced Paramedic Care, and Mental Health crisis intervention) through the use of trial desks, pilot services, and national collaborative strategies, and following the anticipated completion of the APP Roster Review in Q1, is expected to implement a UCR Scheduling solution in Q2 or Q3.

Health Transport

22. Following work on evaluating taxi-eligible and development of a delivery proposal, the Health Transport workstream has ceased, transferring all resource and deliverables to a standalone NEPTS Improvement Programme, which will be accountable to Strategic Transformation Board.
23. It will continue to look to develop and optimise access points and pathways to support provision of transport following the outcome of a clinical assessment, based on the integration of the newly developed Digital Front End, Ambulance Performance Framework, and Remote Integrated Care models.

Directorate led IMTP Deliverables 2025/26 (Q4 Update)

24. In addition to the strong progress made during 2025/26 across the Clinical Model Transformation Programme and implementation of the Integrated Clinical Services Model and introduction of the new Ambulance Performance Framework, the Trust has also made good progress across the breadth of directorate led IMTP deliverables (see appendix further details).

25. A total of 94 IMTP Deliverables were outlined in the plans for 2025/26 which included actions to be delivered 'in year' and other 'multi-year' actions rolling over into year 2 of the plan. The deliverables have been organised by strategic objective and sub-categorised by responsible directorate.

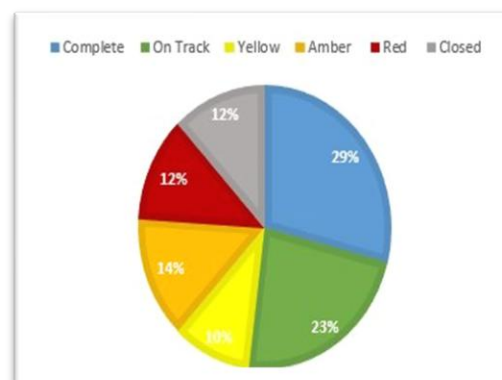


Table 2: Overview of IMTP Deliverables 25/26 by Strategic Objective & RAG status

Strategic Objective	Directorate	Green	Yellow	Amber	Red	Not Started /Closed	Complete
SO1: Right Care & Advice	Operations	2	4	1		6	2
SO2: Enabling our People	Operations	2					
	People & Culture	11	1	1		2	3
	Corporate Governance	1					4
SO3: Forefront of Innovation & Technology	Digital	3	1	8		2	2
	Finance & Corporate Resources	1			2		4
SO4: Collaboration	Partnerships & Engagement		2				4
SO5: Quality Driven & Clinically Led	Quality, Safety & Patient Experience	1	1	1	8		7
SO6: Exceptional Value	SP&P	1		2	1		
	Finance & Corporate Resources					2	1

26. A total 27 deliverables (29%) have been completed in year. Some key highlights (over and above progress reporting in previous quarters) include strong progress developing our estate with practical completion dates scheduled for the Bangor Fleet workshop and Monmouth Ambulance Station in April-26. Funding for the 2026/27 Fleet Business Justification Case (BJC) has also been secured from Welsh Government. A new Quality Improvement hub using the Life QI platform has been

launched in Q4. The Trust successfully achieved the organisational 25/26 savings target of £8.5 million, delivering a £0.555m over achievement.

27. A total of 22 deliverables (23%) are reported as 'Green' and on track and these are actions that span 'multi-year' delivery and will roll over into 2026/27.

28. There are 13 deliverables (14%) reported with an Amber 'cautionary status', predominantly linked to slippage on timescales against planned delivery dates. These deliverables have been reviewed with revised completion dates applied and will be rolled over and be delivered in 2026/27. The key Amber reported deliverable to flag following discussion in STB is the Concerns Management Improvement Programme and implementation of the new 'Listening to People' regulations. Considerable efforts have been undertaken in support of the 'recovery period to reduce the concerns back log, however it was recognised that further work is required to continue this work to deliver a fully recovered position. This work will continue into Q1 whilst the wider programme continues to deliver the key improvement work and implementation of the new regulations. It was agreed that this programme of work will be included as standing item at STB for regular 6 weekly monitoring and assurance.

29. STB focussed its attention on the 11 deliverables (12%) reported as Red and 'off-track' with slippage reported and wider internal / external factors that could impact delivery. These are outlined in the table below:

Table 3: Overview of 'Red' reported IMTP Deliverables 2025/26

Ref	IMTP Deliverable	RAG Status	Progress Update
1	Estates SOP refresh in the context of AWC funding	Red	Capital position challenging - no pipeline for additional capital funding from Welsh Government. No immediate requirement to update Estates SOP.
2	Resource to support de-carbonisation of our fleet	Red	Executive agreement to deliver de-carb actions within current resource and financial envelope.
3	De-Carb Action Plan (DAP)	Red	Rolled over into directorate planning 26/27
4	Evaluation of fume mitigation report	Red	Internal staffing issues reported – rolled over into 26/27 directorate plan
5	Health Inequalities maturity matrix	Red	Superseded following new Health Impact Assessment (HIA) regs passed in Q3 – rolled over for 26/27 directorate plan



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6	Draft Population Health Plan	Red	Capacity challenges to undertake work – joint post with Public Health Wales proposed to create capacity. Rolled over into directorate planning 26/27
7	Health & Safety culture framework	Red	Capacity issues in team prevented progress – rolled over into 26/27
8	Always On & Duty of Quality reporting	Red	Always on reporting delayed due to capacity – rolled over into 26/27
9	Population health reporting – surveillance opportunities	Red	Resource dependant (digital) – to be considered as part of directorate planning 26/27
10	Population Health: Primary and secondary prevention opportunities scoped by end of Q3	Red	Resource Dependency. Will require multi-Directorate support: Digital, Operations, Clinical. To be considered as part of directorate planning 26/27
11	Public health shared research bid (population health)	Red	Internal resource dependency – to be considered as part of directorate planning 26/27

IMTP 2025/26 'What good looks like' statements

30. Included in the 2025/26 IMTP were a series of statements that described 'what good would look like' as a result of delivering the key priorities and actions outlined in the plan. A mid-point (six month) update was provided to FPC at the end of Q2 and an end of year update is provided in the appendices with a detailed assessment of progress.

Ministerial Priorities 2025/26

31. The Trust provided submissions against four of the Cabinet Secretary's 2025/26 priorities for NHS Wales, including Timely Access to Care, Prevention, Community Capacity and Mental Health. An end of year assessment against the key deliverables / actions by Ministerial Priority is included in the appendices.

IMTP Deliverables and Reporting Arrangements for 2026/27

32. The refreshed 2026-29 IMTP and technical appendices were formally approved by Trust Board in March following a letter of endorsement from the JCC. The IMTP includes a consolidated list of prioritised IMTP deliverables for the next three-year delivery period (see table below). Detailed 'Plans on a Page' for each strategic objective were provided as part of the IMTP submission detailing the key milestones and delivery timelines for each IMTP deliverable (see appendices).

Table 4: Overview of 2026-29 IMTP Deliverables by Strategic Objective & Priority

Strategic Objective	No of Deliverables	Priorities		
		MUST	SHOULD	COULD
SO1 - Providing the right care or advice, in the right place, every time.	18	15	1	2
SO2 - Enabling our people to be the best they can be	8	8	0	0
SO3 - Being at the forefront of innovation and tech	8	6	1	1
SO4 - Developing Services in Collaboration	2	1	1	0
SO5 - Being quality driven and clinically led	8	6	2	0
SO6 - Delivering exceptional value	3	1	2	0
TOTAL	47	37	7	3

33. Work is underway to refresh the internal planning processes (including updated directorate level plans) to ensure effective delivery and progress reporting arrangements are in place. This will include a review and alignment of the IMTP reporting arrangements by strategic objective into the respective committees, strengthening visibility and assurance across the Trust committee structure.

34. The refreshed 2026-29 IMTP and technical appendices were formally approved by Trust Board in March following a letter of endorsement from the JCC. The IMTP includes a consolidated list of prioritised IMTP deliverables for the next three-year delivery period (see table above). Detailed 'Plans on a Page' for each strategic objective were provided as part of the IMTP submission detailing the key milestones and delivery timelines for each IMTP deliverable (see appendices).

RECOMMENDATION

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

NEXT STEPS

36. The next steps are as follows:

- Refresh and update the internal planning processes to accommodate the revised IMTP deliverables for 2026/27 (end of Q1).
- Align the IMTP Deliverables reporting across the committee structures (from Q1).
- Update Directorate level plans for 2026/27 (end of Q1) and continue the work to refresh the longer-term digitised approach for directorate level plans.

Welsh Ambulance Services University NHS Trust

Clinical Model Transformation (CMT) Programme Workstream Updates



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Clinical Model Transformation (CMT) Programme
Workstream Updates
Released: 9th April 2026

Gareth Taylor, Programme Manager



Navigation



Status	Description	Characteristics
Green	Project is on track and progressing well, meeting or exceeding expectations in terms of schedule, budget, quality, and objectives. Action Required: No immediate action is necessary, but ongoing monitoring and regular reporting are still required to ensure the project maintains its positive trajectory.	• Project milestones and deliverables are being achieved as planned. • Risks and issues are under control or adequately mitigated. • The project is progressing within the defined timeline and budget. • Key performance indicators are being met or surpassed.
Yellow	Provides an early warning that challenges or barriers are anticipated, but are not yet impacting on progress. Action Required: Close monitoring of factors anticipated to impact on progress, contingency planning, and reprioritisation if appropriate.	• Workload reprioritisation has been required to keep the project on track i.e. the impact has been transferred. • The project remains on track overall, however there are notable issues or risks or amber/red statuses recorded against key enablers, or interdependent projects that may impact over time. • The project remains on track overall but there may be moderate slippage against some tasks or actions.
Amber	An amber status signifies a cautionary state, indicating that the project is encountering challenges or potential risks that need attention to prevent further escalation. Action Required: Close monitoring of the project, proactive measures to mitigate risks, and corrective actions to address identified issues should be taken promptly to prevent further deterioration.	• Some project objectives are not being met as planned. • Certain milestones are at risk of being missed. • There are notable issues or risks that could impact project success if not addressed promptly. • Project performance or progress is below expectations but can be recovered with timely actions.
Red	A red status indicates a critical situation where the activity is significantly behind schedule, over budget, or facing major issues that jeopardize its success. Action Required: Immediate attention and intervention are necessary to address the issues and bring the project back on track.	• Major project objectives are not being met. • Critical milestones are consistently missed. • Key deliverables are incomplete or of poor quality. • Significant risks or issues are unresolved, and their impact on the project is severe.

RAG Status Definitions

Digital Front-End Workstream

Executive Sponsor: Jonny Sammut

Senior Responsible Owner: Aasha Cowey

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Digital Front-End Workstream Update



Report Date:	Current RAG	Previous RAG	For Noting:			Executive Sponsor:	Jonny Sammut
APR-26	Green	Yellow	Virtual Assistant: Live Agent Pilot Live Symptom Checkers: Test Environment installed and beta testing in progress			SRO:	Aasha Cowey
Objective	In Scope	RAG Status	RAG Trend	Current Position		Forward View	
Symptom Checker Implementation	Replace the outdated OSC to align with the 111 Call Prioritisation and Streaming System (CPSS).	Green	↔	- Technical development continues, with test systems in place for web content and protocol checking, and work is ongoing to establish live server environments - Welsh translation work is progressing, with costs confirmed as lower than expected and being managed through cross-charge arrangements. - Translation validation is focused on sense-checking for public comprehension rather than clinical validation, with minor improvements identified during beta testing. - Clinical efficacy validation is recognised as a distinct requirement and is being actively managed through the risk register. - Test Environment of the new symptom checkers has been received and is now actively being tested by the Clinical Team. Once Beta testing has been completed, we will move forward with Alpha Testing with the wider symptom checker team.		- Key milestones include completion of Welsh translation work and confirmation of timelines and final costings. Milestones also include agreed communications approaches keeping key stakeholders sighted. - Continued live system readiness, including clarification of validation processes and dependencies. - Maintained oversight of clinical efficacy risks and ensure appropriate multidisciplinary review arrangements are in place post go-live.	
Virtual Assistant: Phase 2		Green	↑	- Presentation on the implementation of Albot and practical guidance was delivered at the Digital Health Rewired Conference in March which was well received. - The review and categorisation of approximately 3,800 ALBOT feedback responses has been completed, with analysis ongoing to extract actionable learning. - The Live Agent pilot has successfully moved into live production, with positive early feedback and no major operational concerns reported. The pilot will conclude at the end of the agreed four-week period due to resource constraints. - Analytic reporting is being developed to support performance monitoring, with initial work underway to define metrics and benefits for senior stakeholders. - Accessibility requirements are being met to minimum WCAG standards, with ongoing discussion around the distinction between technical compliance and content quality. - A soft communications approach is being developed to ensure consistent and accurate messaging for internal and potential external audiences.		- Complete and refine analytics and benefits reporting to support future CMT discussions and decision-making. - Close the virtual assistant task and finish group following the pilot, transitioning activity into clearly defined BAU processes - Use learning from feedback sessions, including engagement with learning disability groups, to inform future iterations and broader rollout considerations. - Finalise and implement a proportionate communications strategy aligned to pilot outcomes and organisational readiness.	

↓

Digital Front-End
Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:		Executive Sponsor:	Jonny Sammut
MAR-26	Green	Green	Virtual Assistant: Live Agent Pilot Live Symptom Checkers: Test Environment installed and beta testing in progress		SRO:	Aasha Cowey / Wyn Morris
Deliverable / Task	RAG Status	RAG Trend	Current Position			Forward View
People & Change	Amber	↔	- From April 2026, the Interim Assistant Director of Digital Services will become SRO of the Digital Front End workstream covering maternity leave - Key focus for the new financial year will be identification of funding streams to support intended delivery, in particular around recruitment to support website development. - Work is underway to re-evaluate existing risks to distinguish between the people required for transforming NHS111 Wales website versus the BAU resource required to manage existing non-CMT priorities. This includes considerations for online symptom checker management and content management due to ongoing OCP processes within other directorates.			Risks to be taken through DFE Delivery Group once reviewed.
Content Management System Procurement	Paused	↓	- Due to financial and resource constraints we are unable to proceed with the procurement of the CMS, therefore this will be paused until the new financial year when the business case will be developed with Welsh Government input. - As a delivery group our recommendation that this is delivered in parallel with the establishment of a new recurrent team.			This deliverable will be reframed in conjunction with the 2026/2027 IMTP



Remote Integrated Care Workstream

Executive Sponsor: Lee Brooks

Senior Responsible Owner: Ceri Griffiths

Remote Integrated Care

Report Date:	Overall Programme RAG	Previous RAG	For Noting:		Executive Sponsor:	Lee Brooks
APR-26	Green	Yellow	Attention to be given to the risks associated with implementation of the Single Clinical CAD Module and availability of reporting metrics and overall readiness. Mitigated risk of milestone slippage combatted through navigation with supplier to ensure SAT is completed prior to end of year.		SRO:	Ceri Griffiths
Deliverable	Scope	RAG Status	RAG Trend	Summary Position		
Structured Education & Professional Development for Remote Care	Standardise Education Plans (including Clinical Supervision and CPD)	Yellow	↔	- Progress continues across the professional development workstreams, with acknowledgement that there will need to be operational input to implement proposed CPD and Supervision arrangements. A paper is to be shared next cycle highlighting the proposed CPD content. - Clinical Supervision model is shaping well, with governance defined and expansion planned, though operational engagement on abstraction stays the key dependency. - The Remote Clinical Care Career Framework provides a solid foundation for transparent progression and is now being integrated into organisational workforce planning by the People Development Team. - Workforce capability work is yielding early insights that are informing targeted education, cultural change, and preparation for the move to a single clinical queue.		
	Professional Career Framework					
	Confident & Competent					
Integrated Digital & Clinical Systems Enhancement	Single Clinical CAD Module	Green	↔	- Single CAD Progressing with agreed new terminology of Integrated Care Clinical Queue (ICCCQ). Risk: associated with reporting availability for Go Live with a mitigation of minimum reporting requirements to be decided. Overarching risk raised re. Readiness for Go Live in relation to the number of unknowns around the technical, educational, process developments however there is foreseen circumstances that would delay Go Live currently found and the risk is low (to be reviewed weekly). - Mitigated risk of milestone slippage combatted through navigation with supplier to ensure SAT is completed prior to end of year. - Next steps to formally reallocate value from unused 999 ECNS LowCode capacity and apply it to the 111 ECNS contract in the form of eight additional 111 ECNS live licences not wasting £175k of remaining contract value - WCP implementation requires further work through installation. - CPSS developments progressing with an initial quote for developments from MIS received. Require secured funding to progress.		
	WCP Integration					
	Application of CPSS Expansion					
Process Evaluation & Falls Service Optimisation	Exploration into Digital Capabilities	Green	↔	Falls Desk: initial 3-month evaluation of the Falls Desk complete and shared with colleagues internally and externally. Findings highlight positive early impact. Evaluation has been shared with Welsh Government and accepted with the funding on circa £470k released for FY 26/27. Remote Patient Monitoring: Evaluation completed of the Remote Patient Monitoring tools and effectiveness. - Awaiting progress from Digital Front End and Urgent Community Response to operationalise initiatives such as Online Symptom Checkers and Appointment Scheduling.		
	Review & Evaluations					
	Implementation of Appointment Scheduling					
	Operationalisation of Online Symptom Checkers					

Risk Ref:	RISK-158	Responsible Group:	Single Clinical CAD Module Task & Finish Group	Oversight Group:	RICS Digital Project Group	Risk Owner:	Simon Thomas
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Risk Title:	Reporting Readiness Risk – Failure to Implement Required Reporting Changes for 21 April Go-Live					
Risk Description:	IF the required reporting changes cannot be fully implemented, tested, and validated before the 21 April go-live due to pending CAD updates, unclear system behaviours, limited test data, and competing organisational resource demands THEN the reporting team will be unable to produce a full set of accurate, reliable, and timely operational and clinical performance reporting during the initial go-live period, and supervisors/managers will lack real-time insights required to monitor queue behaviour, call progression, and clinical risk RESULTING IN reduced organisational assurance, compromised decision-making; inability to identify early system issues, increased operational burden on teams, reduced visibility of patient safety risks, and potential negative impact on external reporting obligations (CMT, Welsh Government, and commissioner returns).					
Existing Controls:	- Initial test incidents to be entered and tested through the training environment (to be expanded) - Live reporting configuration has been migrated					
Planned Mitigation:	- Development of a minimum reporting requirement set for Go Live with an iterative plan developed for remaining configuration - Acceptance of the issue that					
Risk Approach	Opening Score			Current Score		
	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score
Mitigate	5	4	20	5	4	20
Recommendation / Actions Required (from Oversight Group):	- Due to the Cross-Project or Cross Workstream Relevance, risk is being raised to CMT for direction - Strategic alignments and objectives - Potential Need for Additional Resources or Authority					

Risk Ref:	RISK-163	Responsible Group:	Single Clinical CAD Module Task & Finish Group	Oversight Group:	RICS Digital Project Group	Risk Owner:	Martin O'Connor
Risk Title:	Overall Readiness Risk – Failure to Implement Required Changes for 21 April Go-Live						
Risk Description:	IF progress on the outstanding unknowns relating to the CAD changes for the Integrated Care Clinical Queue (ICCCQ) is delayed or does not occur, and the SAT and UAT exercises do not operate as intended, THEN there is a risk that agreed processes will not be finalised in time and operational teams will require additional training and subsequent development time may be required, RESULTING IN a workforce that is unprepared and unable to operate effectively, the need to allocate further offline time for ‘mop-up’ training, and a subsequent delay to the delivery and implementation of the Integrated Care Clinical Queue (ICCCQ).						
Existing Controls:	1. Early SAT and UAT for functionality 2. Prioritisation of SOPs outlining Chair's approval vs formal governance routes 3. Development of training packages based on knowns						
Planned Mitigation:	1. Resolve unknowns early through a structured technical/clinical escalation forum – Dedicated huddles with leads to close all outstanding unknowns with clear owners and deadlines. 2. Strengthen SAT/UAT readiness and execution – Pre-confirm test environments, scripts, and access, regular reviews, escalate blockers at once to avoid test failure affecting timelines. 3. Develop training and operational processes in parallel with testing – Produce early draft SOPs and training content based on confirmed elements, consider a contingency plan for rapid “mop-up” training if needed.						
Risk Approach	Opening Score			Current Score			
	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	
Mitigate	2	4	8	2	4	8	
Recommendation / Actions Required (from Oversight Group):	1. Strategic alignments and objectives 2. Potential Need for Additional Resources or Authority – decisions required on minimum viable product.						

Issue Ref:	ISS-61	Responsible Group:	Single Clinical CAD Module Task & Finish Group	Oversight Group:	RICS Digital Project Group	Risk Owner:	Simon Thomas
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Issue Title:	Reporting Readiness Risk – Failure to Implement Required Reporting Changes for 21 April Go-Live					
Issue Description:	A risk has been identified (linked to RISK-REF) that the full suite of revised reporting outputs required to support the new CAD changes will not be fully implemented or available for the Go-Live date of 21 April therefore there will be a subset of data which will not be reported on from Go-Live.					
Issue Impact:	With reporting not operationally ready, there will be a period post–Go-Live where data may: • require additional cleansing or re-configuration, • present quality inconsistencies, or • be temporarily omitted from essential performance, operational, or clinical reporting. This creates potential gaps in oversight of operational activity and patient safety indicators.					
Planned Mitigation or Decision Required:	1. Develop and agree a minimum viable reporting set that must be in place for Go-Live to ensure operational visibility and patient safety. 2. Establish and communicate a phased timeline for full reporting delivery following Go-Live, including configuration, validation, and quality assurance steps.					
Issue Approach	Opening Score			Current Score		
	Impact	Urgency	Issue Score	Impact	Urgency	Issue Score
Mitigate	Medium	Medium	Medium	Medium	Medium	Medium
Recommendation / Actions Required (from Oversight Group):	1. Due to the Cross-Project or Cross Workstream Relevance, issue is being raised to CMT for direction and subset of minimum reporting requirements to follow for approval. 2. Strategic alignments and objectives 3. Potential Need for Additional Resources or Authority					



Urgent Community Response Workstream

Executive Sponsor: Andy Swinburn

Senior Responsible Owner: Sonia Thompson

Urgent Community Response Workstream Update	Report Date:	Current RAG	Previous RAG	For Noting:		Executive Sponsor:	Andy Swinburn
	APR-26	Yellow	Yellow	Scheduling - March ‘go live’ postponed due to sporadic operational APP cover and allow work to be done on preferred model. Falls & Frailty - Review to be carried out on rejected BCU Falls referrals. WG confirmed year 2 funding for Falls Allocation Desk ACPDG - APP Roster Review aim to get OMDA modelling completed by March.		SRO:	Sonia Thompson
	Project/Working Group	Scope	RAG Status	RAG Trend	Summary Position		
	UCR Scheduling	Finding solutions to barriers to UCR Scheduling to allow testing and evaluation prior to implementation.	Yellow	↔	- Planned ‘go live’ on 02/03 was postponed after discussion as there was no significant change and sporadic operational APP cover. - Agreement to implement once APP Roster Review has been completed (due late March 2026) to allow for more consistent operational APP coverage. Provides additional time for development of MIS software solution and provision of dedicated scheduler.		
	Palliative, Falls & Frailty Response Model	Review the impact of existing falls and frailty services with the purpose of designing efficient and sustainable urgent care service models that provide timely, appropriate, and effective care for patients across Wales.	Amber	↔	- Plan to take Falls Referral Guide to National Falls Implementation Group to get clarification and agreement on clinician level for referral. Clinical review to be undertaken on BCU rejected referrals. - Falls APPNAV (FAPPNAV) trial, which was started in February with underspend from WG funding, continues throughout March. Also training provided to Ambulance Care colleagues to trial increasing Falls Responder response in March. - WG confirmed Year 2 funding for Falls Allocation desk. - Ongoing discussions with BCU regarding palliative care opportunities. HD cancer therapy services pathway gone live, initially only for APP or APPNAV referral. Ongoing reporting issues continue to affect ability to deliver on national reporting as required.		
Tasking Optimisation			Green	↔	- As of the 26th March 2026, the MHRV has been fully decommissioned. - BT work ongoing to resolve ICT issues for Powys hub. - Ongoing work in preparation for new 999/111 CAD interface, which is due to ‘go live’ in April. Working through training materials and documentation to support CTAS clinicians.		
Advanced Practice Delivery Group			Green	↔	- Ongoing work surrounding APP Roster Review, OMDA on track to have modelling done for all Health Board areas by end of March. Local discussions ongoing to agree changes to rosters. - APP Power BI dashboard going through final QA approval before going live. - Planning for ACPDG to change to UCRDG (Urgent Community Response Delivery Group), this will allow UCR projects to transition to BAU once completed.		



Emergency Response Workstream

Executive Sponsors: Lee Brooks (Call Flow and Prioritisation Stream) and Andy Swinburn (Improving OHCA Outcomes Stream)

Senior Responsible Owners: Ceri Griffiths (Call Flow and Prioritisation Stream) and Greg Lloyd (Improving OHCA Outcomes Stream)

Emergency Response Service

Call Flow and Prioritisation Stream



Report Date:	Current RAG	Previous RAG	For Noting:			Executive Sponsor:	Lee Brooks
APR-26	Green	Green	Rapid Clinical Screening – Closure Report Submitted. Call Flow Implementation (Phase 2) – Formal project closure underway HCP Call Flows – Test of change underway SMS Functionality – Project Initiated			SRO:	RCS: Greg Lloyd Call Flow: Ceri Griffiths HCP Call Flows: Becci Smith SMS Functionality: Gill Fleming
Project/Working Group	In Scope	RAG Status	RAG Trend	Summary Position			Forward View
Rapid Clinical Screening	Delivery of downstream Rapid Clinical Screening function including recruitment to B7 Clinical Navigator roles, implementation of Clinical Leadership arrangements for screening function, and all technical and operational arrangements.	Green	↔	• Project Closure Report has been submitted for noting at next CMT Board. This then will formalise the closure of the project group.			• Formal closure of Rapid Clinical Screening Project Group
Call Flow Implementation Phase 2 (Orange Now, Yellow Soon, and Green Planned)	Delivery of new Emergency Ambulance Performance Framework as directed by Welsh Government including all technical and operational arrangements.	Green	↔	• Project Closure Report is in draft and is expected early May			• Approval and closure of Project Groups
SMS Functionality / Communication and Messaging Enhancement Functionality	Deliver phased improvements to patient messaging by enhancing SMS and progressing to RCS, using safe automation to improve experience, reduce duplicate contacts, and maintain safety, equity, and governance.	Green	↔	• Project documentation in draft with Terms of Reference, and project documentation alongside a project plan. • A dedicated Process & People Sub-Group has been created to incorporate members from PEI, Operations, Quality and Audit to ensure compliance and focus on our people and how the change will affect their day-to-day. • A dedicated Technical & Finance Sub-Group will be created to incorporate members from ICT, finance, and IDS to provide technical feasibility, financial assurance, and governance evidence to enable safe, affordable, and approval delivery of SMS expansion and the future transition to RCS.			• Develop a phased delivery roadmap, including dependencies and milestones, to enable future transition to RCS. • Finalise Terms of Reference and core project documentation, including approval of the project plan
Healthcare Professional Call Flows Implementation Group	Collaboratively redesign our Health Care Professional Flows aligned to our Integrated Clinical Services Model and the new Ambulance Performance Framework.	Amber	↓	• Test of Change is currently underway and results expected early April due to this the project is currently paused until a way forward can be decided.			• Stakeholder and Engagement sessions to be planned following the output of the Test of Change



Emergency Response Service

Improving OHCA Outcomes Stream

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Andy Swinburn
APR-26	Green	Green	Progress continues on early recognition within the community. There are 120 defibrillators out in the community with GoodSAM volunteers and mapping has taken place to increase the radius available for volunteers. Termination of resuscitation guidelines have been updated with an education package to reflect this. Due to complications with access to the OHCA registry, WAST are looking at the proposal to host in house.	SRO:	Greg Lloyd

Project / Working Group	In Scope	RAG Status	RAG Trend	Summary Position
Early Recognition & Call for Help	- Enhancing public awareness and engagement for early cardiac arrest response - Enhancing CPR awareness to empower early recognition and response in key touch points	Green	↔	Continued partnership is agreed between Cardiff Metropolitan University and WAST to continue work with teachers to specifically embed CPR into the curriculum for schools, additional funding has been provided this year to recruit a specialist in education.
Early CPR	Strengthening partnerships to promote GoodSAM adoption	Green	↔	There was a slight delay with the development of a bilingual CPR resource for universities while the European Resuscitation Council was updating their guidelines. Now this is complete the resource is expected to be circulated in April 2026; this is also to include the promotion of GoodSAM amongst students.
Early Defibrillation	Develop a mobile responder network by increasing GoodSAM volunteer's and defibrillator access	Green	↔	- Survey results were received at the OHCA Delivery Group that outlined barriers to accepting GoodSAM alerts. Action plan being developed to address technical guidance and distance setting which were the top two barriers that WAST could influence. - New expansion to rural response radius was implemented on 24th March 2026.
ALS & Post Resus	Build clinician confidence and capability in cardiac arrest decision making	Green	↔	- On 15th April 2026, the Trust will introduce the updated JRCALC Termination of Resuscitation (TOR) and new Verification of Death (VOD) guidelines into clinical practice. 47% of EMS staff have completed the accompanying LM365 education package as of 24th March 2026. A total of 1578 staff have enrolled and 1110 of these have completed.
Data & Analytics	Trial and implementation of further data and analytics for Welsh OHCA	Amber	↔	After a meeting took place with Welsh Government, it was seen that some barriers remain with sharing data for the OHCA registry. It has been proposed that a registry could be hosted within WAST and Jonny Sammut is currently exploring this option before creating a proposal for Welsh Government.



APPENDICES

Project Highlight Reports (HLR1s)



Remote Integrated Care Workstream

Executive Sponsor: Lee Brooks

Senior Responsible Owner: Ceri Griffiths

Reports submitted to the
**RICS Workstream Board on
the 11th February 2026**



Clinical & Professional Practice

Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	Rhiannon Roynon
18.03.2026	Yellow	Yellow	Group not quorate for endorsements of any papers, utilised time to discuss progress and updates only.	Project Manager	Rebecca Whitmore
Scope:		The planning, coordination, and delivery of training / education programs to support the clinical and professional growth of Integrated Care teams, advancing clinical standards and fostering professional development. Fostering innovative, clinically safe ideas to support Integrated Care in managing demand over the upcoming Winter period.			

Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View
Clinical & Professional Development: Clinical Supervision & CPD Arrangements	Yellow	↔	- Clinical Supervision early draft paper shared with the group outlining the need for a two-pronged approach to strengthen current number of supervisors with an EOI to be release. - An early draft of a CPD offer discussed with uncertainty of allocated hours for CPD discussed and requiring confirmation. Paper will be updated to provide a holistic approach to CPD for Remote Care Teams.	- Paper to be strengthened by including comments from operations and clinical navigators - Paper to be presented at next board outlining the CPD arrangements proposed for Remote Care Teams.
Career Framework	Green	↑	- Career Framework for Remote Clinical Care drafted and proved; includes mapped roles, bandings, duties, and progression routes. - Interactive version created (role click-throughs to JDs, band pathways, training links). - Useful for CPD mapping, succession planning, and workforce development.	Framework now transitioning to People Development Team for organisation-wide integration.
Confident & Competent Workforce	Yellow	↔	- Survey completed with 87 clinicians completed, early analysis shows variation in confidence especially around minor ailments and self-care pathways. - Evidence shows disparity between self-reported confidence and actual referral behaviour, showing anxiety and risk aversion.	- Convert early findings into structured learning interventions delivered through: - On-the-floor coaching - Digital posters/prompts - Classroom sessions aligned with CPD - Prepare clinicians for the single clinical queue by addressing gaps in exposure (e.g., minor illness for CSD staff).

↓

Digital Project Group

Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	Mike Brady
02.03.2026	Green	Yellow	Group to take assurance that developments are on track to support the CAD go live. Risk & Issue Escalation: Reporting Availability for CAD Go Live.	Project Manager	Rebecca Whitmore
Scope:		The management and enhancement of digital platforms to support the effective delivery of operational services. Focusing on initiatives to support operational delivery pre-Winter and long-term, sustainable solutions.			

Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View
Single CAD (Integrated Care Clinical Queue)	Green	↑	- Testing of endpoints to Health Boards showcased no barriers therefore no additional requirements (e.g., Funding) to proceed - Training to commence w/c 16th March with Clinicians receiving 3hrs protected time and engagement sessions underway with good attendance across Integrated Care. - SOPs in development, meeting weekly, to continue momentum. - Technical infrastructure in place with a plan for CAD installation underway, hardware poses no concerns, and configuration in progress with support from MIS.	- SAT and UAT scheduled for w/c 16th March. - Q&A sessions to start w/c 30th March for drop-in sessions. - Operational Order in development for structure for Go Live followed with floor walking arrangement for support.
Remote Monitoring Solution – Decommissioning of Luscii	Green	↑	- Communication to be issued to Clinicians for an end date of Luscii usage end of March. - Conversations underway with Luscii and Care Homes. - Links with Informatics to plan for SQL for data retention.	Definitve end date of Luscii usage and subsequent information retention, DPIA amendments, contract arrangements, etc., to follow
Welsh Clinical Portal	Yellow	↑	Conversations with MIS underway to look at completing the previously raised quote to install WCP into, at least, the training CAD to proceed with payment. Cautionary status as still awaiting further details.	To be installed, tested and reviewed in the TRAINING CAD with an aim to implement into live post-Single CAD.
CPSS Application	Green	↔	- Early discussions with MIS to map feasibility and requirements for embedded CPSS into the 999 Environment - Training discussions in progress alongside with recruitment to obtain x6 Call Handlers to complete trial. - Quote received from MIS for technical developments (<£4k) with potenital cost savings associated with the revenue from single CAD.	- Feasibility and timescales to be determined following conversations. - Secure funding for technical developments.
Exploration into Digital Capabilities	Not Started		To commence Summer 2026 following completion of key deliverables.	



People & Culture Project Group

Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	N/A
-	Closed	Green	Project Group agreed to be stood down from the RICS Structure as deliverables are associated with Integrated Care Business-As-Usual – note elements which impact the RICS delivery will be brought through the Workstream Board for awareness if necessary.	Project Manager:	N/A



Process Project Group

Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	James Gough
-	Green	Green	Group unable to meet due to delivery requirements - highlight report produced virtually.	Project Manager:	Rebecca Whitmore
Scope:		The designing and improving operational processes to ensure the efficient and effective delivery of Integrated Care, focusing on ensuring RICS encompasses CSD and 111 Processes to seamlessly form one Remote Integrated Care Team.			

Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View
Evaluations Inclusive of functions such as Care Planning, Falls Desk, etc.	Green	↔	Falls Desk: initial 3-month evaluation of the Falls Desk complete and shared with colleagues internally and externally. Findings showcase positive early impact. Evaluation has been shared with Welsh Government and accepted with the funding on circa £470k released for FY 26/27. Remote Patient Monitoring: Evaluation completed of the Remote Patient Monitoring tools and effectiveness.	Exploration into a Care Planning Evaluation and Mental Health Offer
Operationalisation of Online Symptom Checkers	Not Started		To coincide with the <i>Digital Front End Workstream</i>	
Appointment Scheduling	Not Started		To align with the progress within <i>Urgent Community Response Workstream</i>	Await direction of travel from proposals, e.g., Scheduling Paper from UCR, to begin planning and implementing appointment scheduling in Integrated Care.
Standard Operating Procedures Single Clinical CAD Module	Yellow	↔	On track for SOP realignment with the Single Clinical CAD Module (reporting through the Digital Project Group) however a cautionary status provided due to the number of unknowns regarding the system.	Full suite to be ready and approved by 21 April



Urgent Community Response Workstream

Appendix – Project Highlight Reports (HLR1s)

Reports submitted to the
UCR Workstream Board on
11th February 2026



UCR Scheduling

Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	Peter Green
24/03/26	Yellow	Yellow	March 'go live' postponed due to sporadic operational APP cover and allow work to be done on preferred model.	Project Manager	Richard Ashby
Scope:		Finding solutions to barriers to UCR Scheduling to allow testing and evaluation prior to implementation.			
Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View	
Implementation	Yellow	↔	- Planned 'go live' on 02/03 was postponed after discussion as there was no significant change from December and sporadic operational APP cover. - Planned to implement once APP Roster Review has been completed to allow for more consistent operational APP coverage. Also work will be done on MIS software solution and providing dedicated scheduler.	- Aim to restart in 2026, with a work done on 'preferred' model. - Evaluation to take place after 'go live' with options paper to be produced if further changes recommended.	

Palliative, Falls & Frailty Response Model



Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	Edward O’Brian
24/03/26	Amber	Amber	Review to be carried out on rejected BCU Falls referrals. WG confirmed year 2 funding for Falls Allocation Desk Ongoing reporting issues continue to affect ability to deliver on national reporting as required.	Project Manager	Richard Ashby
Scope:		Review the impact of existing falls and frailty services with the purpose of designing efficient and sustainable urgent care service models that provide timely, appropriate, and effective care for patients across Wales.			
Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View	
Falls Referral Pathway	Amber	↔	- Plan to take Falls Referral Guide to National Falls Implementation Group to get clarification and agreement on clinician level for referral. - Clinical review to be undertaken on BCU rejected referrals. Noted staff that staff continue to use the previous referral process. Safeguarding measure no longer in place for previous process.	Set up Task & Finish group to clinically review BCU rejected falls referrals.	
Falls Allocation Desk	Complete	↔	- Falls Desk went ‘live’ on 12/11/25 – record as completed. - Falls APPNAV (FAPPNAV) trial, which was started in February with underspend from WG funding, continues throughout March, evaluation on impact on complex cases to follow. Also training provided to Ambulance Care colleagues to trial increasing Falls Responder response in March. - WG confirmed Year 2 funding for Falls Allocation desk.	Understanding of Clinical Navigator interface with ideal response metrics.	
Reporting	Red	↔	Due to interdependencies within our own system, unable to deliver desired national reporting on metrics to Welsh Government, as the Power BI Dashboard for Falls is not fit for use with the additional data that was requested. Completion by December 2025 as required is increasingly unlikely. Additional support from the Digital Team will be needed for completion.	Falls Dashboard with the requested additional data to deliver required national reporting.	
Palliative	Green	↔	- Ongoing discussions with BCU regarding palliative care opportunities. - HD cancer therapy services pathway gone live, initially only for APP or APPNAV referral.	ePCR Palliative/EOLC audit planned in Q4 26/27	



Tasking Optimisation

Report Date:	Current RAG	Previous RAG	For Noting	Project Lead:	Darren Panniers
24/03/26	Green	Green	MHRV – Decommissioning plan and final shift 26 th March. APP Navigator – APP Power BI awaiting final approval. CTAS T & F – Group being started with aim to standardise and improve CTAS support.	Project Manager	Richard Ashby
Scope:		Designing the optimum configuration of our Urgent Community Responders, ensuring efficient tasking of the most appropriate resource to meet the patients’ needs.			
Task	RAG Status	RAG Trend	Current Position	Forward View	
TASK & FINISH GROUPS – Key Updates					
Mental Health Response Vehicle	Closed	↔	- Group have produced a decommissioning plan for MHRV. - Final operational shift on 26th March	Project ending in March.	
WAST APP Navigator	Closed	↔		All health boards now have an APPNAV model at various stages of operation, will continue to monitor and look for opportunities for further integration or extending hours.	
CTAS T&F Group	Green	↔		Ongoing work within the group to be determined, to include AQM training and transition, national agreement and local connections.	



Advanced Clinical Practice Delivery Group

Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	Kerry Robertshaw
24/03/26	Green	Green	APP Roster Review aim to get OMDA modelling completed by March.	Project Manager	Ruth Lemin
Scope:		Continue to develop advanced practice in WAST supporting not just WAST but, the wider health care system.			
Task / Milestone	RAG Status	RAG Trend	Current Position		Forward View
Workforce	Yellow	↔	- Ongoing work surrounding APP Roster Review, OMDA on track to have modelling done for all Health Board areas by end of March. Local discussions ongoing to agree changes to rosters. - APP Power BI dashboard going through final QA approval before going live. - Planning for ACPDG to change to UCRDG (Urgent Community Response Delivery Group), this will allow UCR projects to transition to BAU once completed.		Work ongoing with OMDA to update the original roster keys to include all APP rotational elements, roster review can progress after that.
Reporting	Amber	↔			Overall data/reporting issues will be escalated through to Senior Leadership Team and Executive Leadership Team via the Clinical Transformation Model Board.
Admin	Green	↑			



Emergency Response Workstream

Appendix – Project Highlight Reports (HLR1s)

SMS Functionality / Communication and Messaging Enhancement Functionality Update

Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	Gill Pleming
01-04-2026	Green	N/A	Inaugural report for CMT	Project Manager	Michelle Morgan
Scope:		Reduce avoidable duplicate calls and support informed patient decisions and provide them with information regarding their call through an improved use of SMS functionality.			
Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View	
Communication and Messaging Enhancement Functionality Project Group	Green	N/A	- Project meeting series has been set up with the inaugural meeting to take place on 01/04/26. - Sharepoint site set up for RAID logging. - Project ToR to be approved at project meeting. - T&F Groups have been set up. - Workshop actions in review.	- Project specification document to be drafted and reviewed at the next project meeting. - Project plan to be drafted and agreed at the project meeting, including tasks and milestones with deadlines.	
Process & People T&F Group	Green	N/A	- Inaugural group meeting took place 25/02/26. - Fortnightly meetings set up. - Process mapping for SMS functionality has started with 999 touch points identified.	- DPIA to be completed. - EQIA to be drafted. - Process mapping to continue. - Review of CSP scripts to be undertaken. - Exit (PDI) scripts, single point of entry, welfare scripts, etc., to be automated.	
Technical & Finance T&F Group	Green	N/A	- Inaugural group meeting to take place 07/04/26. - Fortnightly meetings set up.	MIS scoping exercise to be started.	



Welsh Ambulance Services University NHS Trust

IMTP Delivery & Assurance Highlight Report (Quarter 4) All Y1 Directorate Deliverables *(Outside Scope of CMT)*



GIG
CYMRU
NHS
WALES

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

IMTP Delivery Highlight Report
Released: April 2026

Strategy, Planning & Performance

Summary of Position

Deliverables:

Total (non CMT) deliverables specifically committed to delivery within the IMTP is **94** (incl. closed and paused deliverables)

27 Complete

13 Amber

22 Green

11 Red

9 Yellow

**12 Not
started/Closed**

Summary of Position by Strategic Objective / Directorate

Deliverables:

Total (non CMT) deliverables specifically committed to delivery within the IMTP is **94**

<u>Strategic Objective</u>	<u>Directorate/Objective</u>	<u>Green</u>	<u>Yellow</u>	<u>Amber</u>	<u>Red</u>	<u>Not Started/Closed</u>	<u>Complete</u>
S01	Operations	2	4	1		6	2
S02	Operations	2					
	People & Culture	11	1	1		2	3
	Corporate Governance	1					4
S03	Digital	3	1	8		2	2
	Finance & Corporate Resources	1			2		4
S04	Partnerships & Engagement		2				4
S05	Quality, Safety & Patient Experience	1	1	1	8		7
S06	SP&P	1		2	1		
	Finance & Corporate Resources					2	1

Status	Description	Characteristics
Green	Project is on track and progressing well, meeting or exceeding expectations in terms of schedule, budget, quality, and objectives. Action Required: No immediate action is necessary, but ongoing monitoring and regular reporting are still required to ensure the project maintains its positive trajectory.	• Project milestones and deliverables are being achieved as planned. • Risks and issues are under control or adequately mitigated. • The project is progressing within the defined timeline and budget. • Key performance indicators are being met or surpassed.
Yellow	Provides an early warning that challenges or barriers are anticipated, but are not yet impacting on progress. Action Required: Close monitoring of factors anticipated to impact on progress, contingency planning, and reprioritisation if appropriate.	• Workload reprioritisation has been required to keep the project on track i.e. the impact has been transferred. • The project remains on track overall, however there are notable issues or risks or amber/red statuses recorded against key enablers, or interdependent projects that may impact over time. • The project remains on track overall but there may be moderate slippage against some tasks or actions.
Amber	An amber status signifies a cautionary state, indicating that the project is encountering challenges or potential risks that need attention to prevent further escalation. Action Required: Close monitoring of the project, proactive measures to mitigate risks, and corrective actions to address identified issues should be taken promptly to prevent further deterioration.	• Some project objectives are not being met as planned. • Certain milestones are at risk of being missed. • There are notable issues or risks that could impact project success if not addressed promptly. • Project performance or progress is below expectations but can be recovered with timely actions.
Red	A red status indicates a critical situation where the activity is significantly behind schedule, over budget, or facing major issues that jeopardize its success. Action Required: Immediate attention and intervention are necessary to address the issues and bring the project back on track.	• Major project objectives are not being met. • Critical milestones are consistently missed. • Key deliverables are incomplete or of poor quality. • Significant risks or issues are unresolved, and their impact on the project is severe.

RAG Status Definitions

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

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Operations EMS Deliverables Q4 position update					
Efficient and effective dispatch of the right resource	Review of the skill mix of emergency response crews throughout 2025/26	Complete		Review of EA Skill mix completed and recommendations supported by ELT. Objective as framed in IMTP complete and work to be taken forward in 2026/27 to implement the recommendations in collaboration with trade union partners.	Further actions to be carried over into 2026-27 directorate plans
Rapid call answering, initial triage & onward referral	New CCC in Ty Elwy fully operational in Q1	Complete		All work and transition of staff into Ty Elwy completed	
Fulfil our statutory requirements for civil contingencies, ensuring our preparedness through testing, learning & training	Continue to plan and prepare for major incidents as per the responsibilities of the Civil Contingencies Act and collaborate with the JCC on further developments the preparedness and response to major incidents e.g. Manchester Arena Inquiry and Grenfell Inquiry throughout 2025-28	Green	High	- HART Uplift - Business case submitted to Welsh Government for consideration. Awaiting feedback anticipated in Q2 2026 - IRD (Incident Response Desk) - T&F Group established with Terms of Reference drafted, Options appraisal on the IRD will be submitted to SLT following estates visit on 9th April. - Volunteers to Major Incidents – Training to commence in Q2 with 6 courses planned.	- Multi-year deliverable - Deliverable carried over into IMTP 2026-27

S01: Providing the right care or advice, in the right place, every time

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Operations Ambulance Care Deliverables Q4 position update					
A clear vision for Ambulance Care services that supports wider health & care transformation	An internal vision for Ambulance Care services agreed by the end Q1	Yellow	High	Vision development to be completed by end of QTR2 in the 2026 –27 IMTP	- Timeline re-framed for 2026/27 - Deliverable carried over into Directorate Plans 2026-27
	Plans to respond to the requirements of the national vision for non-emergency transport and the internal vision for Ambulance Care developed and implemented throughout 2025-27	Green	High	WAST engaged on the development of the JCCC NEPTS vision document. The WAST response will form part of the NEPTS improvement programme for 2026/27	- Multi-year deliverable - Deliverable carried over into Directorate Plans 2026-27
	The future shape of the Ambulance Care fleet will be agreed and a delivery plan developed by the end of Q4	Yellow	High	- Mar 26 - SLT indicated that a more strategic direction was required regarding stretchers. Following discussions at FSDG 25.03.26 agreed a stretcher review workshop will be held April - Jan 26 - Feedback window extended to 13th Jan to allow colleagues who were unable to attend Fleet Workshop on 6th Jan due to adverse weather. Feedback currently being reviewed and will be incorporated into SLT paper for consideration in Feb/Mar. EV position not 100% clear. 4 Large vans on hold due to financial year. Fleet keen to push but estates capacity.	Deliverable carried over into Directorate Plans 2026-27

S01: Providing the right care or advice, in the right place, every time

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Operations Ambulance Care Deliverables Q4 position update					
A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	Current plurality model reviewed and updated by end Q4	Yellow	High	Mar 26 - Impact analysis for each of the rosters currently being completed.	Deliverable carried over into Directorate Plans 2026-27
	Data and insights to improve co-ordination and decision making with health boards throughout 2025/26	Not Yet Started		All rescheduled to be part of the NEPTS improvement programme and board 2026 – 2027	Deliverable carried over into IMTP 2026-27 – NEPTS Improvement
	Digital solutions to enhance patient experience adopted in NEPTS by end of Q4	Not Yet Started		All rescheduled to be part of the NEPTS improvement programme and board 2026 - 2027	Deliverable carried over into IMTP 2026-27 – NEPTS Improvement
	NEPTS roster review completed by end of Q2	Yellow	High	Work has commenced on the NEPTs roster review and detailed modelling. Working party 4 taking place in April 2026	Deliverable carried over into IMTP 2026-27 – NEPTS Improvement
	Review of NEPTS and UCS alignment completed with a delivery plan by end Q4	Amber	High	Workstream will be picked up by NEPTs improvement board	Deliverable carried over into IMTP 2026-27 – NEPTS Improvement

S01: Providing the right care or advice, in the right place, every time

Objective	IMTP Deliverable	Q3 RAG Status	Delivery Confidence	Progress Summary
Operations Ambulance Care Deliverables Q4 position update				
A transfer & discharge service supporting HBs with their transformation agendas	Engagement will take place with health boards throughout 2025/26	Closed		▪ ELT recommendation to close deliverable.
	Internal vision for Transfer & Discharge (T&D) services reviewed by end Q1	Closed		▪ ELT recommendation to close deliverable.
	Opportunity to develop a 24/7 major trauma desk assessed by the end of Q4	Closed		▪ ELT recommendation to close deliverable.
	Proposed T&D model will be agreed internally by end Q4	Closed		▪ ELT recommendation to close deliverable.

S02: Enabling our people to be the best they can be

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Operations Deliverables Q4 position update					
Ensuring the right Capacity needed to achieve our purpose	Outputs of the work of the Shift Overrun task and finish group delivered by Q2	Green	High	▪ Significant work undertaken via the T&F group to reduce shift over runs during 25/26 with tangible improvements demonstrated. ▪ Further work identified to support improvement including the new dispatch optimisation steering group established to take forward remaining pieces of work from the original over runs group chaired by ADO EMS- will carry over to 26/27- to realise benefits of alternative dispatch arrangements, smart tethering, return to base/travel time footprint	▪ Multi-year deliverable ▪ Deliverable carried over into Directorate Plans 2026-27
Rapid call answering, initial triage & onward referral	Review and evaluation of the demand & capacity in 111 with a roster review completed by the end of Q4	Green	High	▪ Demand and capacity review undertaken in 111 and review of rosters completed ▪ New 111 rosters will be live on GRS on 1st June 2026 and full implementation completed in Q2.	▪ Multi-year deliverable ▪ Deliverable carried over into IMTP 2026-27

S02: Enabling our people to be the best they can be					
Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
People and Culture Deliverables Q4 position update					
Ensuring the right Capacity needed to achieve our purpose	A post implementation review of the of the All-Wales Flexible Working Policy processes in WAST undertaken during 2025/26	Complete	Complete	Policy has been developed and reviewed through appropriate governance channels for approval. Policy in now available for utilisation.	
	Actions within the Strategic Workforce Plan delivered throughout 2025/26	Green	High	Workforce Planning Dashboards have been developed and utilised. Focus of the team is on EA skills mix, however deliverable comes under ops.	Moved to BAU
	ESR National Optimisation, NHS Project & interface with GRS developed in Q1 to be delivered throughout 2025-27	Green	Moderate	A number of ESR optimisation projects have been completed to date and work continues on other areas of development rolling into 26/27 including "subjective codes enhancement", "data warehouse interface" and "systems managers programme"	- Multi-year deliverable - Deliverable carried over into IMTP 2026-27
	Improving Attendance plan delivered throughout 2025/26	Complete	Complete	- This has been reopened and reframed as the following deliverable: - Absence Management: Achieve a sustained reduction in sickness absence through targeted action on work-related stress, supporting colleagues and managers to take timely action and promote long-term wellbeing.	Deliverable carried over into IMTP 2026-27 (reframed)
	Nurse retention plan will be delivered throughout 2025/26	Closed	N/A	Deliverables reviewed and not considered a priority for 25/26. Action to be re-positioned and included in directorate plan.	Deliverable carried over into Directorate Plans 2026-27
	Recruitment strategy developed by the end of Q4	Yellow	High	Initial conversations have commenced to scope/explore what this might look like.	Roll over as a 26/27 IMTP deliverables
	Undertake preparations for Future NHS Workforce Solution Transformation Programme during 2025/26	Green	High	All NHS Wales organisations to be live by Q1 2028/29, timeframe slightly accelerated. Project Board established, with an agreed ToR. Design Workshops commenced.	- Multi-year deliverable - Roll over as a 26/27 IMTP deliverables

S02: Enabling our people to be the best they can be

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
People and Culture Deliverables Q4 position update					
Ensuring the skills and Capability needed to achieve our purpose	Excellence and consistency for education and development will be delivered across WAST in line with University Trust Status priorities (section 8)	Green	Moderate	- WAST Education Programme progressing as planned. 3 Clinical Instructors from Ops are started in March. Continue to develop accredited courses for L7 Integrated Care and Quality Improvement - Reframed under the "Development for All" deliverable	Deliverable carried over into Directorate Plan 2026-27 (re-framed)
	Our WAST Way leadership behaviours framework and an aligned development framework, developed and launched in 2025/26	Complete	Phase 1 - Complete Phase 2- 26/27 IMTP	Our WAST Way Leadership Behaviours and Development Framework launched in 2025/26. Commence Phase 2 in 2026/27.	Roll over as a 26/27 IMTP deliverables
	People & Culture Plan evaluated and refreshed in 2025/6	Paused	N/A	- Endorsement for PCC to extend the Plan until 2027. - Deferred to align with organisation-wide Long Term Strategy refresh.	Deliverable carried over into Directorate Plan 2026-27
	The capability of managers to lead / manage change developed, supported by a Change Management Toolkit throughout 2025-28	Green	High	2x accredited Change Management courses facilitated in March, training a further 24 colleagues. 1-1s with Change Leads continuing, seeking to understand progress to date, current challenges and changes planned over the next 12 months for each CMT workstream	Roll over as a 26/27 IMTP deliverables
	WAST People Development Plan (PDP) signed off by end Q4	Green	High	- People Development Policy endorsed. Your Best digital platform launched. Further work ongoing to map career pathways. - Reframed under the "Development for All" deliverable	Roll over as a 26/27 IMTP deliverables but reframed

S02: Enabling our people to be the best they can be					
Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
People and Culture Deliverables Q4 position update					
Establishing our Culture as the way we achieve our purpose	Anti-Racist Wales, LGBTQ+ Disability, Sensory Loss Standards, Armed Forces, Covenant Duty, Carers Leave Bill plans implemented throughout 2025/26	Green	High	Good progress has been made against initiatives throughout Q4, and the plan will continue to progress throughout 2026/27	Deliverable carried over into Directorate Plan 2026-27
	Our compassionate practices approach expanded and embedded throughout 2025/26	Green	High	Social Partnership Events scheduled throughout Q1.	Deliverable carried over into Directorate Plan 2026-27
	Sexual Safety Plan delivered throughout 2025-28	Green	High	Professional Boundaries, Inappropriate Behaviour and Sexual Safety Training delivered to South Central Senior Managers. Engaging with CTMUHB L&D Team who have recently rolled out a sexual harassment e-learning module.	Roll over as a 26/27 IMTP deliverables
	Strategic Equality Plan 24-28 (4 Year plan) implemented throughout 2025-28	Green	High	Good progress has been made against initiatives throughout Q4, and the plan will continue to progress throughout 2026/27	Deliverable carried over into Directorate Plan 2026-27
	Health and Wellbeing Plan implemented throughout 2025-29	Amber	Low	TRiM training ongoing. Health Surveillance Business Case submitted to Capital Development, awaiting outcome. Health Diagnostic work has stopped due to Digital capacity to support. Preparations underway for SEQOHS application in Q1.	Deliverable carried over into Directorate Plan 2026-27
	Develop and implement new process and practices to enhance our approach to amplifying colleague voices throughout 2025/26	Green	High	- Reframed as the following deliverable: Staff Survey & Pulse Survey: Increase engagement and participation through targeted interventions, ensuring all colleague voices are heard, and effectively use data to drive informed decisions and actionable insights. 2025 NHS Staff Survey participation rate was 43.2% (35.2% in 2024 and 23.2% in 2023). Qualitative and quantitative data received and being analysed.	Roll over as a 26/27 IMTP deliverables

S02: Enabling our people to be the best they can be

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Corporate Governance Deliverables Q4 position update					
Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	Engage with staff to ensure that their ESR Welsh language competencies are up to date by end Q1	Complete		As of June 2025, 96% of staff have recorded their Welsh language skills, with monthly reminders to those yet to include this information being sent.	
	Undertake a gap analysis via ESR Welsh language competency data by end Q2	Complete		Gap analysis complete	
	Engage with priority service areas that deal with patients & public on the Welsh language skills by end Q3	Complete		As of December 2025, a total of 28 MS Forms responses had been received from WAST patient/public-facing services re: their needs to increase bilingual service provision in their respective areas. This information is helping to inform the bilingual skills recruitment strategy being progressed in conjunction with the Trust's Recruitment Team.	

S02: Enabling our people to be the best they can be

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Corporate Governance Deliverables Q4 position update					
Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	Five-year Welsh language clinical consultation plan by end Q2	Green	Moderate	A draft 5-Year Clinical Consultation Plan has been developed which includes measurable objectives, timeframes and proposed Responsible Officers. Meeting attended with WLCO and WG representatives in December 2025 to update them on progress. Draft plan presented to the CAG in February 2026 – to be brought back to CAG in April 2026 with a completed QIA, before onward travel to CQGG (general discussion), and Operations SLT (operationalisation).	Deliverable will be removed from the IMTP and feature as part of the Corporate Governance Directorate Plan for 2026/27.
	Review current recruitment processes for the Trust consider the need for Welsh language skills when looking to advertise new posts by end Q4	Complete		Current recruitment processes reviewed in conjunction with Recruitment Manager and a checklist developed to support the Trust when considering the need for Welsh language skills when looking to advertise a new post. Checklist is currently going through approval route – this is being coordinated by the Recruitment Manager.	

SO3: Being at the forefront of Innovation & Technology

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Digital Deliverables Q4 position update					
Pillar 1 Everyday Essentials	eTimesheets delivered by Q2	Amber	Low	- A specification is in development which will see these two projects come together, and the migration of GRS to a cloud platform in Q1 2026/27. Work completed between WAST, the supplier and DHCW regarding the Microsoft Azure tenant integration – which is now functional and allows login to GRS Cloud client. Further work is required to allow single sign on - this will not delay the migration project, but is important to resolve to simplify the user experience. User Acceptance Testing (UAT) is due to commence early January 2026 for 4 weeks, with a 'dry run' scheduled in February, and full migration planned for April-May 2026. - Digital representatives are part of the technical group for eTimesheets, but have so far been unable to provide much support as the specification is still moving through completion internally with the relevant T&F group, to document operational requirements for supplier development. This specification will be submitted to the supplier for feedback and any subsequent returns for queries / clarification on requirements, prior to agreement on development timeline/financial implications.	Rolled over to IMTP 26/27 and will be delivered Q1
	Cloud-based GRS implemented in 2025/26	Amber	High	GRS Cloud migration taking place 12th to 13th May 2026, technical work complete and dry run signed off, with one outstanding issue which is still under investigation by vendor – Android mobile application non-functional, but interim GRS Web workaround in place approved by Project Board. Multiple Comms released since Dec 25 to inform staff of their MFA requirements for SSO and more recently the new GRS Support SharePoint page, containing their self-service steps to ensure continued access. Further Comms released 16/4/26 on Siren News and steps in place to set iPad lock screen with same comms. Operational management teams to have direct Comms via email from Resourcing Mgmt Team and will also be sent to SOT attendees list after pre-emptive notice on previous informal SOT. Go/No-Go with vendor on 5th May 2026. Operation plan in draft awaiting timings from vendor for go live 24hr period to be sent to Project Board and SOT for oversight. Resourcing and ICT support in place for go live with Vendor and Apps team providing in hours hyper-care for 2 weeks post go live.	Rolled over to IMTP 26/27 and will be delivered Q1

SO3: Being at the forefront of Innovation & Technology

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Digital Deliverables Q4 position update					
Pillar 1 Everyday Essentials	Simplified sign on implemented by end Q4	Amber	Moderate	Proof of Concept testing continues to be undertaken.	Decision on how to proceed in 26-27 (aligning capacity to demand and prioritisation) is being agreed as part of the current IMTP annual process. This project may be deprioritised.
	Robotic Process Automation RPA scaled up by end Q4	Amber	Moderate	An Automation Developer is expected in FY 26/27Q2. A Business Analyst is already in post, with recruitment underway for an RPA Developer to support delivery and accelerate product development	- Redeveloped multi-year milestones being set for 26-27 - Deliverable carried over into Directorate Plans 2026-27 (BAU)
	iPad replacement phases 1 & 2 completed by Q3	Green	Moderate	Replacement rollout is underway. Over 1,400 devices have already been bought back by staff, with the programme now beyond the halfway point.	Deliverable carried over into Directorate Plans 2026-27 (BAU)

SO3: Being at the forefront of Innovation & Technology

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Digital Deliverables Q4 position update					
Pillar 2 Digital Pioneers	SMS functionality implemented in NEPTs by end of Q4	Complete	High	NEPTS one-way SMS has been implemented and delivered. For IMTP 27-28 we have a deliverable to expand SMS functionality across services to improve access for patients and their engagement with key frontline services e.g. clinical navigator function	
	Visual interactive voice response IVR in NHS 111 Wales available in contact centres Q4	Closed	Low	This item has been deprioritised and has not been included in the 26-27 IMTP	
	AI development in line with national direction throughout 2025-28	Green	High	The Trust's new AI Steering Group which launched in October 2025, is bringing an essential governance mechanism around decision making, advice, and policy with regards to the approach of Responsible AI. The group provides advice to project leads and teams on AI-related innovation ideas, tooling or implementations. An AI policy is in development, with a risk on the corporate register. A governance framework for Responsible AI has been devised, supporting ethical, safe and fair assessment, judgement and decision-making. Focus for 26-27 IMTP will be the expansion of the governance and compliance frameworks for WAST, strategic alignment of AI ambition, and continuation as an expert advisory function.	Deliverable carried over into IMTP 2026-27
	Innovation lab developed by end Q2	Amber	Moderate	With the Digital Innovation lead now in place, formal scoping of the digital innovation and solutions lab has continued throughout Q4. This will be aligned to our emerging DDAT (Digital, Data and Technology governance) governance framework which is aligned to Q2 in the 26-27 IMTP	Deliverable carried over into IMTP 2026-27
	Drones will be tested with the aim to deploy by Q2	Complete	High	Following all necessary trials, testing and sign-offs, the first live operational deployment of the HART drone took place successfully on 26th December 2025.	

S03: Being at the forefront of Innovation & Technology

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Digital Deliverables Q4 position update					
Pillar 3 Digital Transformation	EMS & NEPTS CAD replacements - business case(s) written Q2-Q3	Amber	Low	This work has been delayed to capacity and requirement for technical expertise to support the scoping and development of the preferred CAD solution. A cost pressure proposal was submitted as part of IMTP development for 2026/27. This was not formally supported; however, funding is being explored within directorate level budgets. This work has been prioritised as an IMTP deliverable for 2026/27 and will roll forward. 2026/27 IMTP Deliverable ref. 30 – ‘Develop key requirements and appraisal of options for the EMS, 111 and NEPTs CAD replacement, including strategic direction’).	Deliverable carried over into IMTP 2026-27
	Emergency Services Network (ESN) phase 2 Full Business Case developed by end Q3 2026	Green	High	Outline Business Case submitted Q2 2025.	Deliverable carried over into IMTP 2026-27

SO3: Being at the forefront of Innovation & Technology

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Digital Deliverables Q4 position update					
Pillar 4 Security, Safety & Cyber	AI safety / Policy guidance developed by end of Q3	Yellow	Moderate	- AI Steering Group established in Oct-25 and has developed a Responsible AI decision-making framework for the Trust. - The AI Policy is in development, and although delayed in 2025/26, is now planned in the 2026/27 directorate plans – expected Q2.	- Delivery timelines extended - Deliverable carried over into Directorate Plan 2026-27
	Smart station initiative will be rolled out by Q4	Not Started	Low	This item has been deprioritised and has not been included in the 26-27 IMTP	Work has been de-prioritised for 26/27

SO3: Being at the forefront of Innovation & Technology

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Digital Deliverables Q4 position update					
Pillar 5 Data, Information & Insight	Individual insights to support individual performance monitoring and development developed and rolled out during 2025/26	Amber	Moderate	- Some progress has been made in year towards achieving the clinician level insight reporting, including the reproduction of the Airway Log dashboard, and the validation of the line reporting / team structure -related data behind ePCR. However, delivery of clinician level metrics will need to continue throughout 2026/27, as there are further expectations for individual insights, metrics and analysis. Competing priorities (such as the Ambulance Performance Framework data & reporting) has had direct impact on the ability of the Insight & Data Services (IDS) function to deliver on these requirements. - Redeveloped milestones to be set for 26-27 directorate plan	- Multi-year deliverable - Deliverable carried over into Directorate Plans 2026-27
	NDR programme will commence and take place throughout 2025-27	Amber	High	Delivery in 2025/26 was impacted by competing priorities and demands on the wider IDS team (such as supporting the Ambulance Performance Framework). However, in agreement with the Programme Board and DHCW, milestones for 2026/27 have now been set, including "what good looks like" type descriptions. Whilst primarily supporting national collaborative work, these objectives also enable WAST-specific goals, including establishment of an OHCA outcome dataset and registry.	Deliverable carried over into Directorate Plans 2026-27

SO3: Being at the forefront of Innovation & Technology

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Finance & Corporate Resources Deliverables Q4 position update					
The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	Bangor Fleet Workshop completed in 2025/26	Complete	High	Practical completion scheduled for 22nd April. Final kit elements to be installed in April/May (delayed but now rescheduled) and Fleet Team will move in late May/early June.	
	BJC for 2026/7 vehicle procurement will be written and submitted in line with WG timescales	Complete	High	Document submitted on 28th November. Funding received.	
	Dolgellau Ambulance Station completed in 2025/26	Green	Moderate	Due for completion mid May.	Deliverable carried over into Directorate Plans 2026-27
	Estates SOP will be reviewed in context of AWC funding by end Q3 (includes consideration of AWC schemes e.g. Swansea)	Red	Low	- Current Estate SOP runs from 2018 – 2028. The capital position from Welsh Government for 2026/27 is challenging with no pipeline for additional funding anticipated. There is therefore no immediate requirement to update the Estates SOP for the AWC schemes e.g. Swansea) 2026/27 period, and this can be re-considered for the next year. - Work will continue to complete the 6 Facet survey to provide key intelligence regarding current building conditions and wider considerations to inform future estates schemes. ELT decision to remove this as an IMTP Deliverable for the 2026/27 IMTP.	Deliverable carried over into Directorate Plans 2026-27

SO3: Being at the forefront of Innovation & Technology

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Finance & Corporate Resources Deliverables Q4 position update					
The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	Monmouth Ambulance Station completed in 2025/26	Complete	High	Practical completion received. Handover April 2026. Commissioning during May and date for team relocation TBC (May)	
	Resource and support to further enhance the approach to decarbonising our fleet to be explored during 2025/26	Red	Low	Discussions are still ongoing within FinCoR. This action is wider than resources to decarbonise the fleet and will need to be considered in the context of resources to support all actions within the DAP and the new Strategic Delivery Plan when confirmed (and subsequent WAST response). Highlighted as a cost pressure for 26/7 IMTP but not supported.	▪ Deliverable carried over into Directorate Plans 2026-27
	The 2025/26 vehicle procurement programme will be delivered by end Q4	Complete	High	Complete.	

SO4: Developing services in collaboration

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Partnership& Engagement Deliverables Q4 position update					
Meet the requirements of being a named body under the Wellbeing of Future Generations Act	A process for evidencing application of Wellbeing Objectives through our established governance frameworks developed during Q2	Complete		▪ At the end Q4, web-based working marking 1st year anniversary of WBO. (see website)	
	A programme of internal and external communication of our Wellbeing Objectives enacted in Q1 (was updated to Q3 Activity)	Complete			
	Action plan to address gaps in five ways of working developed by the end of Q4	Yellow	Moderate	▪ This work is still ongoing and will form part of the wider piece of work to create strategic opportunities for increased Health Board engagement and collaborative working.	▪ Rolled over into IMTP 26-29 deliverables
	Undertake maturity assessment against the five ways of working (Link to above)	Yellow	Moderate	▪ This work is still ongoing and will become BAU and moved to the Directorate plan	▪ Deliverable carried over into Directorate Plans 2026-27

SO4: Developing services in collaboration

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Partnership & Engagement Deliverables Q4 position update					
University Trust Status (UTS) in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation (R&I)	Our research priorities will be delivered throughout 2025-28	Complete		Research annual report completed and received. Co-production and implementation of RD&I initiatives ongoing with Welsh Government and Research Innovation networks.	
	Oversee the development of any appropriate additional plans to deliver UTS priorities for 2025-28 (NB priorities will be delivered in other areas of IMTP)	Complete		No longer required as no additional plans have been needed.	
Well placed to influence system thinking / strategy development	Quantitative and/or qualitative measures will be developed in Q1 to evidence the proposed approach to strategic engagement	Complete		- Survey currently live to seek feedback on ambulance performance framework communications. - Transition to BAU Regular feedback cycles	
	Strategic engagement will take place in support the development of our new CMT model throughout 2025-28	Complete		Focus has been on communication on the changes to the Ambulance Performance Framework. Phase 2 is complete.	

SO5: Being quality driven and clinically led

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Quality, Safety and Patient Experience Deliverables Q4 position update					
Defining our focus and delivering on population health and health inequalities	Delivery plan for the Population Health Plan developed by end Q2	Amber	Moderate	Draft Population Health Plan and health inequalities matrix have received assurance. While delivery is delayed due to resource constraints, the plan supports strategic objectives and compliance with 2023 standards. A refresh is planned for IMTP 2026-2029 to embed population health as routine practice.	Deliverable carried over into Directorate Plans 2026-27
Excellent clinical leadership	Learning Disability role in remote clinical team by end of Q2	Complete		Learning Disability Clinical lead recruitment achieved and completed.	
	Violence & Aggression risk mitigation actions to be taken forward in Q2	Yellow	High	- Violence & Aggression Policy delayed pending impact assessments. - Assessments now complete with Policy scheduled for Policy Group on 27.5.26.	Deliverable carried over into Directorate Plans 2026-27
High quality Health & Safety systems	Initial evaluation of the fume mitigation work completed end Q2	Red	Low	Evaluation not completed due to internal staffing issues	Deliverable carried over into Directorate Plans 2026-27
Meaningful engagement and co-production communities	Implementation of audit recommendations on community involvement by the end of Q2	Green	High	- The Patient Experience & Community Involvement Operating Model has been evolving as elements of the Organisational Change Process remain in progress, however the Model established going forward is through a commissioning route under an Integrated Medium-Term Plan aligned Model; with activity commissioned through direct requests from teams to take forward engagement work to help progress key service deliverables. - Completion expected to coincide with OCP end of Quarter 1.	Deliverable carried over into Directorate Plans 2026-27

SO5: Being quality driven and clinically led

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Quality, Safety and Patient Experience Deliverables Q4 position update					
Systems that meet the requirements of the Duty of Quality and Duty of Candour	Thematic analysis learning from harm via medical examiner reporting undertaken during Q2	Complete		Q4 Update: Thematic analysis from Medical Examiner reporting was removed from Q2 deliverables as it is now ongoing business, forming part of the biannual Learning from Deaths Report. The last report was submitted on 9 May 2025 and well received; the next is due 4 November 2025. Further analysis depends on IDS capacity and national Datix Cymru developments. Inclusion in Commissioning Intentions is under consideration.	
Defining our focus and delivering on population health and health inequalities	Updated health inequalities maturity matrix for reducing impact completed by end Q1	Red	Low	- The requirement to update the health inequalities maturity matrix has been superseded by the Health Impact Assessment (HIA) regulations passed in Nov-25, with detailed guidance released in Feb-26. Work is now required to develop our response to the regulations to fully understand our role in health inequalities and how the HIA will be delivered and in alignment to other impact assessments (e.g. Quality Impact Assessments). - This work will need to be completed by Apr-27 to fully embed and operationalise the HIAs across the organisation. This work will therefore roll over into 2026/27 as a directorate led action.	To be taken forward in Directorate Plan for 26/27
	Draft Population Health Plan approved in Q1	Red	Low	Updated provided to Quest Committee (3rd Feb). Population health remains a key commitment for the trust, however due to capacity challenges (in part aligned to the organisation prioritisation the APF and CMT and loss of specialist resources) the anticipated progress against the population health plan has not been achieved. The Trust has continued to work with Public Health Wales and has revised the placement opportunity for a Public Health Specialist Registrar to join WAST. It is hoped that by creating a joint placement between Public Health Wales or a Health Board and WAST, the opportunity might create greater interest in 2026 and subsequently offer specialist support to exploit the opportunities identified in the Baseline Report completed in 2025. This work will roll over into 2026/27 as part of directorate level plans.	To be taken forward in Directorate Plan for 26/27

SO5: Being quality driven and clinically led

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Quality, Safety and Patient Experience Deliverables Q4 position update					
High quality Health & Safety systems	A Health & Safety plan for WAST incorporating further improvements to legislative compliance, & manual handling developed in Q1	Complete		- Health & Safety Plan for 2025/2026 now includes legislative compliance and manual handling improvements. - Completed in Quarter 2, 2025/2026	
Systems that meet the requirements of the Duty of Quality and Duty of Candour	Develop data engineering and modelling around harm developed in Q1	Complete		- A piece of analysis on the consequences of hospital handover delays was completed in Q3 and subsequently refreshed in Q4. The updated analysis, (completed by the digital team) was used as evidence within the Avoidable Harm report, produced in partnership with QSPE. - Insight from this work has therefore been delivered and is already contributing to organisational understanding of harm associated with handover. - The analysis is planned to be repeated at intervals throughout the 26/27 to support ongoing assurance. - The remaining element of this deliverable is the automation of the reporting process. While the analytical insight has been delivered, the automation work (in digital) is still in progress and will be taken forward in the next period.	

SO5: Being quality driven and clinically led

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Quality, Safety and Patient Experience Deliverables Q4 position update					
High quality Health & Safety systems	A Health & Safety culture change framework will be developed in Q3	Red	Moderate	No progress made on Culture Change Framework due to staff issues within the department.	To be taken forward in Directorate Plan for 26/27
Systems that meet the requirements of the Duty of Quality/Candour	'Always On' and Duty of Quality Reporting will be delivered by end of Q4	Red	Moderate	Annual Duty of Quality reporting continues to be delivered on time and in line with Manual for Accounts timelines and expectations. The maturity of the Duty of Quality Annual report continues to go, and this year will absorb the annual report for IPC and Safeguarding. Always on Reporting continues to challenge. the Delivery timescale was updated in the November 25 update. QPM steering group have confirmed that MIQPR reporting can continue via the website (creating an element of always on) however this will not be translated into Welsh in its entirety and instead the title and links will be in Welsh language on the appropriate platform, but the report itself will be in English. The publication of the MIQPR dashboard onto the Trust website is delayed due to the necessity to 1. update the metrics in line with the new Clinical Model and outcomes-based reporting. 2. create a duplicate dashboard with translated labelling for publication on the website. In addition, the exploration of monthly reporting aligned with the H&C Quality standards is impacted by long term absence in the Quality Governance team.	To be taken forward in Directorate Plan for 26/27
	A formal patient & public reference group will be in place by the end of Q4	Complete		The People & Voice Community Network has been refreshed to act as the formal Reference Group and working is continuing to expand the group to reflect diverse communities.	

SO5: Being quality driven and clinically led

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Quality, Safety and Patient Experience Deliverables Q4 position update					
To achieve compliance with National Performance Indicators and regulations related to Putting Things Right and Legal Services	Deliver Putting Things Right improvement Recovery Plan	Amber		The Recovery Plan continues to be implemented throughout Q4 with improvements demonstrated in the reduction of open complaints. There is a paper being presented to Strategic Transformation Board in Apr-26 providing a detailed update and data.	Deliverable carried over into IMTP 2026-27
Meaningful engagement and co-production communities	Continuing commitment to improving experiences for people with a learning disability*	Green	High	This has continued through an internal commissioning model. On behalf of the Digital Directorate the team have been commissioned to canvas patient networks, including learning disability groups, for involvement in both 111 webchat point of contact and a broader digital strategy session.	This is rolled over as Business as Usual. with work commenced in Q1. Planning, new engagement process will be in place to support continuing commitment by end of Q1 to coincide with completion of OCP. Have agreed with Learning Disability Lead and Consultant for Mental Health that we will formally hand this over at end of Q1.
Excellent clinical leadership	Secure the Lead Midwife Post by end of Q1	Complete		Q4 Update: Post filled 1 July 2025	

S05: Being quality driven and clinically led

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Quality, Safety and Patient Experience Deliverables Q4 position update					
Defining our focus and delivering on population health and health inequalities	Worked example of surveillance opportunities by end Q3	Red	Low	▪ Resource Dependency. Will require support from the Digital Directorate	▪ To be taken forward in Directorate Plan for 26/27
	Primary and secondary prevention opportunities scoped by end of Q3	Red	Low	▪ Resource Dependency. Will require multi-Directorate support: Digital, Operations, Clinical.	▪ To be taken forward in Directorate Plan for 26/27
	Submit a shared research bid with Public Health Wales by end Q4	Red	Low	▪ Resource Dependency	▪ To be taken forward in Directorate Plan for 26/27
A culture of quality improvement with robust quality management systems	A Quality Improvement Hub will be relaunched by Q4	Complete		▪ Q4 Update: : Quality Improvement hub branding has been updated on the Siren SharePoint platform and communicated with teams via Quality Management Group and CEO roadshow. The three elements of the hub have been delivered but this will require continual improvement to remain valuable. Simply Do as the platform for WAST Improvement Network has fully launched and the team are now reviewing the ideas that have been submitted. Life QI is the platform to support improvement methodology and learning tools and resources are published via the Qhub on Siren SharePoint. This will be further enhanced through education and continued development of intelligence dashboards.	

SO5: Being quality driven and clinically led

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
Quality, Safety and Patient Experience Deliverables Q4 position update					
Systems that meet the requirements of the Duty of Quality and Duty of Candour	Quality Plan actions will be developed for implementation throughout 2025/26	Complete		Q4 Update: Implementation Plan approved by the Quality, Patient Experience & Safety Committee on 4 November 2025	

SO6: Delivering Exceptional Value

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
SP&P and non-aligned deliverables Q4 position update					
Generate income alongside our core commissioned functions (SP&P)	A commercial strategy based on outcome of market analysis exercise approved by end of Q4	Green	Moderate	A Commercial Plan was developed and approved by the Commercial Steering Group and the Financial Sustainability Governance Programme in April 2026. The plan will now progress through the formal governance process, with consideration by the Executive Leadership Team on 29 April 2026, the Finance and Performance Committee on 19 May 2026, and final approval by the Trust Board on 28 May 2026.	Deliverable carried over into IMTP 2026-27
Developing and implementing our plans for Environmental Sustainability and Adaptation	Adaptation Plans risk assessment undertaken by end Q2 (SP&P)	Amber	Moderate	Deliverable reported as a cautionary ‘amber’ based on timescales for delivery, however in Jan-26 Welsh Government agreed to an extended deadline for WAST to complete the Adaptation Planning Risk Assessment and wider Adaptation Plan by October 2026 (aligned to the next WG delivery milestone). It was noted that WAST is a pan Wales provider and it would be beneficial for WAST to consider wider Health Board plans as part of the process and would therefore require additional time. Work is underway to complete the risk assessment. WG advised that the trust should focus on the highest priority risks facing the organisation (e.g., flooding, adverse hot and cold weather). Work is underway, utilising available organisational information (including business continuity plans) and direct engagement with key groups / leads across the organisation during Q1.	To be taken forward in Directorate Plan for 26/27
	Adaptation Plan drafted for approval by end Q4	Amber	Moderate		
	Refresh of the DAP in response to the revised WG Decarbonisation Strategic Delivery Plan in line with WG timelines	Red	Moderate	Resources not currently available to complete refresh of DAP. ELT level exercise completed to scope out support from directorates for this work. Returns will need to be collated but initial indication that levels of resource to support this will be low.	To be taken forward in Directorate Plan for 26/27

SO6: Delivering Exceptional Value

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary	Position statement for non completed deliverables
SP&P and non-aligned deliverables Q4 position update					
A Value Based approach across the organisation which is embedded in culture	A refreshed approach to Value Based Healthcare will be developed throughout 2025/26	Closed	To support a more consistent and evidence-based approach, VBHC considerations have now been formally incorporated into the governance of both the Commercial Group and the Financial Sustainability Group. Decisions within these forums are required to take a VBHC lens, ensuring that value, outcomes, and contribution to system effectiveness are considered alongside affordability and operational deliverability.		
	Work with the JCC and partners to develop a costing and benefit methodology for emergency ambulance services, NHS111 and non-emergency patient transport services during 2025/26	Closed	- The work with the JCC was not prioritised in 25/26, however linked to this work, the Trust has commissioned Edge Hill University and Swansea University to undertake an independent evaluation of the Clinical Model Transformation which includes a requirement to consider value-based assessment for the wider NHS system as well as for WAST. - In addition the JCC will be commencing a strategic review that will consider organisational costs and benefits.		
Sustainable savings & efficiencies	Savings plans will be reviewed and refreshed by end Q4	Complete	25/26 Savings target was £8.500m and full year achievement is £8.555m so an over achieved position of £0.055m		

'What Good Looks Like' Q4 Highlight Report

1. NHS 111 Wales



- The **111 call abandonment rate** for quarter 4 2025/26 was 14%, remaining above the 5% target. This target has not been achieved since January 2024, with figures over the past year being negatively affected by the transition onto the new 111 CAD system and a recognised demand and capacity gap within the current funded establishment.
- During March 2026, **111 patient survey data**, showed that just 33% of people 'found the 111 service helpful', but with 83% saying 'they followed the advice provided' and 60% saying 'they would consider using the service again'. However, this data was based on just 8 responses during the month, which is a very small sample set from which to draw any meaningful conclusions. Proactive work is ongoing to increase the number of people who take part in completing the survey.
- The number of **111 calls 'stopped at source'** in quarter 4 2025/26 was 20,356, or 11.5% of the total answered calls for that period. This was an improvement on the 17,981 closed with no further follow up in quarter 3 2025/26, which equated to 9.6% of the total calls answered within the service over that time period.
- The Urgent Primary Care **direct booking system** is now available to clinicians for a range of symptoms, which enables them to seamlessly book appointments during in-hour periods.

2. Emergency Medical Services (EMS) – 999

What will good look like for 999 callers in 2027?

- ❑ All patients receive an appropriate and timely response.
- ❑ Patients in life threatening or emergency situations consistently receive an immediate or rapid response.
- ❑ Patients who need to go to hospital are conveyed and handed over quickly.
- ❑ More patients' needs are met closer to home.



What will be different?

- ❑ Achieve 65% red target.
- ❑ Reduce unmet demand by half.
- ❑ Double the numbers of patients safely managed at home or in the community.
- ❑ Increase ROSC rates to between 25-30%



- On 1 July 2025, our new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are **Arrest (Purple)**, for cardiac and respiratory arrests, and **Emergency (Red)**, for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. The median response time for Arrest incidents during quarter 4 was 7 minutes 12 seconds, within the 6-8 minute time bracket, while for Emergency incidents it was 9 minutes 18 seconds.
- Reducing Unmet EMS demand is defined by the Trust as **patient cancellations and clinical safety plan 'can't sends'** declining to the levels seen in the 2019 EMS Demand & Capacity Review. The Can't Send element of this figure was switched off in July 2025 while the number of ambulances being cancelled by patients has significantly reduced over the past year. Quarter 4 2025/26 saw 20,333 ambulances cancelled by the patient, which was a 5.1% reduction on the 21,435 cancelled during the same quarter in 2024/25 and a 23.6% reduction on the 26,627 cancelled during quarter 4 2023/24.
- During quarter 4 2025/26 20.1% of patients were managed via **Consult and Close** with a further 17.3% of patients responded to being managed via **See and Treat**, with no further requirement for a conveyance of any kind. Over the same period 38.6% of patients required a conveyance of some type. This compares to 19.9% for Consult and Close and 17.9% for See and Treat during quarter 4 2024/25. During that quarter, 38.1% of patients were conveyed. This highlights a continued improvement in the Trust's Consult and Close rate and a similar level of performance when comparing the other metrics year on year.
- **ROSC rates** for quarter 4 2025/26 were 22.5%, which was an improvement on the 20.7% achieved during quarter 4 2024/25. However, they remain slightly below the ROSC rate ambition of 25-30%. The main factors that directly influence this metric are response times, bystander resuscitation and response type/numbers, but improvements in these metrics have been seen since the implementation of the new response model on 1st July 2025.

3. Ambulance Care

What will good look like for Ambulance Care users in 2027?

- ❑ Eligible patients receive a prompt, modern transport service to their appointments with easy booking and tracking systems.
- ❑ Patients needing to be transferred from one hospital to another are conveyed to the right place quickly and safely, which helps hospitals manage flow.
- ❑ Patients are transported home safely without having to wait



What will be different?

- ❑ All performance targets on timeliness will be exceeded.
- ❑ Improved efficiency – fewer on day bookings and cancellations
- ❑ All inter-site transfers will be provided within time specified.
- ❑ Patient satisfaction rates will have increased.



- **Targets on timeliness** continue to perform well within Ambulance Care, with Oncology journeys for quarter 4 2025/26 seeing 78.4% of journeys arrive on time while Renal journeys achieved 74.7%, therefore both achieving the 70% target. However, Discharge and transfer journeys booked in advance, at 77.7% for the quarter, did not achieve the 95% target.
- The **volume of on the day cancellations** has increased slightly over the past year, recording a figure of 15% in quarter 4 2025/26, compared to 12.3% over the same period last year. This trend will need to reverse over the next year to realise the planned efficiency improvements, with an improvement plan currently being put in place to help achieve this.
- The **Medical Transfer Protocol Suite (MTPS)** was introduced, consisting of three Medical Priority Dispatch System protocols. The three additional protocols provide more granularity to the assessment and coding of transfers for step up of care; routine inter facility transfers and mental health transfers and improve understanding on the nature and urgency of transfer demand and the resources required to complete them in a timely manner.
- In terms of **patient satisfaction rates**, in March 2026, 95% of patients were 'happy with the transport they received'. Also, 86% of patients were happy when asked 'how long did you wait for your transport to take you home after your appointment'. These figures were based on 292 responses over the course of the month which was also an improvement on last year.

4. Our People



- **Sickness absence**, across all directorates, was 7.47% for March 2026, which failed to achieve the 6% target. This figure was also slightly above the 7.46% recorded in March 2025.
- **Staff turnover rates** have seen a downward trend since late 2023 and the 7.75% recorded in March 2026 was the second lowest figure recorded in the past 3-years and below the 8.42% seen in March 2025.
- The **NHS Staff Survey completion rate** for 2035 was 43.2% (an increase of 8% in comparison to 2024 with a completion rate of 35.2%).
- **PADR rates** for March 2026 were at 76.7%, which remained below the 85% target, and also below the 82.3% figure recorded for March 2025. Figures declined after June 2025 and have remained around 76% since that time. All directorates are being actively encouraged to ensure that PADR compliance and staff engagement is viewed as a priority.
- Women's Health Network – 96 members; Black Asian and Ethnically Diverse Network – 6 members; WAST Voices – 83 members; Nothing Without Us (Staff Disability Network) – 17 members; Working Carers Network – 15 members and Culture Champions – 120.

5 Our Digital Roadmap

What will good look like for digital in 2027?

- ❑ We use cutting-edge systems to ensure impenetrable cybersecurity.
- ❑ Digital solutions are integrated into daily life, giving enhanced efficiency and experience.
- ❑ We lead in innovation with state-of-the-art technologies supporting strategic goals.
- ❑ We embrace a digital-first strategy for transformation, maintaining agility and patient-focused efficiency.
- ❑ We enable integrated, actionable data across platforms for strategic decisions and excellence.



What will be different?

- ❑ No successful breaching cyber attacks
- ❑ Reduced numbers of calls to helpdesk and improved first resolution rate.
- ❑ Increased number of technology exploration projects scaled up.
- ❑ Increased number of users confident in accessing, using and interpreting data
- ❑ Increased levels of patient and staff satisfaction and adoption of our digital solutions



- Closed report goes to every F&P. **No successful breaching cyber-attacks** so far this year.
- Monthly KPI report produced from calls logged with the **service desk**. First time resolution has increased to 55% in March 2026, an increase of 9% on the same period last year.
- The Digital Directorate has published its **Digital Plan for 2024-2029**. The Directorate's new Digital Innovation and Transformation arm is currently under development and is likely to launch in quarter 1 2026/27. The Directorate has also launched the new **111 website virtual assistant**, named Albot, in November 2025. Quarter 4 saw 17,395 patients having interactive conversations with the new Albot service.
- There is a drive to increase the number of users confident in accessing, using and interpreting data and the Directorate has just **recruited into a Data Enablement role** during quarter 4 to help achieve this going forward.

6 Partnerships and the Wider System



- A **reputation audit** was conducted to capture feedback from across the Trust's key stakeholder groups (including Senior Health Board leaders, managers and wider system partners). The findings were then thematically organised and presented at a Board Development session.
- The CMT **transformation programme** continues to engage with highly influential stakeholders to secure support for our new clinical model which was introduced during the second half of 2025.
- We will continue to develop and deliver **world class research and innovation** that has far reaching impact. Our partnerships continue to grow with R&I collaborators such as Warwick University. WAST has contributed to innovative policy changes and groups such as the NHS R&D framework and toolkit. There is on-going work to measure the Trust against the NHS R&D Framework.
- The new Commercial function has been established in the Trust with a key objective to deliver commercial activities and opportunities to increase the level of external commercial income with key partners and stakeholders. This work is underpinned by the development of a detailed organisation wider Commercial Plan.

7 Quality Driven and Clinically Led



- All Duty of Candour requirement have been met and learning acted upon. The Trust has a Quality Strategy and a Quality Plan. Both are in response to the statutory Duty of Quality. The Trust has a new Putting Things Right AD in place following an OCP. The **Trust now regularly reports on a Duty of Candour metric**, specifically whether the 'in person' notification has been sent. The Duty of Candour was triggered on 17 occasions during quarter 4 2025/26, down from 26 times during the same period last year.
- The Trust publicly reports on seven key clinical indicators within the MIQPR. The **ROSC rate** is not yet consistently achieving the 25-30% target range but did record a rate of 27.4% in August 2025. Call to Door times for both Stroke and STEMI are now reported regularly within the MIQPR, but with both being over 2 hours in quarter 4 2025/26, it is recognised that these remain too long. A key area for development is data linking (via NHS numbers) to enable the TRUST to track patient outcomes once they have been handed over into hospital care.
- A **People's Experience Framework** has been launched which will be used to frame and deliver all experience work across the Trust. The framework is a maturity matrix aimed at empowering us to evaluate the Trust's current position and develop ambitious improvement plans for people's experience through a value lens.
- The **Strategic Workforce Plan** was produced in late 2024, which sets out the Trust's road map through to 2030 for key workforce actions. These include, expanding the apprenticeship programme, increased CPD opportunities, developing new clinical leadership structures around the new clinical model transformation, a coaching and mentoring framework and increased clarity on career pathways in the Trust.

Assurance against the Ministerial Priorities 2025/26

BACKGROUND

WAST submitted four templates as part of the 2025/26 IMTP submission covering plans against four of the Ministerial priorities for NHS Wales, including:

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

The Trust did not submit a template in relation to the Women's Health priority as the delivery expectations in the NHS Wales Planning Framework were focussed on Health Board led activities (including the Women's Health Hubs). However, we provide progress to Welsh Government through IQPD and JET meetings on our plan for maternity and neonatal support to our clinical teams, having permanently appointed our lead midwife this year.

ASSESSMENT

The following table sets out the key areas for WAST against the priorities, and the milestones to be achieved at the end of year Q4 position. The table sets out the actions the trust committed to in 2025/26 against each ministerial priority, RAG status and a progress summary.

Cabinet Secretary Priority	WAST Deliverables / Objectives & Actions	RAG	Progress
Timely Access to Care	Ambulance Target Review & Call Categorisation Respond to the outcome of the Welsh Government-led Task & Finish group to determine the appropriateness of the current Red 8-minute target.	Complete	▪ Successful implementation of the new Ambulance Performance Framework completed in 25/26. ▪ Phase 1 of the new APF (Purple & Red) successfully implemented in July. ▪ Phase 2 of the new Orange, Yellow and Green Categories implemented in Dec.
	Rapid Clinical Screening Transition to a clinically prioritised emergency response model with early clinical input to improve the accuracy of prioritisation, providing more timely response to the most critically unwell patients	Complete	▪ Rapid Clinical Screening has been fully implemented as part of the new clinical model and is operational through introduction of the new Clinical Navigator role.
	RICS Strengthen and expand the use of the Call Prioritisation Streaming System (CPSS) enabling call handlers to provide safe, effective advice and referrals to a broader range of calls	On Track	▪ CPSS used by RICS Support Desk Call Handlers to contact suitable patients waiting on the Integrated Care Clinical Queue. ▪ Further CPSS piloting in the 999-environment planned for 26/27.

Cabinet Secretary Priority	WAST Deliverables / Objectives & Actions	RAG	Progress
	Design and implement processes and policies to deliver an effective integrated care clinical team including revisions to SOPs, alignment of terms and conditions, strengthened quality and safety governance arrangements, and implementation of a Home and Remote Working Model to enhance service delivery and support seamless collaboration		- Integrated Care Education and Audit Team OCPs are complete. The Integrated Care Frontline Management OCP is now formally complete and transition of colleagues to new roles is due in Q1 26/27. - Single Integrated Care Clinical Queue to be implemented during April 2026 which will also see further updating and further alignment of SOPs. - Focus for 26/27 will be on improving productivity and efficiency through improved flows and processes where possible.
	Transfer & Discharge Service Model Engage with commissioners to develop a Transfer & Discharge service model appropriate to Health Board & strategic service development needs - including opportunities to implement a Transfer Clinical Hub (subject to external funding)	De-prioritised and paused	- Work has been undertaken to develop a future model for T&D across Wales with options and a business case presented to commissioners for consideration. It was not prioritised for implementation by commissioners. - This action has been 'paused' and it has not been prioritised for 2026/27, however WAST will continue to work with National Programmes / Health Boards to improve hospital discharge & transfer services.
	Non-Emergency Patient Transport Service (NEPTS) Continued development of the service to ensure the right capacity is in place to meet demand to support planned care and cancer services.	Cautionary Status	- Work has continued throughout 2025/26 to deliver improvements across NEPTS. - NEPTS Improvement Programme to be established for 26/27 to improve service productivity with a focus on reducing cancellations and better aligning current capacity with demand. - NEPTS roster review has identified opportunities to deliver capacity improvements to better meet demand. Roster review will form part of the Improvement Programme during 26/27.
Population Health and Prevention	NHS 111 Wales website: the website will provide information and advice to support people to access the right part of the health system or self-care, preventing escalation of care unnecessarily. NHS111.Wales Improvement Deploy a Virtual Assistant integrated with Robotics AI to empower patients with the tools and information needed to manage their health needs more autonomously, enhancing accessibility and supporting self-care. Online Symptom Checker (OSC) Identify and implement an effective Online Symptom Checker tool to enhance patient access to timely, accurate advice	On Track (Cautionary status re-funding)	- Cautionary Status: The Trust has continued to explore options to support development of the 111 website, though the key dependency is securing funding to enable establishment of dedicated capacity to support and lead website development. Engagement with key stakeholders will continue regarding options to secure external funding and other opportunities in 26/27. 111 Virtual Assistant (Albot) implemented to support patients accessing the NHS 111Wales website. Around 5,500 patients have interacted with Albot every month to date. - Preparatory clinical and technical development work has been undertaken in readiness to embed the new Online Symptom Checkers. Due for implementation in Q1 26/27.
	Falls services: Objectives are to lift patients at the earliest opportunity to prevent deterioration and avoid hospital conveyance where safe and appropriate to do so. Where hospital conveyance is	On Track	The trust has continued to work closely with the Six Goals programme to support the design of the National Community-based framework for Wales. Specifications for both the Level 1 Falls Responders and Level 2 Enhanced Falls

Cabinet Secretary Priority	WAST Deliverables / Objectives & Actions	RAG	Progress
	required, the aim is to convey in a timely manner to prevent further deterioration. By the end of FY25/26: Optimise the current Falls Level One Service in line with Health Board specifications and remit, National Falls Framework, and WAST Falls Response to provide an effective and safe Falls Service across Wales. We will also develop the subsequent transformational amendments to Falls incident management and deployment (including RICS, RCS, Care Planning, and UCR Hubs) to ensure patient safety.		Responders have been developed. We have also undertaken a scoping exercise to align our falls responders to the national specifications and identify areas where further development is required. As part of our Remote Integrated Care Service (RICS) we have established (with additional WG investment) a Falls Response Desk. This is a Pan Wales desk, operational 07:00 – 19:00hrs with a falls desk clinician and falls desk response co-ordinator. Since go live the desk has managed over 1,400 incidents. A comprehensive evaluation has been completed and in March 2026 confirmation was received from WG that non-recurrent funding was available to continue the desk for 2026/27. Evaluation of the desk will continue over 26/27 and alongside development of a business case to seek recurrent funding.
Building Community Capacity	APP Navigators By the end of FY26/27: Deliver an APP Navigator in every Health Board, fully integrated into Health Board MDT hubs to enhance collaboration, optimise resource allocation, and ensure a consistent, equitable service offer across all seven Health Boards. To deliver this, a roster review will also be conducted to support efficient deployment and service consistency.	On Track	- APP Navigators embedded in all health boards as part of multi-disciplinary teams. - Implementation of revised rosters due in Q2 26/27. - Optimisation of resource utilisation will continue through 26/27, including progression of scheduling work.
	Care Planning Explore opportunities to schedule care through the planned deployment of internal responders including Community Welfare Responders, Falls, Mental Health, and Advanced Paramedic Practitioners etc, including expanding volunteer and community response resource i.e. Community Welfare Responders (CWRs) as required.	On Track	- Care Planning function reviewed in year which led to a refresh of the team's priorities and increased training offer to reflect refinements. - Formal evaluation of Care Planning due in 26/27 for a more robust assessment on operational, patient and staff impact.
	End of Life Care By the end of FY27/28: In collaboration with Health Board Specialist Palliative Care Teams, integrate Palliative Care Paramedics (PCPs) into the Advanced Practice portfolio and deploy a PCP in every Health Board, fully operationalising PCPs within our commissioned service offer to deliver an equitable, patient-centred, and specialised palliative care service	On Track	- Marie Curie funding support provided in 25/26 now complete. - Palliative Care Paramedics in place across 2 health boards. - Opportunities to continue to be explored with Health Boards on integrating palliative care offer into current APP provision.
	CTAS (formerly PTAS) By the end of FY26/27: Deliver a Clinical Triage Assessment Service (CTAS) in every Health Board to facilitate direct patient access to remote specialist clinical care (e.g. physiotherapists). Collaborate with Health Boards to implement an integrated model that enhances patient access and	Complete	Work progressed in 2025/26 to expand the Clinical Triage Assessment Service (CTAS) across Health Boards. Continued development and roll out of this concept was paused in support to the national Six Goals programme of work to develop Health Board led Single Points of Access (SPOAs). WAST continues to support the Six Goals.

Cabinet Secretary Priority	WAST Deliverables / Objectives & Actions	RAG	Progress
	delivers a consistent, equitable service across all seven Health Boards.		
Mental Health Access	As part of our remote integrated care offer, we will explore opportunities to schedule care through the planned deployment of internal responders including Mental Health By the end of FY26/27: we aim to evaluate and optimise the Mental Health Response Vehicle (MHRV) blended model and expand across Wales as part of a wider developing mental health service offer.	Cautionary Status	▪ A Mental Health Response Vehicle concept was developed and piloted in South-East Wales in 2025/26. A detailed evaluation was completed and considered by the organisation in Q4. Whilst the pilot demonstrated patient and system benefit, it was agreed that the pilot would be stopped and available mental health resources would support the remote clinical assessment function in RICS. ▪ Work will continue in 26/27 to engage with partners on improving access to mental health pathways across community and acute services. There will also be a focus on increasing our CPD offer in relation to mental health to ensure our workforce are skilled and empowered in this space.

Strategic Objective 1- Providing the right care or advice in the right place, every time

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
1.	Complete a formal academic evaluation of the Clinical Model and Ambulance Performance Framework changes to understand the benefits, impact and opportunities for improvement	Complete phase 1 of data collection and begin initial documentary analysis	Begin development of phase 2 data collection including designing and arranging stakeholder interviews and focus groups	Complete phase 2 of data collection (qualitative) with the circulation and analysis of a staff survey	Complete interim evaluation of the APF following 12 months of clean data	- Completion of observational exercises - Completion of validation of collated data - Completion of final analysis and including modelling	Final synthesis and report (2028/29)
2.	Undertake a detailed assessment of clinical flows, processes and functions to optimise productivity, efficiency and outcomes across the model, with a specific focus on improving care for high-risk patient groups (Stroke, STEMI, NOF). This will be enabled through targeted improvement and a consistent approach to benefits realisation, using clear metrics, measures and baselines to improve clinical outcomes, care and experience	Establish the Benefits Realisation Framework, including governance (Benefits Realisation Group), digitised PowerBI scorecards with agreed metrics, and a Trust-wide communications approach	Finalise the Benefits Realisation methodology, agree Benefit Profiles with named owners, and complete risk and productivity workshops to support transition of the new clinical model into BAU	Validate baselines, targets and tolerances, and implement core Benefits Management tools, including a fully operational Benefits Register, defined data flows, and dependency mapping	Produce and present the first formal Benefits Realisation Report	Transition to BAU and agreed reporting and monitoring structures post-programme	
3.	Develop a business case to secure external or internal funding for a modern digital front end for NHS 111 Wales including simultaneous replacement of the current Content Management System and establishment of a substantive NHS 111 Wales Online multi-disciplinary team	Scope out and develop Outline Business Case	Socialise business case through governance routes	Decide next steps dependant on business case decision			
4.	Replace the outdated Online Symptom Checker (OSC) tool to align with the 111 Call Prioritisation and Streaming System (CPSS)	Complete Go-live delivery report				Review ongoing opportunities including NHS Wales App integration and use within wider NHS Wales settings	Review ongoing opportunities including NHS Wales App integration and use within wider NHS Wales settings
5.	Deliver a system-wide action plan to accelerate improvements in out-of-hospital cardiac arrest (OHCA) outcomes in Wales by implementing targeted interventions in public awareness, CPR training, defibrillator access, advanced life support, and data analytics	Deliver updates to Welsh Government learning platform and develop bespoke bilingual CPR resources for schools to develop a generation of life savers to improve the likelihood of bystander CPR for future cardiac arrest patients	Roll out new clinical practice guidelines on resuscitation and verification of death, reducing the incidence of inappropriate resuscitation attempts and increase Return of Spontaneous Circulation (ROSC) and survival to discharge rates in OHCA	Deliver the Welsh OHCA reporting of survival to discharge for end to end measurement and benchmarking, leading to targeted improvements across the UK and internationally	Implement "PADmap" systems to intelligently map the placement of community defibrillators to increase the number of PADs retrieved to the scene of an OHCA and address health inequalities associated with historic PAD placement		
6.	Redesign and implement revised Health Care Professional (HCP) call flows aligned to our integrated Clinical Services Model, and evaluate and optimise them post implementation	Complete 'current state' mapping exercise and begin external stakeholder engagement	Develop chosen recommendation into defined process development and undertake subsequent testing (solution proposal)	Implement the agreed process (Go Live), including training plans, monitoring and assurance process, and approval of Standard Operating Procedures (SOPs)	Complete evaluation, including lessons learned		
7.	Operationalise the key recommendations of the Emergency Ambulance (EA) skill mix review	Agree and begin implementation of options and actions to enable progressive realignment of paramedic, EAP and EMT WTE numbers	Establish defined rota lines for paramedic, EAP and EMT staff aligned to the required skill mix to guide recruitment and internal movements	Facilitate voluntary staff discussions and opportunities to move across rota lines	Complete end of year review and confirm next steps for ongoing workforce realignment	Continue full workforce realignment	Complete full workforce realignment

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

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
9.	Work with supplier to pilot and evaluate the alignment of MPDS and CPSS	- Complete technical integration activities, including supplier configuration of CPSS within the 999 system - Undertake clinical safety assessment, readiness testing, and pilot set-up - Recruit and train Call Handlers for pilot delivery, with targeted engagement and communications issued - Secure funding and issue Purchase Order (PO) to supplier for integration and pilot implementation	- Launch the live pilot of CPSS/MPDS alignment within the 999 environment - Monitor performance, safety and user experience throughout the pilot period	- Conduct a full evaluation of the pilot, including clinical, operational, and technical findings - Produce recommendations and decide whether to scale up the solution - Develop a Business Case to secure required funding and approval, if expansion is recommended	- Optimise workflows, SOPs, training, and technical components based on pilot learning - Prepare for wider rollout , including operational readiness planning (subject to approval and funding) - Complete year-end summary and develop the next-phase IMTP plan		
10.	Optimise and evaluate current provision of the falls desk to inform delivery of the function post current funding arrangements	Agree the Benefits Framework and initiate structured data collection, including confirmation of data capture mechanisms	Finalise and test the evaluation strategy, ensuring alignment with organisational quality, performance, and benefits realisation standards	Complete full internal evaluation (qualitative and quantitative), with findings synthesised into a formal report including clear recommendations	Develop an options appraisal and business case for the future of the Falls Desk, engaging Clinical, Finance and Operational stakeholders to inform 2027/28 decision-making (subject to evaluation outcomes)		
11.	Increase the number of patients treated at home or in the community by optimising and more effectively utilising our advanced practice resources across Wales (including APP roster review, scheduling advanced practice clinicians and increasing utilisation) aligned to the ‘preferred response’ outlined in the Ambulance Performance Framework	- Complete OMDA remodelling of APP rosters across all Health Board areas, commencing with Cardiff & Vale UHB, and incorporating rotations critically between operational response and APPNAV - Establish Point of Care (PoC) testing evaluation (6 months) as funded (externally funded by HEIW)	Implement approved rosters in areas with sufficient staffing capacity, embedding the new model into operational practice	Commence the impact assessment of the roster changes, highlighting and correcting any areas of shortfall or issues in the new roster lines	- Review Time, Purpose, Skill (TPS) intelligence and APPNAV/SPoA activity to model demand and capacity for APP provision, with resourcing prioritised to SPoA services, followed by operational APP scheduling, and then commissioned Primary Care and SPCT rotations, informed by APPNAV presence across each Health Board area for a minimum of 12 hours per day - Undertake preparatory work on funding cases for commissioned models in PC/SPC based on outcome of review	- Complete modelling of demand, resourcing and capacity to support SPOA coverage and APPNav growth to increase SPOA capacity, including assessment of UCR POC resourcing requirements versus distribution of SAPPs, and alignment of UCR POC rostering with modelling outcomes and review findings - Revisit the right resource for the right patient discussions and standing up more APP scheduling (e.g. blue lights) alongside CMT development and findings	
12.	Establish a NEPTS improvement programme and detailed plan to increase the productivity and efficiency of the NEPTS service to address current performance challenges and risks. Improvement actions will include (1) NEPTS roster review, (2) Enhanced data and analytics to improve co-ordination and performance management, and (3) Explore digital solutions to improve productivity and patient experience (e.g. Patient Cancellations)	- Complete roster engagement process, develop final options, confirm revised plurality provision, and complete required procurement processes - Develop dashboards and reporting tools with partners to support decision making - Implement HCP and Patient Zone functionality, excluding patient bookings, and identify additional digital products to support delivery	- Implement agreed roster proposals - Implement dashboards and reporting capability - Implement patient booking functionality	- Review utilisation and refine products - Implement additional products or develop a costed proposal where further funding or support is required	Review implementation and refine to maximise benefits realisation		
13.	Undertake a strategic service review of NEPTS	Establish project structures to oversee delivery of the objective (subject to appropriate funding)	Develop scope and complete required processes to identify provision required to support delivery	Complete the review process	Identify and confirm required actions and next steps		

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

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
14.	Implement two key recommendations from the Manchester Arena Inquiry (Incident response desk and additional duty operations manager capacity) to enhance organisational readiness for major incidents and events	Await outcome of submitted case to confirm scope	Implement HART South growth from 6 to 8 per team (subject to WG approval), strengthening operational readiness for major incidents	Develop full outline business case for HART (North) and submit to Welsh Government for consideration			
15.	Develop and implement operational plans for upcoming major national events, working with Welsh Government and partner organisations as a Category 1 Responder (including the Tour de France and the UEFA European Football Championship)	Assess readiness and implement initial preparation plan for Major Events	Execute plan and address gaps in preparedness	Develop and deliver training for internal and external stakeholders	Review progress and define next steps for ongoing readiness		
16.	Deliver the Covid Inquiry recommendations to enhance organisational readiness for major incidents	Receive the Module 3 report on publication, assess recommendations, and develop a subsequent action plan for following quarters					
17.	Undertake a review of preparedness against the Wales resilience framework to improve compliance with national resilience standards and ensure that arrangements under the Civil Contingencies Act remain robust and up to date	Complete risk scoring and gap analysis	Update and approve critical plans	Prepare for targeted training programmes		Deliver targeted training programmes and multi-agency exercises	

Linked Performance Metrics

Our Improvement Expectations:
Patients will have a better experience accessing our services through multiple channels with an expanded suite of online symptom checkers supporting self-care and navigation
Connected patient records to inform safe and consistent clinical decision-making
Where required, patients are directly and seamlessly booked into the right service

How we will monitor impact and Organisational Ambitions

- Number of patients using our 111 Virtual Assistant ‘ALbot’ option (Increasing trajectory)
- NHS 111 webchats as a % of website hits (Ambition of 1.35%)
- NHS 111 Wales website hits (Increasing trajectory)
- Number of patients accessing the online symptom checkers (Increasing trajectory)
- 999 calls answered within 6 seconds, Median and 95th percentile (Maintain against current target)
- NHS 111 Call handling abandonment rate (Maintain within 10-15% rate)

Our Improvement Expectations:
Patients will receive a clinically led remote clinical assessment to best understand their needs
Patients will be provided with the care options to meet their needs, including advice, signposting, scheduled urgent care response or an emergency ambulance

How we will monitor impact and Organisational Ambitions:

- 111 outcomes (in particular, to 999 and ED) (Maintain current levels)
- % and activity Consult and Close (999) (Improvement trajectory to 22%)
- Time to Integrated Care Consultation (RICS 1) 90% percentile and associated median (Improvement trajectory)

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

Linked Performance Metrics

Our Improvement Expectations:
Emergency service provision is clinically led, with enhanced senior clinical decision-making at the point of access and response
Patients in life-threatening or emergency situations consistently receive an immediate and rapid response
Patients are taken to the most appropriate destination of care, or receive care closer to home, supported by improved system coordination
Patients taken to hospital are handed over quickly, improving safety and system flow
An agile and flexible clinical workforce supports emergency response, with opportunities for clinicians to work across emergency response, integrated care and system partner settings, strengthening clinical decision-making and patient flow

How we will monitor Impact and Organisational Ambitions:
Primary Clinical Outcome Measures:

- Return of Spontaneous Circulation (ROSC) at hospital (Improvement trajectory to 25-30%)
- Stroke Call to Door Time (for confirmed stroke) median (1.5 hours)
- Stemi Call to Door Time Median (1.5 hours)
- NOF Call to Door Time Median (In development)
- Chain of survival metrics (Improving trajectory)

Secondary Process Measure:

- Arrest (Purple) median and 90th percentile (Maintain current performance with 6-8 minutes and 20 minutes for 90% percentile)
- Emerg (Red) median and 90th percentile (Improvement trajectory to meet 6-8 minutes median and 20 minutes for 90% percentile)
- Now (Orange) median (Improvement trajectory 60-minute median)

Other measures:

- % (to plan) EMS hours produced (Maintain 95%)
- Hospital handover: Wait 45 W15 and Total Lost Hours (Improvement trajectory 0 waits over 45 minutes and less than 6,000 hours per year Pan Wales)
- ‘Can’t send’ and ‘cancelled by patients’ (volume) (Reduction < 5,770 per month)
- Average Jobs per Shift (Emergency Ambulance) (improvement trajectory 2.3 jobs per shift)

Our Improvement Expectations:
More patients will be managed safely at home or in the community to best meet their ongoing care needs and avoid conveyance to hospital where appropriate
Patients ongoing care needs will be better met with improved join up and co-ordination of care with wider services
Patients will have their care needs met through a scheduled appointment with the right clinician from our urgent community response team

How we will monitor impact and Organisational Ambitions:

- % and activity see and treat/pathways (non-convey to ED from on scene)
- Reduction in the number of conveyances into ED as a % of verified incidents
- APP Utilisation

Our Improvement Expectations:
Digitally enabled services improve ease and reliability of booking and journeys can be tracked by patients and carers
Connected WAST and Health Board systems improve efficiency and reduce duplication
Eligibility criteria are reviewed to ensure support is targeted to those with greatest clinical need
Demand and capacity modelling ensures the right resources are in the right place at the right time
Patient experience feedback is routinely captured through digital surveys

How we will monitor impact and Organisational Ambitions:

- % NEPTS activity cancelled (by Capacity Management Plan, by patients and by health boards) (Improvement trajectory >10%)
- Renal repeated cancellation rates (Reduction - 0)
- Oncology journeys arriving within 45 minutes in advance of, and 15 minutes after appointment (NEPTS) (Maintain achievement against 70% target)
- Advanced discharge and transfer journeys collected less than 60 minutes after booked time (NEPTS) (Improvement trajectory >60 minutes)

Strategic Objective 2 - Enabling our People to be the Best they can be

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
18.	Embed the Anti-Sexual Harassment Policy and deliver the supporting implementation plan to create a culture of sexual safety across the Trust	Guide the All Wales People Network to develop and implement an Anti-Sexual Harassment Policy plan, including creation of standardised All Wales resources and training materials	Conduct a mid-point review of sexual harassment prevention measures and workplace safety to assess progress and identify areas for improvement	Deliver targeted training sessions for Senior Management Operational Teams, including Line Managers and Duty Operations Managers (DOMs)	Undertake a structured review of colleague experience and data relating to sexual harassment to inform future promotion and next milestones	- Complete All Wales People Network review of the Anti-Sexual Harassment Policy - Monitor local policy implementation and sexual harassment incidents in the workplace	
19.	Achieve a sustained reduction in sickness absence through targeted action on work-related stress, supporting colleagues and managers to take timely action and promote long-term wellbeing	- Produce data on costs of sickness absence to share with managers, TUs and colleagues across the organisation - Design and test an intuitive digital risk assessment tool that helps managers and employees identify stress factors early and take preventative action - Secure formal approval for the Stress Management Policy, finalise documentation, and prepare clear guidance materials for Trust-wide distribution	Launch the Stress Management Policy and digital risk assessment through a structured engagement plan, including interactive workshops, manager briefings, and communication campaigns to drive awareness and adoption			- Strengthen the Trust’s approach to managing long-term sickness by enhancing collaboration between teams, improving the quality and consistency of sickness-absence reporting and manager discretion, and establishing monthly engagement between People Services and Directorates to review and progress priority absence cases - Transition to BAU, with ongoing focus on embedding of the Stress Management Practical Tools and further workshops if required	Review sickness absence management, wellbeing provision, and opportunities for further digitisation across People and Culture processes
20.	Increase engagement and participation through targeted interventions, ensuring all colleagues voices are heard, and effectively use data to drive informed decisions and actionable insights	- Procure digital platform to replace Hive - Develop and implement a plan for supplementary pulse surveys aligned to key themes identified in the 2025 survey - Publish organisational results for the 2025 survey	- Procure digital platform to replace Hive - Prepare and deliver the 2026 staff survey	Prepare and deliver the 2026 staff survey	Analyse 2026 staff survey results		
21.	Commence Phase 2 of Our WAST Way by embedding Our WAST Way Leadership Behaviours and Development Framework (inc. Managers Essentials) and progressing the next phase to strengthen leadership and effective management	- Gather feedback from leaders, managers and teams to identify priorities - Finalise Phase 2 design and select initial pilot elements - Confirm accreditation partners, and secure executive sponsorship and resources	Launch targeted communications, develop and pilot key elements with selected groups, and capture real-time feedback to refine content and tools	- Broaden pilots to additional teams, introduce further elements where feasible, refine content using feedback and engagement data, and share interim results through a Leadership Community event - Audit recruitment materials for cultural alignment, integrate behaviours into selection criteria and interview questions, develop guidance for managers, and reflect Our WAST Way within onboarding and candidate communications	Evaluate piloted elements and overall engagement and impact, share learning across WAST, and identify priorities for wider rollout in the following year	Deliver and scale the Our WAST Way Phase 2 Leadership Path, strengthening peer learning, coaching and mentoring, and reinforcing consistent leadership behaviours	Embed Our WAST Way as the Trust’s core leadership and management approach, with leadership development, coaching, mentoring, and self-assessment and 360 feedback operating as business as usual
22.	Enhance managers’ ability to lead, navigate and manage change confidently, reinforcing cultural transformation and organisational resilience	- Further develop the change management toolkit - Implement an organisational change heat map - Enhance alignment between change management and Our WAST Way, including connection to Senior Responsible Officer (SRO) and Executive Sponsor development offers - Develop and implement a development plan for the Change Community, supported by a communications and engagement plan					

Strategic Objective 2 - Enabling our People to be the Best they can be

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
23.	Ensure development for all by delivering a comprehensive approach to career pathways, succession planning, and professional development across the Trust. This includes establishing talent pipelines for Executive and Senior Leadership roles, launching the People Development Plan, and expanding Apprenticeship and Essential Skills provision to support career progression. In addition, strengthen Trust-wide Education Quality Assurance by implementing consistent, accredited, high-quality curriculum and professional practice standards	- Launch and promote the People Development Plan - Provide education quality assurance across WAST to support local delivery teams - Deliver the WAST Education Programme to all Practice Educators, Trainers and Tutors	- Launch and promote the People Development Plan - Provide education quality assurance across WAST to support local delivery teams - Deliver the WAST Education Programme to all Practice Educators, Trainers and Tutors - Develop Leadership Framework which provides a structured approach to attracting, developing and retaining people in leadership roles	- Review job descriptions and map qualifications - Provide education quality assurance across WAST to support local delivery teams - Deliver the WAST Education Programme to all Practice Educators, Trainers and Tutors - Complete a talent assessment framework to review to understand current and future capability and skills - Create succession plans and maps for leadership roles - Develop Leadership Framework which provides a structured approach to attracting, developing and retaining people in leadership roles	- Review job descriptions and map qualifications - Provide education quality assurance across WAST to support local delivery teams - Deliver the WAST Education Programme to all Practice Educators, Trainers and Tutors - Create IDPs aligned with the framework and succession map - Create succession plans and maps for leadership roles	- Review the impact of the People Development Plan and refine based on feedback, continuous improvement, and alignment with the NHS Future Solution, ESR replacement - Continue delivery of education quality assurance - Continue delivery of professional practice training - Commence phase 2: development & acceleration of the succession planning programme,with a focus on stretch roles, coaching & acting up, readiness review and stress testing	Commence phase 3: transition & sustainability of the succession planning programme, with a focus on planned transitions, internal appointments, pipeline refresh,and providing Board assurance
24.	Design and implement an inclusive Recruitment Strategy that attracts, engages, and retains diverse top talent aligned with our organisational values and workforce needs	- Gather stakeholder feedback on initial proposals and approach - Deliver Contact Centre open days in Newport and Swansea to engage ethnic minority communities and promote recruitment activity - Implement structured support mechanisms for new employees in collaboration with People Networks and the Retention Lead - Work with the Prince's Trust to provide work experience opportunities for young people from ethnic minority backgrounds	- Develop the first draft recruitment strategy, integrating stakeholder feedback and further review - Deliver Contact Centre open days in Newport and Swansea to engage ethnic minority communities and promote recruitment activity - Implement structured support mechanisms for new employees in collaboration with People Networks and the Retention Lead - Work with the Prince's Trust to provide work experience opportunities for young people from ethnic minority backgrounds	- Develop the first draft recruitment strategy, integrating stakeholder feedback and further review - Implement structured support mechanisms for new employees in collaboration with People Networks and the Retention Lead - Work with the Prince's Trust to provide work experience opportunities for young people from ethnic minority backgrounds	- Secure formal endorsement through the People and Culture Committee and prepare for publication - Work with the Prince's Trust to provide work experience opportunities for young people from ethnic minority backgrounds	Implement short-term actions within the approved Recruitment Strategy	Begin implementation of long-term actions within the approved Recruitment Strategy
25.	Undertake preparatory work to support the implementation of the Future NHS Workforce Solution (Electronic Staffing Record)	- Contribute to the design and development of the new system - Undertake required organisational readiness and engagement activities provided by NHS Business Service Authority (NHSBSA) prior to implementation	- Contribute to the design and development of the new system - Undertake required organisational readiness and engagement activities provided by NHSBSA prior to implementation	- Contribute to the design and development of the new system - Undertake required organisational readiness and engagement activities provided by NHSBSA prior to implementation - Implement programme management and governance foundations in readiness for implementation	- Contribute to the design and development of the new system - Implement programme management and governance foundations in readiness for implementation - Undertake required organisational readiness and engagement activities provided by NHSBSA prior to implementation	Implement the Future NHS Workforce Solution	Go live of the Future NHS Workforce Solution, replacing ESR

Linked Performance Metrics

Our Improvement Expectations:
Our people deserve to feel valued, supported, and equipped to thrive
Our people will work in a culture where everyone feels safe, is able to grow, and experiences genuine wellbeing at work

- How we will monitor impact and Organisational Ambitions :**
- % of successful applicants (recruited) from under-represented groups (Improvement trajectory 7%)
 - % of 111 calls presented in Welsh, answered in Welsh (Improvement trajectory 70%)
 - Staff sickness (Improvement trajectory <6%)
 - Staff turnover (Maintain <10%)
 - PADR Rate (Improvement trajectory >85%)
 - Statutory and Mandatory Training Completion (Maintain >85%)

Strategic Objective 3 - Being at the Forefront of Innovation and Technology

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
26.	Deliver a cloud-based Global Rostering System (GRS) solution, enabling an organisational decision on implementing the e-timesheet solution	● Migrate the on-premise GRS platform into a vendor-supported cloud environment					
27.	Launch and embed updated Digital, Data and Technology (DDAT) Governance Framework	● Finalise and sign off scope of the Digital, Data and Technology (DDAT) Governance Framework alongside TOR for the Digital Oversight Group ● Implement new work process to approve and prioritise in-year requests	● Launch the Digital Oversight Group and associated forums, including the Digital Solutions Lab and Digital Champions network ● Report new KPIs including a focus on human centred design, adoption and benefits		● Undertake an internal review of new processes and standard operating procedures, using findings to iteratively improve the service ● Launch phase one of the digital learning offer to support WAST staff with skill development and resources for digital innovation, adoption, and user-centred design		
28.	Expand SMS functionality across services to improve access for patients and their engagement with key frontline services e.g. clinical navigator function					● Review opportunities, prioritise and develop a road map drawing on lessons learned from earlier NEPTS implementation ● Deploy agreed SMS functionality across key services ● Evaluate patient experience, engagement, and service impact	
29.	Establish safe, ethical and effective use of AI across WAST through a Responsible AI Framework and targeted staff capability-building	● Deliver Executive Leadership Team and Board development sessions to determine organisational risk appetite and strategic AI opportunities,with the expected outcome of an AI ambition statement for WAST	● Develop and publish an AI ethics and safety framework, including governance arrangements to support with safe use, procurement, and development of AI technologies	● Develop and deliver a targeted awareness campaign and training to specific staff groups (e.g. administrative, compliance, management) to support informed and responsible use of AI tools			
30.	Develop key requirements and appraisal of options for EMS, 111 and NEPTS CAD Replacements, including strategic direction	● Establish a dedicated project team with specialist digital expertise and cross-directorate involvement ● Develop a detailed project plan covering requirements gathering through to procurement	● Develop and document requirements for each CAD system	● Undertake market evaluation and benchmarking to inform development of the business case ● Develop the business case for CAD replacements, incorporating requirements, market insights and strategic options	● Develop the business case for CAD replacements, incorporating requirements, market insights and strategic options		
31.	Develop the full Business Case for Emergency Services Network (ESN) Phase 2, covering handheld radios, fixed vehicle devices, field services, and resource funding through 2031/32 (as part of the UK national programme)	● Complete ESN Phase 2 Full Business Case (FBC)	● Secure sign-off and submit the FBC to Welsh Government				
32.	Implement ePCR application refresh and renewal of contract	● Renew the contract and develop WAST wireframes of the new app to support iterative design of the application ● Develop software and database schema for the new application and complete the Functional Design Specification (FDS) for the app and web portal ● Develop user acceptance testing (UAT) criteria, and conduct beta and user testing, confirming acceptance before progressing	● Conduct digital clinical safety risk assessments and provide assurance against DCB0129 and DCB0160 standards ● Confirm UAT complete, and deployment readiness, and deliver user training				
33.	Combine internal WAST datasets and link with external datasets to provide richer intelligence and the evidence impact of the CMT and other improvements	● Deliver an internal workshop to agree opportunity and focus for connected datasets (e.g. CMT benefits, health inequalities),and establish a working group to support delivery	● Connect datasets, conduct analysis and deliver insights for agreed top priority focus or hypothesis (initial focus likely to be OHCA survival), with further areas explored throughout Q2-Q4				
34.	Strengthen information governance and technical capability to enable WAST to support the All-Wales data sharing ambitions though the National Data Resource	● Support national work to develop All-Wales data sharing agreement(s), engage the public for transparency, and agree the confidentiality approach	● Establish information governance arrangements with system partner(s) to enable data sharing for secondary analysis (e.g. assessing CMT impact on wider systems, OHCA survival post 30 days)	● Build data pipelines from WAST to cloud-based National Data Analytics Platform (NDAP) and connect appropriate datasets in line with IG arrangements established in Q2	● Explore NDAP tooling and apply it to WAST-specific analytical project (e.g. natural language processing of unstructured medical examiner feedback, automated clinical coding of ePCRs)		

Strategic Objective 4 - Developing Services in Collaboration

[illegible]

Strategic Objective 5 - Quality Driven and Clinically Led

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
37.	Develop a consistent organisational framework that brings together quality improvement, change management and project management methodologies	- Agree and document a single organisational Quality Improvement framework - Define and agree roles, responsibilities and governance arrangements for quality improvement delivery and oversight	Align the Quality Improvement framework with existing planning, delivery and assurance processes to support consistent application	Pilot the framework through a small number of priority programmes and use learning to refine the approach prior to wider adoption			
38.	Develop and implement a Trust-wide Quality Assurance Forward Improvement Plan, informed by self-assessment, aligned to strategic objectives and supported by clear ownership and monitoring arrangements	Support completion of Quality Assurance Self Assessments across all areas of the organisation and present assurance and gap analysis to Quality Management Group (QMG)	Align the forward improvement plan, developed from the gap analysis with Institute for Healthcare Improvement (IHI) principles, and map clear links to strategic objectives	Monitor delivery of this forward improvement plan through a lens of Health and Care Quality standards utilising a range of qualitative and quantitative measures	Link assurance activity, evaluation of improvement activity and learning from control processes, to inform Quality Planning for IMTP deliverables		
39.	Review and refresh the Strategic Quality Plan to ensure it remains current, aligned to organisational strategic objectives, national policy requirements and emerging quality priorities, and deliver the updated plan through a phased implementation		Commence a structured, collaborative review of the Strategic Quality Plan, engaging key stakeholders to confirm the strategic vision and identify priority areas for strengthening, including Duty of Quality priorities	Update the strategic quality narrative and implementation plan to ensure that key quality priorities have increased focus and visibility with clear actions and associated outcomes	Seek approval for, and publish, the revised Strategic Quality Plan, including the updated implementation plan	Deliver the revised Strategic Quality Plan, implementing agreed actions and monitoring progress against defined outcomes	Develop the subsequent Strategic Quality plan, informed by learning, performance and emerging national and organisational priorities
40.	Strengthen the Patient Voice Network to support meaningful and effective community involvement in the development of planned service changes	Review the current Patient Voice Network arrangements, including reach, representation and effectiveness	Strengthen mechanisms for involving patients, families and communities in planned service change and improvement activity	- Strengthen mechanisms for involving patients, families and communities in planned service change and improvement activity - Embed strengthened engagement mechanisms and expand involvement - Improve feedback loops to demonstrate how patient and community input influences decisions and service design	- Embed strengthened engagement mechanisms and expand involvement - Improve feedback loops to demonstrate how patient and community input influences decisions and service design		
41.	Implement and embed a person-centred, compassionate and learning-focused concerns management system that enables early listening and resolution, delivers proportionate and timely investigation, provides clear and empathetic responses, and systematically uses learning to prevent future harm and improve patient safety and experience	- Implement early listening discussions delivered by appropriately trained and experienced staff - Implement an integrated and safe concerns triage process - Agree proportionate investigation pathways, including scope, depth and timescales, with affected patients or their loved ones	- Establish and implement alternative and early resolution pathways - Embed compassionate, clear and non-legalistic response standards - Commit to resolving a high proportion of concerns at Stage 1 (within 10 working days where appropriate)	- Embed revised concerns regulations and Listening to People guidance - Implement consistent response content, including clear information on actions, changes and improvements - Begin using National Concerns Management Experience Survey feedback to inform improvement - Evidence reduction in Learning From Events reports submitted to the Welsh Risk Pool		- Advance and further develop investigation pathways and early resolution approaches - Strengthen consistency and quality of person-centred responses - Embed learning from complaints and concerns across services - Refine and mature the concerns management system - Demonstrate sustained reductions in Learning From Events reports linked to previous concerns - Evidence systematic use of learning to improve quality, safety and patient experience	- Sustain improvements in early resolution, investigation quality and response timeliness - Demonstrate embedded organisational learning from concerns - Evidence ongoing reductions in harm and continued improvement in patient experience

Strategic Objective 5 - Quality Driven and Clinically Led

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
42.	Deliver clinically led, evidence based mental health care that provides the right care, in the right place at the right time	- Publish and implement Mental Health Delivery Plan aligned with Welsh Government Mental Health and Well-being 10-year Strategy - Engage with third sector partners to improve open access to mental health pathways across community and acute services to offer stepped care models	- Engage with third sector partners to improve open access to mental health pathways across community and acute services to offer stepped care models - Develop Mental Health Clinical and Patient reported outcomes and experiences measurement framework and dashboards	Expand our Community Partnership by co-producing local mental health and well-being hubs with third-sector organisations to improve access and equity	Review and evaluate progress		
43.	Establish a skilled,empowered mental health workforce through CDP, innovation, partnership working and lived experience	- Identify and design tools to create a training package which will support the implementation of trauma-informed ways of working - Formulise involvement of service users and carers in strategy reviews and policy development	Commence production of training tools and packages	Deliver trauma-informed ways of working and crisis intervention training for practitioners	- Deliver trauma-informed ways of working and crisis intervention training for practitioners - Formulise involvement of service users and carers in strategy reviews and policy development - Evaluate progress		
44.	Implement the Medicines Management Hub systems and processes, subject to funding	Complete design, regulatory preparation (to include pharmaceutical waste disposal), and project documentation for the Medicines Management Hub	Commence procurement, facility fit-out, and workforce training for the new Hub	Deliver systems integration and pilot operation	Achieve full operational launch, including controlled drugs integration	Complete post-implementation review and optimisation of the Medicines Management Hub	
45.	Restructure and deliver the Flu Vaccination Programme for 2026 /27 aligning with 2025/26 report recommendations	Review 2025/26 recommendations and begin planning for the 2026/27 programme	Implement the plan, prepare communications, and engage stakeholders to support 2026/27 programme delivery	Deliver rollout of flu vaccination across WAST	Continue programme delivery, collate data, and complete evaluation and end of year report with recommendations for future years		

Linked Performance Metrics

Our Improvement Expectations:
Organisational decision making and delivery is underpinned by our unwavering commitment for quality delivered through our quality management approach

- How we will monitor impact and Organisational Ambitions:**
- National Patient Reported Experience Measure (An average overall experience score of 85%)
 - Concerns (stage 1) Early Resolution (Improvement trajectory 40%)
 - Enactment of the Duty of Candour within five days of receipt of request (Improvement trajectory 100%)
 - National Reportable Incidents (including never events) (Reduction)
 - Joint Investigation Framework (referral to health boards) (Reduction to 7)

Strategic Objective 6 - Value and Sustainability

Ref	Deliverable	26/27				27/28	28/29
		Q1	Q2	Q3	Q4		
46.	Embed a Trust-wide Financial Sustainability Programme (FSP) to improve financial decision-making, organisational capability, and delivery of recurrent cost efficiencies aligned to the Trust's financial plan	- Develop the cycle of business and forward plan for the FSP, establish baseline data, identify and prioritise initial workstreams, and launch the communications and engagement plan - Commence directorate-level delivery against the financial savings plan, monitor progress regularly, and finalise all savings targets for 2026/27	Mobilise priority efficiency schemes, implement benefits tracking for the Service Review, and develop a capability plan to strengthen financial literacy and skills	- Undertake the mid-year review, embed FSP processes and decision-support tools into business planning, and begin planning for the 2027/28 savings plan - Commence work to generate initial savings proposals for 2027/28	- Validate recurrent efficiencies and confirm the recurrent/non-recurrent split, complete a programme effectiveness review with lessons learned, and commence forward planning for FY27/28 - Finalise savings targets for 2027/28		
47.	Establish a fully functioning Commercial Function, underpinned by an approved Trust wide Commercial Plan and deliver at least two sustainable income generation streams	Engage stakeholders across the organisation on the draft Commercial Plan and establish the Commercial Steering Group	Finalise and formally launch the Commercial Plan, whilst recruiting the core commercial resource required to support delivery	Develop detailed business cases for prioritised income generation and cost recovery opportunities	Commence implementation of approved opportunities, as endorsed by the Commercial Steering Group and approved by the Financial Sustainability Group	- Mobilise approved income generation streams, including finalising delivery models, agreements and performance measures - Initiate delivery of income generation streams with formal performance monitoring in place - Assure performance and sustainability of income generation streams through review and optimisation - Demonstrate recurring benefits and embed delivery as business as usual	

Linked Performance Metrics

Our Improvement Expectations:
Through robust financial planning, deliver of our comprehensive savings improvement programme and generation of income through commercial activities we want to ensure that the organisation meets its statutory obligation to deliver financial balance

How we will monitor Impact and Organisation Ambitions:

- Financial balance (Maintain 100% financial balance)



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Agenda Item No.

11

REPORT TITLE

Monthly Integrated Quality Performance Report – March/April 2026

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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



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REPORT SUMMARY:

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

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **March/April 2026**.
2. The general data quality in the report is good (and the amount of data comprehensive), but a number of specific data quality issues have previously been identified. Some have been resolved, and others are being worked through with a clear Executive focus on Phase 2 of the Ambulance Performance Framework, which is now live. Additional capacity is being sought for the Insight & Data Services (IDS) function with a number of appointments into new posts being made, but onboarding and then a lead in time for these new staff to come up to speed is required. In the interim, IDS capacity is being actively managed by senior IDS managers and also through a CMT Metrics Workplan. The CMT Metrics Workstream has now closed, with any outstanding actions passing to the new CMT Benefits Workstream.
3. The new Purple (Arrest) and Red (Emergency) categories were implemented as scheduled on 1 July 2025. Early performance data indicates that the Arrest category is operating within the expected target range; however, Emergency performance remains outside the desired thresholds. On 2 December, the second phase of the New Ambulance Performance Framework went live. This phase removed the previous Amber and Green categories and introduced three new classifications: Orange (Now), Yellow (Soon), and Green (Planned). Analysis of data following implementation shows that Orange (Now) median response times, including call-to-door intervals, are currently longer than expected and not meeting performance ambitions. The Trust is currently working up its year three Clinical Model Transformation Programme structures to focus on realising the benefits (ambitions).
4. 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 2026 and is not expected to within the current resource envelope. The transformation focus for 111 is on the digital front end, with a re-roster designed improve shift patterns for our people and reduce sickness and turnover is well advanced.
5. Ambulance Care, in particular, Non-Emergency Patient Transport Service’s (NEPTS) performance is stable, with oncology and renal journeys remaining above target; however, the level of cancellations (by the Trust, by patients and by health boards) is a concern. The NEPTS Improvement Programme is the main action to respond to the level of cancellations.
6. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People and Culture Plan.



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RECOMMENDATION(S)

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

The Committee is requested to:

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

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

1. Annex 1 - Monthly Integrated Quality and Performance Dashboard



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
139 - Failure to deliver our Statutory Financial Duties in accordance with Legislation

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
13 May 2026	Hugh Bennett, Assistant Director, Commissioning & Performance (signing off on behalf of Rachel Marsh, Executive Director of Strategy, Planning & Performance)



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SITUATION

1. The purpose of this report is to provide senior decision-makers within the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **March/April 2026**.

BACKGROUND

2. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level, which aim to demonstrate how the Trust is performing across four integrated areas of focus:
 - Our Patients (Quality, Safety and Patient Experience).
 - Our People;
 - Finance and Value; and
 - Partnerships and System Contribution.
3. December’s Board Development received a presentation on options for the MIQPR, based on feedback received from NEDs and Executives. The following actions were agreed:
 - a) To review the current set of KPIs against the Trust’s strategic objectives, with a view to reducing the number of KPIs (the Trust will undertake the usual review against the IMTP and other changes in the health care system in Wales)
 - b) Disaggregate the MQIPR into committee specific KPIs, but retain the overall scorecard for each committee in order to avoid silo working and maintain an overall awareness of the Trust’s operating context across its balanced scorecard
 - c) Report by exception, so for the committee specific KPIs, only that that are off target will receive a narrative detailing what is causing the KPI to be off target and what is being done about it. For KPIs that are on target, graphs will be provided in an appendix with no supporting narrative
 - d) Retain the balanced scorecard as a way of achieving strategic alignment in a quantitative form
 - e) Seek to add a more predictive element to the reporting (this will take a period of time to achieve, but the Trust has a strong track record of forecasting & modelling)



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- f) Remove the use of upward/downward trend as a target and replace with agreed benchmarks/targets
 - g) A greater use of statistical process control charts, but agreement to empower the Trusts' analysts to determine the best way of visualising the data
4. These changes will take place over a number of months, with full go live in Q1 & Q2, once the 2026-29 IMTP has been agreed and once the Trust is in a new financial year. Trust Board received a report to its March meeting on a revised scorecard (set of metrics) and revised ambitions (benchmarks and targets). The ambitions are to be further developed into performance improvement trajectories.
5. As a first step, this F&P report focuses on the KPIs for which it is the lead committee (from the existing MIQPR list of metrics). The May 2026 Trust Board will receive some metrics with trajectories, with further modelling required on the more complex indicators, and more metrics with SPC charts. The next iteration of the F&P Committee MIQPR will include trajectories and a revised set of metrics.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

6. **Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.
7. **999** call answering times during April 2026 saw the 95th percentile increasing to 19 seconds but is significantly lower than February 2025 (33 seconds). However, the 65th percentile and median performance times remained consistently good. Work has been undertaken on demand and capacity analysis of 999 call demand and shared with senior managers in EMSC.
8. **111 call answering performance has minimally decreased over recent weeks**, with the call abandonment rate for April 2026 being 18.8%, and therefore not achieving the 5% target. 111 demand in April 2026 did see an 8% increase compared to March 2026. In addition, the external rostering review suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to reach performance without an increase in its workforce (including efficiencies). The current position with commissioners is to focus on efficiencies (roster practices) and the 111 digital front-end as a way of managing demand rather than investment in call handlers.



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A letter has been sent to commissioners proposing that the performance metrics and ambitions are reviewed.

9. **111 Clinical response:** clinical ring back times for patients with the highest priority rose were significantly below target at 74.9%. Response times for lower priority calls also showed a decrease, decreasing to 25.8% and 24.23% for P2CT and P3CT respectively. A deep dive into P2CT and P3CT performance has recently been undertaken. This has identified an increase in the use of the Clinical Advice Line (CAL) by 111 call handlers, which erodes the time available for 111 clinicians to complete P2CT and P3CT assessments with patients. Levels of clinician sickness were also identified. The deep dive included remedial actions, in particular, CAL reprioritisation work and a focus on sickness reduction.
10. **Ambulance Response** (safety / patient experience): on 1 July 2025, the Trust's New Ambulance Performance Framework was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. In March 2026, there were 934 purple calls to the ambulance service, around 2.65% of all calls, and 4,780 (Emerg) red calls, around 13.55% of all calls. The main measure for Purple Arrest calls is the Return to Spontaneous Circulation (ROSC) rate which was 23.9% in April 2026 compared to 22.5% in March 2026, with an underlying upward trend.
11. The March 2026 median response times for purple and red calls were 7 minutes 37 seconds and 9 minutes 25 seconds respectively, with the required range being 6- 8 minutes. Operations SLT recently received a report that identified two issues: 1) the deflection rate from RCS0 to Integrated Care is not behaving in the way the Trust anticipated and 2) the impact of handover lost hours on the Trust's capacity to respond. For 1) the Trust is reviewing whether some Emerg incidents in the RCS0 cohort should go straight to dispatch, therefore reducing the RCS0 demand, comparing old Red volumes with new Arrest/Emerg and consideration of whether further Clinical Navigator capacity is required to reduce the number of time outs. For 2) W45 is key. No issues of clinical or operational practice were identified.
12. On 2 December, the second phase of the New Ambulance Performance Framework went live. Amber and Green categories were removed, and new Orange (Now), Yellow (Soon) and Green (Planned) categories were introduced for those patients needing a face-to-face response. The changes are designed to improve patient safety and patient outcomes by better stratifying patient

demand. The March 2026 median response times for Now (Orange) was 1 hour 24 minutes, higher than the desired one hour.

13. Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has decreased to 89% in April 2026. Whilst there has been a reduction in handover lost hours, the Trust lost 13,748 hours in April 2026, with W45 equating to less than 7,000 hours per month, so the lost hours remain a significant drain on the Trust's ability to respond in a timely manner. The Trust's main focus is to continue to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme. Areas of focus for 2025/26 include: -

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

14. Ambulance Care: Oncology performance in April 2025 was 73.85%, achieving the 70% target. Renal performance remains above the 70% target achieving 74.09%. Advanced discharge and transfer journey performance decreased to 71.6% (95% target), with this primarily being an issue with capacity. Same day discharge and transfer journey performance achieved 95%, hitting the 95% target. These are positive metrics, but discussions through the IMTP development process have identified that cancellations (whether by the Trust, by patients or by health boards) are too high, accounting for 18% of demand (served demand + cancellations). The Trust is already undertaking a complex and difficult re-roster of NEPTS transport and has a range of improvement actions underway, with a particular focus around digital solutions e.g. two way texting, apps for patients and apps for drivers, but through the IMTP development process, the Trust has decided to establish a new NEPTS Improvement Programme to support and drive further transformation in this area.

Our People (workforce resourcing, experience, and safety)

15. Hours Produced: The Trust produced 115,155 Ambulance Response unit hours during April 2026 and delivered an emergency ambulance unit hours production (UHP) of 89%, not achieving the 95% target.



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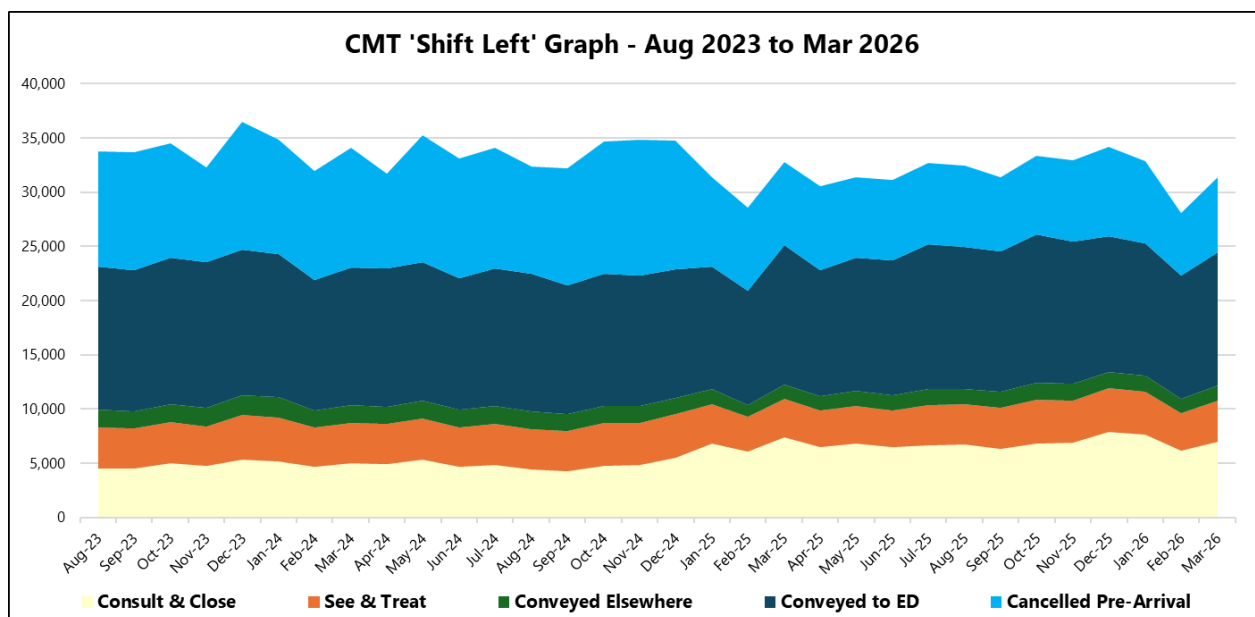
- 16. Response Abstractions:** EMS abstraction levels increased to 33.25% during April 2026 not achieving the 30% benchmark figure. Response sickness abstractions stood at 7.25% (benchmark 5.99%).

Finance & Value

- 17. Financial Balance:** At Month 12 the Trust achieved both its External Financing Limit and its Capital Resource Limit.

Partnerships & System Contribution

- 18.** The consult & close rate was 19% in April 2026, a slight decrease from the previous month (20%) and not achieving the IMTP ambition of 22%; however, there has been a material uplift in the consult & close rate as a result of the CMT Programme.
- 19.** Same Day Emergency Care (SDEC) centres continue to see only a low level of ambulance activity.
- 20.** Finally, the following graph aims to provide a composite picture of the impact of the Trust's CMT Programme through a longer period of time. The time series analysis clearly shows the uplift in the consult & close rate, a reduction in patient cancellations, with conveyance to ED remaining stable (the Trust has actually seen increased conveyance of high acuity patients resulting from reduced cancellations and increased ambulance availability), but with see & treat not really demonstrating any movement. This is an area of focus into 2026/27.



RECOMMENDATION

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

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

March/April 2026

Annex 1 – Top Indicator Dashboard



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Annex 1 – Top Indicator Dashboard
Version 1.0
Released: May 2026

by Commissioning & Performance Team



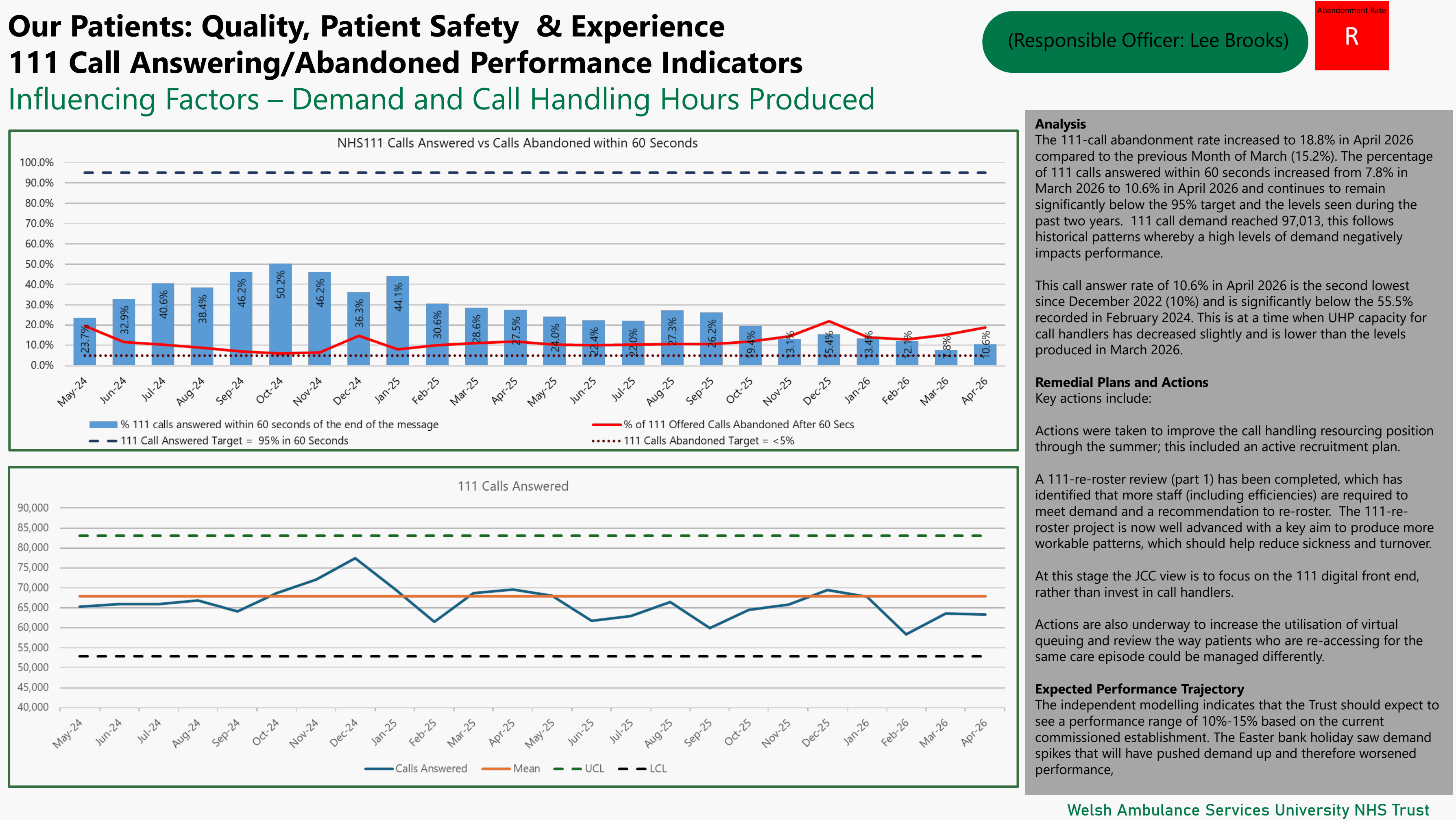
Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators		Target 2026/27	Feb-26	Mar-26	Apr-26	2 Year Average	RAG	Top Monthly Indicators		Target 2026/27	Feb-26	Mar-26	Apr-26	2 Year Average	RAG
Our Patients								Capacity							
Timeliness Indicators								Hours Produced for Emergency Ambulances	95-100%	96%	93%	89%	93%	A	
NHS111 Call Handling Abandonment Rates	<5%	13.1%	15.2%	18.8%	12.0%	R		Sickness Absence (<i>all staff</i>)	<6%	8.25%	7.47%	N/A	7.88%	R	
111 Clinical Triage Call Back Time (P1)	>90%	90.3%	92.4%	74.9%	95.1%	R		Staff Turnover Rate	<10%	7.78%	7.75%	7.87%	8.14%	G	
999 Call Answer Times 95th Percentile	00:06	00:12	00:03	00:19	00:22	R		Statutory & Mandatory Training	>85%	88.73%	89.19%	89.40%	86.30%	G	
Arrest (Purple) Median	6-8 Minutes	06:49	07:37	N/A	N/A	G		PADR/Medical Appraisal	>85%	73.52%	76.65%	76.52%	74.26%	A	
Emerg. (Red) Median	6-8 Minutes	08:54	09:25	N/A	N/A	R		Number of Shift Overruns	<2,800	3,342	3,507	3,222	3,681	R	
Now (Orange) Median	<30 Minutes	01:14	01:24	N/A	N/A	R		Value							
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	>70%	78.9%	79.3%	73.9%	76.6%	G		Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100.00%	100.00%	N/A	100%	G	
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	>90%	74.4%	77.6%	71.6%	78.4%	R		EMS Utilisation Metric (CHARU)	30%	28.1%	29.2%	30.7%	29%	G	
Clinical Outcomes / Quality Indicators								Average Jobs per Shift (All Vehicles)	2.73	2.71	2.75	2.83	2.55	A	
Return of Spontaneous Circulation (ROSC)	>25%	21.4%	22.5%	23.9%	21.1%	A		NEPTS on the Day Cancellations		14.8%	14.7%	15.3%	14%		
Stroke Patients with Appropriate Care	>95%	87.7%	89.7%	87.5%	88.9%	A		Partnerships / System Contribution							
Stroke Call to Hospital Door Times	Under Review	02:21	02:15	02:35	02:27			CMT							
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	>95%	73.2%	78.2%	75.0%	70.2%	R		Successful Consult & Close Outcome	>22%	19.6%	20.0%	19.7%	17.6%	R	
National Reportable Incidents reports (NRI)		4	4	N/A	4			No of Handovers over 45 mins	Zero	4,564	4,791	4,534	5,771	R	
Can't Send & Cancelled by Patient Volumes	<6000	4,806	5,771	5,712	7,316	G		Number of Handover Lost Hours	<7500	14,957	16,469	13,748	18,306	R	
Concerns Response within 30 Days	>75%	59%	70%	N/A	62%	A									
Enactment of the Duty of Candour Total		6	5	N/A	5										

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

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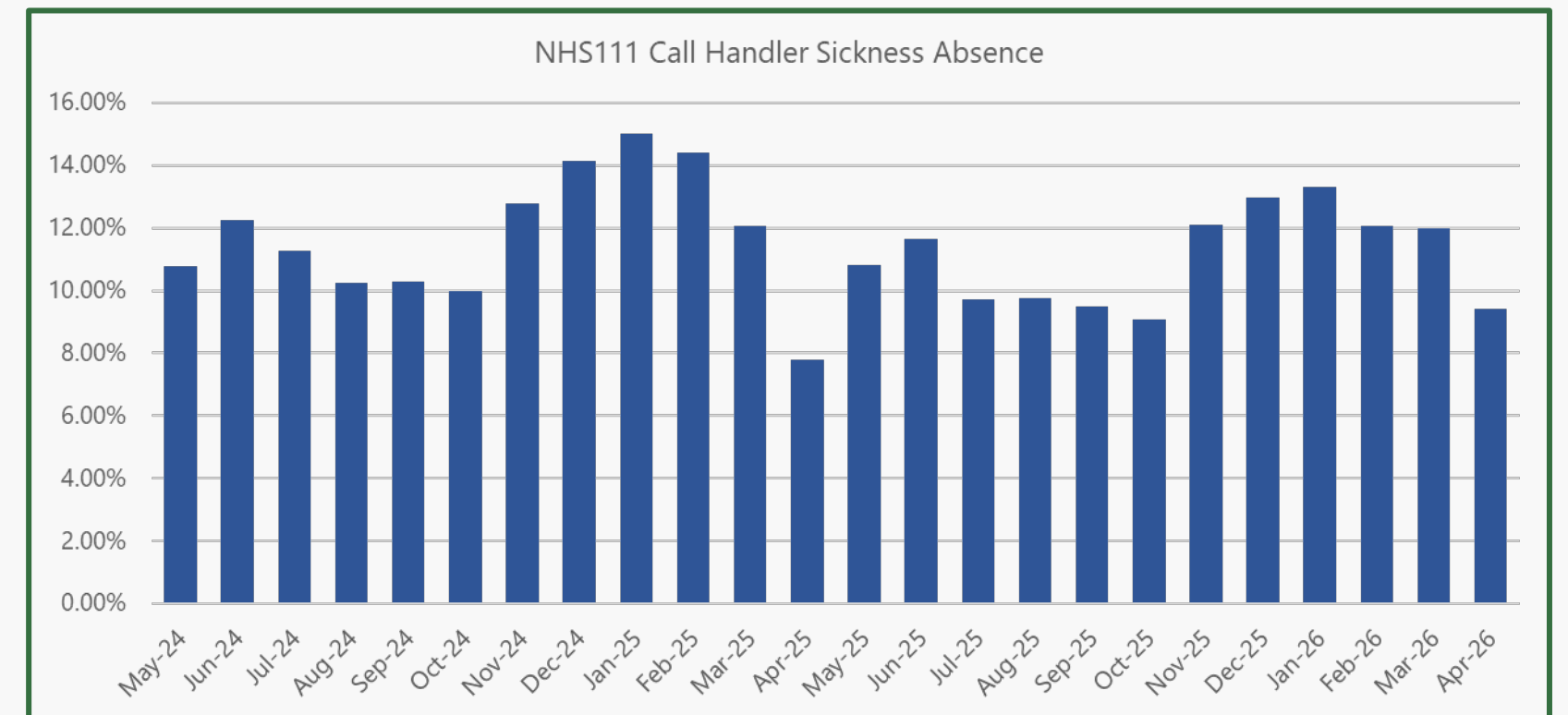
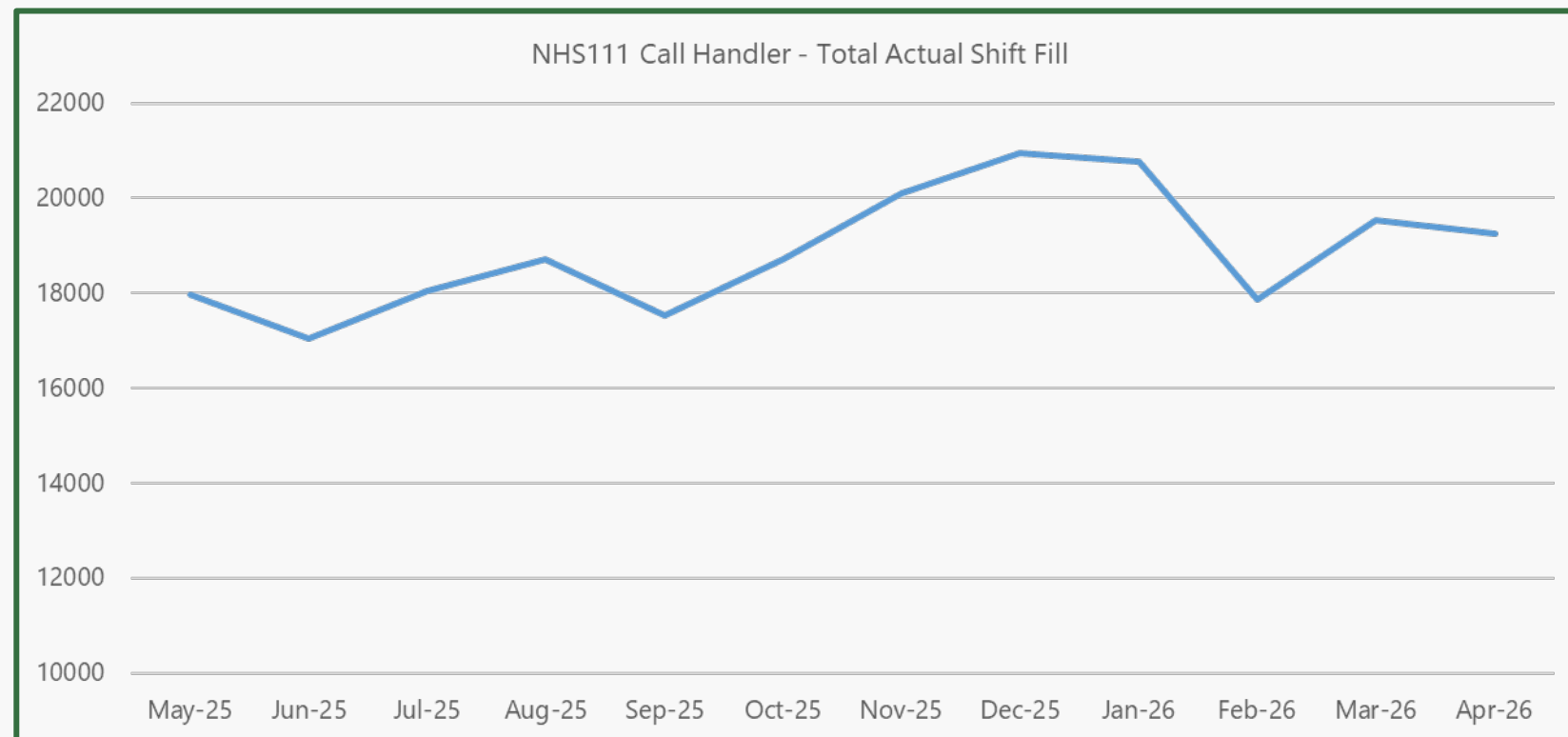
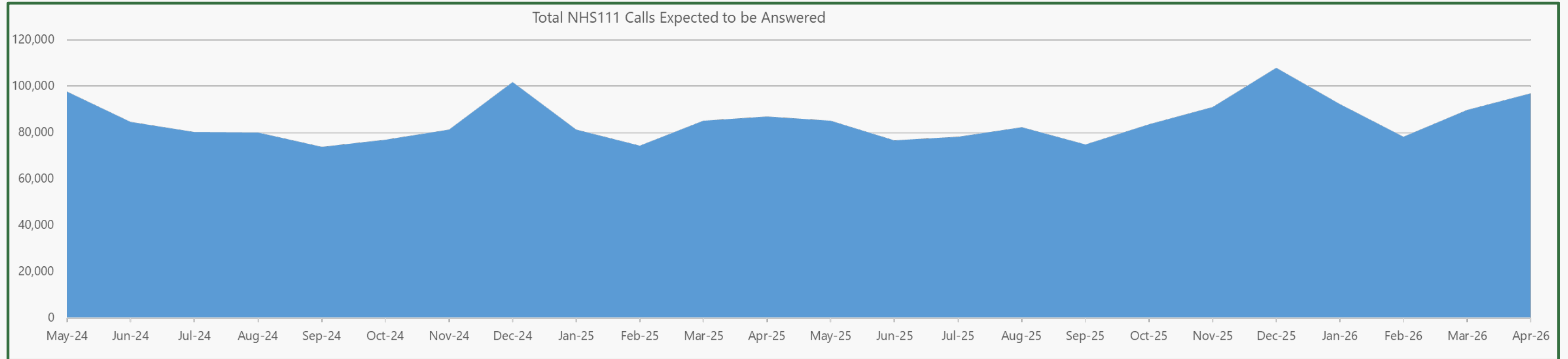


Our Patients: Quality, Patient Safety & Experience

111 Call Answering/Abandoned Performance Indicators

(Responsible Officer: Lee Brooks)

Influencing Factors – Demand and Call Handling Hours Produced



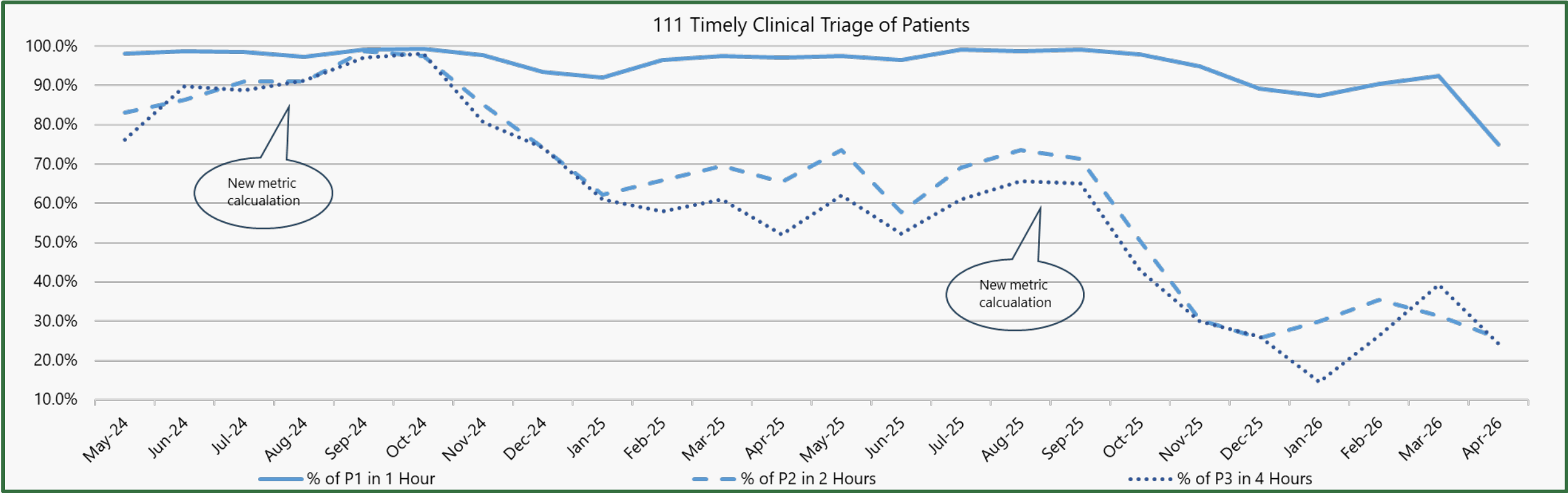
Our Patients: Quality, Safety & Patient Experience

111 Clinical Assessment Start Time Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

P1CT
R



Analysis
The highest priority calls, P1CT, dropped drastically below the 90% target, recording 74.9% in April 2026.

Ring back times for lower category calls decreased during April 2026, with P2CT calls at 25.8% and P3CT at 24.2%. A factor affecting this would be increase in demand.

Number of clinician hours produced a slightly decreased during April, reducing from 11,094 hours in March 2026 to 10,456 hours in April 2026.

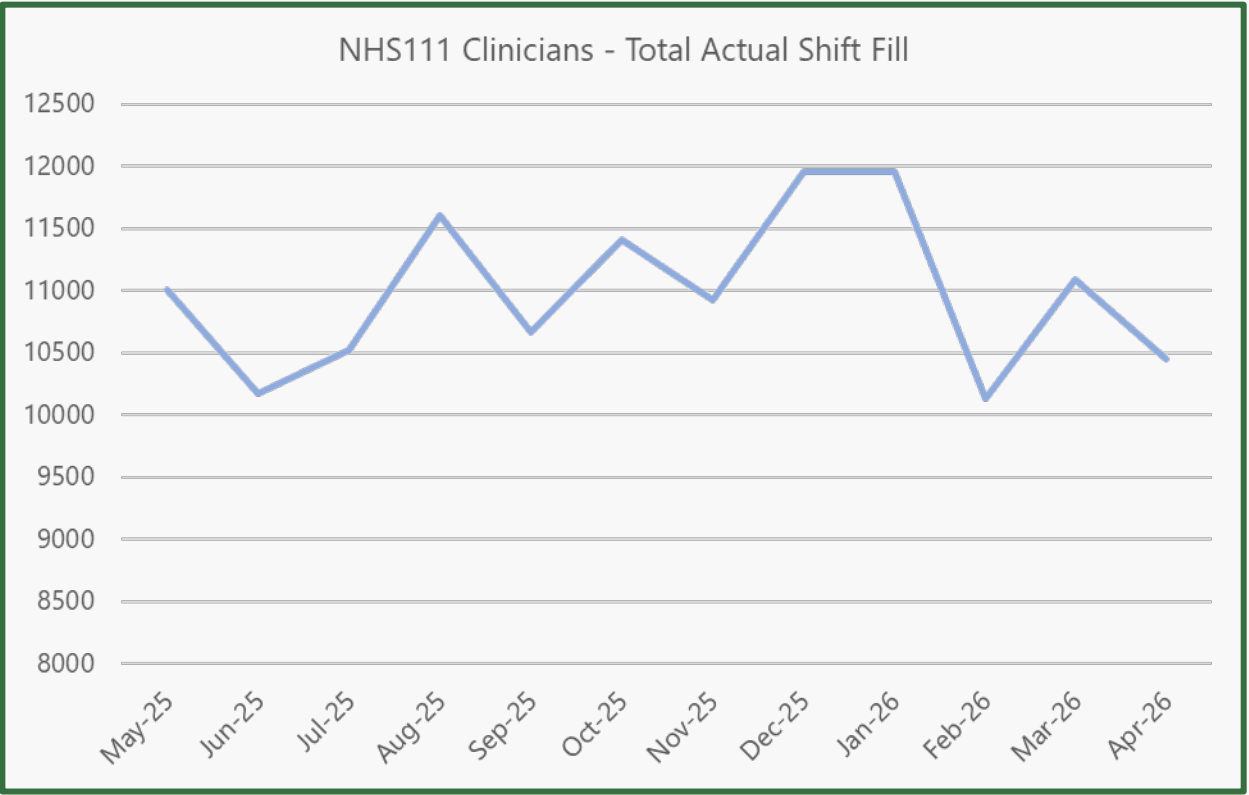
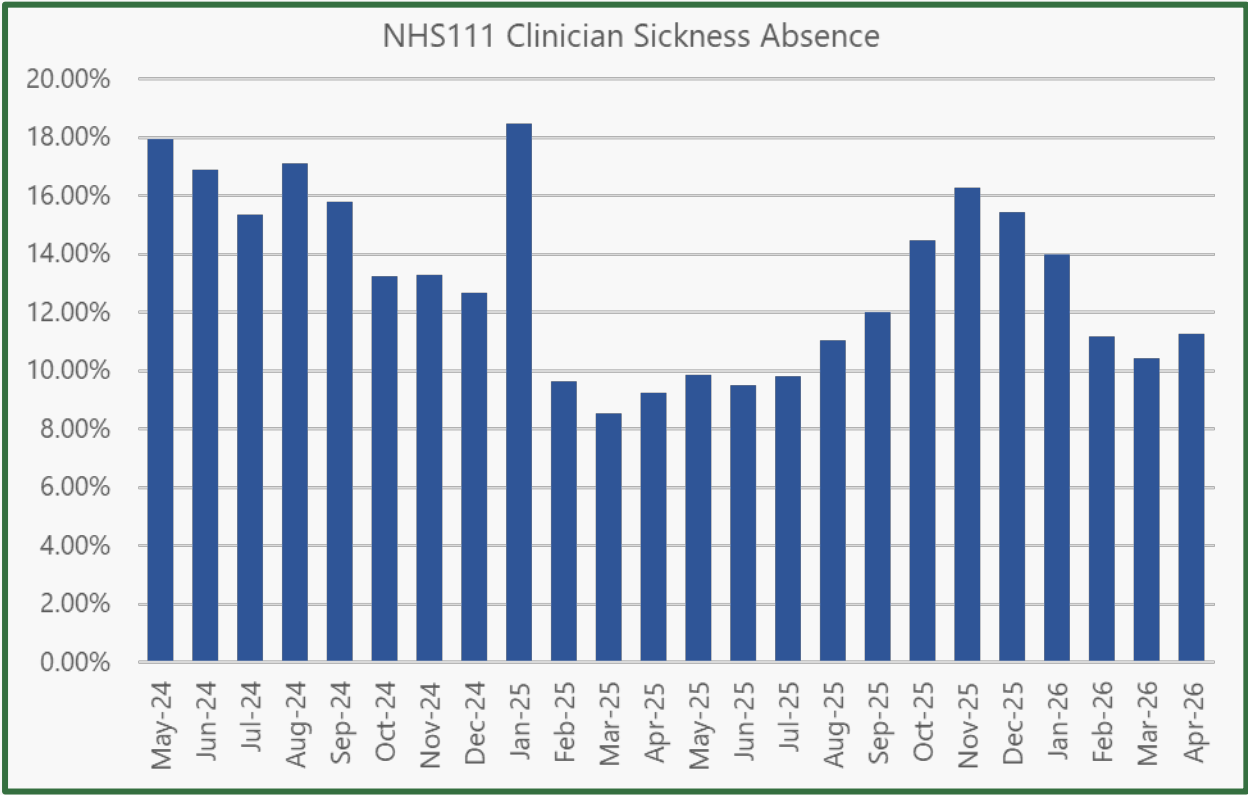
Remedial Plans and Actions
The key actions include:

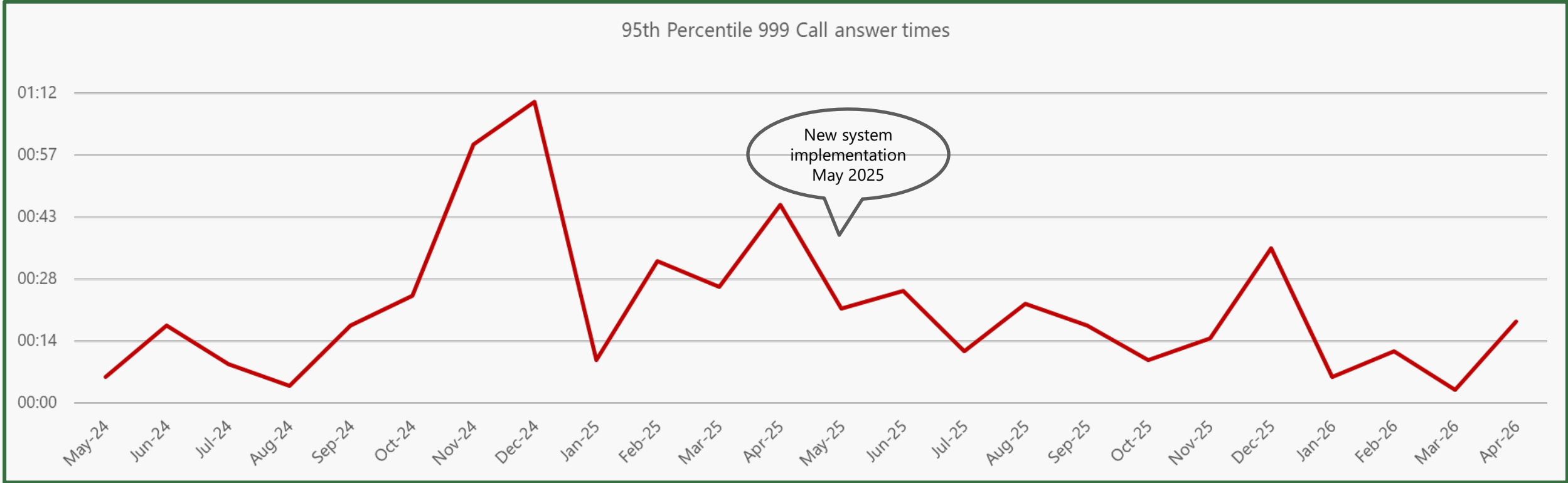
A focus on delivering the benefits of the new 111CAS. A review to determine appropriate levels of capacity to meet increasing demand, including rostering practice (review now live).

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

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

Expected Performance Trajectory
The external rostering review also suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to reach performance without an increased workforce.





Analysis
The 95th percentile 999 call answering performance increased to 19 seconds in April 2026 but is significantly lower than February 2025 (33 seconds). This remains above the 6 second target; however, the median call answer time for the 999-service has been consistently good at 1 second.

There was a minimal decrease in demand during April 2026 to 44,710 calls from 44,661 in March 2026.

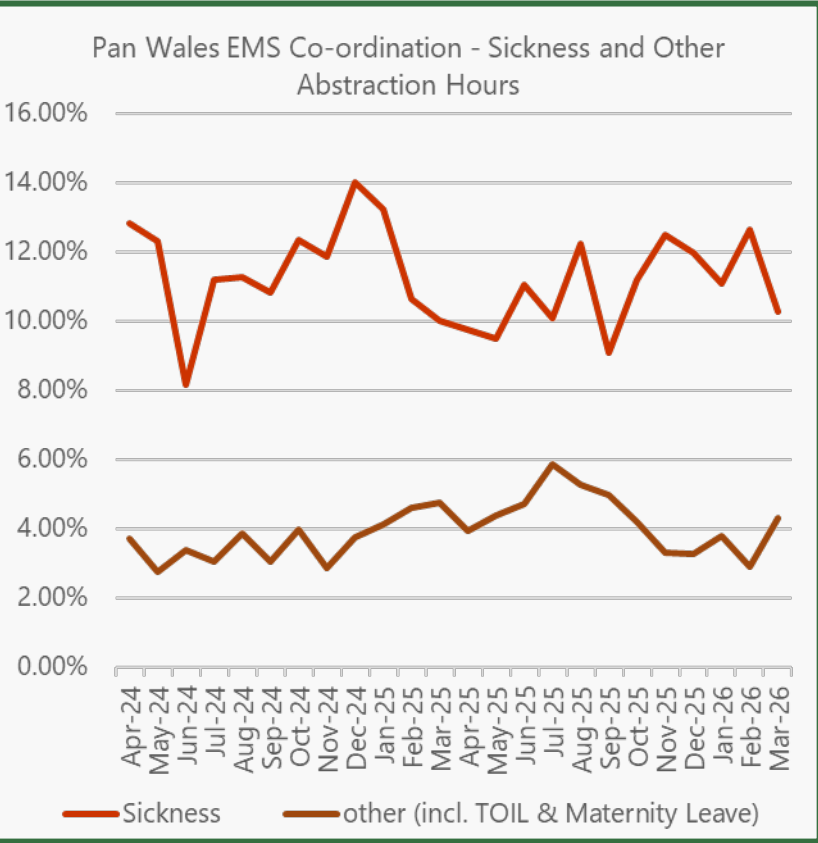
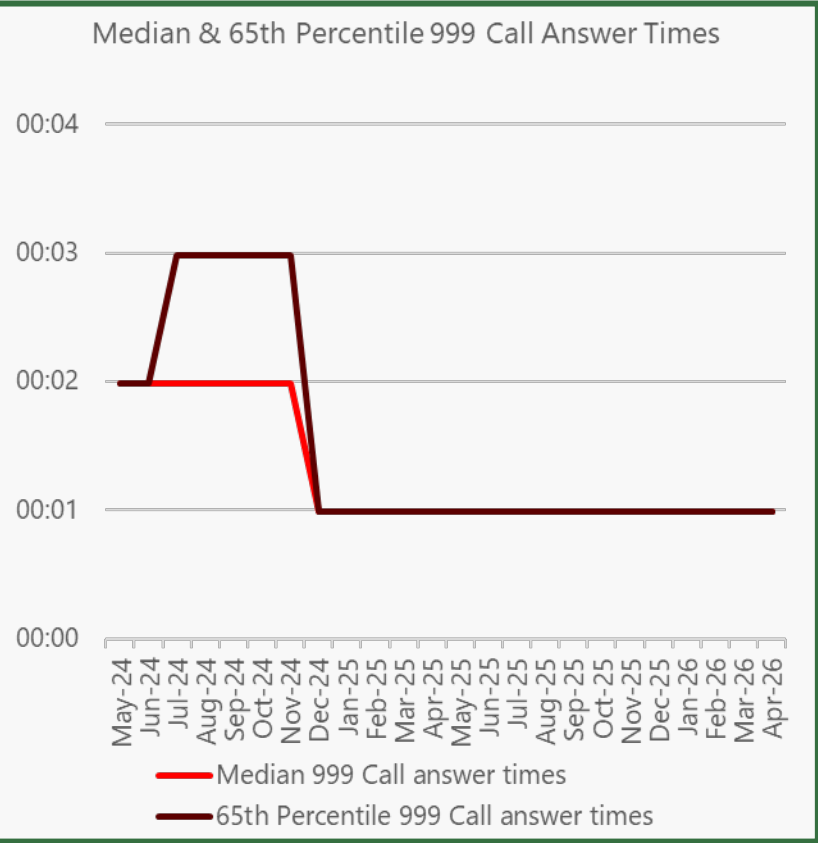
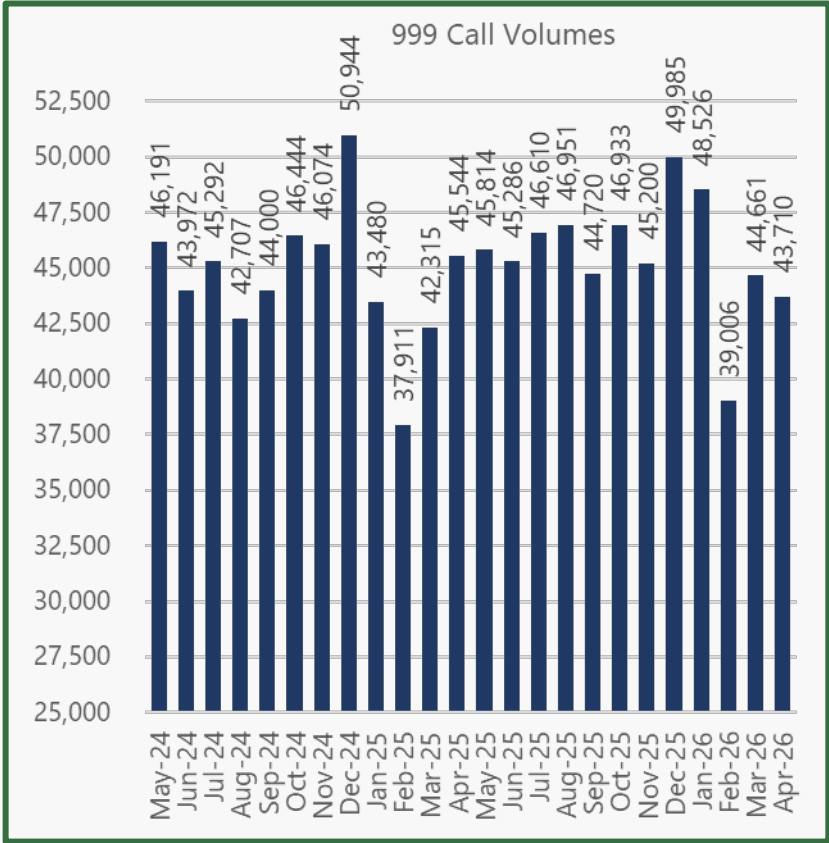
Call taker UHP for the month of March 2026 was at 87% and all EMSC sickness level saw an increase, from 9.99% in March 2025 to 10.29% in March 2026.

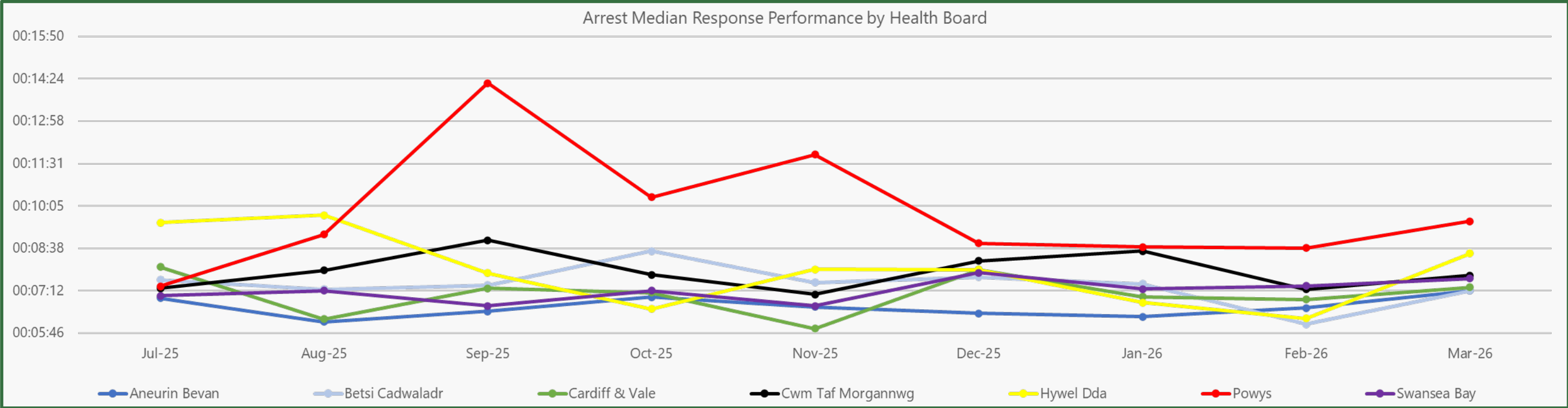
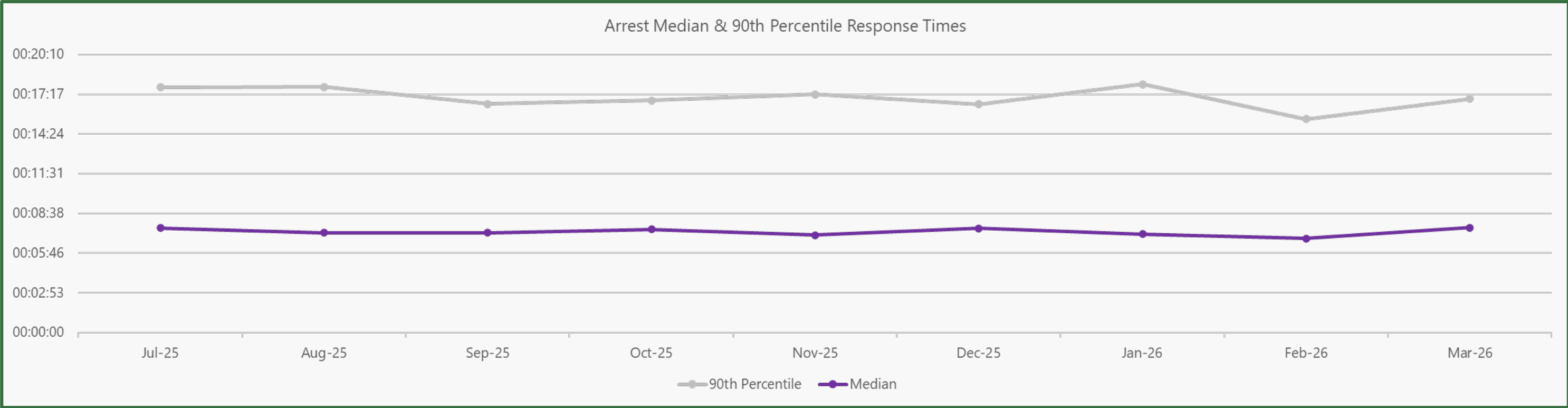
Remedial Plans and Actions

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

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

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



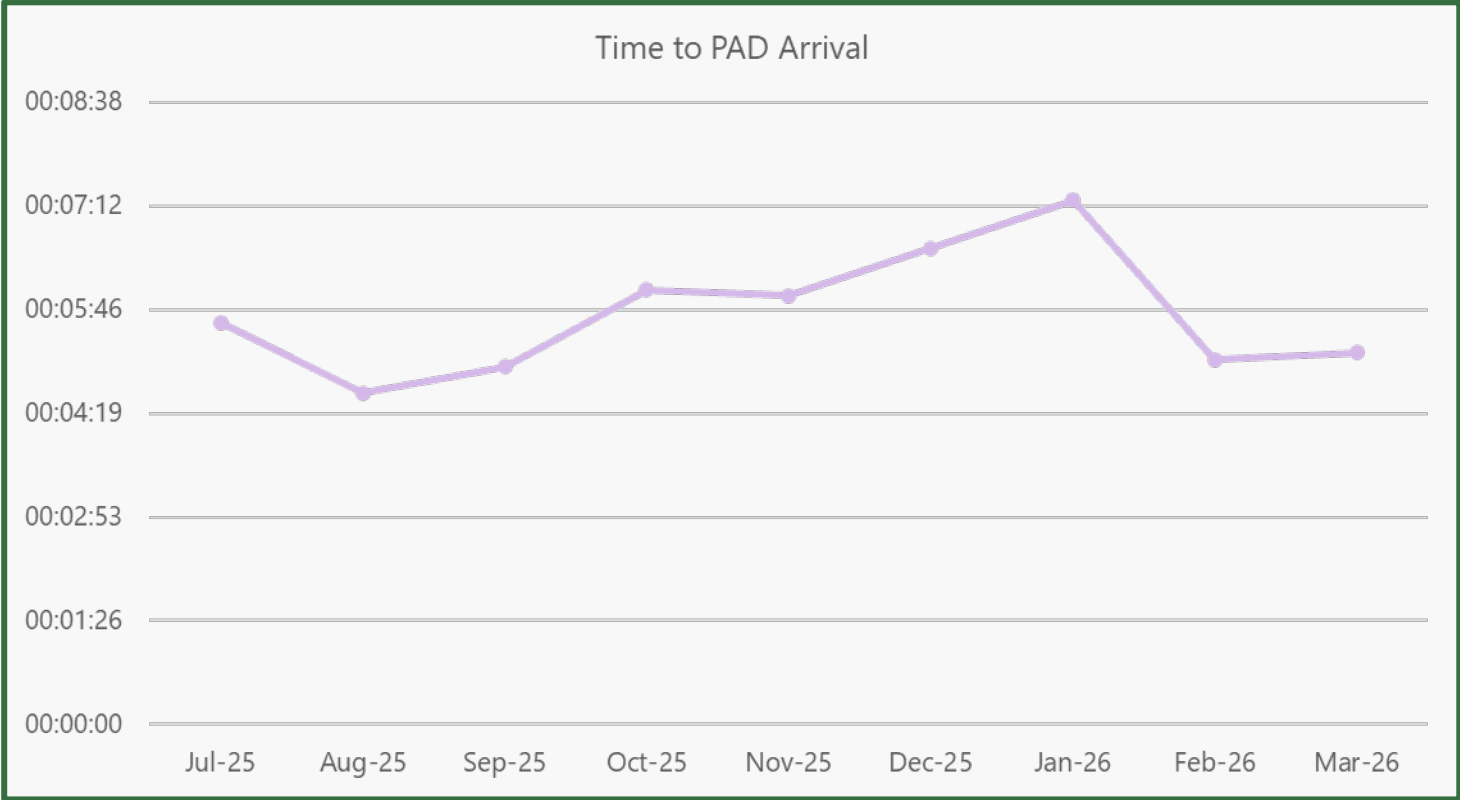
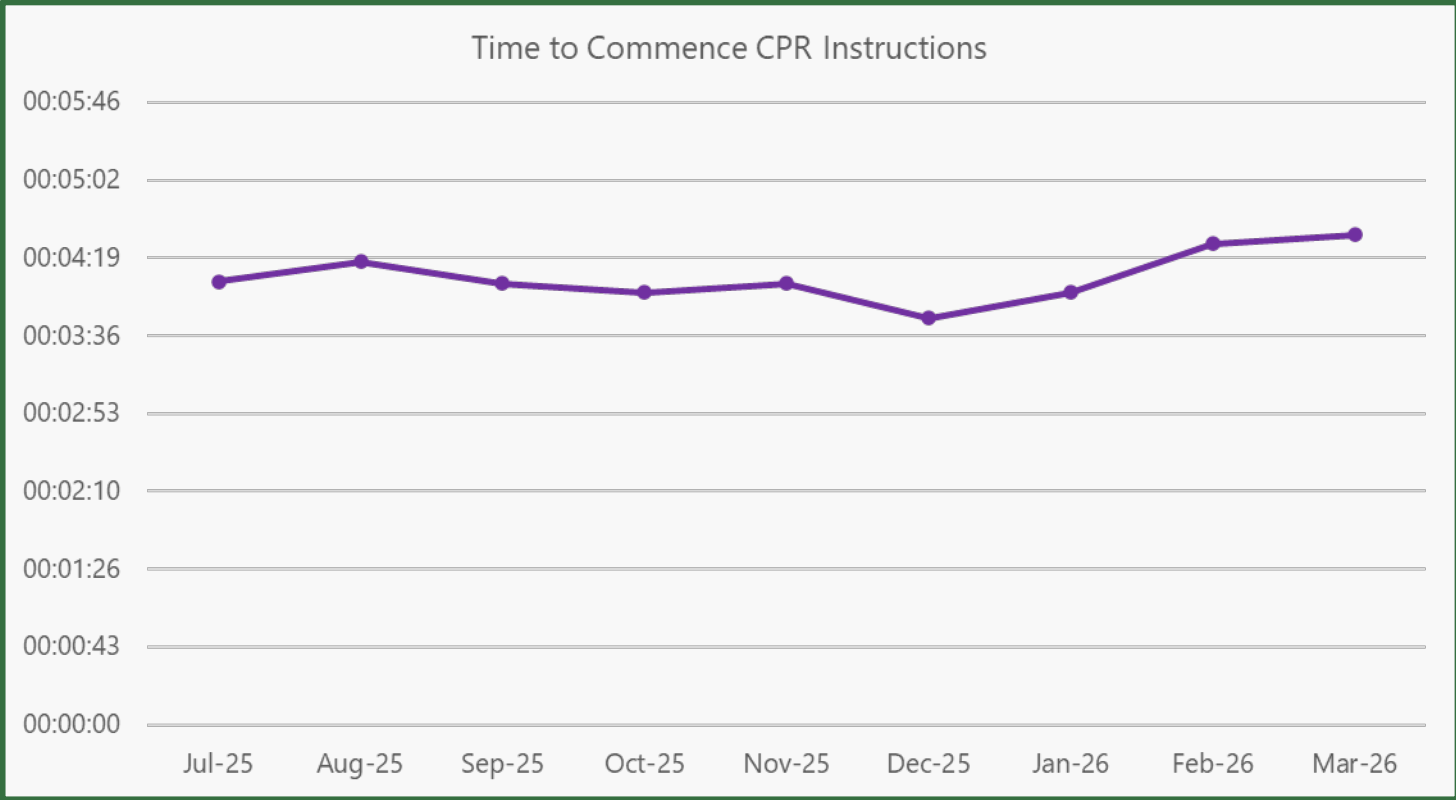
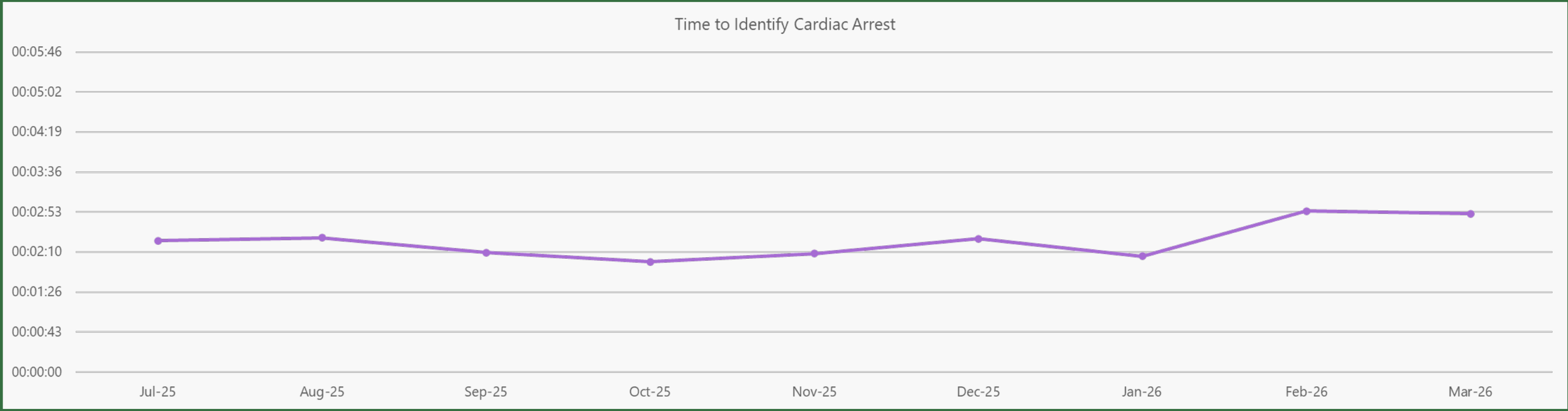
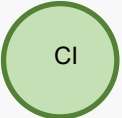


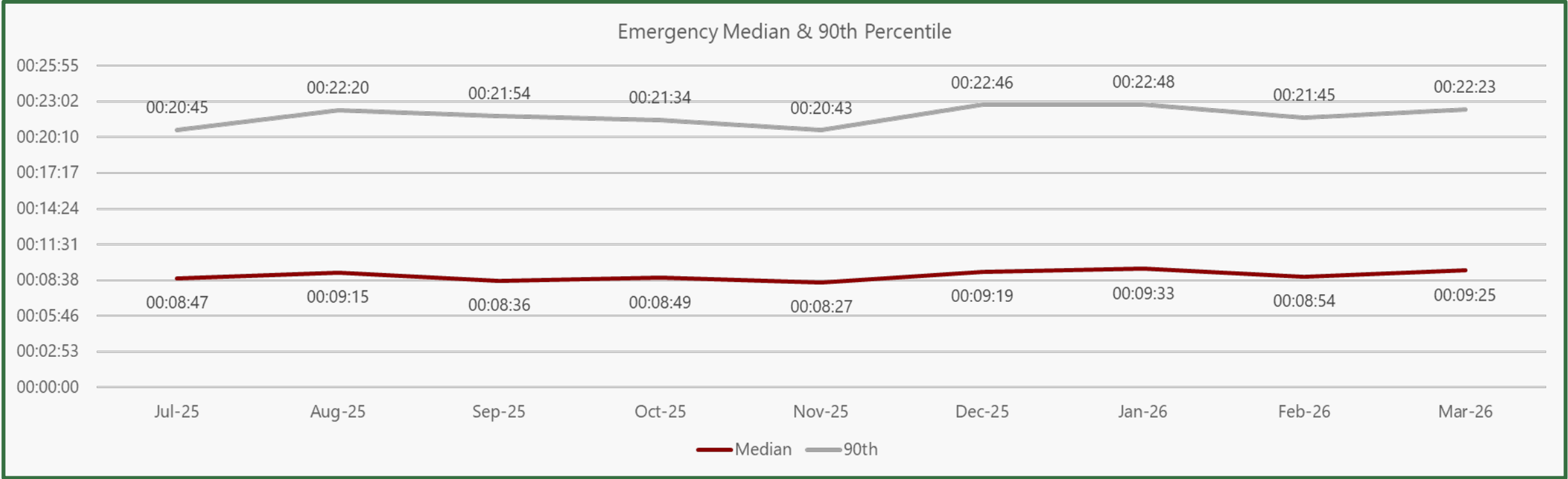
Our Patients: Quality, Safety & Patient Experience

Arrest Purple Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)





Analysis

In March 2026 there were 4,780 Emerg (Red) calls, around 13.55% of all calls.

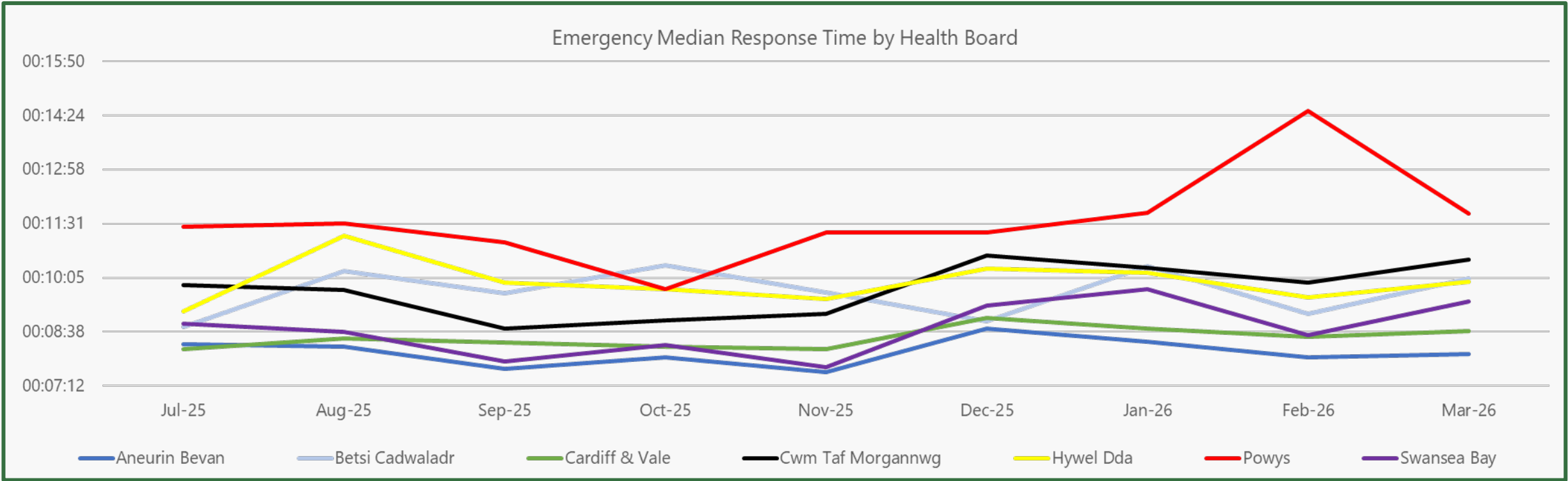
The median response time in March 2026 for Emerg incidents was 9 minutes 25 seconds. Aneurin Bevan health board had the lowest median time of 8 minutes and 2 seconds, and Powys had the highest at 11 minutes and 47 seconds.

For Emerg calls, the 90th percentile response time was 22 minutes 23 seconds. Aneurin Bevan had the lowest time of 17 minutes and 34 seconds, and Powys had the highest at 32 minutes and 45 seconds.

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

Remedial Plans & Actions

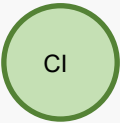
Arrest is performing better than the Trust modelled, but Emergency performance is worse than the Trust modelled. Operations SLT recently received a report that identified two issues: 1) the deflection rate from RCS0 to Integrated Care is not behaving in the way the Trust anticipated and 2) the impact of handover lost hours on the Trusts’ capacity to respond. For 1) the Trust is reviewing whether some Emerg incidents in the RCS0 cohort should go straight to dispatch, therefore reducing the RCS0 demand, comparing old Red volumes with new Arrest/Emerg and consideration of whether further Clinical Navigator capacity is required to reduce the number of time outs. For 2) W45 is key.



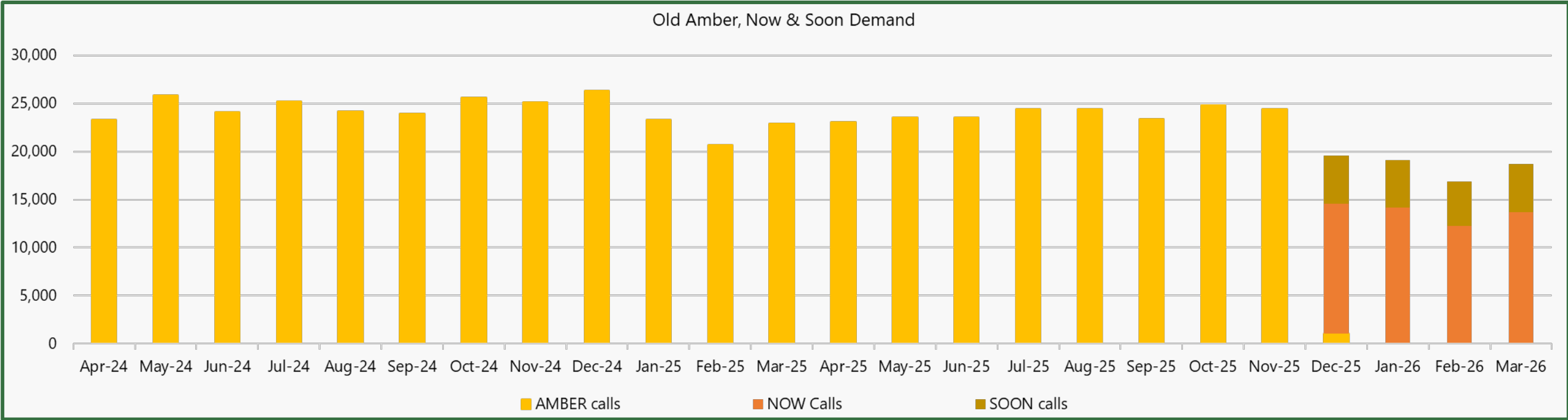
Our Patients: Quality, Safety & Patient Experience

Amber Performance Indicators

(Responsible Officer: Lee Brooks)



Influencing Factors – Demand, Hours Produced and Hours Lost



Analysis

In December 2025 the existing Amber category, was replaced by Orange (now) and Yellow (soon). However, some calls were recorded as the old Amber category.

The median response time in March 2026 for Now incidents was 1 hour 23 minutes 53 seconds. Powys health board had the lowest median time of 55 minutes and 11 seconds, and Swansea Bay had the highest at 2 hours 29 minutes and 24 seconds.

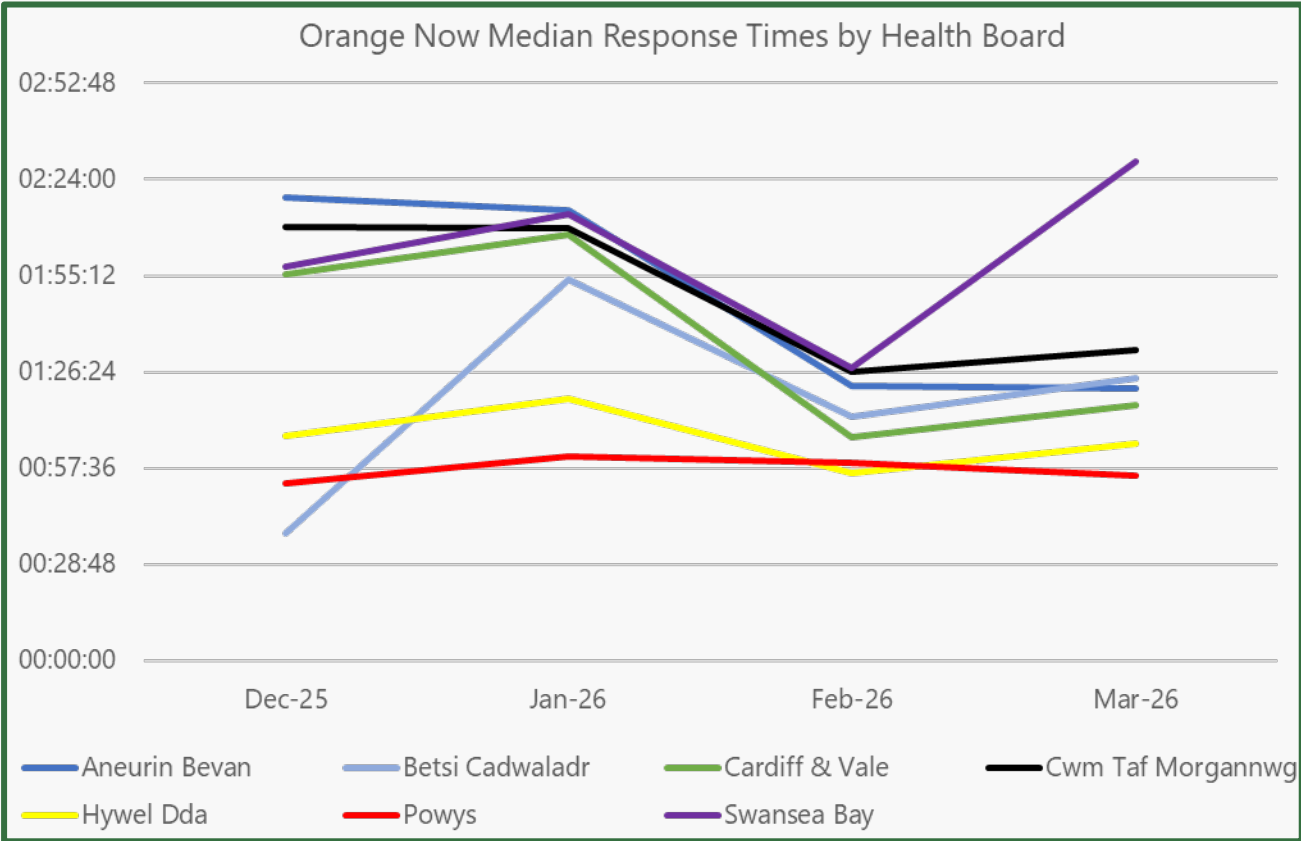
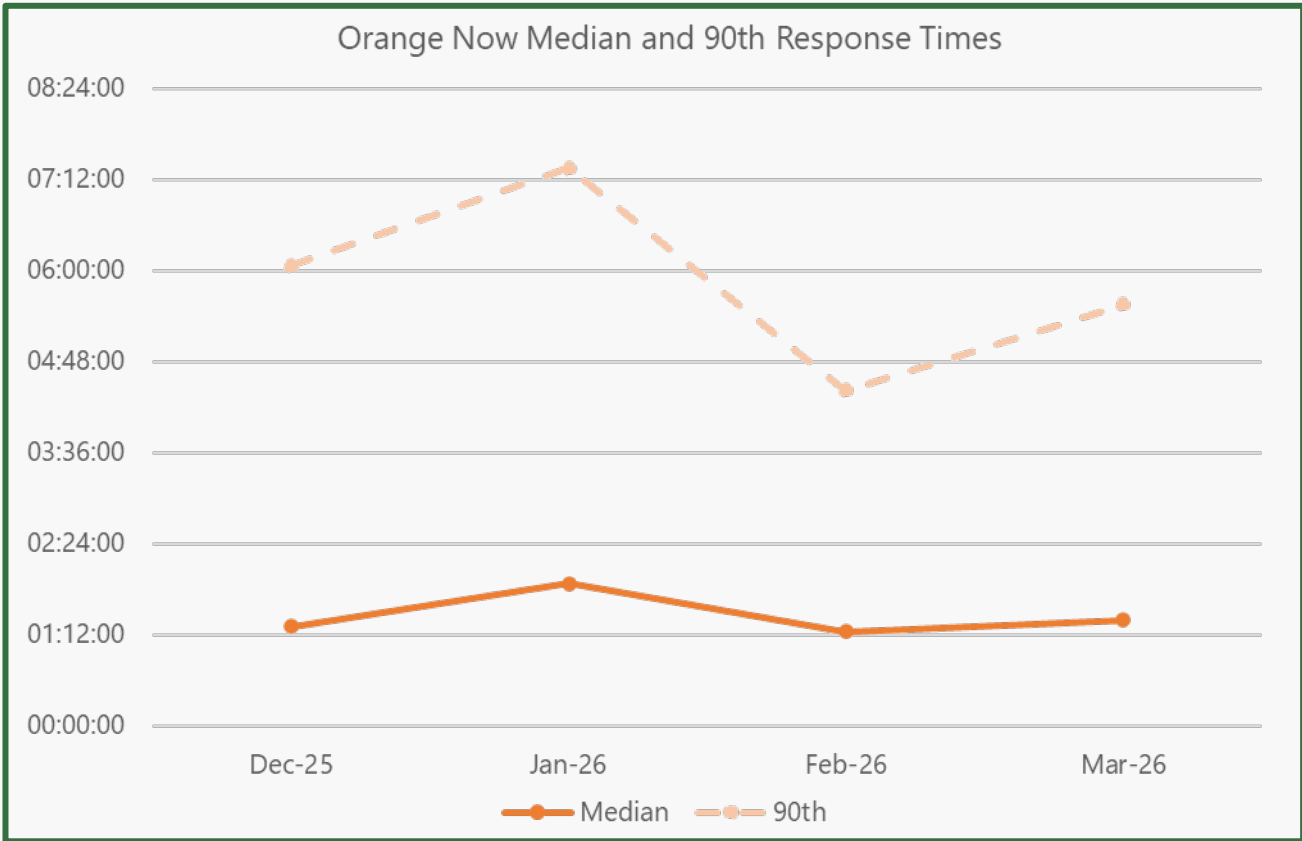
For Now calls, the 90th percentile response time was 5 hours 33 minutes 19 seconds. Powys had the lowest time of 3 hours 49 minutes and 53 seconds, and Swansea Bay had the highest at 8 hours 21 minutes and 28 seconds.

Remedial Plans and Actions

Monitoring of phase 2 will continue via Now and Soon categories.

Expected Performance Trajectory

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



Our Patients: Quality, Safety & Patient Experience

Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

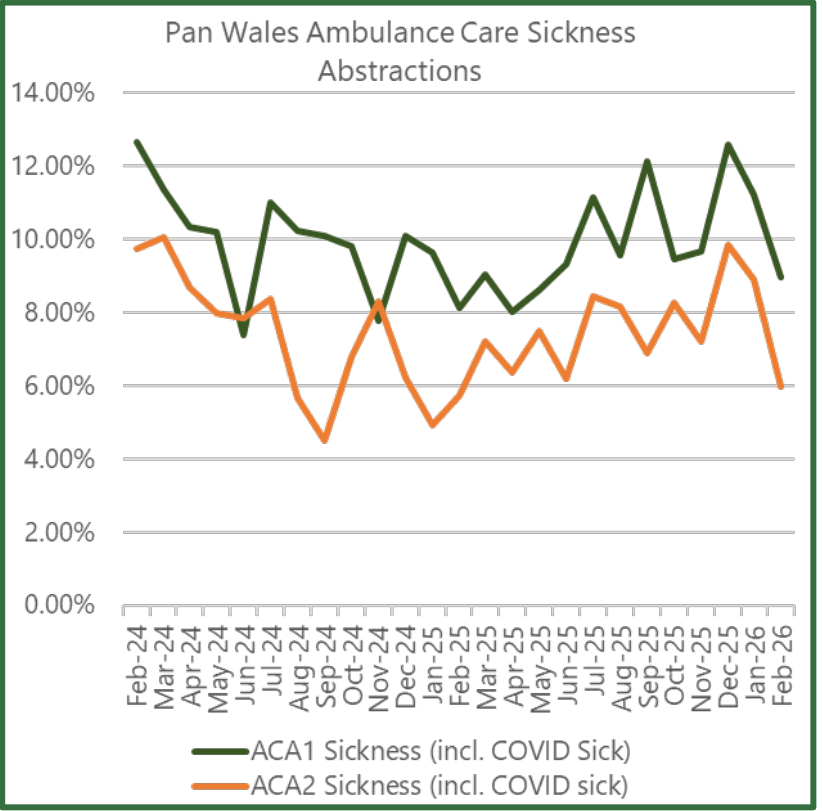
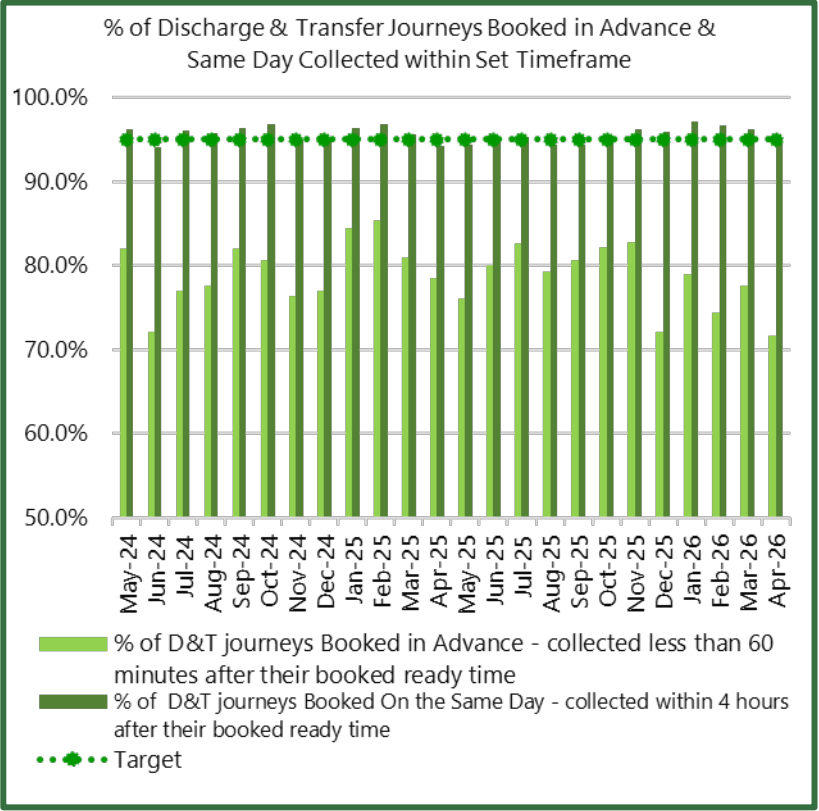
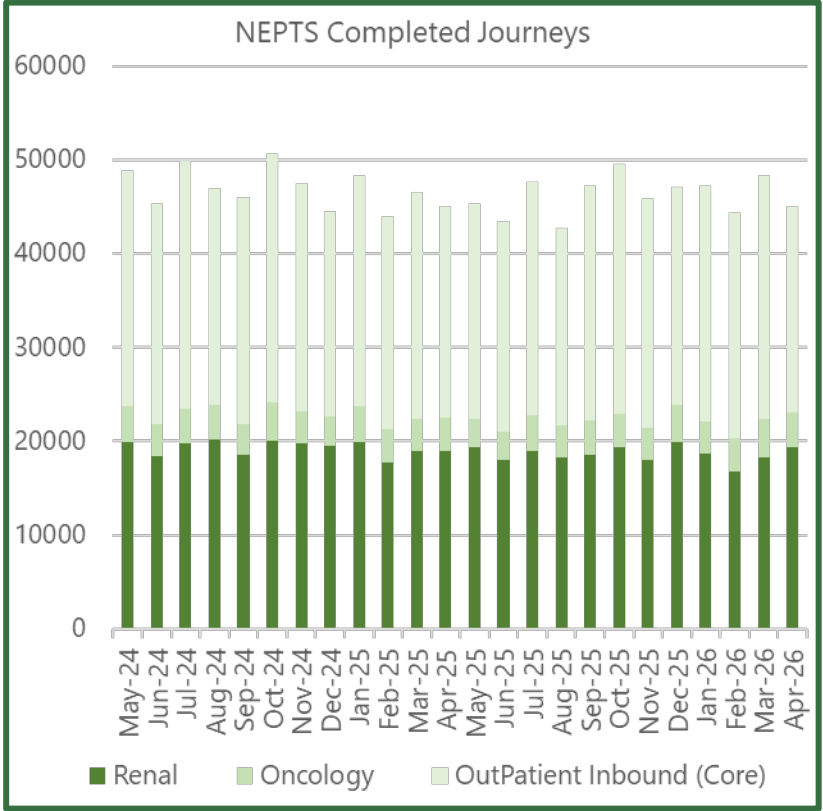
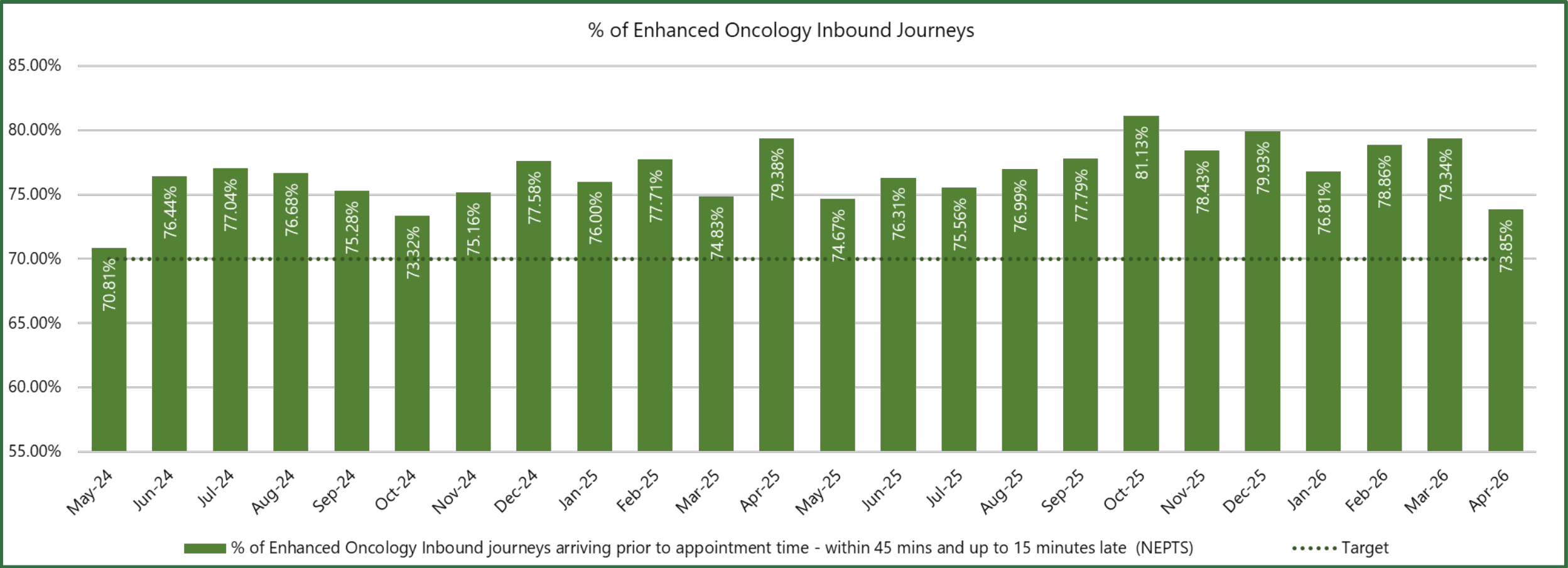
D&T

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Oncology

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CI



Analysis

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment decreased in April 2026 to 71.6% and remain below the 95% target. Discharge and Transfer journeys booked on the same day achieved 95% in April 2026, achieving the target (95%).

Renal journeys arriving within 30 minutes prior to their appointment time decreased from 77.08% in March 2026 to 74.09% in April 2026 and continued to achieve the agreed performance standard of 70%.

Call volumes answered minimally decreased to 20,327 calls during April 2026, from 21,079 in March 2026; and the average speed of call answering increased from 42 seconds to 4 minutes and 7 seconds.

In February 2026, ACA1 sickness remained above the 5.99% target, at 8.96% and ACA2 sickness also remains minimally above the 5.99% target at 6%.

Remedial Plans and Actions

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

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

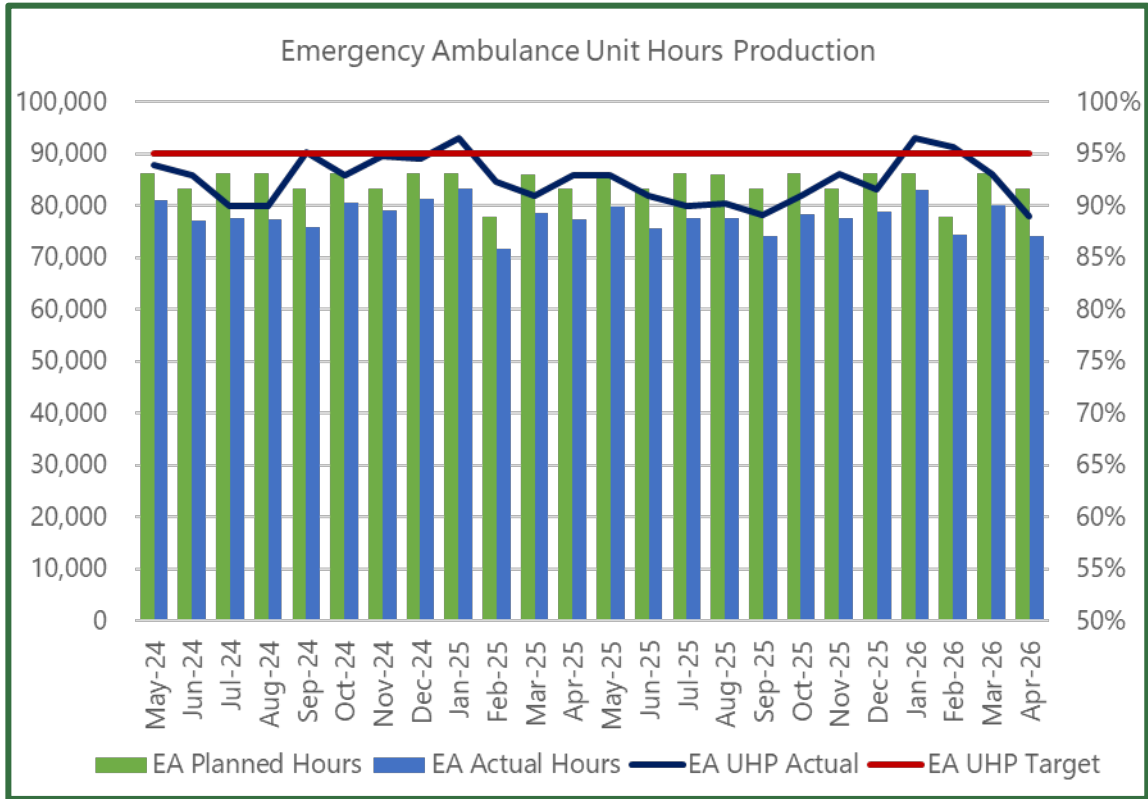
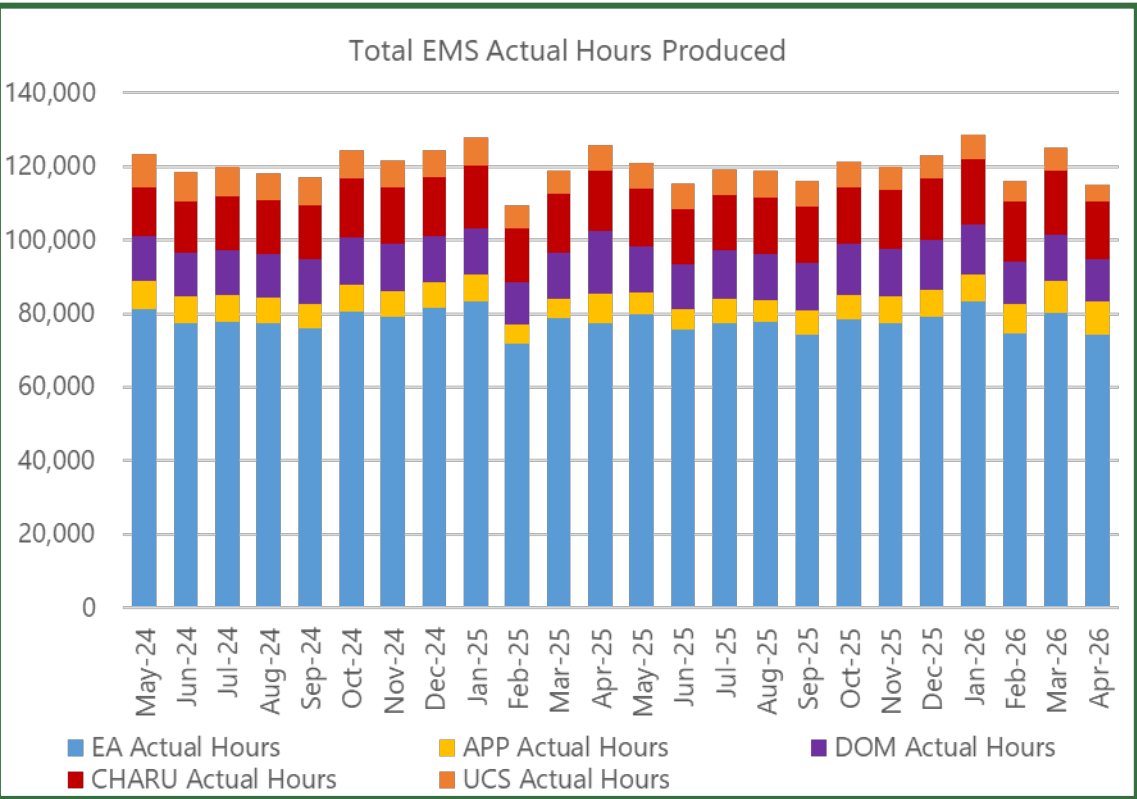
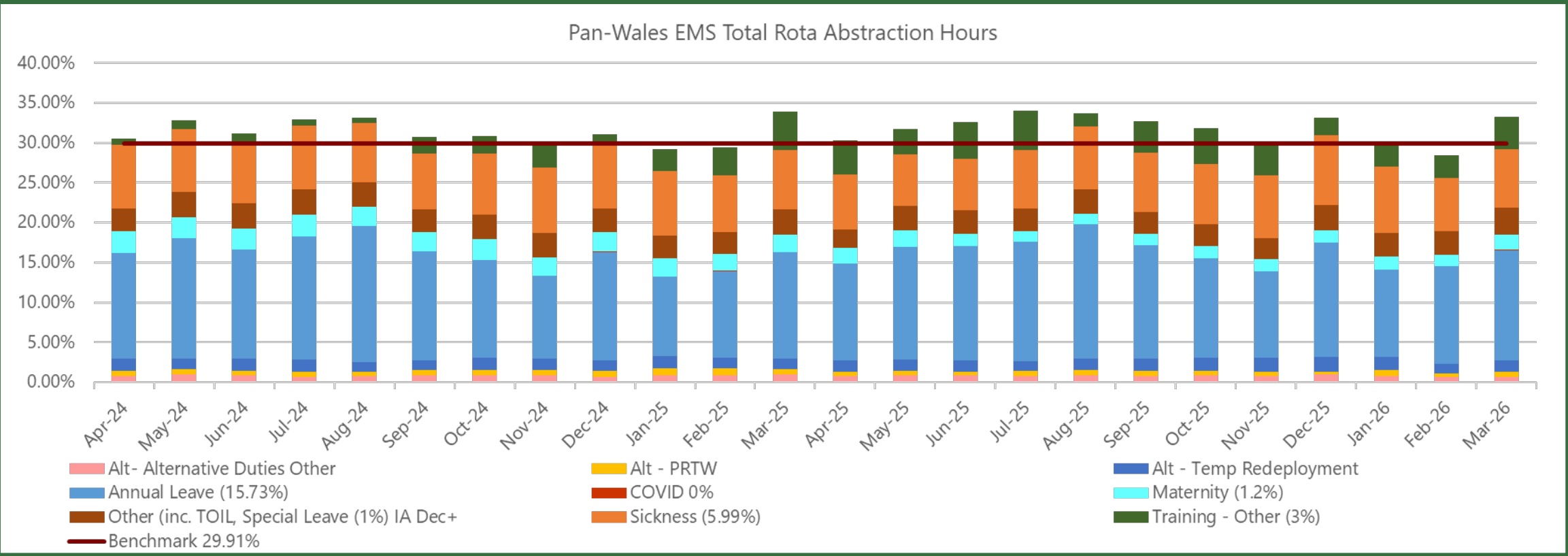
Expected Performance Trajectory

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

Our People

Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)



Analysis

Monthly abstractions from the rosters are key to managing the number of hours the Trust produces, as are the total number of staff in post. March 2026, saw total EMS abstractions (excluding Induction Training) of 33.25%. This was a minimal decrease on the 33.86% recorded in March 2025 and remains above the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 13.83% followed by sickness at 7.25%.

The total EMS hours produced is a key metric for patient safety. The Trust produced 115,155 hours during April; a decrease compared to the 124,935 hours produced during March 2025.

Emergency Ambulance Unit Hours Production (UHP) achieved 89% in April which equated to 74,227 Actual Hours.

In April 2026 CHARU UHP was 88% against the full roll out requirement.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Our People

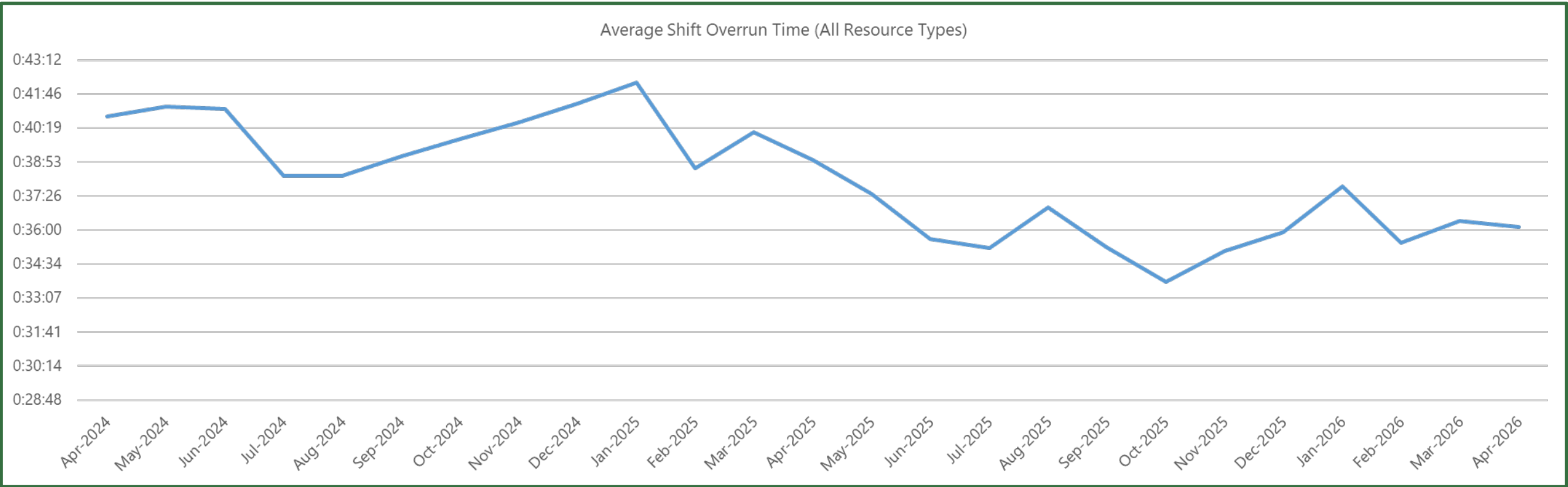
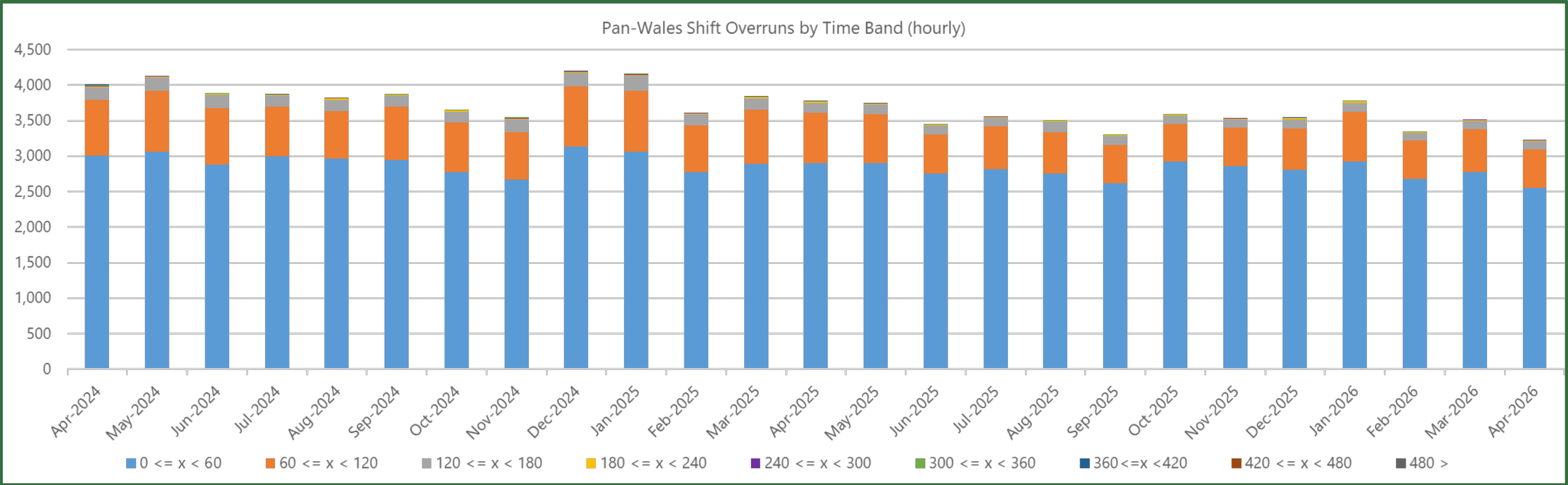
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns

R

CI



Analysis

There were 3,222 shift overruns during April 2026. The trend continues to be downward over the past two years.

The average overrun figure for April 2026 was 36 minutes and 7 seconds, a slight decrease from March 2026 (36 minutes 22 seconds). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 79.4% of the total. 16.6% fall within the 61 to 120-minute category, 3.5% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.1% in the 241 minutes and over category.

Remedial Plans and Actions

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

Collaborative work is ongoing with our Trade Union Partners via the Dispatch Framework Steering Group to find and test innovative ways to reduce overruns for our people; however, it must be noted that there is a limit to what the Trust can do to mitigate the impact of handover lost hours. The application of W45 remains the key solution.

Expected Performance Trajectory

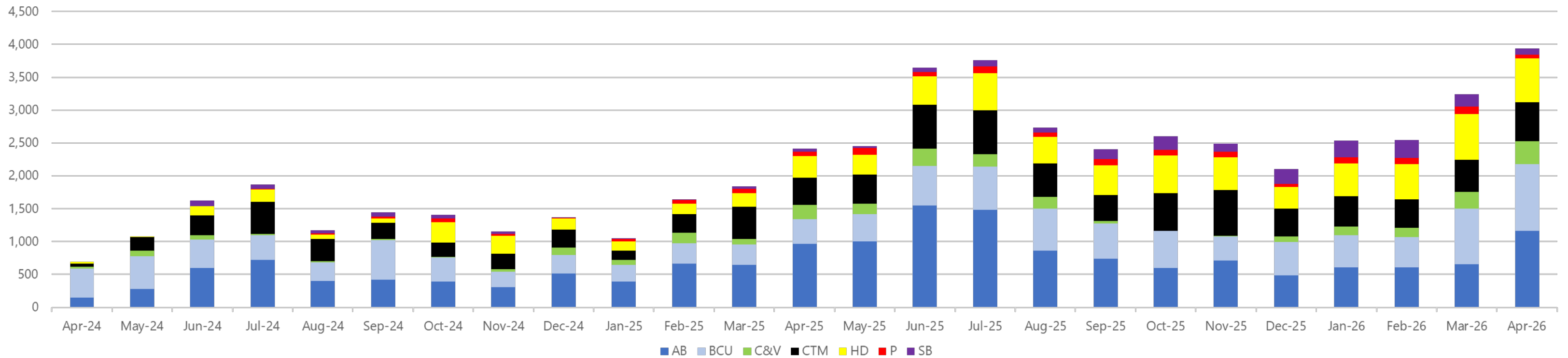
Overruns correlate with handover lost hours and may begin to decrease as handover times continue to reduce.

Finance, Resources and Value

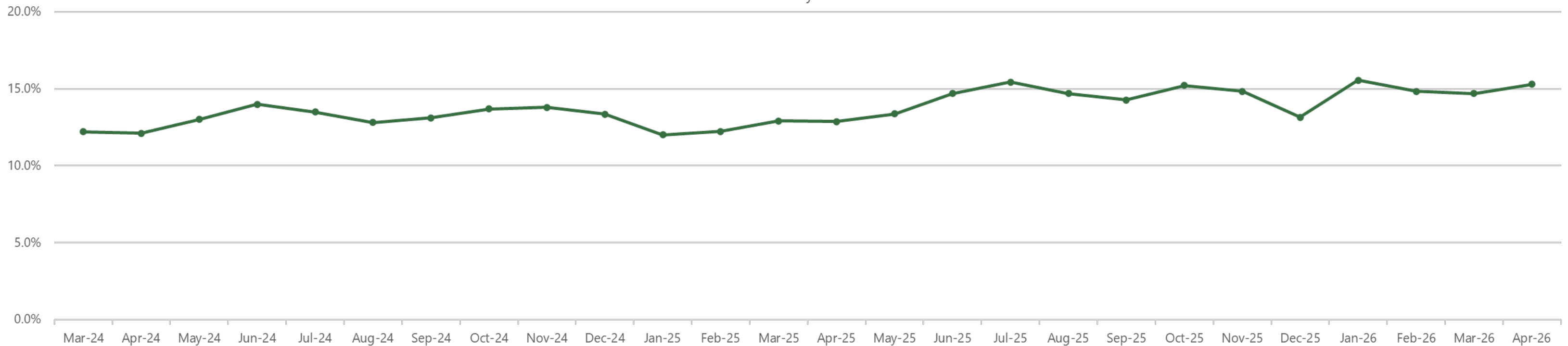
Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Capacity Management Plan - No Resource At Planning by Health Board



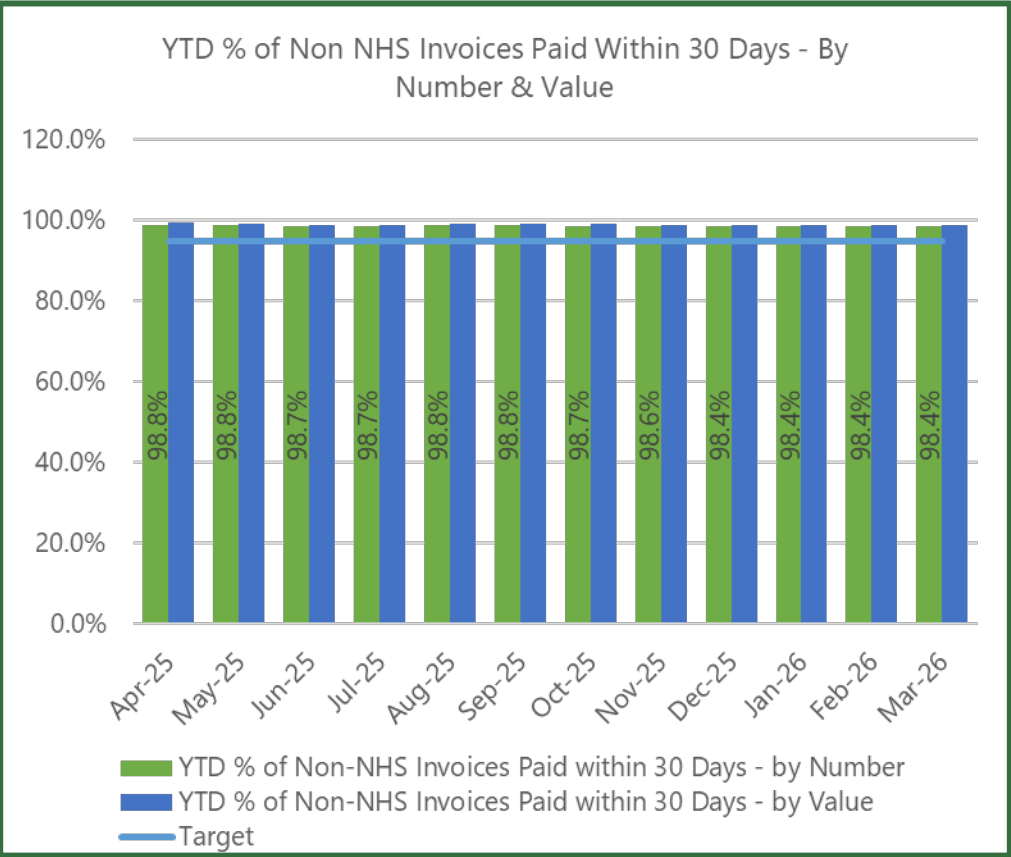
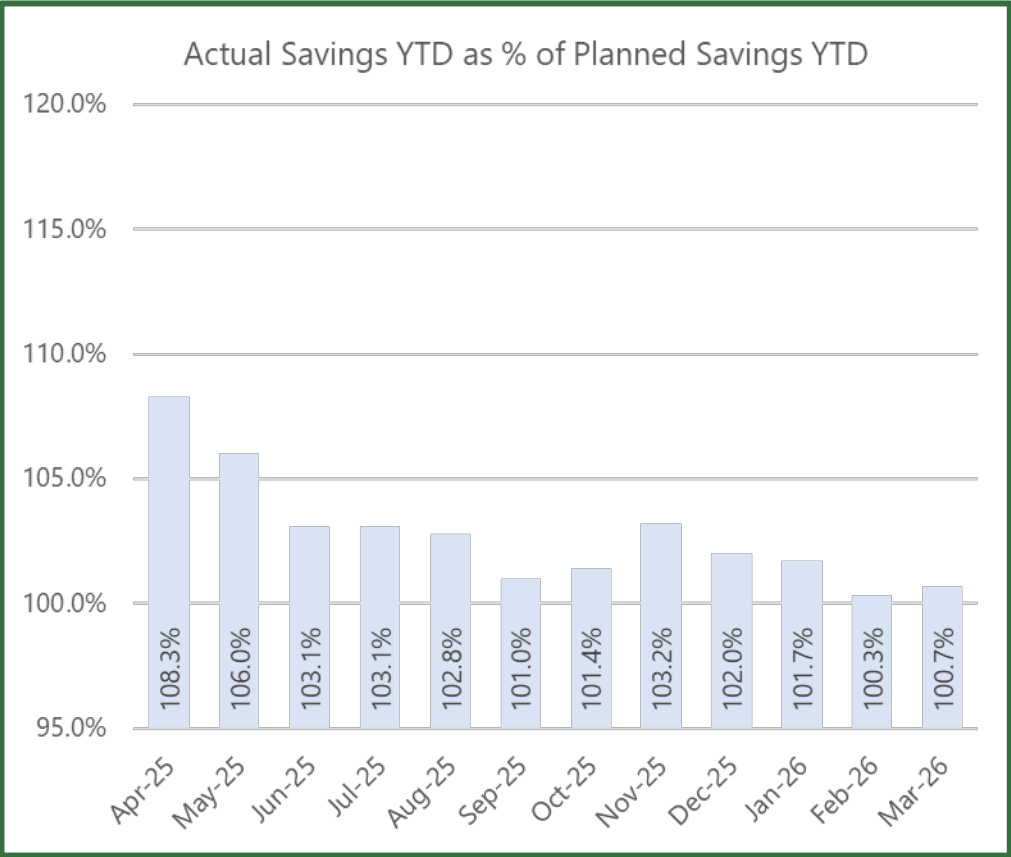
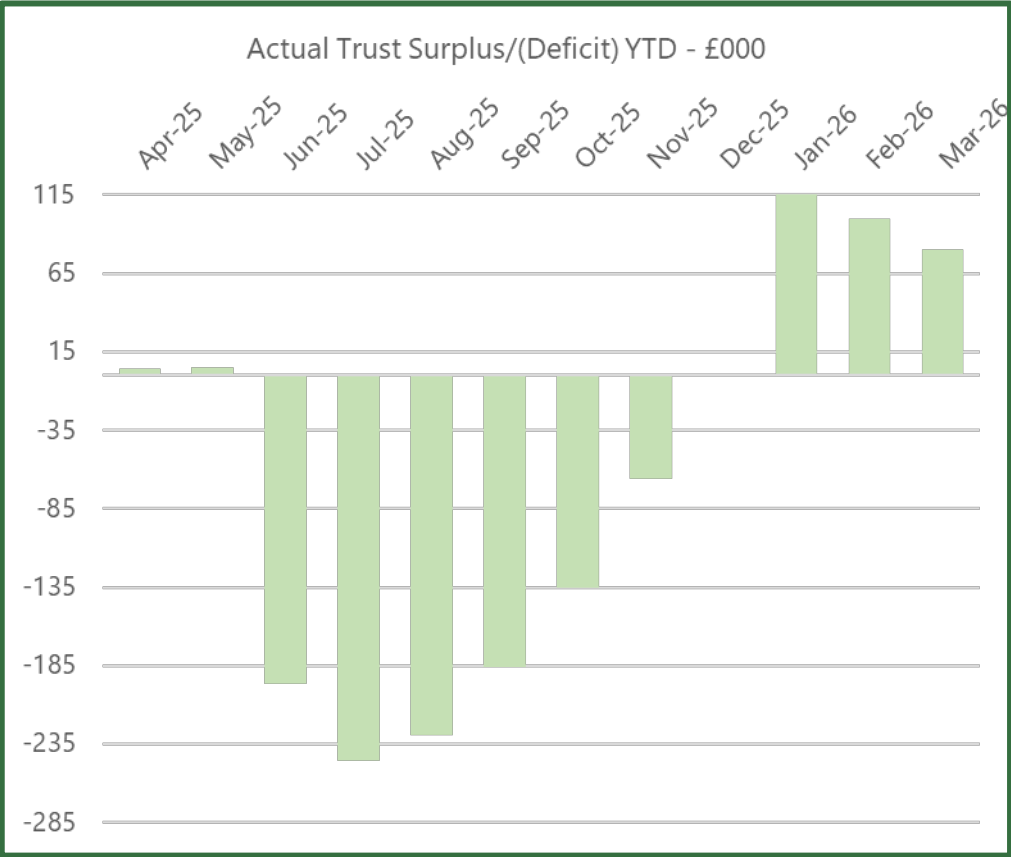
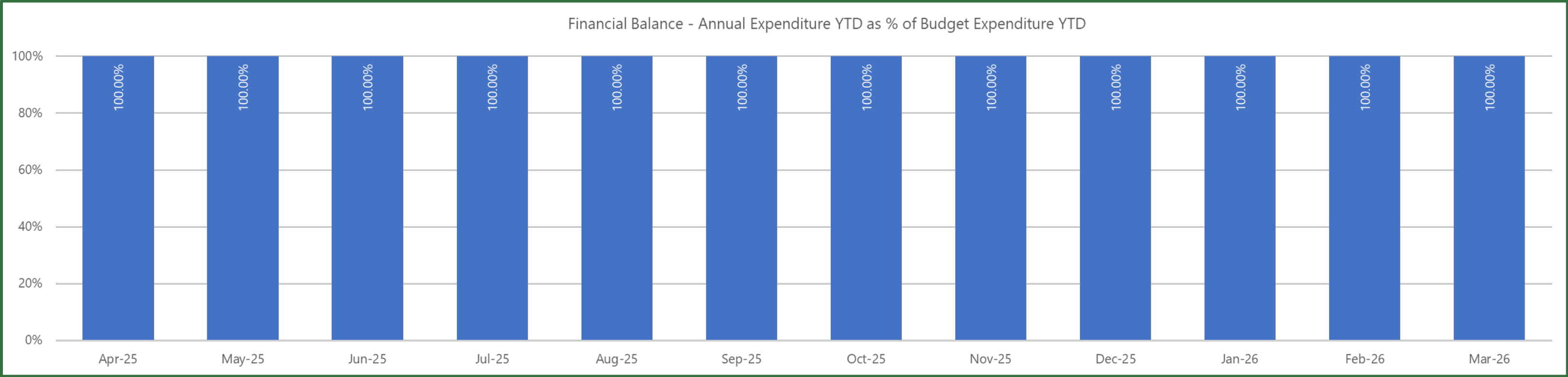
Volume of on the Day Cancellations



Finance, Resources and Value

Value - Finance Indicators

(Responsible Officer: Chris Turley)



Finance, Resources and Value

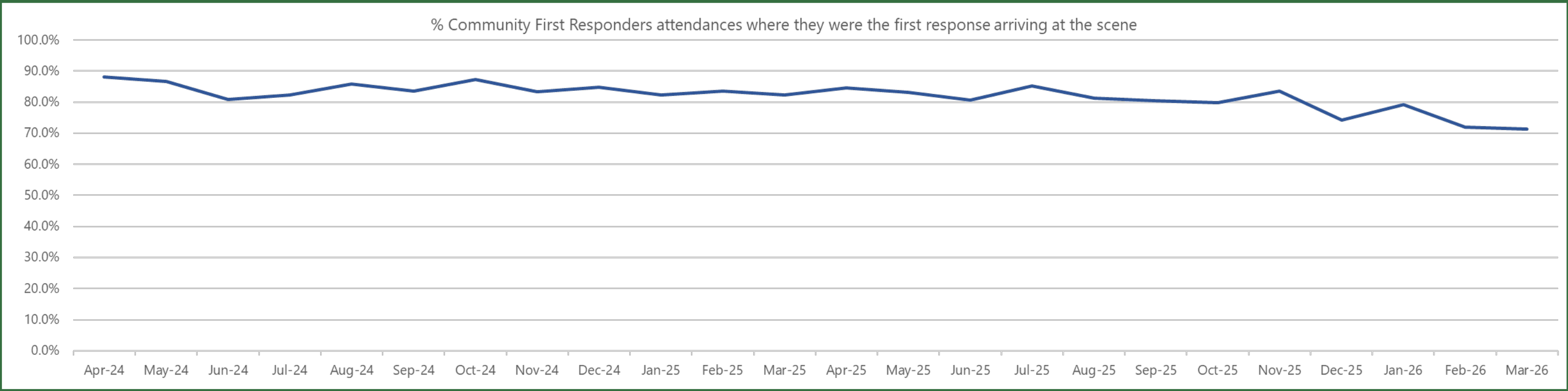
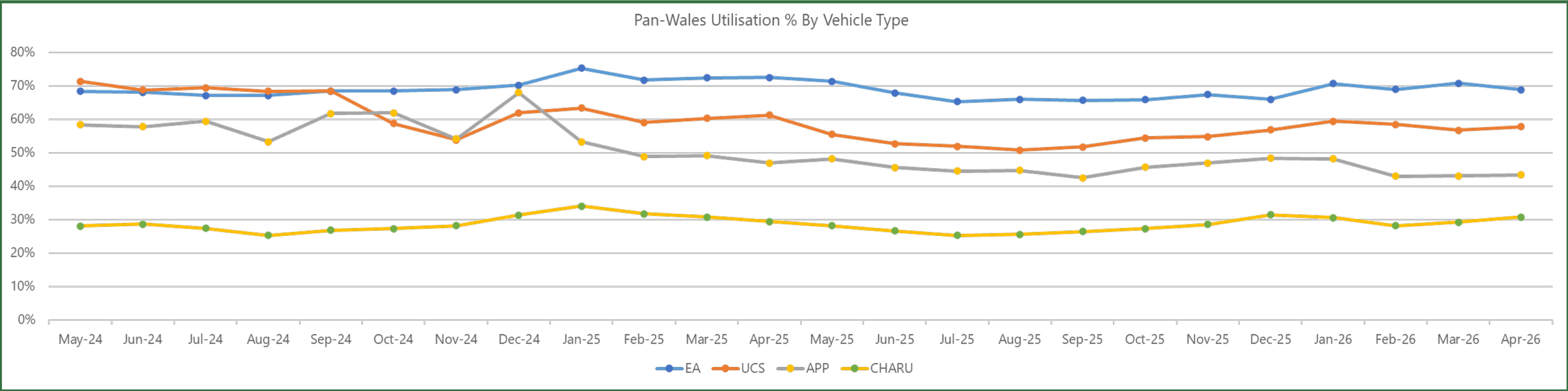
EMS Utilisation

(Responsible Officer: Lee Brooks)

CHARU
Utilisation

G

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

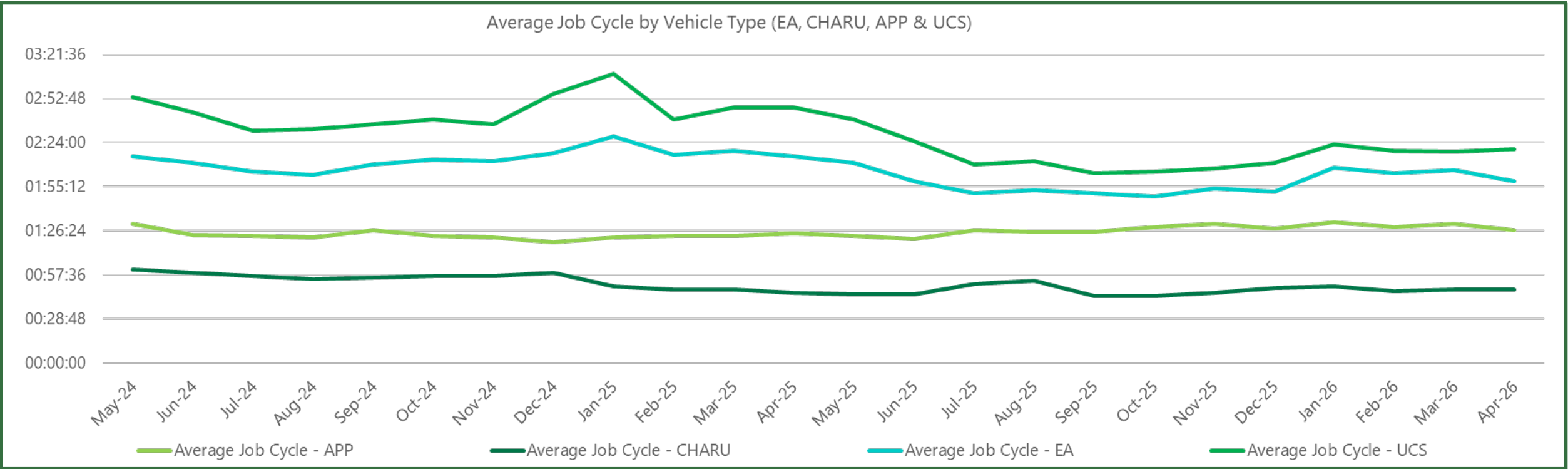
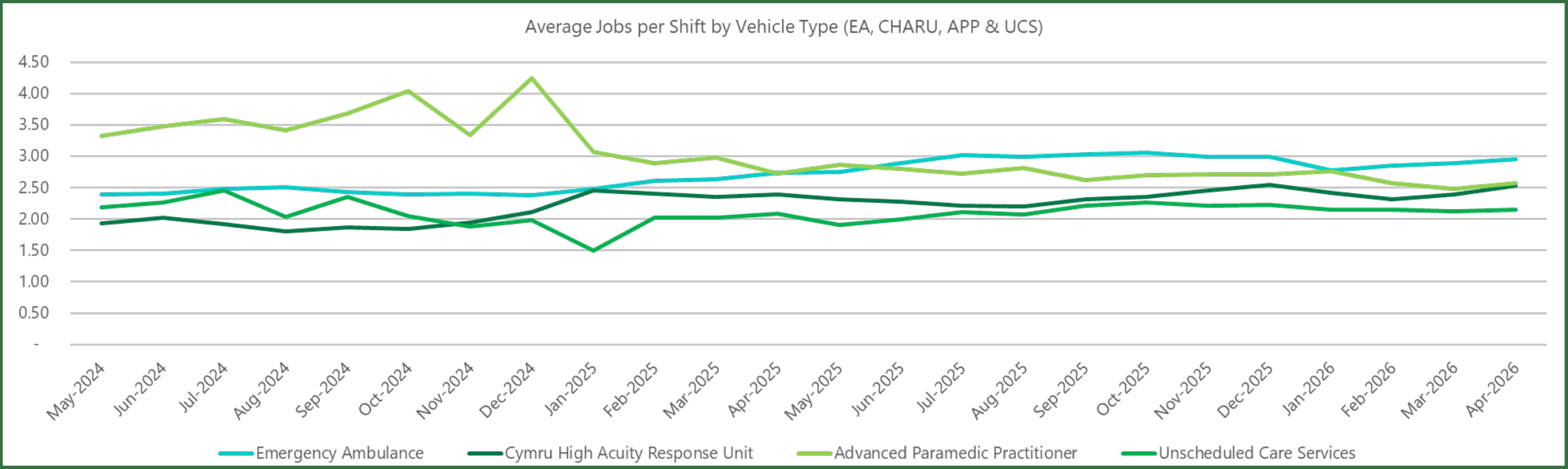


Finance, Resources and Value

Average Job/Shift Times

(Responsible Officer: Lee Brooks)

Jobs Per Shift
A



Analysis

Overall average jobs per shift was 2.83 in April 2026, a minimal increase from March 2026 (2.75). EAs averaged 2.96 jobs per shift and UCS crews 2.15. The D&C review conducted by ORH indicated that 2.3 jobs per shift was the optimum level for EAs if at full establishment and if handover was reduced to target levels and full transformation by the Trust.

APPs attended on average 2.57 jobs per shift and CHARU's 2.54. We would expect CHARUs to be low, as they need to be free to respond very quickly, but it is not clear why APPs are so low.

As demonstrated in the bottom graph, the average job cycle minimally increased in April for UCS (2 hours and 20 minutes). APPs (1 hour 29 minutes) and EAs (1 hours 59 minutes) minimally decreased and CHARU remained constant with March 2026 at 48 minutes.

Remedial Plans and Actions

There are two key actions underway for APPs a) scheduling (that is responding to the code set they are designed to focus on), and the APP re-roster, which is due to take place in Q4 last year and into Q1 + Q2 this year.

Expected Performance Trajectory

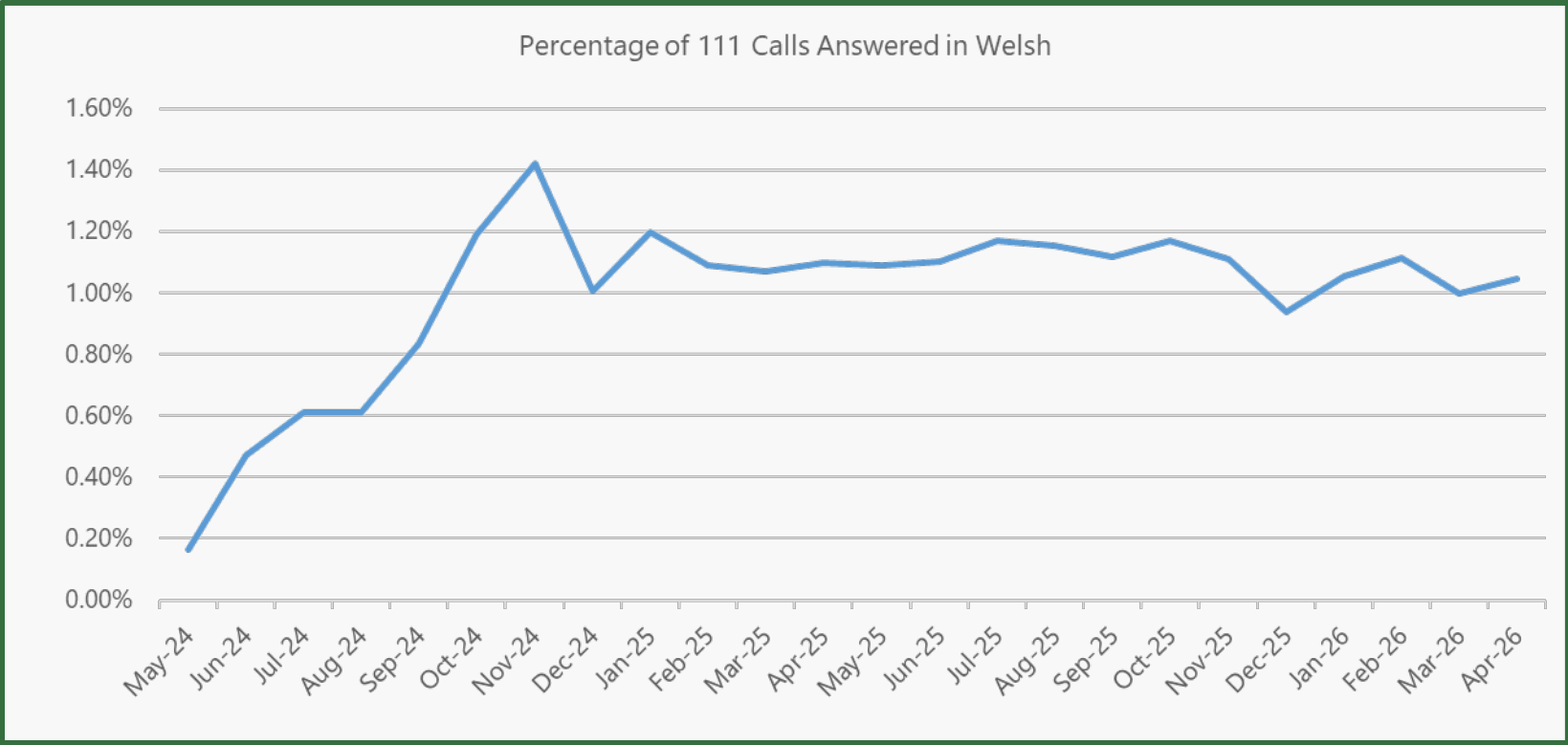
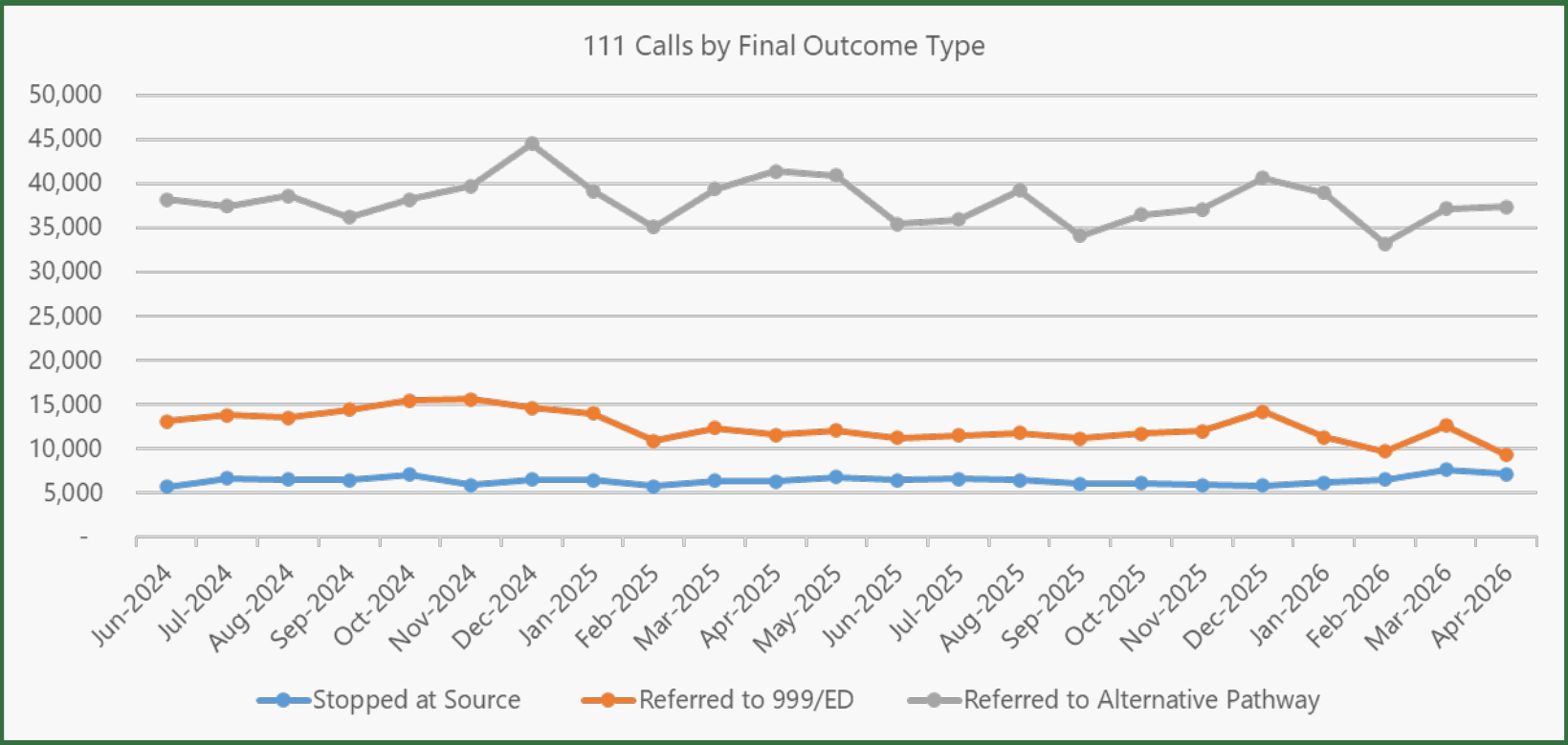
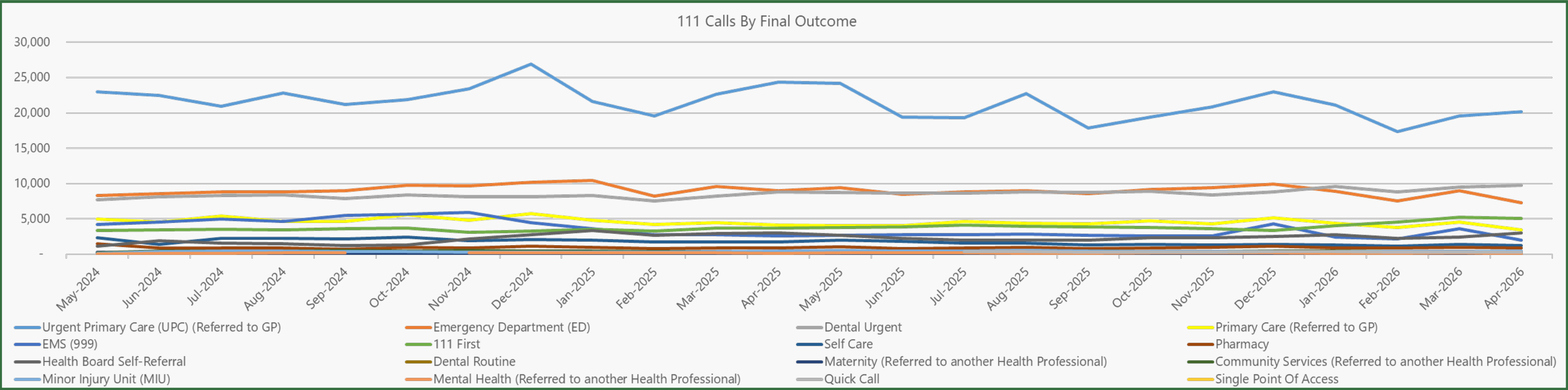
EA job per shift is already better than benchmark and CHARUs should be low so they are free to respond. The area of focus is for APPs. Currently, the Trust has modelled a level of increased utilisation, via the re-roster work. This has been converted into jobs per shift and will be included as a trajectory in the Trust Board MIQPR.

Partnerships / System Contribution

NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

Influencing Factors – Demand and Clinical Hours Produced

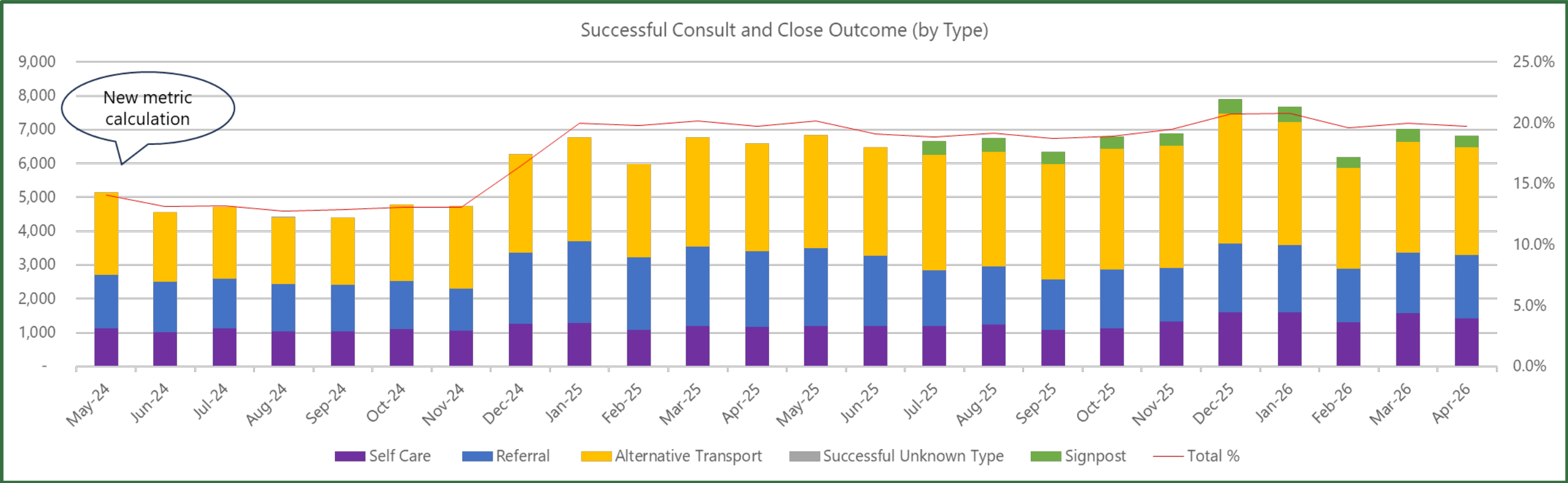
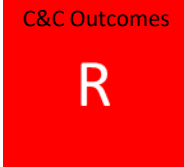
(Responsible Officer: Lee Brooks)



Partnerships / System Contribution

Consult & Close Indicators

(Responsible Officer: Lee Brooks)



Analysis

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

Contributions from Clinical Service Desk (CSD) (8.92%), NHS111 (6.36%), WAST APP (0.92%), Health Boards using Physician Triage and Streaming Service (PTAS) (0.12%), Mental Health Clinician (0.54%), Screening (0.06%), Rapid Assessment (2.16%) and 999 Single Point of Access (SPOA) (0.06%) achieved 19.7% in April 2026, a minimal decrease compared to March 2025 (20%), not achieving the 22% target. In April 2026, the number of 999 calls resulting in a Consult and Close outcome was 5,820, down from 7,010 in March 2026.

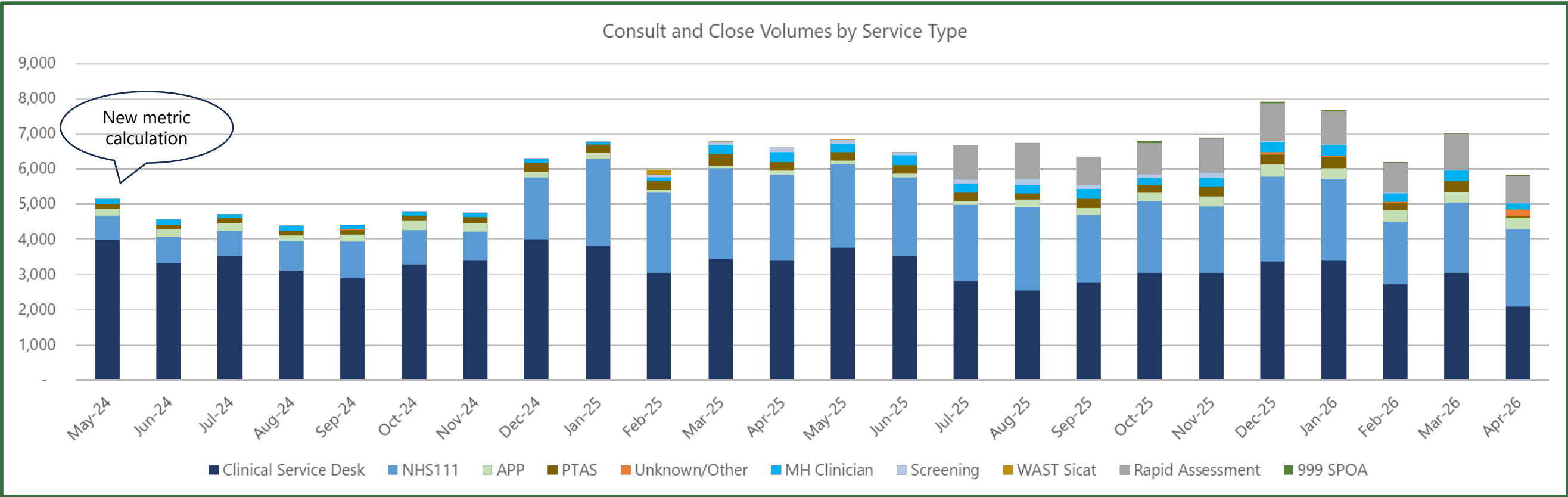
Of the calls successfully closed in April 2026, 1,429 patients received an outcome of self-care; 1,869 patients were referred to other services (including to Minor Injury Units and SDEC), 3,182 were advised to seek alternative transport services to acquire treatment and 336 were signposted.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support.
- Implementation of 15 recommendations from commissioner review.

Expected Performance Trajectory

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



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 / PCR's	Patient Care Record(s)	UHP	Unit Hours Production
CI	Clinical Indicator	ePCR	Electronic Patient Care Record	LTS	Long Term Strategy	JRCALC	Joint Royal Colleges Ambulances Liaison Committee	U/A RTB	Unavailable – return to Base
CHARU	Cymru High Acuity Response Unit	FTE	Full Time Equivalent	MACA	Military Aid to the Civil Authority	PECI	Patient Engagement & community Involvement	VPH	Vantage Point House (Cwmbran)
COOs	Chief Operating Officers	GDPR	General Data Protection Regulations	MIU	Minor Injury Unit	POD	Patient Offload department	WAST	Welsh Ambulance Services University NHS Trust
COPD	Chronic Obstructive Pulmonary Disease	GPOOH	General Practitioner Out of Hours	MPDS	Medical Priority Dispatch System	PPLH	Post Production Lost Hours	WG	Welsh Government
COVID-19	Corona Virus Disease (2019)	GTN	Glyceryl Trinitrate	NCCU	National Collaborative Commissioning Unit	PSPP	Public Sector Purchase Programme	WIIN	WAST Improvement & Innovation Network
CMT	Clinical Model Transformation	HB	Health Board	NEPTS	Non-Emergency Patient Transport Services	QPSE	Quality, Patient Safety & Experience		
CSD	Clinical Service Desk	HCP	Health Care Professional	NEWS	National Early Warning Score	RCS	Rapid Clinical Screening		
CSP	Clinical Safety Plan	HD / HDHB	Hywel Dda / Hywel Dda Health Board	NHS	National Health Service	RICS	Remote Integrated Care Service		

Definition of Indicators

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



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Agenda Item No.

12

REPORT TITLE

Digital Reporting

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, Director of Digital Services
Author(s) of report	Dr Leanne Smith, Deputy Director of Digital and Kimberly Abraham, Digital Support Administrator

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report brings to the committee updates relating to activities of the Insight & Data Services (IDS), ICT, Digital Innovation & Transformation, and the Clinical Digital Unit functions, as well as progress against the Digital Plan (see the **Appendix** for metrics and project status).



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Alerts

2. **Workload & Prioritisation:** The Digital teams are still involved in a significant number of projects and delivery activities, often with competing priorities and limited specialist capacity to facilitate all organisational needs. The Directorate regularly receive requests to support new projects, or information about changes to scope or direction of existing commitments and have to decide on how to resource the request and priority. Until the overarching Digital, Data and Technology (DDaT) governance framework which includes the new Digital Oversight Group (DOG) group is established (see paragraph 6) the Digital Leadership Group (DLG), who meet weekly, have a standing item on their agenda to ensure these new requests are appropriately considered against the existing workload, and not lost in the backlog.

Highlights

3. We continue to make progress on recruitment for core roles across the directorate:
 - Recruitment within the **Digital Transformation and Innovation** continues to progress. The Digital Adoption Facilitator post is currently being advertised and there has been significant interest in the role. This will be the final role to complete the Digital Transformation and Innovation team and will support the directorate with embedding co-design and person-centred change in the directorate.
 - **Clinical Digital Unit** functions have focused on maintaining patient safety at the interface between frontline clinical practice and digital systems. The team has provided clinical safety oversight of live systems and change activity, actively managing risks and supporting informed decision-making in operationally pressured settings. This has provided assurance that digital systems remain safe, fit for purpose, and aligned to real-world clinical workflows.
Digital Front End recruitment is underway with four roles in the job evaluation process, following the formation of these key roles, further recruitment will continue to ensure delivery of the workstreams.
 - Recruitment activity continues across the **ICT team** into vacancies, including a new Digital Automation and Low Code developer role. Several job descriptions have recently gone through successful job evaluation and are progressing towards recruitment.
 - **Insight and Data Services** (IDS) are almost at full establishment, with just two core vacancies and one new position for a Data Science & AI lead going through Job Description development. The Records Team also have support from colleagues on alternative duties in recent months.
4. **Clinical Model Transformation (CMT):** we continue to support the CMT with significant contribution already made in 2025/26 and a new phase of objectives detailed in the IMTP for



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2026/27 (see appendix for an overview of the workstreams). Highlights from the current reporting period include:

- **Online Symptom Checkers (Digital Front End):** Progress continues on the development of the online symptom checkers. ICT has deployed the latest update to the test environment, and testing of the enhanced administration functionality is underway. Build activity for the live system servers is progressing, and go-live is expected in July. Integration with the 999 CAD system and the address validation solution is currently being tested within the suppliers' test environment. Welsh-language translation has been completed, subject to any further amendments identified through testing.
- **Virtual Assistant (Digital Front End):** Following the conclusion of the four-week live Agent web-chat pilot, system metrics and lessons-learned feedback have been captured and are being compiled into a report. Work is ongoing on the integration of WhatsApp. Additionally, the team have been shortlisted for a Health Services Journal Digital Award – under the category of 'empowering patients through digital'. The award ceremony is taking place later this month.
- **Electronic Patient Care Record** (phase 2) redesign is progressing as per timelines, integration with a new build of the ePCR engine (epr4) will significantly open opportunities for WAST to build upon, these include use of Artificial intelligence in the operational environment.
- **The Integrated Clinical Call Queue (ICCCQ)** successfully went live on Tuesday 21st April. Some initial technical issues in the configuration were identified early and rectified within the first couple of days. External 111 performance reporting has been temporarily paused while data validation takes place relating to the time to start triage data and metrics. There also remains significant work regarding verification of other metrics before reporting can be finalised. There are also outstanding actions assigned to the project team regarding data protection and IG compliance before the solution can be fully assured from a digital perspective.

5. **National DOS:** WAST continue to be an active participant in a national project to unify the multiple Directories of Service (DOS) managed around all public health orgs in Wales. As WAST's DOS database is robust and well managed, and the interfaces well utilised, the team are heavily involved in the discovery and scoping phases of this national project being led by Welsh Government. During this reporting period there has been no further progress to report against as we await further engagement from the National Project team post-election.
6. **Digital Oversight Group:** A temporary new-work process will be in place for the new financial year, to ensure all new requests for digital are assessed against consistent criteria, enabling better transparency and prioritisation. The aim is to make the process of raising a digital idea/ solution extremely simple for our colleagues and that they feel supported throughout. Automation will be used to simplify the administrative process to make efficiencies where possible. From June 2026, the Digital Oversight Group (DOG) will go live,



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giving colleagues a simple, supported way to raise digital ideas and see how they are assessed and prioritised.

7. **Human-centred design with the wider digital leadership team:** The third human-centred design workshop is currently being created to help establish this new way of working within the Digital directorate. The aim is that all members of the WDLG understand the importance and the value of engaging with users early on when designing new digital solutions and will hopefully become BAU with the DT&I team leading on this work for all digital projects.
8. **ePCR updates:** The following enhancements were delivered as part of the February 2026 application update:
 - Following strong interest at the CEO roadshows, the ePCR survey has been reopened for a further 7 days and will now close on 22/04/2026.
 - Verification of death (VOD) and Termination of Resuscitation (TOR) section of the ePCR OOHCA section is updated with the current JRCALC guidelines.
 - The Future Care Plan is awaiting activation to be turned on, pending completion of the training package and TerraFix updates.

Additionally, the team have been shortlisted for a Health Services Journal Digital Award – under the category of Outstanding Achievement in EPR Implementation and Optimisation, with Parchment to Pixels a Digital Transformation. The award ceremony is taking place later this month.

9. **ePCR refresh:** the wider application refresh is progressing as planned and remains on schedule for the Summer 2026 deadline. We have a meeting on the 5th May to go through the wireframe with the ePCR refresh team. Our aim is to implement a three-week training period to ensure the workforce receives the necessary training ahead of the launch of the refreshed ePCR system. In addition, the following work is in development:
 - The Tenant structure has now been developed to represent the workforce structures for both the Clinical and Operations Directorates. We are currently up to Senior Paramedics and Operational Managers within the structure.
 - The Just in Case (JIC) section has been renamed to the Remote Written Instruction section. Remote written instruction section has been developed and is ready to be activated within the ePCR system once the Medication Management team have completed their standard operating procedure and information governance and training requirements. This will allow doctors who provide written orders for the administration of 'Just in Case' medications to enter these directly into ePCR via a secure 'tunnel'. This development will significantly strengthen governance, safeguard colleagues and the Trust, and help ensure that patients approaching end of life receive appropriate medication in a timely manner.



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10. **AI Developments:** The Trust's new AI Steering Group which launched in October 2025, is bringing an essential governance mechanism around decision making, advice, and policy with regards to the approach of Responsible AI. The group provides advice to project leads and teams on AI-related innovation ideas, tooling or implementations. An AI policy is in development, with a risk on the corporate register. A governance framework for Responsible AI has been devised, supporting ethical, safe and fair assessment, judgement and decision-making. Focus for 26-27 IMTP will focus on expansion of the governance and compliance frameworks for WAST, strategic alignment of AI ambition, and continuation as an expert advisory function.
11. **Innovation Labs & Digital Engagement:** The Digital Transformation and Innovation team have mapped their objectives for the upcoming year and have established key deliverables to ensure these objectives are achieved. The team will engage with key internal and external stakeholders on the innovation/solution lab to promote and support all new digital ideas at WAST. The team have already been successful in engaging with all ePCR users on what they would like to see from the ePCR upgrade later this year and upgrades will be based on user's feedback. There is also a plan underway to introduce two "Digital Engagement Vehicles", which will include kitting out decommissioned NEPTS vehicles for the Directorate to use to visit and engage with our wider workforce across Wales on all things digital, data and technology.
12. **GRS Cloud:** migration is due to take place 12th to 13th May 2026, following a go/no-go decision with the vendor on 5th May. All technical work is complete and a dry run has been signed off, with one outstanding issue which is still under investigation by vendor (i.e. Android mobile application non-functional, but interim GRS Web workaround in place approved by Project Board). Communications have been released regularly since December to inform staff of their multi-factor authentication requirements for single-sign on, and more recently to promote the new GRS Support SharePoint page, containing self-service steps to ensure continued access. Further comms are planned for 16/4/26 on Siren News and iPad lock screen. Operational management teams will also have direct comms from Resourcing Management Team, and a full Operations Plan is in draft.
13. **eTimesheets:** A specification is in development which will see these two projects (GRS Cloud and eTimesheets) come together, and the migration of GRS to a cloud platform in Q1 2026/27. Work completed between WAST, the supplier and DHCW regarding the Microsoft Azure tenant integration – which is now functional and allows login to GRS Cloud client.

Digital representatives are part of the technical group for eTimesheets but have so far been unable to provide much support as the specification is still moving through completion internally with the relevant T&F group, to document operational requirements for supplier development. This specification will be submitted to the supplier for feedback and any subsequent returns for queries / clarification on requirements, prior to agreement on development timeline/financial implications.



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Lowlights

14. **Data Management:** following an internal audit regarding data management across the Trust (i.e. outside of the Insight & Data Services, IDS, function), one limited finding resulted in a recommendation about the operating model and professionalisation of data & analytical technical experts across WAST. This was considered by the Executive Leadership Team, noting the challenges and risk currently faced, as well as the desired level of maturity in the future. It was concluded that a review of the IDS backlog items would be conducted by the requesting Directorates (to ensure alignment with strategic objectives and appropriate prioritisation). Additionally, a Strategic Data Plan will be developed, with a target operating model and supporting Community of Practice, to help strengthen and assure the data management practices around WAST. The Digital Oversight Group, or another relevant forum, will also be utilised to help ensure ongoing prioritisation of new requests throughout the year.
15. **Records Requests:** Following the identification of an organisational risk regarding Subject Access Request compliance and delivery, a Records Recovery Taskforce has been established, reporting into the Information Governance Steering Group. This group is addressing risk and issues around three themes: Compliance + Efficiency & Resilience + People & Change. The 8-week recovery plan is seeking to improve processes and documentation, evidence compliance, demonstrate learning, bolster training, introduce appropriate automation and tooling, and increase visibility and reporting. Updates are being provided to IGSG and a closure report will be produced in July.
16. **CAD Replacement:** current amber status (as shown in the Appendix) is due to initial engagement and assignment of dedicated resource yet to take place. Digital team representatives are to meet with the Senior Operational Leadership Team in May to start discussions on a way forward. The next Digital teams Design thinking workshop (in June 2026) will be considering how human-centered design can be used to assist in capturing the future CAD requirements from a user's perspective.
17. **ESN Phase 2:** On the Digital Plan (see Appendix), the goal for 2025/26 was to submit the Outline Business Case to Welsh Government – an activity which was completed in the summer. The original plan was then to submit one Full Business Case (FBC) to encompass all ESN projects, but this plan has changed. Instead, Welsh Government have requested the FBC for handheld and Fixed Vehicle devices be submitted in September 2026 with the Air-to-Ground element being separated and submitted as soon as possible in the new year. This approach has now reverted with the convergence of the Air to Ground element and the handheld and fixed vehicle device. Therefore, one ESN Phase 2 FBC will be submitted in September/October. Dates have been agreed with the relevant committees for the Governance route. The ESN Phase 2 FBC will be presented to OCP Programme Board on 23rd



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July, at the Executive Leadership Team meeting on 5th August, Finance and Performance Committee on 15th September and at the Trust Board on 24th September.

18. Capacity within the **Digital Front End (DFE)** workstream means that in-year planned discovery work with suppliers to refine Content Management System requirements has been postponed. This was in order to ensure BAU functions were prioritised and protected. As delivery for the workstream transitions out of programme structures without ongoing funding identified, there is a risk that insufficient capacity is placing additional pressure on existing staff if ownership and resourcing are not clearly agreed. The risk and a mitigation plan is being developed by the workstream. However, following the confirmation from Welsh Government via JCC that recurrent revenue funding of £1.23m has been secured for development of the NHS 111 Wales online offer, recruitment of critical roles is in progress, enabling a new programme of work to be established to fully redevelop the 111 Wales Website in line with the DFE ambitions.

RECOMMENDATION(S)

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

The Finance & Performance Committee is requested to:

1. Acknowledge the contents of the paper and determine if this provides assurance on the progress of the Digital Plan activities, IMTP commitments and CMT involvement of the Digital Directorate teams.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

The Finance & Performance Committee is requested to receive the following:

1. Appendix: Digital Reporting May 2026 – Metrics (pdf)



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to objectives and what good looks like\]](#)

☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

BAF Risks:

- 671 – Inappropriate use of AI Technologies
- 623 – Failure to comply with Data Protection Legislation (now managed locally by Digital Directorate)
- 690 – SAR and disclosure of Records compliance

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [\[link to standards\]](#)

☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred

Quality Enablers (select all that apply) [\[link to standards\]](#)

☐ Leadership	☒ Workforce	☐ Culture
☒ Information	☒ Learning Improvement & Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to goals\]](#)

☐ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☒ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
05.05.2026	Digital Leadership Group (sign-off)



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Agenda Item No.

13

REPORT TITLE

Information Governance Progress Report

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, Director of Digital
Author(s) of report	Dr Leanne Smith, Assistant Director of Digital

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report brings to the committee an update on the Information Governance (IG) activities of the Trust and related areas, including Information Security, Records Requests and Management, Freedom of Information, and Data Quality. Information Governance Highlight Reports are presented monthly to the Information Governance Steering Group (IGSG)



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chaired by the Trust's Senior Information Risk Owner (SIRO, and Director of Digital Services). The IGSG reports via AAA to the Executive Leadership Team (ELT).

2. This paper covers data and intelligence from the period of **1 February 2026 to 31 March 2026**, and the topics discussed at the **March** and **April** meetings of IGSG.

Alerts

3. The **cyber threat** level for a particular information system used within the Trust was raised to High in March. The escalation to high, was for the organisation's *external* cybersecurity threat level, specifically related to the system's external server following the identification of a vulnerability. Actions to remedy have been identified and were completed within 2 weeks (by the end of March). This did represent a temporary but significant increase in cyber risk exposure. IGSG noted that current reporting lacked clear visibility of mitigations in instances such as this, meaning the group could not provide assurance to ELT; and that other reporting of cyber indicators elsewhere in the Trust appeared to be trending negatively. However, it should be noted that this newly detected threat was mitigated swiftly, and a suite of actions supporting the cyber improvement plan (CIP) are in progress.
4. **Records Recovery:** The Records Services team is experiencing ongoing demand and capacity pressures, resulting in backlog growth and impact on compliance and performance. Whilst Subject Access Request non-compliance is recognised as a high-impact information governance risk to the Trust (with legal, regulatory, reputational and patient impacts), the risk and issue is across the broader records services remit. A Records Recovery Taskforce has been established, alongside daily stand-up meetings with the team, to manage the current pressures but also deliver on improvements aiming to reduce the compliance risk around processes and case handling and provide assurances. This Recovery group will report into IGSG and has set a clear plan of how to meet expectations and demonstrate measurable improvement in an eight-week period (noting that some improvements activities identified will continue beyond this time period).
5. **CCTV risk:** in-vehicle CCTV recording arrangements have been identified as a material IG risk, due to inconsistent recording settings across the fleet, absence of a completed DPIA, and lack of prior staff consultation. Continuous recording in some vehicles was not fully aligned with existing policy or staff awareness, creating lawfulness, proportionality and privacy risks, particularly in clinical sensitive environments. The group agreed to ensure panic-button only activation of internal CCTV recordings as an interim control, these interim actions have reduced immediate risk exposure; however, full assurance cannot be provided until consultation is completed and a DPIA-informed decision is agreed by IGSG. A clear plan and recommendation will be brought back to IGSG for further consideration shortly.



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Highlights

6. **IG Toolkit:** the IG Toolkit for 2025/26 was submitted on the 31 March 2026 as planned, overall meeting minimum expectations. (See separate FPC agenda item for outcome report and full submission.) Notably, several areas within the submission exceeded those expectations, providing robust assurance regarding the organisation's overall IG maturity. The completion of the IG Toolkit submission marks a significant organisational improvement as it represents the first full submission achieved by the Trust. Eight standards were assessed as exceeding expectations, with the remaining standards meeting the required threshold. The submission process was carried out with integrity, underpinned by evidence and transparency, further strengthening the level of assurance that can be taken from the result. However, it should be noted that the compliance status is based on self-assessment rather than external audit assurance, so any future audit activity could identify gaps requiring remediation.
7. **Mandatory IG training:** compliance remains consistently above target, around 92%, which has been sustained for the majority of 2025/26, with no current signals of decline. This will continue to be monitored closely.
8. **Meeting Minutes & Recordings Guidance:** Following a previous discussion on new guidance to support the production of meeting minutes and AAAs, a technical paper was received detailing the controls available for Microsoft Teams meetings (virtual and hybrid) and the use of AI-tooling to support with note taking. The group agreed that *transcripts* should become the default mechanism for minute/AAA production instead of *video* recordings, helping minimise data collection and risk of unofficial and unnecessary Trust records being created and being subject to FOI requests and SARs. Communication is needed to ensure video recording is used sparingly, and technical configuration and security controls need further investigation and refinement with DHCW support to help mitigate remaining risks. The approach presented supports organisational efficiency, reduces IG risk, and aligns with governance expectations.
9. **Clinical Safety Guidelines:** the new NHS-wide Clinical Safety Review Guidelines represent a major improvement to digital governance, mandating stronger, earlier, and more structured safety assessment of systems across WAST. Following their introduction in April 2026, they will help enhance record keeping assurance, reduce risk at entry, and reinforce IG and clinical safety controls across the organisation. The Clinical Digital Unit are finalising a Clinical Safety Review briefing to be brought to a future IGSG meeting.
10. **Cyber Assurance Enhancements:** cyber assurance has been further strengthened through the implementation of a new monitoring platform. This platform enables the identification of staff email addresses exposed in external breaches, allowing for proactive remediation and mitigation of risks associated with such exposures.



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Lowlights

11. **NIIAS Audits:** audits of appropriate access to our information systems is carried out via the National Intelligence Integrated Auditing System (NIIAS) - a system managed by DHCW. However, audits have not been conducted since November 2025, due to technical access issues to NIIAS. This means that WAST have been unable to monitor inappropriate access to national patient systems for several months, resulting in a risk that such access may have occurred but is not being contained or investigated. This impacts our ability to abide by the terms of the Welsh Control Standard for Electronic Health and Care Records. Although alerts generated during the access limitation period have not been lost, and the technical issues are now resolved and access restored, there is now a significant backlog to review, adding pressure to the IG team.
12. **DPIA Backlog:** the Trust continues to have a significant Data Protection Impact Assessments (DPIA) backlog, with numerous assessments currently in progress or awaiting review. Whilst progress has been made, the volume and age of outstanding DPIAs remains a concern from an assurance perspective. This exposes the organisation to potential regulatory non-compliance, ICO scrutiny, and reputational damage. A recovery plan has been developed to respond to challenges around late engagement, retrospective DPIAs, capability gaps, and limited IG capacity. Other mitigation actions are underway, including a risk-based review of all outstanding DPIAs, escalation of non-engagement, and cancellation of some DPIAs where relevant. However, continued Executive oversight is required until the backlog is reduced and assurance restored. Progress will continue to be reported from IGSG into Executive Leadership Team monthly.
13. **FOI Compliance:** Performance is significantly below target, driven by limited capacity and increasing request complexity. Failure to meet statutory FOI timelines presents a statutory, reputational and ICO enforcement risk, including increased likelihood of complaints and regulatory challenge. Directorates have been asked to prioritise FOI responses, indicating a heightened risk of statutory non-compliance. A process review is underway to reduce operational inefficiency, as well as how to better prioritise within Directorates.
14. **Data Breach Management:** a significant Subject Access Request (SAR) related breach occurred when a meeting recording could not initially be located, leading to delays in fulfilling the request, and a formal notification given to the ICO. Following a Microsoft tenant-wide search, the recording was recovered and the ICO notification was subsequently rescinded. Remedial actions are now underway, including improved processes for identifying verbal SARs, strengthened retention and recording management, and the development of a DPIA and SOP for investigation meeting recordings. A deep dive review of breaches is planned for a forthcoming meeting of IGSG once data improvement work with the Quality Management Group (QMG) is complete.



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RECOMMENDATION(S)

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

The Finance & Performance Committee is requested to:

1. Consider the contents of the paper and whether this gives assurance on the progress of the Trust's Information Governance arrangements and related specialist activities for Data Quality, Records Management, Freedom of Information requests and Information Security.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

n/a (see separate agenda item for IG Toolkit submission and outcomes reports)

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to objectives and what good looks like\]](#)

☒ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☐ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

BAF Risks:

- 623 – Failure to comply with data protection legislation (no longer on BAF, managed by Directorate)
- 260 - Significant and sustained cyber attack resulting in denial of service and loss of critical system
- 671 – Unauthorised or inappropriate use of AI technologies



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- 690 – SAR and disclosure of Records compliance (recently accepted onto Corporate Register)

Other Risks monitored by IGSG:

- Risk of delay in testing of the disaster recovery plans / flips for critical operational systems.
- ePCR compliance risk
- CCTV compliance risk

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [\[link to standards\]](#)

☒ Safe	☐ Timely	☒ Effective
☐ Efficient	☐ Equitable	☐ Person Centred

Quality Enablers (select all that apply) [\[link to standards\]](#)

☒ Leadership	☐ Workforce	☐ Culture
☒ Information	☐ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to goals\]](#)

☐ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☒ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
6 May 2026	Content taken from March and April 2026 IGSG Highlight Reports and AAAs



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Agenda Item No. 13.1

REPORT TITLE

IG Toolkit Status Update - FY25/26 Submission

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, SIRO and Director of Digital Services
Author(s) of report	Kelly Holding, Data Protection Officer

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The IG Toolkit has been successfully submitted for the 25/26 financial year, with confirmation that the organisation is meeting all minimum standards at the point of submission. This is the first time that the Trust has achieved a Minimum Standards Met submission since the introduction of the IG Toolkit. Below is a breakdown of categories and associated outcome.



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Category	Outcome
Leadership and Oversight	Expectations Exceeded
Policies and Procedures	Minimum Expectations Met
Training and Awareness	Minimum Expectations Met
Individual Rights	Expectations Exceeded
Records of Processing and Lawful Basis	Expectations Exceeded
Contracts and Information Sharing	Minimum Expectations Met
Risks and DPIAs	Expectations Exceeded
Breach Response and Monitoring	Expectations Exceeded
FOI	Expectations Exceeded
Information Security	Expectations Exceeded
Video Surveillance	Minimum Expectations Met
Business Continuity	Expectations Exceeded

Note: unlike NHS England's DSPT submissions, the Welsh IG Toolkit not currently independently audited and relies on the organisation's self-submission of evidence.

2. Ongoing CCTV and Video Surveillance Risk Mitigation

The DPIAs relating to CCTV and video surveillance systems have been reviewed and updated as part of the IG Toolkit submission process. A number of risk mitigation actions have already been completed, contributing to a reduction in overall risk. A small number of risk mitigation actions remain ongoing. These actions are being actively progressed in collaboration with Fleet and Estates and will continue to be monitored until fully implemented.

3. Next Steps

The new submission will open on 17 April 2026 with a submission required by 31 March 2027. Several new requirements will be introduced including for the following: -

- Process or Policy Statement regarding the use of AI
- Process for handling data subject complaints
- An up-to-date Information Asset Register
- A DPIA for each AI solution in use

A new IG Toolkit Action plan will be produced capturing the new requirements and ensuring all existing requirements continue to be maintained during the financial year.



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RECOMMENDATION(S)

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

The Finance & Performance Committee is requested to:

1. Acknowledge the update and outcomes of the IG Toolkit FY25/26 submission.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

Appendix - IG Toolkit Full Submission Report



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [[link to objectives and what good looks like](#)]

☐ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

BAF risk 623

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [[link to standards](#)]

☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☐ Equitable	☐ Person Centred

Quality Enablers (select all that apply) [[link to standards](#)]

☐ Leadership	☐ Workforce	☐ Culture
☒ Information	☐ Learning Improvement & Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [[link to goals](#)]

☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☒ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
13 April 2026	IGSG



Welsh Information Governance Toolkit

Form version 18 by Welsh IG Toolkit

Achievement status: Expectations Exceeded 75%

Submitted: 30-Mar-2026

Generated: 30-Mar-2026 16:58:37 (489ms)

Organisation details

Welsh Ambulance NHS Trust

RT4

Not Specified

Not Specified

Organisation website

<https://ambulance.nhs.wales/>

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Senior Information Risk Owner name

Jonny Sammut

Senior Information Risk Owner email

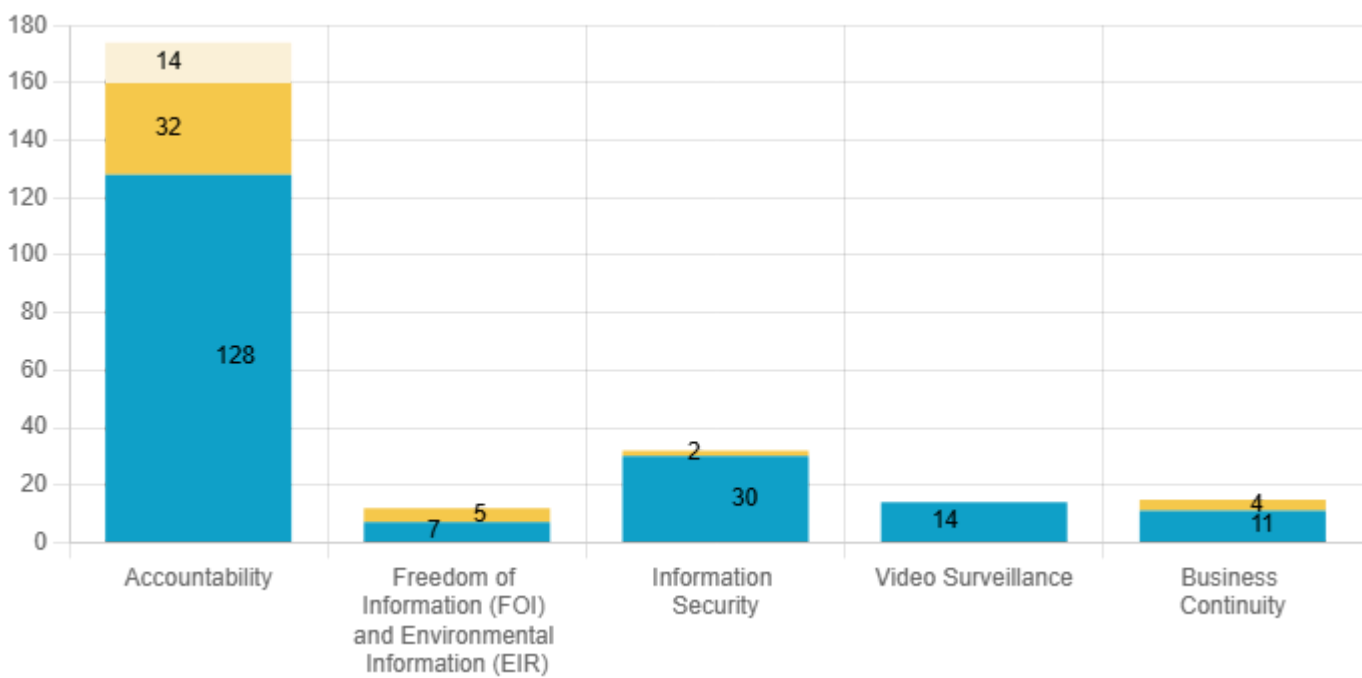
jonny.sammut@wales.nhs.uk

Form Dashboard

Legend

■	Minimum Expectations
■	Minimum Expectations not met
■	Expectations Exceeded
■	Expectations Exceeded not met

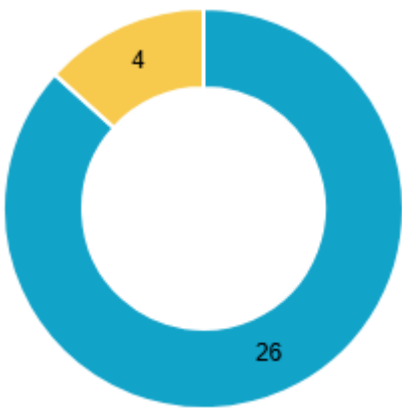
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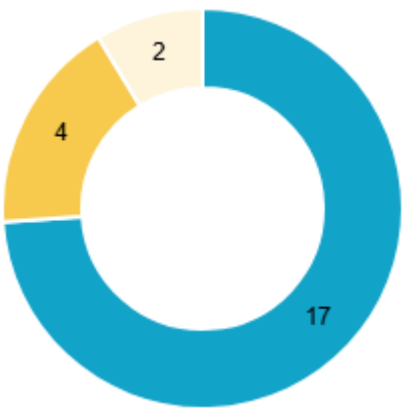
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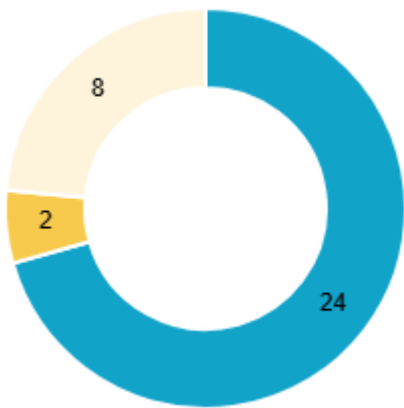
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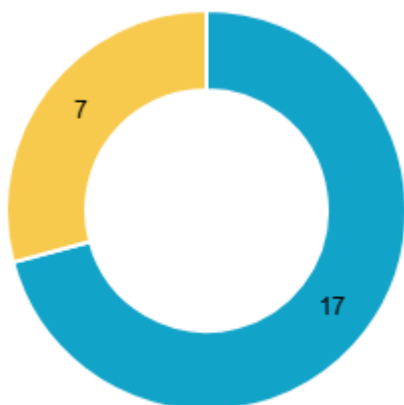
Policies and Procedures



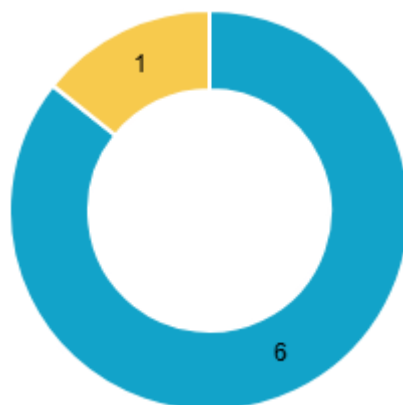
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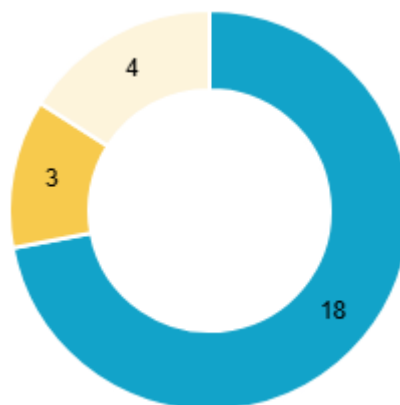
Individuals Rights



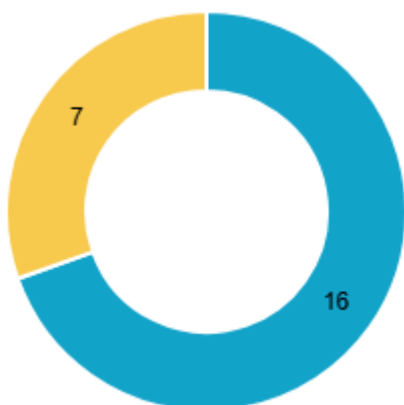
Records of Processing and Lawful Basis



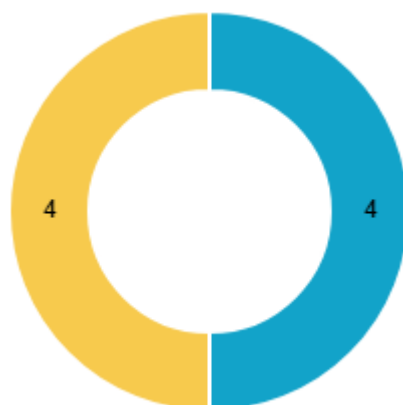
Contracts and Information Sharing



Risks and Data Protection Impact Assessments (DPIAs)



Breach Response and Monitoring



Accountability

Leadership and Oversight

Minimum Expectations

100% (26/26)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

LO-ME-1

Does the senior management team or Board have overall responsibility for IG and data protection in the organisation?

Yes

LO-ME-2

Are there clear reporting lines and responsibilities set out for IG and data protection in the organisation?

Yes

LO-ME-3

Does the organisation have appropriate individuals, groups or committees set up that provide direction and oversight across the organisation for information governance?

Yes

LO-ME-4

Are all improvements and targets to IG functions, identified through completing the Welsh IG Toolkit or similar, documented in the form of an IG action/improvement plan?

Yes

LO-ME-1

Please provide evidence to demonstrate that the senior management team or Board has overall responsibility for IG and data protection.

UPLOADED FILES

 [Management Responsibilities Extract from Policies.pdf](#)
 [Data Protection Policy 080224.pdf](#)
 [IG Hierarchy Structure.xlsx](#)

ALTERNATIVE DESCRIPTION

Please see policies extract evidencing senior responsibilities over IG.
 The Information Governance Steering Group meet monthly to oversee IG matters. This in turn provides reports to the Executive Leadership Team, Quality, Experience and Patient Safety Committee and ultimately the Trust Board.
 Trust Board papers are published on the website and include areas on IG.

LO-ME-2

Please provide evidence to demonstrate that there are clear reporting lines and responsibilities set out for IG and data protection in the organisation.

UPLOADED FILES

 [IG Hierarchy Structure.xlsx](#)
 [Oversight and Reporting Lines.pdf](#)

LO-ME-3

Please provide evidence to demonstrate that the organisation has appropriate individuals, groups or committees set up that provide direction and oversight across the organisation for information governance.

UPLOADED FILES

 [Oversight and Reporting Lines.pdf](#)
 [INFORMATION GOVERNANCE STEERING GROUP TOR 2023 v2.pdf](#)

ALTERNATIVE DESCRIPTION

To support the Senior Information Risk Officer (SIRO) and Caldicott Guardian, a nominated group known as the Information Governance Steering Group (IGSG) work to a set of annually reviewed duties, reporting to the Executive Leadership Group, and presentation of key indicators to the relevant Board Committee.

LO-ME-4

Please provide evidence to demonstrate that all improvements and targets identified through completing the Welsh IG Toolkit or similar, are documented in the form of an IG action/improvement plan.

UPLOADED FILES

 [IG Toolkit Improvement Action Plan 25 26..xlsx](#)

ALTERNATIVE DESCRIPTION

LO-ME-8

Has the organisation appointed a Data Protection Officer (DPO) or DPO Service?
Yes

LO-ME-9

Does the DPO fulfil the requirements in line with UK data protection legislation, including:

- ✓ Expert knowledge of data protection law and practices
- ✓ Reports directly to the senior management
- ✓ Is given the required independence to perform their tasks
- ✓ Is adequately supported and provided with sufficient resources to perform their role

LO-ME-10

Has the organisation appointed a Senior Information Risk Owner?
Yes

LO-ME-11

Is the Senior Information Risk Owner a senior individual (director level role) in the organisation?
Yes

LO-ME-12

Has the organisation appointed a Caldicott Guardian?
Yes

LO-ME-13

Is the Caldicott Guardian a senior individual (director level role) in the organisation?
Yes

LO-ME-14

Is the Caldicott Guardian easily accessible as a point of contact for staff?
Yes

LO-ME-15

Has the organisation assigned staff with operational responsibility for IG and data protection?
Yes

LO-ME-16

Do staff with IG and data protection responsibilities have:

- ✓ The authority, support and resources to carry out their duties effectively
- ✓ Job descriptions that clearly set out their duties and reporting lines to management

LO-ME-17

Does the organisation promote the contact details of relevant IG colleagues to all staff, setting out who may be best placed to provide support?
Yes

LO-ME-18

Has the organisation appointed operational staff to support the implementation of Freedom of Information (FOI) and Environmental Information Regulations (EIR)?
Yes

LO-ME-15

Please provide evidence to demonstrate that the organisation has assigned staff with operational responsibility for IG and data protection.

UPLOADED FILES

 [IG Hierarchy Structure.xlsx](#)
 [Information Governance SharePoint.pdf](#)

LO-ME-17

Please provide evidence to demonstrate that the organisation readily promotes who to contact if staff have any queries relating to data protection and information governance.

UPLOADED FILES

 [Information Governance SharePoint.pdf](#)
 [IG contact.pdf](#)

ALTERNATIVE DESCRIPTION

Please see extract from IG SharePoint page with contact details.
 Contact details are made available on Privacy Notices, Leaflets and organisational wide awareness posts as needed.

LO-ME-18

Please provide evidence to demonstrate how this responsibility is formally assigned?

UPLOADED FILES

 [CGM JD Evidence for IG Toolkit.pdf](#)

LO-ME-19

Is the organisation registered with the Information Commissioner's Office (ICO)?

Yes

LO-ME-20

What is the organisation's ICO registration number?

Z8061456

LO-ME-21

What is the date the organisation's current ICO registration is due to expire?

30-Jul-2026

LO-ME-22

Are the details held by the ICO about the organisation's registration accurate and up to date?

Yes

Expectations Exceeded

100% (4/4)

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

LO-EE-1

Are IG matters regularly reported to the senior management team or Board?

Yes

LO-EE-1

Please provide evidence to demonstrate that IG matters are regularly reported to the senior management team or Board.

UPLOADED FILES

 [1. IGSG AAA Report Nov 2025 Redacted.pdf](#)

LO-EE-2

Do decision-makers promote a proactive, positive culture of IG and data protection compliance across the organisation?

Yes

LO-EE-2

Please provide evidence to demonstrate that decision-makers promote a proactive, positive culture of data protection compliance across the organisation.

UPLOADED FILES

 [WAST Digital Plan 2024 2029 eng. compressed copy.pdf](#)

ALTERNATIVE DESCRIPTION

Notices are issued on Siren from senior leads referencing importance of data protection and information security. Please also see the WAST Digital Plan which is promoted across the Trust and on the WAST webpage (<https://ambulance.nhs.wales/files/publications/strategies-and-plans/wast-digital-plan-2024-2029/>). The plan confirms commitment to Compliance with Regulatory and Strategic Frameworks as a key pillar.

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Policies and Procedures

Minimum Expectations

100% (17/17)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section.If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

PP-ME-1

Does the organisation have up to date IG related policies and procedures in place for:

- ✓ Data Protection/Information Governance
- ✓ Records Management (including records retention)
- ✓ Information Security
- ✓ Data Quality

PP-ME-2

Do policies and procedures clearly set out:

- ✓ The responsibilities that all staff have regarding information governance
- ✓ How the organisation only collects, uses and shares the minimum amount of data necessary for the purpose
- ✓ How the organisation ensures that data is only available to those who need it
- ✓ How the organisation stores data only for as long as is needed
- ✓ How the organisation informs individuals what is being done with their data

PP-ME-3

Are these policies and procedures made readily available to all staff?

Yes

PP-ME-4

Does the organisation monitor compliance with the policies and regularly review their effectiveness?

Yes

PP-ME-1

Please upload relevant policies and/or procedures.

UPLOADED FILES

-  [Records Management Policy v2.0 APPROVED PG 23.10.2024.pdf](#)
-  [Information Security Policy v2.1.pdf](#)
-  [Data Protection Policy 080224.pdf](#)
-  [Data Quality Policy v1.0 14052024.pdf](#)

PP-ME-3

Please provide evidence to show that the organisation makes policies, operational procedures, and guidance readily available to staff

UPLOADED FILES

-  [Policies on SharePoint.pdf](#)
-  [Policies Tab on IG SharePoint.pdf](#)

ALTERNATIVE DESCRIPTION

All policies are accessible from the Trust's SharePoint page.

PP-ME-4

Please provide evidence to demonstrate that the organisation keeps a record of the spot checks, that have been carried out, including details of any actions, who has approved any actions and who is taking them forward if applicable.

UPLOADED FILES

-  [Compliance Monitoring Schedule 2026.xlsx](#)

ALTERNATIVE DESCRIPTION

The attached Compliance Monitoring Schedule sets out the monitoring activities and checks we currently perform. In addition, the Trust is subject to Internal Audit under the NHS Wales Internal Audit Programme. This year, an audit on Records Management was undertaken.

PP-ME-5

Does the organisation have policies or procedures in place to make sure that personal data breaches can be detected, managed and appropriately recorded?

Yes

PP-ME-6

Does the organisation have policies or procedures in place to assess any data breaches and if required, report them to the Information Commissioner's Office (ICO) within the statutory time frames?

Yes

PP-ME-7

Are there up to date policies or procedures to manage staff access to the premises and systems that process personal data?

Yes

PP-ME-8

Does the organisation have effective and up to date Freedom of Information (FOI) & Environmental Information Regulations (EIR) policies and/or procedures and relevant guidance outlining high level responsibilities?

Yes

PP-ME-5

Please provide a copy of or an extract from the relevant policies or procedures.

UPLOADED FILES

 [RLDatix Reporter User Guide updated March 23 final.pdf](#)
 [SharePoint, reporting breaches.docx](#)
 [Data Breaches Section Data Protection Policy.docx](#)

ALTERNATIVE DESCRIPTION

User guides on submitting incidents to the Datix system are available. In addition, guidance on the IG SharePoint page is available which covers reporting data breaches. The Data Protection Policy also refers to reporting data breaches.

PP-ME-9

Does the organisation have policies or procedures in place that advise staff how to securely dispose of confidential records/data that are no longer required?

Yes

PP-ME-6

Please provide a copy of or an extract from the relevant policies or procedures.

UPLOADED FILES

 [Data Breaches Section Data Protection Policy.docx](#)
 [NHS Wales Guidance Personal Data Breaches March 2021.pdf](#)

PP-ME-7

Please provide a copy of or an extract from the relevant policies or procedures.

UPLOADED FILES

 [EPGN 003 Building Security.docx](#)
 [Access Control Policy. 020120.pdf](#)
 [Information Security Policy v2.1.pdf](#)

PP-ME-8

Please provide a copy of or an extract from the relevant procedure and guidance outlining high level responsibilities.

UPLOADED FILES

 [FOI Guidance Document \(16.09.24\). IGSG Fbk 221024 LT 171124.pdf](#)
 [FOI Guidance Notice.PNG](#)

PP-ME-9

Please provide a copy of or an extract from the relevant procedure and guidance outlining the disposal process.

UPLOADED FILES

 [Disposal section of Info Sec policy.docx](#)
 [WAST Data Disposal SOP v1.0.pdf](#)

Expectations Exceeded

66% (4/6)

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

PP-EE-1

Are all new and updated policies and procedures reviewed and approved by a senior staff member prior to implementation?

Yes

PP-EE-2

Does the organisation actively inform staff about updated policies and procedures?

Yes

PP-EE-3

Does the organisation keep a record to positively confirm staff have read and understood relevant policies and procedures?

No

PP-EE-1

Please provide evidence to demonstrate that policies and procedures are reviewed and approved by a senior staff member prior to implementation

UPLOADED FILES

 [Data Protection Policy_080224.pdf](#)

ALTERNATIVE DESCRIPTION

All polices are required to go through the Policy Approval process. This includes stakeholder engagement, approval of the Policy Lead, through to Policy Group and on to Committee approval. Example Data Protection Policy shows all the approvals received.

PP-EE-2

Please provide evidence to demonstrate that the organisation actively informs staff about updated policies and procedures

UPLOADED FILES

 [Approved Policies May 2024.pdf](#)

ALTERNATIVE DESCRIPTION

Approved policies are posted on the Siren News for all staff. Example uploaded.

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Training and Awareness

Minimum Expectations

100% (24/24)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

TA-ME-1

Has an IG, data protection and cyber security Training Needs Analysis (TNA) been completed in the last twelve months?

Yes

TA-ME-2

Does the IG and data protection TNA meet the needs of all staff and includes key areas of IG and data protection including:

- ✓ Handling requests for information
- ✓ Sharing of staff and patient personal information
- ✓ Information security
- ✓ Breaches of personal information
- ✓ Records management

TA-ME-3

Does the TNA include induction and refresher training for all staff, regardless of how long they will be working for the organisation, their grade or contractual status?

Yes

TA-ME-4

Does the organisation regularly review the TNA to ensure that it remains accurate and up to date?

Yes

TA-ME-1

Please provide a copy of the TNA that includes Data Protection/IG training needs.

UPLOADED FILES

 [IG Training Matrix Final v1.xlsx](#)

TA-ME-4

Please confirm the date the TNA was last reviewed.

16-Oct-2025

TA-ME-5

Does the organisation have a training log/register of staff training compliance in place?

Yes

TA-ME-6

Are all staff required to complete mandatory IG refresher training at appropriate intervals?

Yes

TA-ME-7

Are measures in place to ensure staff understand the training?

Yes

TA-ME-8

Does the organisation make relevant training materials easily accessible for staff?

Yes

TA-ME-7

Please provide evidence to demonstrate that measures are in place to verify staff understanding of the training.

ALTERNATIVE DESCRIPTION

On completing the training, there is a test at the end. The Training is only fully complete if the test is passed

TA-ME-8

Please provide evidence to demonstrate that the organisation makes relevant training materials easily accessible.

UPLOADED FILES

 [Training and Awareness IG SharePoint Page.pdf](#)
 [MetaCompliance Training Available from Teams.pdf](#)

ALTERNATIVE DESCRIPTION

In addition to the ESR IG Training module for all staff and volunteers, additional training and materials are available for all staff on the IG SharePoint page and also via MetaCompliance which can be accessed from Teams. An IG Refresher Module based on ESR content has also been developed and hosted on LMS365 to enable easier access to complete the required core training. A Training Needs Analysis has also been undertaken.

TA-ME-10

Does the organisation meet or exceed a compliance rate of 85% across all staff groups for the completion of IG mandatory training every two years?

Yes

TA-ME-11

Are levels of low training compliance targeted for improvement?

Yes

TA-ME-10

Please provide evidence to demonstrate that the organisation meets or exceeds the compliance rate of 85% for the completion of IG mandatory training.

UPLOADED FILES

 [IG Compliance September 25.PNG](#)

TA-ME-11

Please detail interventions undertaken to address levels of low training compliance and targeted improvement.

Training figures are reported to senior managers monthly. ESR reminders are sent to all staff to complete training where it is due for renewal or has expired.

Low-level compliance is reported to the Executive Leadership Team via the AAA Report following IG reports into IGSG. Individual-level reports are regularly provided to Senior Leads to target non-compliant individuals.

TA-ME-12

Have all staff with operational responsibility for IG and data protection received appropriate training to carry out their role, including refresher training or relevant continued professional development (CPD) activities?

Yes

TA-ME-13

Has the appointed Data Protection Officer received appropriate training to carry out their role and are they provided with continuous professional development to maintain their expert knowledge?

Yes

TA-ME-14

Has the appointed Caldicott Guardian received appropriate training to carry out their role and received refresher training at least every two years?

Yes

TA-ME-15

Has the appointed Senior Information Risk Owner received appropriate training to carry out their role and received refresher training at least every two years?

Yes

TA-ME-12

Please provide evidence to demonstrate that staff with operational responsibility for IG and data protection have received appropriate training.

UPLOADED FILES

-  [ICA Certificate in Compliance 2020 Certificate.pdf](#)
-  [DPPC 2023 attendance.pdf](#)
-  [Eleri Jones .pdf](#)
-  [20230510 084753 resized.png](#)
-  [Act Now Certificate Judith Birkett.pdf](#)
-  [Charlotte Jones GDPR cert.pdf](#)
-  [Charlotte Hardy GDPR cert.pdf](#)
-  [certificate.pdf](#)

ALTERNATIVE DESCRIPTION

The mandatory ESR training module includes sections on IG, Records Management, and Cyber Security. Specifically, the modules covers: - Data Protection and the Principles of UK GDPR Individual Rights, including right to be informed and subject access requests (including when to seek advice from IG leads when receiving requests for information) Information and cyber security Examples of data breaches, and their consequences for

TA-ME-13

Please provide evidence to demonstrate that the appointed Data Protection Officer has received and is provided with appropriate continuous professional training.

UPLOADED FILES

-  [KH DPO Certificate.pdf](#)

TA-ME-14

Please provide evidence to demonstrate that the appointed Caldicott Guardian has received appropriate training and received refresher training at least every two years.

UPLOADED FILES

-  [54928 Certificate 09Jun2025130225.pdf](#)
-  [56836 Certificate 09Jun2025130120.pdf](#)
-  [56837 Certificate 09Jun2025125746.pdf](#)

TA-ME-15

Please provide evidence to demonstrate that the appointed Senior Information Risk Owner has received appropriate training and received refresher training at least every two years.

UPLOADED FILES

-  [Jonathan Sammut SIRO Certificate.pdf](#)
-  [Introduction to Risk Management for SIROs and IAOs Workbook Completed March 2026 JS.pdf](#)

ALTERNATIVE DESCRIPTION

organisations and individuals Records management principles, and best practice. IG staff complete regular CPD training including internal workshops, on the job training and supervision, completion of ICO modules on Data Protection, as well as attending webinars and awareness forums (when relevant). Soft skills courses are also attended including Change Ambassador Program and Leadership Coaching. The 2 x DPCMs are attending the DHCW provided BCS Data Practitioner Course training in April 2026.

Expectations Exceeded

20% (2/10)

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

TA-EE-1	TA-EE-2	TA-EE-3
Has the organisation assigned responsibilities to specific staff for managing IG and data protection training across the organisation?	Do the appropriate staff oversee or approve the induction and refresher training?	Does the organisation have suitably qualified staff resources available to deliver training?
<i>Not answered.</i>	<i>Not answered.</i>	<i>Not answered.</i>

TA-EE-6

Does the organisation keep evidence that it regularly uses a variety of methods to raise staff awareness and the profile of IG and data protection, for example by emails, team briefings and meetings, posters, handouts and blogs?

Not answered.

TA-EE-8

Does the organisation meet or exceed a compliance rate of 95% across all staff groups for the completion of IG mandatory training every two years?

Not answered.

TA-EE-9

Does the organisation regularly report IG training compliance levels to the appropriate forum?

Yes

TA-EE-9

Please provide evidence to demonstrate that training compliance is regularly reported to the senior management team or Board.

ALTERNATIVE DESCRIPTION

Training figures are reported monthly to IGSG

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Individuals Rights

Minimum Expectations

100% (17/17)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

IR-ME-1 Does the organisation have a procedure in place for dealing with requests to exercise the range of individual rights under data protection legislation including: ✓ Right to be Informed ✓ Right of Access ✓ Right to Rectification ✓ Right to Erasure ✓ Right to Restrict Processing ✓ Right to Data Portability ✓ Right to Object ✓ Rights relating to automated decision making	IR-ME-2 Does the organisation take steps to make all staff aware of how to recognise a request from an individual under data protection legislation, and their responsibilities to ensure any such request is dealt with? Yes	IR-ME-3 Does the organisation have specific staff responsible for managing and responding to individuals following requests made under data protection legislation? Yes	IR-ME-4 Does the organisation maintain a log of all written and verbal requests from individuals, made under data protection legislation, that records receipt of the request, tracks its progress, and outcomes? Yes
IR-ME-1 Please provide a copy of your individual rights policy/procedure. UPLOADED FILES  Data Protection Policy 080224.pdf  Data Subject Rights Requests Procedure V1.0.pdf  Subject Access Request Standard Operating Procedure 1.0.pdf		IR-ME-3 Please provide the job title or team responsible for managing and responding to individual rights requests. Records Services and Archives Team	IR-ME-4 Please provide a redacted extract (remove the name/address/other identifiers of data subjects) of the request log. UPLOADED FILES  3. Records Requests 2025 (Redacted).xlsx

IR-ME-5

Does the organisation provide information that informs individuals how they can exercise their rights under data protection legislation?

Yes

IR-ME-6

Does the organisation take steps to make all staff aware of how to inform individuals where to locate privacy information and how they can exercise their rights?

Yes

IR-ME-7

Where the organisation processes children's information, is particular care taken to write privacy information in clear, plain language which is age appropriate?

Yes

IR-ME-8

Does the organisation utilise a layered approach to provide privacy information in a variety of formats?

Yes

IR-ME-8

Please provide evidence of the privacy notices in place, including, where applicable, privacy information for children.

ALTERNATIVE DESCRIPTION

Privacy information is provided to data subjects through a range of formats and methods. Written notices are available on the following links: -

<https://ambulance.nhs.wales/use-of-site/privacy-policy/>
<https://111.wales.nhs.uk/privacypolicy/defaultNew.aspx>

This includes an Easy Read / Child Friendly Privacy Notice.

In addition, recorded messages are played to 111 callers advising that information may be shared with GPs, that calls are recorded, and informing them where further privacy information is available. Recorded messages are played to NEPTS callers advising them that calls are recorded, and informing them where further privacy information is available. Hardcopy privacy notices are provided on request and as part of NEPTS Engagement surveys which are

requested by post. Patient/Participant information sheets are provided as part of research projects. Supplementary information is also developed and provided where necessary depending on the project.

IR-ME-9

Does privacy information include:

- ✓ The identity and contact details of the controller
- ✓ The contact details of the data protection officer
- ✓ The purposes of the processing and the lawful basis being relied upon
- ✓ The organisations who personal information is shared with
- ✓ The period for which personal data will be retained
- ✓ The existence of individual rights
- ✓ The right to lodge a complaint with the ICO

IR-ME-13

Are responses to individual rights requests maintained in line with the Records Management Code of Practice?

Yes

IR-ME-10

Where the organisation transfers personal information to any third countries or international organisations, is the processing documented within your privacy information?

Yes

IR-ME-11

Where the organisation relies on legitimate interests as a lawful basis, are the legitimate interests pursued documented within your privacy information?

N/A

IR-ME-12

Where the organisation relies on consent as a lawful basis, is the right to withdraw consent documented within your privacy information?

Yes

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

IR-EE-2

Are regular reports produced on performance to ensure that requests under data protection legislation, are processed in line with legislation and organisational procedures?

Yes

IR-EE-3

Does the organisation take reasonable steps to check the accuracy of the personal information it holds and, if necessary, can inaccuracies be rectified or highlighted?

Yes

IR-EE-2

Please provide a copy of the reports made to the senior management team or Board.

ALTERNATIVE DESCRIPTION

KPIs on individual rights requests are reported monthly in the IG Highlight report to IGSG.

IR-EE-3

Please describe how the organisation checks the accuracy of the personal information it holds and, if necessary, how it rectifies or highlights any inaccuracies.

There are numerous WAST procedures that cover data accuracy checks at patient contact including: -

CSD - V1.2 ECNS
Quality Assurance
Policies and Procedures
CSD FINAL.pdf

CCC/999 - Siren –
Operations - AMPDS
Guidance 4.3.pdf
MPDS Quality
Assurance Policy V2 3
100119.pdf

11 Operations SOP 3.1
x.pdf
Manual Call Document
SOP V6

Clinical - CN 12 2022 -
Utilising TerraPACE
App.pdf - Report
Completion and
Mandatory Fields

111 WDS Records
Rectification Process

Data Subject Individual
Rights Procedures -
Right to Rectification

IR-EE-4

Does the organisation regularly review privacy information to ensure that it is accurate, up to date and effective?

Yes

IR-EE-5

If the organisation plans to use personal data for a new purpose, is there a process in place to update the privacy information and communicate the changes to individuals before starting any new processing?

Yes

IR-EE-5

Please provide evidence that the organisation has detailed within a relevant policy or procedure how it updates privacy information and communicates this to prior to new processing taking place.

UPLOADED FILES

 [DPIA Procedure v2.pdf](#)

ALTERNATIVE DESCRIPTION

Any new purposes are to undergo the DPIA Screening / DPIA process where privacy information is reviewed/updated as a result

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Records of Processing and Lawful Basis

Minimum Expectations

100% (6/6)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section.If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

RP-ME-1 Does the organisation have a formal 'Record of Processing Activities' (ROPA) that: ✓ Is regularly reviewed to ensure that it remains accurate and up to date ✓ Documents the lawful basis, or bases, relied upon for different processing activities ✓ Documents the purpose for the processing of personal information for each activity on the ROPA	RP-EE-2 Where consent for processing information is obtained from individuals, does the organisation keep evidence of what, when and how the individual was informed? Yes	RP-EE-3 If the organisation relies on legitimate interests for the lawful basis, are appropriate 'legitimate interest assessments' (LIA) completed prior to the processing? Yes	RP-EE-4 Can the organisation demonstrate that all processing on the 'Record of Processing Activities' (ROPA) is covered by the privacy information? Yes
RP-ME-1 Please provide a copy or an extract of the organisational ROPA. UPLOADED FILES  Data Processing_Log (ROPA) 2026 Updated.xlsx	RP-EE-2 Please describe how obtained/withdrawn consent is recorded? Teams which utilise consent forms include PECL, Comms, Occupational Health, Putting Things Right, Records Services. Each team retains signed copies of the consent forms, including any withdrawals within the individual patient or staff files.		

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

RP-EE-4

Does the organisation
proactively review
records of previously
gathered consent to
confirm and refresh the
consent as required?

Yes

I confirm that all answers provided and evidence
uploaded is accurate and up to date

Yes

Contracts and Information Sharing

Minimum Expectations

100% (18/18)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

CIS-ME-1	CIS-ME-2	CIS-ME-3	CIS-ME-4
Does the organisation have policies or procedures to ensure that contracts are in place with all suppliers, contractors, data processors and third parties?	Does the organisation ensure all contracts for suppliers, contractors, data processors and third parties are documented in a log, register or registers as appropriate?	Does the organisation carry out pre and post procurement checks to make sure that suppliers, contractors, data processors and third parties it uses, comply with data protection legislation?	Where the organisation uses a third party to destroy records and equipment, is there a written contract in place?
Yes	Yes	Yes	Yes

CIS-ME-1

Please provide a copy of the policy and/or procedure that ensures the necessary contracts and agreements are in place.

UPLOADED FILES

-  [Data Protection Policy 080224.pdf](#)
-  [WAST Standing Orders Schedule 2.1 Standing Financial Instructions v.5 approved 270122.pdf](#)
-  [Procurement Cyber Security and Information Governance Assurance when Procuring Products and Services.pdf](#)
-  [WAST Supplier Management SOP V1.2.pdf](#)

ALTERNATIVE DESCRIPTION

It is a mandatory requirement to conduct a compliant procurement

process before entering a contract, this is applied at legislative level under the Public Contracts Regulations 2015. Please see attached WAST Supplier Management SOP (ICT/Digital Directorate) and the over-arching Trust Standing Orders - Standing Financial Instructions (which the SOP refers to).

CIS-ME-2

Please provide evidence that all contracts are recorded.

UPLOADED FILES

-  [Copy of WAST Contract IG Toolkit REDACTED.xlsx](#)
-  [ICT Contracts ICT SMT v1.07 \(Redacted\).xlsx](#)

ALTERNATIVE DESCRIPTION

CIS-ME-3

Please provide evidence of the organisation's pre and post procurement processes.

UPLOADED FILES

-  [WAST Supplier Management SOP V1.2.pdf](#)
-  [WAST Supplier Survey Questionnaire.xlsx](#)

ALTERNATIVE DESCRIPTION

The Cabinet Office Procurement Policy Note provides guidance of what action should be taken when procuring products and services. WAST's processes include: -

Pre-Procurement Checks

- Specifications set out minimum standards / requirements to be met
- Procurement Documentation (e.g contracts) incorporate data protection legislation
- Conduct a DPIA and Cloud Security Assessment where relevant

Post Procurement Checks

- DPIA undertaken for any changes to systems or processes that involve processing of personal data
- Audits undertaken to

CIS-ME-4

Please provide a copy of the contracts in place with suppliers that provide destruction services.

ALTERNATIVE DESCRIPTION

Estates manage all WEEE waste destruction and erasure when required. Shredders are available at all WAST sites and are managed locally.

There are contracts in place for confidential waste contractors and WEEE waste and erasure whereby POs are raised at the time for ad hoc collections under NHS Wales Terms and Conditions.

Third parties will usually be held to NHS Wales Terms and Conditions

which contain additional schedules as needed. For example, suppliers processing personal data will be provided with a Data Processor Schedule as part of the NHS Wales Terms and Conditions. Suppliers may also be procured through national framework agreements which also require that Data Processor or, where relevant, Joint Controller Schedules are incorporated. Where a supplier is identified and a DPIA is completed, it is ensured they are issued with the relevant contractual agreement, security due diligence and cloud assessment as applicable.

ensure:

- relevant security certifications are maintained (e.g. ISO, Cyber Essentials) and
- annual Penetration Tests conducted.
- Audit records are maintained by the Supplier which relate to security events.

In terms of the legal / procedural framework wrap around this, is captured through:

- o UK GDPR and the Data Protection Act 2018
- o Public Contracts Regulations 2015 (shortly to be replaced by the Procurement Act 2023 supplemented by the Procurement Regulations 2024)
- o Welsh Procurement Policy Notes / UK Government Procurement Policy Notes
- o Trust Standing Financial Instructions
- o NWSSP – Procurement Services – policies and procedures
- o Trust Data Protection Policy
- o Trust Information Security Policy (specifically paragraph 7.15 of this policy)
- o Trust DPIA Procedure
- o Digital Services Supplier Management SOP

CIS-ME-5

Do your organisation's
IT system suppliers
have cyber security
certification?

Yes

CIS-ME-6

Have standard
contracts/clauses been
developed and made
available where
required, for all
suppliers, contractors,
data processors and
third parties?

Yes

CIS-ME-6

Please provide an extract of the standard contract/clause.

UPLOADED FILES

-  [Confidentiality agreement one way NHS Body discloser.doc](#)
-  [Confidentiality agreement one way NHS Body recipient.doc](#)
-  [WELSH AMBULANCE SERVICE NHS TRUST Vendor Acceptable Use.docx](#)
-  [Confidentiality agreement mutual disclosure.doc](#)
-  [Data Security and Confidentiality Agreement Temp Staff Students V2 FINAL.doc](#)
-  [Data processing agreement \(controller to processor\) \(within UK and UK to EEA\).doc](#)

ALTERNATIVE DESCRIPTION

Where NHS Wales Terms and Conditions are used, the Data Processing schedule is completed. WAST also have Template standalone and addendum Data Processing agreements. Where procurements are made from frameworks such as G-Cloud and NHS Business Services Framework, again the data

processor schedules are utilised.

WAST also uses an Acceptable Use Agreement where access to systems/data/resources is required.

<https://nwssp.nhs.wales/ourservices/procurement/services/documents/terms-and/conditions/>

CIS-ME-7

Does the organisation ensure that security and confidentiality clauses/agreements are in place for:

- ✓ Permanent staff
- ✓ Temporary and agency staff
- ✓ Students and volunteers
- ✓ Locum workers

CIS-ME-7

Please provide extract of the security and confidentiality clauses/agreements for ALL staff as detailed.

UPLOADED FILES

-  [Confidentiality Agreement.docx](#)
-  [Non Clinical and Temporary Fixed Term Staff RM6160 Full Terms and Conditions 1.pdf](#)
-  [Permanent All Wales A4C Contract 26.09.2019 Annual Leave Updated 15.02.2022.doc](#)
-  [Template Bank Worker Agreement.pdf](#)
-  [Agency Staff Call Off Terms and Conditions.docx](#)
-  [Data Security and Confidentiality Agreement Temp Staff Students V2 FINAL.doc](#)

ALTERNATIVE DESCRIPTION

Temp/Agency Staff - Whereagency staffareappointed via a framework, theframework terms and conditions apply which include provisions on confidentiality.

CIS-ME-8

Does the organisation document existing information sharing protocols/agreements, their durations and who is party to them?

Yes

CIS-ME-9

Is there a process in place for agreeing and approving ad-hoc sharing of personal data?

Yes

CIS-ME-10

Has the organisation acknowledged and signed up to the Wales Accord on the Sharing of Personal Information (WASPI)?

Yes

CIS-ME-8

Please provide an extract of the information sharing protocols/agreement log.

UPLOADED FILES

 [1. Information Sharing Index Log v4 2025 \(Redacted\).xlsx](#)

CIS-ME-9

Please provide evidence of the process for the ad hoc sharing of personal information.

UPLOADED FILES

 [Data Protection Policy_080224.pdf](#)

ALTERNATIVE DESCRIPTION

The IG team review proposals for data sharing, regardless of whether an ad-hoc or a more permanent flow is required. WASPI DDAs and ISPs are established where required. There have been occasions where a DDA has been put in place for a one-off disclosure. The Records Team may receive requests for records outside of already approved disclosure routes, which are then referred to the IG team for consideration. WAST has also published the Confidentiality Code of Conduct which includes a section on 'Disclosures' and the process that should be followed. It is recognised that ad hoc data disclosures will be required from time to time during the performance of the duties of the Trust. However, any data disclosure will be required to have at least one lawful basis for

disclosing the data and should be documented. In addition, any disclosing of patient data will require satisfying confidentiality rules (either implied or explicit consent, public interest or legal obligation. Please see Confidentiality Code of Conduct.)

Expectations Exceeded

42% (3/7)

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

CIS-EE-1

Is there a review process in place to ensure contracts and agreements remain up to date for:

Not answered.

CIS-EE-2

Are all information sharing agreements/protocols reviewed at regular intervals and is the Information Sharing Register maintained in accordance with any changes/updates?

No

CIS-EE-3

Are new and reviewed information sharing agreements/protocols regularly reported to relevant senior management team or Board?

Yes

CIS-EE-4

Has the organisation acknowledged and signed up to the Welsh Control Standard for Electronic Health and Care Records, and does the organisation commit to the common standards and principles when sharing electronic health and care records?

Yes

CIS-EE-3

Please provide evidence of escalation to the senior management team or Board.

UPLOADED FILES

 [Screenshot from Feb 2026 IG Report Data Sharing.png](#)

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Risks and Data Protection Impact Assessments (DPIAs)

Minimum Expectations

100% (16/16)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

RIA-ME-1	RIA-ME-2	RIA-ME-3	RIA-ME-4
Does the organisation take steps to make all staff aware of the need to consider a Data Protection Impact Assessment (DPIA) and the process to be followed? Yes	Does the process detail that a DPIA is considered: ✓ In advance of the processing of personal data commencing ✓ When contemplating changes to existing or new projects ✓ When contemplating existing or new services or systems	When carrying out a DPIA, are staff aware they need to seek the advice and guidance of the Data Protection Officer (DPO)? Yes	Does the organisation maintain a register for all completed and ongoing DPIAs? Yes

RIA-ME-1

Please provide evidence of the process.

UPLOADED FILES

 [Data Protection Policy 080224.pdf](#)

 [DPIA Procedure v2.pdf](#)

 [Data Protection Impact Assessments \(DPIA\) SharePoint Page.pdf](#)

ALTERNATIVE DESCRIPTION

Information on DPIAs is included on the IG SharePoint page. There is also a procedure made available to all staff.

RIA-ME-3

Please provide evidence that staff have been made aware of the requirement to seek advice and guidance of the DPO.

UPLOADED FILES

 [Data Protection Impact Assessments \(DPIA\) SharePoint Page.pdf](#)

 [DPIA Standard Wording.docx](#)

 [DPIA Procedure v2.pdf](#)

ALTERNATIVE DESCRIPTION

In addition to this being included in the Data Protection Policy, DPIA Procedure, and DPIA SharePoint page, standard wording is also emailed to project leads when the DPIA process commences.

RIA-ME-4

Please provide a copy or extract of the Register.

UPLOADED FILES

 [DPIA Log 2026 Redacted.xlsx](#)

ALTERNATIVE DESCRIPTION

The Trust DPIA Log is kept as a SharePoint list.

RIA-ME-5

Are staff made aware of who should finalise the DPIA in the organisation?

Yes

RIA-ME-6

Are all DPIAs reviewed and signed off by a nominated person?

Yes

RIA-ME-7

Where the DPIA identifies any residual high risks, is there a process for the Information Commissioner's Office (ICO) to be consulted, prior to processing commencing?

Yes

RIA-ME-8

Does the organisation's risk register include clear links between the corporate and the departmental risk registers, and the risk assessment of information assets?

Yes

RIA-ME-5

Please provide evidence that staff have been made aware of the nominated person who should finalise the organisation's DPIAs.

UPLOADED FILES

-  [DPIA Procedure v2.pdf](#)
-  [Data Protection Impact Assessments \(DPIA\) SharePoint Page.pdf](#)
-  [DPIA Process Map IG SharePoint Site.png](#)

ALTERNATIVE DESCRIPTION

It is included in the DPIA procedure that DPIAs must be signed off by the DPO prior to the commencement of the processing.

RIA-ME-7

Please provide evidence of the process for consulting the ICO in such circumstances.

UPLOADED FILES

-  [High Risk ICO Notification, DPIA Procedure.docx](#)

ALTERNATIVE DESCRIPTION

Please see extract from the DPIA procedure with specific reference to the ICO.

RIA-ME-8

Please describe how risk registers and the risk assessment of information assets are linked

The Trust's risk management process provides a structure for identifying and managing risks at all levels in the organisation. There are 3 Tiers at which risks may be identified, managed, controlled and monitored, these being:

- Tier 1 - Corporate
- Tier 2 - Directorate
- Tier 3 - Local – site or service/operational

Risks scored as high (15-25) are reviewed monthly, medium risks (8-12) are reviewed quarterly, and low risks (1-6) are reviewed every 6 months. These reviews take place with the risk owners supported by the risk team. The Board Assurance Framework is formally updated quarterly and reviewed by the ADLT and ELT as the senior internal risk forums before reporting to the Committees and Trust Board. Any additional actions on the high rated risks in between the cycles are reported verbally or in the cover report where

appropriate.
Principal risks are assigned to an Executive Director for ownership and to a Committee for oversight and assurance. A risk owner is the individual best placed, through their authority and influence, to take responsibility for mitigating the risk and is responsible for:

- Ensuring the risk is managed appropriately, controls are in place to mitigate the risk and an action plan is identified to address gaps in control measures;
- Reviewing the risk register at appropriate intervals and that progress is being made at sufficient pace to reduce the risk score to the target risk level;
- Liaising with action owners to ensure they are aware of their responsibilities for delivering actions (action owners have responsibility for activities to address gaps); and
- Reporting on the overall status of the risk.

Principal risks are presented to each Committee meeting in line with the agreed review cycles and are presented by the responsible Executive Director. The Audit

Committee receives the BAF at each meeting and it has oversight of the effectiveness of the systems and processes for the management of risks and the BAF.

The Information Risk Policy sets out the various methods for identifying and escalating IG and DP risks and concerns, including: -

- Identification through Information asset management reviews, escalated by the Information Asset Owner
- Identification through DPIAs (DPIAs have a risks table section where risks are then managed /escalated as needed under the DPIA procedure)

- Identification and management through incident reporting procedures, managed then through the Datix-risk system.

RIA-ME-9

Has the organisation
adopted a Risk
Management process:

- ✓ That includes provision for IG risks
- ✓ That includes appropriate policies, procedures and measures to identify record and manage information risks
- ✓ Where the policy/procedure sets out how the organisation, and where appropriate its data processors, manage information risk
- ✓ Where the policy/procedure sets out how the organisation monitors compliance with the information risk policy/procedure

RIA-ME-9

Please provide a copy
of the organisation's
risk management
policy/procedure.

UPLOADED FILES

 [Information Risk](#)

[Policy v1.5.pdf](#)

 [Risk Management](#)

[Policy v2.0 250925](#)

[Approved by TB.pdf](#)

Expectations Exceeded

100% (7/7)

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

RIA-EE-2

Is there a formal procedure to identify, record and manage risks associated with information assets in the organisation's information asset register?

Yes

RIA-EE-2

Please provide a copy of the policy/procedure.

UPLOADED FILES

 [Information Risk Policy v1.5.pdf](#)

 [Information Asset Owners and Administrators Handbook V5.pdf](#)

RIA-EE-3

Are high level unmitigated risks reported to the senior management team?

Yes

RIA-EE-4

Are DPIAs used to inform and assist in the development of privacy information to meet specific needs of the project/service?

Yes

RIA-EE-5

Are DPIA policies/procedures regularly reviewed to ensure they remain reflective of requirements?

Yes

RIA-EE-6

Are DPIA figures made available/visible to the senior management team or Board?

Yes

RIA-EE-6

Please provide evidence of the reporting of DPIA figures to the senior management team or Board.

ALTERNATIVE DESCRIPTION

DPIA figures are reported every month to the IGSG as part of the IG highlight report.

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Breach Response and Monitoring

Minimum Expectations

100% (4/4)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section.If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

BM-ME-1

Does the organisation have an incident management system in place to register, report and follow up on data breaches?

Yes

BM-ME-2

Where the organisation suffers a data breach or near miss, does the Organisation:

- ✓ Report to the senior management team or Board
- ✓ Report to the DPO when appropriate
- ✓ Notify individuals effected (where appropriate)
- ✓ Report in the incident management system
- ✓ Consider if forming a possible trend
- ✓ Conduct a root cause analysis (where appropriate)

BM-ME-3

Has the organisation suffered a data breach or near miss in the last 12 months?

Yes

BM-ME-1

Please explain how the incident management system works in practice.

The Welsh Ambulance Service Uses Datix Cymru. All Trust personnel have access to Datix and links to access through SharePoint. All staff have a responsibility to report a breach or where a potential breach has been identified. Once this risk has been identified, the Trust member should complete the Datix report as soon as possible. Once the report has been submitted, the Information Governance Team is notified of a new Datix report that may have an Information Governance Concern. The Information Governance Team will then review the report, confirm if there is an Information Governance concern and then proceed with an investigation.

Expectations Exceeded

100% (4/4)

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

BM-EE-1

Does the organisation have in place a process to review, monitor and learn lessons from personal data breaches to prevent re-occurrence?

Yes

BM-EE-1

Please provide evidence to demonstrate the process for reviewing, monitoring and learning lessons from personal data breaches.

ALTERNATIVE DESCRIPTION

Incidents are reviewed and reported monthly to IGSG including narrative of themes. Trends and number of incidents are tracked over time.

BM-EE-2

Is data protection and IG compliance audited?

Yes

BM-EE-2

Please provide evidence of completed audits.

UPLOADED FILES

 [Compliance Monitoring Schedule 2026.xlsx](#)

ALTERNATIVE DESCRIPTION

Audits and checks are completed (see Compliance Monitoring Schedule). An IG team compliance audit on Subject Access Requests was completed in August 2025.

In addition, completion of the IG toolkit acts as a monitoring function for overall IG and data protection compliance, and this is completed annually.

Internal audits are also completed via Audit Wales, and NWSSP.

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Freedom of Information (FOI) and Environmental Information (EIR)

Minimum Expectations

100% (7/7)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

FOI-ME-4	FOI-ME-5	FOI-ME-6	FOI-ME-7
Does the organisation take steps to make staff aware of how to recognise and where to direct any requests that may fall within the scope of Freedom of Information (FOI) or Environmental Information Regulations (EIR) that they may receive and understand the importance of doing so promptly due to the strict time constraints?	Has the Information Commissioner's Office (ICO) Model publication scheme or an organisational ICO approved scheme been adopted and made available to members of the public via the organisation's webpage?	Are clear communication points indicated on the organisation's website sign-posting where further/additional information can be found?	Have staff with responsibility for FOI & EIR received training to enable them to:
Yes	Yes	Yes	✓ Identify the difference between FOI & EIR Requests ✓ Coordinate responses ✓ Deal with complaints and appeals ✓ Deal with internal reviews

FOI-ME-4

Please provide evidence of guidance/training or other relevant information provided to staff outlining responsibilities.

UPLOADED FILES

-  [2024 007 Corporate Governance Notice](#)
- [Freedom of Information Guidance.pdf](#)
-  [FOI Guidance Document \(16.09.24\). IGSG Fbk 221024 LT 171124.pdf](#)

FOI-ME-5

Please provide a link to the organisation's publication scheme.
<https://ambulance.nhs.wales/files/foi-disclosure-logs/foi-publication-scheme-nov-20/>

FOI-ME-6

Please provide evidence of communication points indicating where further/additional information can be found.

UPLOADED FILES

-  [FOI contact on WAST Website.pdf](#)
-  [FOI further information indicators.pdf](#)

Expectations Exceeded

100% (5/5)

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

FOI-EE-1

Is the organisation's website content regularly reviewed to ensure it aligns with its publication scheme with data proactively published where appropriate?

Yes

FOI-EE-3

Does the organisation maintain an FOI disclosure log?

Yes

FOI-EE-4

Are FOI and EIR performance figures regularly reported to the senior management team or Board?

Yes

FOI-EE-3

Please provide a link to the organisation's disclosure log
<https://ambulance.nhs.wales/contact-us/freedom-of-information/>

FOI-EE-4

Please provide evidence of reports made to the senior management team or Board

UPLOADED FILES

-  [1. IGSG AAA Report Nov 2025 Redacted.pdf](#)

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Information Security

Minimum Expectations

100% (30/30)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

IS-ME-1

Are there processes in place for controlling physical and technical access for staff starting, moving and leaving the organisation?

Yes

IS-ME-2

Does the organisation maintain a record of all individuals with access to personal information on electronic systems?

Yes

IS-ME-4

Is staff access to systems:

- ✓ Monitored and Audited
- ✓ And staff are informed that access to the IT systems is monitored and audited

IS-ME-1

Please provide evidence of the organisation's starters, leavers and movers process.

UPLOADED FILES

-  [Access Control Policy 020120.pdf](#)
-  [New starters account creation.pdf](#)
-  [C3 Access Request Form v1.1.pdf](#)
-  [Leavers Process.pdf](#)
-  [EPGN 003 Building Security 2.docx](#)
-  [Access Controls Regime Template.docx](#)

ALTERNATIVE DESCRIPTION

For example, for CAD system access, in addition to NADEX account creation, there is form that users and line managers have to sign, these are recorded in the ICT service point (seec3 Radius form). "All accounts are reviewed monthly and any that have not been accessed within 3 months are disabled."

IS-ME-2

Please provide evidence to demonstrate a record is maintained.

UPLOADED FILES

-  [VUE Access Controls Regime 180124.docx](#)
-  [Extract from recently completed DPIA.PNG](#)

ALTERNATIVE DESCRIPTION

Each application where personal information can be accessed has a user list. (E.g. ePCR, CAD, CAS, WCP etc.)

User registers are contained within the systems/applications themselves including dates and times access was given, account status and permissions assigned. Examples of this include: - Welsh Demographic Service Secure File Share Portal ePCR CAS CAD Cleric and Datix. The DPIA process includes assessment of access controls, and template Access Controls Regimes are available. The example extract that has been uploaded is taken from the VUE Platform. A further extract from a recently completed DPIA is already attached. The user list can be managed on the application itself.

In addition, for ePCR,

IS-ME-4

Please provide evidence to demonstrate access is monitored and audited.

UPLOADED FILES

-  [Monitoring and Inappropriate Use Notice \(1\).pdf](#)

ALTERNATIVE DESCRIPTION

SIEM monitors users logging into machines. Defender for Identity monitors access to O365 account and flags abnormalities. Emails are monitored by MailMarshal FortiAnalyser - monitors internet sites. Microsoft Defender will block malicious sites. NIIS monitors inappropriate access to national systems. Existence of audit logs are checked as part of DPIA process. Audit logs can be obtained and checked on request e.g in response to incidents or complaints.

the user list maintained by IT on the Terrapace application. The user list can be managed on the application itself.

IS-ME-5

Has the organisation submitted a CAF Self-Assessment within the previous 18 months?

Yes

IS-ME-6

Do all computers and other devices used across the organisation have antivirus/anti-malware software installed that is kept up to date?

Yes

IS-ME-7

Does the organisation have a password policy/guidance providing advice to staff on managing their passwords?

Yes

IS-ME-8

Does the organisation have technical controls in place to enforce the password policy and mitigate against password-guessing attacks?

Yes

IS-ME-9

Are the IT systems and the software used in the organisation:

No longer supported by the manufacturer, however the risks are understood and managed for these systems/software and have been reported to the Board or senior management team

IS-ME-7

Please provide a copy of the password policy.

UPLOADED FILES

 [Password extraction from information security_policy.pdf](#)

IS-ME-8

Please detail the controls in place to enforce the password policy.

DHCW control the password Policy for NADEX, along with requirement for MFA. Individual systems are assessed for security controls as part of cloud assessments to ensure password arrangements are appropriate.

IS-ME-9

Please provide a copy of the risk assessment related to unsupported IT Systems or Software

UPLOADED FILES

 [WLARA0002 GRS WAST LEGACY ASSET RISK ASSESSMENT REDACTED.xlsx](#)

ALTERNATIVE DESCRIPTION

A redacted risk assessment of an example system has been uploaded. In addition, all legacy systems are logged on Lansweeper.

IS-ME-12

Do all areas in the organisation, where personal information can be accessed, have physical controls in place to prevent unauthorised access?

Yes

IS-ME-12

Please provide examples of the controls in place to such areas.

Paxton Access Cards
CCTV
Physical security audits
Alarms systems

IS-ME-13

Are staff made aware and encouraged to maintain security measures in their own department/work areas/branch?

Yes

IS-ME-13

Please detail how staff are made aware and encouraged to maintain security measures.

Staff are made aware of physical security requirements through the IS Policy, Access Control Policy and building inductions. Physical security is part of the Information Security Campaign Planner to continue to raise staff awareness. Lock screen screensavers are published to all devices with top tips for physical security.

IS-ME-14

Are staff made aware of the reporting procedures in the event of any physical or technical security concerns?

Yes

IS-ME-14

Please detail how staff are made aware of the reporting procedures.

The Access Control Policy states: ""Any unauthorised access shall be reported as an adverse incident via the DATIX Adverse Incident reporting system"". The Information Security Policy states ""You shall not - Ignore security flaws, faults, weaknesses or incidents you come across (This can include building, ICT or processes etc). o These shall be reported as soon as possible to the ICT Service Desk so they can be raised with the Information Security Team. This shall also be raised on Datix too."

IS-ME-15

If the organisation allows staff to use their own devices (e.g. phones) for work purposes, is there a Bring Your Own Device policy in place?

Yes - a BYOD Policy is in place

IS-ME-15

Please provide a copy of the Bring Your Own Device policy.

UPLOADED FILES

 [2024 016 Digital Services notice Bring Your Own Device \(BYOD\).pdf](#)

IS-ME-16

Does the organisation have in place appropriate procedures and technical controls for the use of mobile devices such as smart phones to prevent unauthorised access/inappropriate use?

Yes

IS-ME-17

Has the organisation issued appropriate guidance to staff, directors, trustees and volunteers in relation to the use of public Wi-Fi for work purposes?

Yes

IS-ME-18

Does the organisation ensure that the passwords of all networking components, such as a Wi-Fi router, have been changed from their original passwords?

Yes

IS-ME-19

Does the organisation ensure that all laptops, tablets or removable devices that hold or allow access to personal data are encrypted?

Yes

IS-ME-16

Please detail the controls in place for smart phones and other mobile devices supported by the organisation.

Machines - Microsoft security baseline, windows defender baseline policy is applied. Bitlocker encryption and various Defender for End-Point attack surface reduction policies.

CAD machines - SophosInterceptX. CAD machines are also on a separate network to prevent unauthorised access.

iPads

We have adopted Mobile Device Management solutions to centralize the management and security of mobile devices and iPad's through InTune. This allows us to enforce security policies, configure devices, and remotely wipe data in case of loss or theft.

To prevent unauthorized access, we enforce strong password policies and utilize multi-factor authentication (MFA) mechanisms. This adds an additional layer of security beyond traditional username and password authentication.

IS-ME-17

Please provide a copy of your organisational policy, procedure or guidance issued to staff in relation to the use of public WIFI.

UPLOADED FILES

 [Public WIFI advice.docx](#)

 [Info Sec Policy Public WIFI.docx](#)

ALTERNATIVE DESCRIPTION

Guidance has been included in the Information Security Policy, it is also referred to in the MetaCompliance Blog under top ten tips, and included in an episode of cyber security metacompliance training.

In the unfortunate event of a lost or stolen device, our organization has the capability to remotely wipe or lock the device, mitigating the risk of unauthorized access to sensitive information.

We also employ whitelisting and blacklisting measures to regulate the types of applications that can be installed on mobile devices. This helps prevent the installation of potentially harmful or unauthorized applications.

MDTs

we have a PIN number required for the driver and attendant (will accept only the driver if no attendant).

Once the PIN is input the system is accessible.

Security aspects are that when the vehicle arrives "on scene" the screen blanks to hid all information. The screen also blanks when "arrival at hospital".

The user has to touch two different parts of the screen to un-hide the information.

When the user logs off the MDT all data relating to jobs carried out by the crew are deleted and the MDT is left with NO patient data.

The radios are protected by a PIN

number to obtain access and work. If we loose or misplace a radio we can stun and or kill remotely.

IS-ME-20

Does the organisation have in place appropriate procedures for the management, transportation and storage of paper records removed from the building?

Yes

IS-ME-20

Please provide a copy of your organisational policy, procedure/SOP for the management of paper records removed from organisational premises.

UPLOADED FILES

 [Information Security Policy v2.1.pdf](#)

Expectations Exceeded

100% (2/2)

Minimum Expectations not met

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

IS-EE-1

Are routine
information security
checks/audits regularly
conducted that
consider compliance
with information
security policies and
procedures and:

- ✓ Any identified areas
of concern are included
in an information
security improvement
plan and escalated
appropriately
- ✓ Information security
audits outcomes are
reported to the senior
management team or
Board

IS-EE-1

Please provide evidence of internal audits/routine checks that have been regularly conducted.

ALTERNATIVE DESCRIPTION

Routine information security assurance activity is undertaken across the Trust. Cyber Assessment Framework (CAF) assessments are completed by the Cyber Security Team across the Trust's portfolio of information assets, providing ongoing assurance against recognised information security standards. In addition, a full NIS self-assessment has been completed.

External assurance is also provided through audits undertaken by the CRU, which assess different elements of NIS on a rolling basis. The Trust is also scheduled to undergo a full external audit, planned for May, which will provide further independent assurance of compliance with information security policies, procedures, and regulatory requirements.

Furthermore, a recent internal audit led by Cyber Team was undertaken on the ICT Service Desk to test user-credential reset process and social

engineering
preparedness.

I confirm that all answers provided and evidence
uploaded is accurate and up to date

Yes

Video Surveillance

Minimum Expectations

100% (14/14)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

VS-ME-1

Has the organisation completed a Data Protection Impact Assessment (DPIA) on their video surveillance systems?

Yes

VS-ME-2

Does the Data Protection Impact Assessment (DPIA) cover video surveillance with functionality beyond image capture for example audio recording and facial recognition where this is in use?

N/A

VS-ME-3

Does the organisation have policies and procedures in place detailing the use of video surveillance?

Yes

VS-ME-1

Please provide a copy of the relevant Data Protection Impact Assessment (DPIA).

UPLOADED FILES

 [Estates CCTV DPIA v2.2 Risks Redacted.pdf](#)

 [Fleet CCTV DPIA v2.2 Risks Redacted.pdf](#)

 [DPIA HART DRONE V1.9 Risks Redacted.pdf](#)

ALTERNATIVE

DESCRIPTION

DPIAs have been completed for - Drones, Fleet CCTV, and Estates CCTV.

VS-ME-3

Please provide a copy of or an extract from the relevant policies or procedures.

UPLOADED FILES

 [CCTV & Surveillance Systems Policy FPC Approved.pdf](#)

ALTERNATIVE

DESCRIPTION

The attached version is the newly revised and final approved policy, which has been approved by all relevant committees including ELT and FPC. It is due to be published at beginning of April 2026.

VS-ME-4

Does the organisation have a nominated individual who is responsible for the operation of the video surveillance system?

Yes

VS-ME-5

Does the organisation have an established process to recognise and respond to requests for video surveillance footage/images?

Yes

VS-ME-6

Does the organisation ensure staff are trained to operate video surveillance systems and can recognise requests for video surveillance footage/images?

Yes

VS-ME-7

How long does the organisation retain recorded video surveillance footage/images?

Standard retention is 28 days.

Footage may be retained for longer where there is a legal need (e.g. in defence of court claims.)

VS-ME-8

Does your organisation ensure that video surveillance footage/images are clear and of a high quality?

Yes

VS-ME-9

Does the organisation securely share and store video surveillance footage/images, limits access to authorised individuals and regularly checks that the video surveillance system is working properly?

Yes

VS-ME-10

Does the organisation have clearly displayed signs that inform individuals that video surveillance is in operation?

Yes

VS-ME-11

Does the video surveillance signage include an explanation of the reason for its use?

Yes

VS-ME-12

Does the video surveillance signage include who to contact about video surveillance?

Yes

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes

Business Continuity

Minimum Expectations

100% (11/11)

Completing all of the questions in this group indicates that you meet the minimum expectations to fulfil your responsibilities set out in this section. If you answer any of the questions in a way that means you do not meet the minimum expectations, additional guidance will appear to support you.

BC-ME-1	BC-ME-2	BC-ME-3
Does the organisation have a business continuity plan that covers information and cyber security?	Has the organisation appointed an individual or team with responsibility for information and cyber security business continuity?	Is there an effective test of the business continuity plan and disaster recovery plan for information and cyber security incidents?
Yes	Yes	Yes

BC-ME-1

Please provide a copy or an extract of the business continuity plan.

UPLOADED FILES

 [ePCR DPIA Extract](#)

[Business](#)

[Continuity.png](#)

 [RPA DPIA Extract](#)

[Business](#)

[Continuity.png](#)

 [UPCC Referrals DPIA](#)

[Extract Business](#)

[Continuity.png](#)

ALTERNATIVE DESCRIPTION

Business continuity arrangements are assessed as part of one of the DPIA questions and as part of Cloud Security Assessments for cloud based software (see DPIA extracts as example). In addition, the Trust has multiple BC Plans which are managed by each directorate. The Trust has an ICT Disruption Plan which covers technical and information security events which can be provided on request (it has not been uploaded due to the sensitive nature of the plan). WAST also has an Incident Response Plan which provides a framework for WAST to respond to a range of incidents within Wales, including major, mass casualty incidents and incidents that require a

BC-ME-2

Please provide evidence to show the organisation has assigned appropriate responsibility for information and cyber security business continuity.

UPLOADED FILES

 [ICT Managers JD BC responsibility.docx](#)

ALTERNATIVE DESCRIPTION

Assistant Director of Digital Services (ICT) has assigned responsibilities within their JD.

BC-ME-3

Please confirm the date a test was last conducted on the business continuity plan.

16-Sep-2025

specialist response. It includes provisions for business continuity events.

BC-ME-4

Are all emergency contacts kept securely, in hardcopy and are up-to-date?

Yes

BC-ME-5

Are staff made aware of:

- ✓ The implication of the Business Continuity Plan for information and cyber security in their role
- ✓ How they can access the plan

BC-ME-6

Does the organisation have working backups of all important data and information that have been tested at least annually?

Yes

BC-ME-5

Please provide evidence of how staff are informed of the business continuity plan for information and cyber security.

UPLOADED FILES

 [BC Awareness Plan from SharePoint.pdf](#)
 [BC Awareness Cyber Resilience.pdf](#)

ALTERNATIVE DESCRIPTION

Exercise Joshua was a full test of the ICT Critical Disruption BC Plan and involved all relevant staff to ensure full awareness of the plan and required actions. The Exercise Joshua Report can be made available on request but has not been uploaded due to the sensitive nature of the information. Relevant excerpts from the report include: -
 "4.1 Service Manager, Head of Service, and Assistant Directors from Operations were invited to the awareness session and the exercise. They were welcome to pass the invitations wider within their teams if they felt it would be beneficial. Business Continuity Leads from all other departments were also invited as they may be dependants or dependencies.
 4.2 Groupings for the

BC-ME-6

Please provide the date of the last backup and recovery test.

14-Oct-2025

breakout rooms were

- 111, CCC, CSD, ODU, and resourcing
- Ambulance Care
- EMS
- Other departmental BC Leads"

In addition 'doomsday packs' have been produced and made available for ease of access at sites when under a BC event.

Expectations Exceeded

100% (4/4)

Completing any proportion of the questions in this group indicates that you exceed the expectations required to fulfil your responsibilities set out in this section. Please note, the questions in this group will be disabled until the minimum expectations are met.

BC-EE-1

Is the business continuity plan for information and cyber security regularly reviewed and updated accordingly?

Yes

BC-EE-2

Has the business continuity plan been approved by the senior management team or Board?

Yes

BC-EE-1

Please provide evidence of the review process.

ALTERNATIVE DESCRIPTION

WAST Incident Response Plan - last updated June 2025.
ICT Disruption Plan - last approved November 2022.
Power Outage Plan - last approved May 2024.

BC-EE-2

Please provide evidence of the approval process.

ALTERNATIVE DESCRIPTION

The Trust has a range of BC Plans to ensure continuity of emergency services, and has a dedicated EPRR Team. Plans include: -
WAST Incident Response Plan - last updated Jun 2025.
111 BC plan - October 2025.
EMSC BC Plan - December 2025
ICT Disruption Plan - last approved 4/8/25.
Power Outage Plan - last update May 2024 by EPRR Specialist Operations.
ICT BC Plan - last approved April 2023 by AD of Digital Services.

I confirm that all answers provided and evidence uploaded is accurate and up to date

Yes



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Agenda Item No. 14

REPORT TITLE

Risk Management and Board Assurance Framework Report

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the seven risks that are relevant to this committee's remit.
2. The summary of these risks is set out in Annex 1, and the more detailed Board Assurance Framework (BAF) is in the reading room. This provides the committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable.



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3. Members are asked to note that each of the principal risks have been reviewed since the last meeting and in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25.
4. **Risk 260** *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems* remains static at a score of 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations. The specific detail and planned mitigations of this risk will be considered in closed session of committee today due to the sensitive and security based nature of these and is not included in Annex 4.
5. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in open session in full transparency. However, members will note that the actions to address individual recommendations are not included in detail in the BAF extract. This is for reasons of sensitivity and security.
6. **Risks 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan*, current score 16 (4x4), is under active review. Work is ongoing to reframe the risk in line with the Welsh Government SDP and the Trust's revised risk presentation approach, which will including the articulation of new and emerging risks. A timeline for this programme of work is in development, reflecting the resources available to support it. The revised risks will clearly distinguish between internal and external controls, assurances and gaps; set out those matters the Trust directly manages and those it monitors; and describe assurance across the three lines of defence.
7. **Risk 671** *Unauthorised or Inappropriate use of AI technologies* remains static at a score of 16 (4x4) with a target of 8 (2x4). An AI Steering Group (AISG) has been established, reporting into Information Governance Steering Group, meeting for the first time in October 2025, to ensure the approach of "responsible AI" across the Trust.
8. **Risk 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* remains unchanged this period and static at a score of 15 (3x5).
9. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* remains static at a score of 12 (3x4) during this period; however, work has commenced to reframe this risk to align with the current context.



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10. **Risk 139** *Failure to Deliver our Statutory Financial Duties in accordance with legislation* remains unchanged at a score of 12 (3x4) during this period.
11. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the risk owner to describe the rationale for each of the risk ratings which is particularly important where ratings have remained static or increased.

RECOMMENDATION(S)

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

12. The Finance & Performance Committee is requested to receive assurance that risks have been reviewed in quarter.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

The Finance & Performance Committee is requested to receive the following:

1. Annex 1 – Principal Risk Summary
2. Annex 2 - Board Assurance Framework (in reading room)



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to objectives and what good looks like\]](#)

☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

As above, this paper goes to mitigations against finance and performance related risks.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [\[link to standards\]](#)

☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred

Quality Enablers (select all that apply) [\[link to standards\]](#)

☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement & Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to goals\]](#)

☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
08 April 2026	Executive Leadership Team

Annex 1 – Principal Risk Summary

CORPORATE RISK REGISTER				
RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
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 (5x4) ➔
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	IF there is a lack of resources and available technology and infrastructure THEN there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines RESULTING IN negative environmental and social impacts causing and reputational damage	Executive Director of Finance & Corporate Resources	16 (4x4) ➔

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
671 FPC	Unauthorised or Inappropriate use of AI technologies	IF staff use Gen-AI tools such as ChatGPT, Co-Pilot or other AI enable platforms outside of approved organisational channels or without appropriate governance THEN information passed into, accessed by, or returned by the AI tools may breach information security and data protection controls, and use of the output may breach transparency, medical device, equality, Welsh Language and ethical requirements RESULTING IN potential breach of confidentiality and data protection law, data, damage to Trust, and non-compliance with other legislation, regulation and standards.		16 (4x4) 
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) 
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of	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	Executive Director of Strategy Planning & Performance	12 (3x4) 

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
	patient safety and experience.	RESULTING IN a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered		
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	IF the Trust does: - not achieve financial breakeven and/or - does not meet the planning framework requirements and/or - does not work within the EFL and/or - fails to meet the 95% PSPP target and/or - does not receive an agreement with commissioners on funding (linked to 458) THEN there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Executive Director of Finance & Corporate Resources	8 (2x4) 



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Agenda Item No. 15

REPORT TITLE

Audit Tracker 25-26 Q4 (Jan-Mar26) - Exception Reporting

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	19 May 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

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

EXECUTIVE SUMMARY:

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

1. This paper provides the Committee with the 2025/26 quarter 4 position with respect to management actions for audits within the purview of this committee.
2. The Audit Handbook notes that it is the responsibility of this committee to:
 - Receive audits in their remit;
 - Monitor management actions to address recommendations; and
 - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.



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3. The Audit Tracker has been updated in quarter 4 of 2025/26. To reduce the volume of papers presented to committee, rather than supply a copy of the tracker, the committee is provided with an audit exception report, of which this is the first version. This will provide the committee with details of high audit actions or audit actions from limited assurance audits, where a final revised date has been sought.
4. It is intended that exception reporting will provide committee with the information it requires to receive assurance regarding the mitigation in place to address the risks identified via internal audits, and provide the necessary information for challenge where further assurance may be needed. The content and format of the exception report will evolve as feedback is received regarding committee requirements.

Internal Audit

5. During 2025/26 quarter 4, there were a total of 22 open internal audit recommendations relevant to the committee. Of the 22 open internal audit recommendations, fourteen were due to be completed in quarter, and eight were not yet due.
6. By end of quarter, one internal audit action was confirmed as completed. The action closed related to the 2024/25 Vehicle Accident Management internal audit and was completed by its 1st revised implementation date.
7. During quarter 4, there were two open high priority internal audits actions on their final revised dates – these have been reported to the private session of this committee.
8. There were also three open internal audit actions related to limited assurance audits on their 2nd (final) revised date (one of which has been reported to the private session of this committee):

Audit Ref. & Description	Original Date	1 st Revised Date	2 nd Revised Date
Audit Action: 053-24/25 Vehicle Accident Management Internal Audit [Action No. 1] ~ Establish a task and finish group with key stakeholders to review current processes, develop and support implementation of guidance checklists.	30/09/2025	31/12/2025	31/07/2026
Audit Action: 054-24/25 Vehicle Accident Management Internal Audit [Action No. 2] ~ Establish a task and finish group with key stakeholders to review current processes and documentation in place. Agree where central listing of documentation will be held and how it will be managed and monitored.	30/09/3035	31/12/2025	30/04/2026



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9. At the end of quarter, there were 21 remaining open actions, which are due for completion as shown below:

Year	Quarter	Period	No. Audit Action Due for Completion
2026/27	Quarter 1	April – June 2026	15
	Quarter 2	July – September 2026	5
	Quarter 3	October – December 2026	1
	Quarter 4	January – Mach 2027	0

External Audit

10. During 2025/26 quarter 4, there no open external audit recommendations relevant to the Committee.

RECOMMENDATION(S)

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

The Committee is requested to:

1. Review and scrutinise the current position regarding high priority and limited assurance audit actions that are on their final revised date and ensure that there is sufficient assurance in terms of mitigation of associated risks.

ADDITIONAL PAPER(S)

n/a



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment	N/A [DPIA Checklist > DPIA not indicated]

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
27 April 2026	Director of Corporate Governance/Board Secretary