Bundle Finance and Performance OPEN 15 January 2024

Agenda attachments
ITEM 0 Open F and P Agenda -15 January 2024

0 09:30 - OPENING ITEMS

1 Chair's welcome, apologies, and confirmation of quorum

2 Declarations of Interest
Declarations of Interest

3 Minutes of last Meeting - 13 November 2023
ITEM 3 OPEN FPC Minutes - 13 November 2023

4 Action Log and Matters Arising
4.2 13 November Committee AAA Report
ITEM 4.1 Action Log (Public) FPC
ITEM 4.2 Finance and Performance Committee Highlight Report November 2023

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - Operations Quarterly Update
ITEM 5 Operations Quarterly Report for Committees 23-24 Q3

6 09:55 - Financial Position for Month 9 - Presentation

7 10:15 - Financial Sustainability Programme
ITEM 7 FPC FSP Update

8 10:30 - Environment, Decarbonisation and Sustainability Update January 2024
Note: ITEM 8.1 has been circulated separately by e mail
ITEM 8 FPC update Jan 2024 - Decarb (1)

9 10:45 - Risk Management and Board Assurance Framework
ITEM 9 Executive Summary Risk Management Report FPC 150124

10 10:55 - Audit Tracker and Audit Reports
10.1 Estates Assurance: Estates Condition
10.2 111 Service Commissioning (Advisory)
ITEM 10 SBAR Audit Tracker to FPC Q3 Reporting - January 2024
ITEM 10 Audit Tracker 2.0 Q3 October-December 2023 - Copy for Committee Reporting post ADLT 05012024
ITEM 10.1 WAST-SSU-2324-02 Estates Condition Final Audit Report
ITEM 10.2 WAST 111 Commissioning Final Advisory Report_for issue

11 11:05 - Integrated Medium-Term Plan (IMTP) 2023 - 2026 - Q3 Delivery & Assurance
ITEM 11 Executive Summary - IMTP Q2Q3 Delivery & Assurance
ITEM 11.1 Appendix 2 1501 - IMTP Delivery Assurance Report Jan24
ITEM 11.2 Appendix 3 Strategy Development Highlight Report

12 11:20 - Integrated Medium-Term Plan (IMTP) 2024-27 - Progress in developing the plan
ITEM 12 Executive Summary - IMTP Planning Progress Jan 24 FINAL

13 11:40 - Monthly Integrated Quality and Performance Report
ITEM 13 MIQPR SBAR FPC November 2023
ITEM 13.1 Annex 1 MIQPR FPC November 2023
ITEM 13.2 Interim ELT Presentation 10.01.2024

14 11:55 - ITEM REMOVED

15 11:55 - Digital Reporting - Cyber
ITEM 15 Digital Reporting Jan 2024 - Cover Paper
ITEM 15.1 Digital Reporting Jan 24 Open FPC

16 12:05 - Fire Safety Compliance - January 2024
ITEM 16 FPC Fire Safety Compliance

16.1 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.

17 Cycle of Business Monitoring Report and Review of Committee Priorities
ITEM 17 Finance and Performance Committee Priorities and Cycle Monitoring Report
ITEM 17.1 Finance and Performance Committee Cycle of Business 2023-24 - Monitoring

17.1 12:10 - CLOSING ITEMS
18 Reflection & Summary of Decisions and Actions
19 Any Other Business
20 Date and Time of Next Meeting; 19 March 2024 - 09:30

MEETING OF THE OPEN FINANCE AND PERFORMANCE COMMITTEE

Held on 15 January 2024 from 09:30 to 12:35 (Includes Comfort Breaks)

Comfort breaks throughout meeting – Total 20 Minutes
Break between Open and Closed – 20 Minutes

Meeting held virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Joga Singh	Verbal	5 Mins
2.	Declarations of Interest	Information	Joga Singh	Verbal	
3.	Minutes of last Meeting – 13 November 2023	Approval	Joga Singh	Paper	
4.	4.1 Action Log and Matters Arising 4.2 13 November Committee AAA Report	Review	Joga Singh	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Operations Quarterly Update	Assurance	Jonathan Edwards	Paper	20 Mins
6.	Financial Position for Month 9	Assurance	Chris Turley	Presentation	20 Mins
7.	Financial Sustainability Programme	Assurance	Angela Lewis	Paper	15 Mins
8.	Environment, Decarbonisation and Sustainability Update January 2024	Assurance	Chris Turley	Paper	15 Mins
9.	Risk Management and Board Assurance Framework	Assurance	Julie Boalch	Paper	10 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
10.	Audit Recommendation Tracker *Internal Audits:* 10.1 Estates Assurance: Estates Condition 10.2 111 Service Commissioning (Advisory)	Assurance	Trish Mills Chris Turley Rachel Marsh	Papers	10 Mins
11.	Integrated Medium-Term Plan (IMTP) 2023 – 2026 - Q3 Delivery & Assurance	Assurance	Rachel Marsh	Paper	15 Mins
12.	Integrated Medium-Term Plan (IMTP) 2024-27 – Progress in developing the Plan	Assurance	Rachel Marsh Chris Turley	Paper	20 Mins
13.	Monthly Integrated Quality and Performance Report	Assurance	Rachel Marsh	Paper	15 Mins
14.	ITEM REMOVED	ITEM REMOVED	ITEM REMOVED	-	-
15.	Digital Reporting	Assurance	Jonny Sammut	Paper	10 Mins
16.	Fire Safety Compliance – January 2024	Approval	Chris Turley	Paper	5 Mins
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.**					
17.	Cycle of Business Monitoring Report and Review of Committee Priorities	Information	Trish Mills	Paper	-
CLOSING ITEMS					
18.	Reflection & Summary of Decisions and Actions	Discussion	Joga Singh	Verbal	5 Mins
19.	Any Other Business	Discussion	Joga Singh	Verbal	
20.	Date and Time of Next Meeting; 19 March 2024 - 09:30	Information	Joga Singh	Verbal	

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Jonathan Edwards	Assistant Director of Operations – Resourcing and EMS Coordination
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Angela Lewis	Director of People and Culture
Joga Singh	Chair and Non-Executive Director
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources

UNCONFIRMED MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 13 NOVEMBER 2023 VIA TEAMS

Meeting started at 09:30

PRESENT:

Joga Singh	Non-Executive Director and Chair of Committee
Professor Kevin Davies	Vice Chair of the Board and Non-Executive Director
Bethan Evans	Non-Executive Director
Martin Turner	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Fflur Jones	Audit Wales
Angela Lewis	Director of People and Culture
Rachel Marsh	Executive Director of Strategy and Planning
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Felicity Quance	Internal Audit NWSSP
Jonny Sammut	Director of Digital Services
Alexandra Toufekoula	Temporary Senior Commissioning and Performance Analyst
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Damon Turner	Trade Union Partner
Chris Turley	Executive Director of Finance and Corporate Resources

APOLOGIES:

Osian Lloyd	Head of Internal Audit NWSSP
Trish Mills	Board Secretary
Liam Williams	Executive Director of Quality and Nursing

69/23 PROCEDURAL MATTERS

The Chair welcomed all to the meeting and reminded attendees that the meeting was being audio recorded. Members noted that any declarations of interest were contained within the Trust's Register of Interests.

Apologies

Apologies were recorded for Osian Lloyd, Trish Mills and Liam Williams.

Minutes

The minutes of the open session held on 18 September 2023 were considered by the Committee and confirmed as a correct record.

Action Log

The Action log was considered, and the following actions were recorded as follows:

Action Number: Action Number 57/23: Financial Position, update on confirmation of the £5.7m funding. An update was provided later on in the Agenda. Action Closed.

Action Number: 58/23: Financial Sustainability Programme, updates to be received on a quarterly basis. Action Closed.

Committee Highlight Report – 18 September 2023

The Committee highlight report from the 18 September 2023 Committee meeting was presented for the Committee's attention.

RESOLVED: The

(1) Minutes of the meeting held on 18 September 2023 were confirmed as a correct record;

(2) Action log was considered and updated as described; and

(3) The Committee highlight report dated 18 September 2023 was presented for information.

70/23 FINANCIAL SUSTAINABILITY PROGRAMME

Angela Lewis presented the Committee with an update on the Financial Sustainability Programme (FSP) adding that it will be a regular quarterly update going forward..

Good progress has been made; as of the end of Q2 2023/24 the Trust was targeted to achieve the targeted £6m savings through ongoing efficiency and income schemes, with an overachievement of £419K vs forecast in month 5 which increased to £521K in month 6. This position was likely to be offset by Winter pressure spending, however. There was a commitment across the organisation to consider further income generation opportunities throughout 2023/24 and there was significant engagement and commitment across the Trust on the delivery of the FSP.

Comments:

The Committee welcomed this positive direction of travel and queried if a risk analysis had been completed to identify any potential pitfalls. Angela Lewis gave assurance that any potential risks were considered adding that the relevant scrutiny and governance channels ere applied before committing to any schemes. The Committee also recognised that to sustain this current level of income generation the Trust may have to push the boundaries around risk appetite.

It was queried whether the vacancy management savings scheme of c£2.3m was a permanent measure and sought clarity in terms of this and whether it would feature going forward. Angela Lewis explained that all the front line posts have been filled, however it was more challenging to achieve in the corporate roles. She added it was a relatively light touch approach to vacancy management and was being managed to ensure front line staff were not affected but that it has had a significant impact on vacancy management. Chris Turley added that the vacancy management aspect had been part of the savings plan over the last 10 years and that the Recruitment Control Panel has supported the delivery of the FSP. Trust reserved the right to move the budget allocations where significant vacancies may arise, and it was a permanent feature of the savings requirement.

With regards to income generation, the Trust was not used to operating in a more commercial environment, and the Committee queried if there was any mileage in liaising with organisations with a more commercial view. Angela Lewis advised that she had met with some commercial organisations and asked for Members to share particularly in a value-based environment organisation if they had any connections or ideas.

RESOLVED: That the Committee noted the report.

71/23 FINANCIAL POSITION MONTH 7, 2023/24

The Committee received an update in the form of a presentation from Chris Turley on the financial position for Month seven, 2023/24. The key points were:

1) The cumulative year to date (at Month 7 end of October 23) revenue financial position reported was an underspend against budget of £0.108m.

2) The Income and Expenditure forecast for 2023/24 is one of breakeven.

3) The Capital plan was being progressed and current planned expenditure of £20.6m was forecast to be fully spent by the end of the financial year.

4) In line with the financial savings plans that supported the Integrated Medium Term Plan (IMTP), gross savings of £4.3m have been achieved against a year-to-date target of £3.7m.

5) Public Sector Payment Policy was on track with cumulative performance to quarter 2, against a target of 95%, of 96.4% for the number, and 98.6% of the value of non-NHS invoices paid within 30 days.

In terms of key assumptions underpinning the year-to-date financial performance the Committee's attention was drawn to the following points:

1) At Month 7 these, remained broadly in line with that within the March approved IMTP/Trust Board financial plan and budget set.

2) Full delivery of c£6m identified savings now assumed and forecast to deliver this as a minimum in 2023/24.

3) A level of contingency & reserves not profiled into the month 7 year to date (YTD) position due to the income risks currently outstanding / only just confirmed.

4) Full impact of the residual pay awards for 2022/23 and 2023/24 and any recurrent impact for 2023/24 of the 2022/23 elements were assumed to be fully funded by Welsh Government (WG).

5) Following confirmation from WG in early November the Trust was not required to contribute anything more to the overall NHS Wales deficit.

6) With regards to the £5.7m funding for the 100 WTE, the funding confirmed in year was £3.5m. The associated risk around the receipt of the balance of the £5.7m has therefore been removed, as it was accepted that the balance of this sum will not be received. The Trust was still able to deliver a year to date and forecast balanced financial position however, due to the following:

    a. A number of short term vacancies materialising within the 100 / overall front line funded establishment;
    b. The greater volatility experienced in seeking to cover some of these through variable pay, with some of the uptake of this not being as great as may have been expected;
    c. The holding of a contingency reserve and a small number of other budgets later into the financial year than is usual due to the previous potential of having some element of funding reduction in year to contribute to the wider NHS Wales deficit reduction. Now it has been confirmed that this is not required, this is available to offset elements of spend previously assumed out of the £2m outstanding funding, and
    d. An increasingly likelihood of over delivery against the Trust's savings target in year

Members were therefore assured that the Trust was still able to forecast delivery of in year balance due to prudent and cautious financial management. The recurring impact of this will be demonstrated in the 2024/25 financial planning discussions but the current assumption was that the full £5.7m will be required on an ongoing basis.

The Committee noted that Capital spend was mostly on track, following the fixing of the 23/24 Capital Expenditure Limit;

1) Orders and tenders being processed for new schemes; and

2) There were noticeable cost pressures being felt across all schemes, this was being reviewed monthly, with cost reports being analysed by scheme owners / project managers then "Value Engineer" when possible, however some of these costs were unavoidable and were therefore adding to cost pressures for some projects.;

Comments:

Following a query into any savings requirements for the next financial year, Chris Turley advised that the focus on all NHS organisations was currently on this year's savings. He added that the amount would be similar to 2023/24 and would be in the region of £6m. Chris Turley explained the challenges, the service pressures and ongoing risks which would affect the savings plan. He added that a report presenting the approach and assumptions for budget setting for 2024/25 would be brought to the next Committee meeting.

It was queried whether there was a true sense of what the irreducible minimum funding was to run a safe service against the risk of the Trust's ambitions going forward. Rachel Marsh explained that work was ongoing to articulate this through the demand and capacity review, but with no extra money the Trust will struggle to transform at pace. She added this would form part of the discussion with Commissioners.

RESOLVED: The Committee:

(1) Noted the financial position for month 7, 2023/24;

(2) It was agreed that a report presenting the approach and assumptions for budget setting for 2024/25 would be brought to the next Committee meeting; and

(3) Noted the update regarding the financial risks and it was accepted that the balance of the £5.7m would not be received, whilst also noting the ways in which the Trust will still be able to forecast a balanced position by financial year end.

72/23 VALUE BASED HEALTHCARE REPORT

Chris Turley explained that the report set out the current position of the Value Based Healthcare (VBHC) Working Group.

The work programme included the following seven workstreams – Patient Recorded Outcome Measures (PROMS), Patient Data Linkage, Patient Recorded Experience Measures (PREMS), Patient Level Information and Costing System (PLICS), Revenue Business Case

Process, Evaluation Framework & Methodology, and Benchmarking.

All the workstreams were progressing well and the Benchmarking work is due to recommence in November 2023 subject to capacity.

Rachel Marsh added that the Trust was developing a VBHC framework to determine the purpose and direction of VBHC which will demonstrate the difference the Trust was making to patients.

RESOLVED: The Committee noted the position and progress on developing Value Based Healthcare within the Trust.

73/23 TACTICAL FORECASTING & MODELLING (WINTER) – 2023/24

Rachel Marsh presented the Winter Forecasting and Modelling Report for 2023/24 which was based on a range of factors including demand, time at hospital, resource capacity and a variety of operational changes and improvements such as roll out of Cymru High Acuity Response Unit (CHARU), increases in consult and close rates, and reductions in sickness absence.

The Trust asked OMDA (Optima) to forecast performance for four separate winter periods in 2023/24.

- Sunday 1st October – Thursday 30th November 2023 ("Oct/Nov");
- Friday 1st December – Saturday 6th January 2024 ("DecJan1");
- Sunday 7th January – Thursday 29th February 2024 ("Jan234Feb"); and
- Friday 1st March – Sunday 31st March 2024 ("Mar").

In each of the above periods three scenarios had been created for each period. Best case, Most Likely Scenario, and Reasonable Worst Case. The 'Most Likely Scenario' within the modelling estimates a Red 8-minute performance of 50% for October & November, declining to 45% in December and early January, before recovering in the New Year. The modelling estimates that the 65% Red 8-minute target will not be achieved at any point through the Winter, with Amber waits also being too long.

Most of the performance metrics were far worse than the Trust would consider acceptable and the '% RED 8mins' performance target (65%) failed to be met in any scenario. These results would be shared with Commissioners to advise them of the impact over the Winter period.

The Trust has several short and long-term actions in place to mitigate this position, and a fuller report will be taken to the Trust Board in November outlining the full plans to improve responses and mitigate harm. The continually challenging situation influenced by worsening handover delays and system pressures was noted by the Committee.

The direct relationship between worsening performance and patient safety and outcomes was acknowledged; with the forecasting presented giving rise for significant concern for patient safety risk and avoidable harm during the Winter period.

Comments:

Members expressed their ongoing frustration across the whole system as there appeared to be no meaningful traction for any improvements, and as the modelling suggests the same challenges from last Winter will again be inevitable.

Rachel Marsh indicated that it was unlikely there would be any improvement to the overall performance given the mitigating actions were mostly outside of the Trust's control. From the Trust's perspective, it was important to demonstrate the actions it was able to deliver.

It was accepted that the long waits for an ambulance were not always the fault of the Trust given the exceptionally long hospital handover delays. There will be an opportunity at the next Emergency Ambulance Services Committee (EASC) meeting for the Trust to present a case for what it could do differently to improve the situation.

Lee Brooks accepted that the modelling has shown that the Winter was not necessarily about achieving the 65% target, it is about keeping as many patients as possible as safe as possible. He added that there were currently delays at hospitals reaching 15 hours where the backstop has been a maximum of 4 hours. From what the current data was showing, the position was worsening.

The Committee acknowledged that the most important aspect of this discussion was that the safety of patients and staff was the overriding priority for the Trust throughout the Winter period, and that the Trust is taking all action within its control to mitigate the risk of avoidable harm to patients.

Rachel Marsh explained the process involved in how particular scenarios were modelled and advised it was part of a collective discussion across several Directorates within the Trust, whereby numerous assumptions were considered.

Members expressed their concern the impact and the detrimental effect this would have on staff, particularly frontline staff, should this modelling assumption for Winter be correct. The Committee was keen to understand the outcome of the discussions of the modelling report at the upcoming meeting of EASC, given the dependency the Trust has on system partners to influence and improve the position.

The Committee felt that some of the assumptions appeared to be optimistic and queried which scenario the Trust was operating to. Rachel Marsh commented that the Trust was operating between the most likely scenario and the reasonable worst-case scenario, due to handovers being worse than predicted.

Members recognised that the worsening situation would inevitably incur significant avoidable harm to patients and reiterated their concerns. A more detailed report would be presented to the Board at its meeting on 23 November, particularly with more narrative and explanation concerning the assumptions around the modelling.

RESOLVED: The Committee

(1) NOTED the outputs from the latest modelling and implied patient safety risk; and

(2) NOTED the Trust has in place plans to improve response times and mitigate harm where this was possible, with a fuller report to come to Board.

74/23 RISK MANAGEMENT AND CORPORATE RISK REGISTER

Julie Boalch updated the Committee on the position of the eight principal risks assigned to it for monitoring, and additionally the Trust's 2 highest scoring risks which were assigned to the Quality, Safety & Patient Experience Committee (QuEST) for oversight. All scores remaining static following Executive Leadership Team (ELT) review and were current as at 1 September 2023 due to the risks having been reviewed throughout October.

The principal risks were presented to the Trust Board on 28 September 2023 and whilst each principal risk has been reviewed during October 2023 in line with the agreed schedule, a full refreshed update will be presented to Trust Board on 23 November 2023.

The Committee also noted the Trust's two highest scoring risks 223 (The Trust's inability to reach patients in the community causing patient harm and death) and 224 (Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service), whilst continuing to be discussed at length at several Committees and the Trust Board, remained at a score of 25.

RESOLVED: The Committee considered the contents of the Risk Management report.

75/23 AUDIT RECOMMENDATION TRACKER

Alex Payne explained that the Tracker had been revised and updated for Quarter two. Engagement with all Directorates had been excellent with 37% of the management actions closed in Quarter two.

The current Tracker was now open for Directorates to review and update for reporting in January and February. There has been good progress working with the Centre of Excellence in Digital Health and Care Wales (DHCW) in building 'Tracker 3.0' which will be the SharePoint solution for the Tracker. Internal testing was currently underway and it was anticipated this would be ready by the end of the financial year.

As the recommendations state, the Committee is asked to review and monitor actions which have been updated, noting that the revised dates were annotated in blue, and to note the proposal for closer scrutiny of the impact of the actions response to audit recommendations going forward.

RESOLVED: The Committee;

(1) Monitored management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue); and

(2) Noted the proposal for closer scrutiny of the impact of actions in response to audit recommendations.

76/23 INTEGRATED MEDIUM TERM PLAN (IMTP) 2023 -2026 - CONFIRMED END OF Q1/Q2 DELIVERY AND ASSURANCE POSITION AND Q3 INTERIM UPDATE

Rachel Marsh introduced the report announcing that the Trust Integrated Medium-Term 2023-26 had been approved by Welsh Government (WG) on 12 September 2023. Since the approval, the Director General for Health and Social Services has issued several Accountability Conditions as listed below:

1) Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximise its improvement trajectory and develop robust mitigating actions to manage financial risks.
2) Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.
3) Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.
4) Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.

The Trust was expected by WG to deliver its commitments in the IMTP against Ministerial priorities that were relevant to the Trust. These were set out in the related reported appendices.

Comments:

Members welcomed the good progress being made and were pleased that the new mental health pathway was due to be piloted in the Aneurin Bevan University Health Board area. Rachel Marsh advised there was no start date yet and once commenced, it should provide the impetus to be more widely rolled out across Wales.

RESOLVED: The Committee noted the update against the Trust's IMTP 2023-26 delivery governance and assurance mechanisms and that the IMTP was approved by WG on the 12 September 2023.

77/23 INTEGRATED MEDIUM TERM PLAN 2024 -2027 PROGRESS IN DEVELOPING THE PLAN

Rachel Marsh reminded the Committee it was a legal requirement that NHS Health Boards and Trusts in Wales must submit to Welsh Government an IMTP covering three years, refreshed annually. However, importantly for the Trust it was also the way in which it set

out the priorities over the next three years for achieving its long-term strategic objectives and deliver the transformation that needs to happen to improve its services, but closely aligned to the commissioning intentions for EMS, NEPTS and 111.

Rachel Marsh assured the Committee that the planning was under way in developing next the IMTP for 2024-27 and the workstreams for development include engagement, gathering intelligence, developing and agreeing priorities, integrated technical planning, writing the plan, and the governance, assurance and approval process. A recent Board Development session also discussed the contents of the plan, with further days scheduled for more discussion.

The planning cycle runs from June 2023 to March 2024, and it was expected the IMTP would be submitted to WG on 28 March 2024 after approval by the Trust Board on the same date.

RESOLVED: The Committee:

(1) Noted the overall progress in developing the IMTP;

(2) Noted the approach and timelines set out in the report; and

78/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

The Monthly Integrated Quality and Performance Report (MIQPR) for September/October 2023 was presented by Rachel Marsh who drew the Committee's attention to the following points:

There has been sustained improvement of the 111 service throughout 2023 with abandonment rates and call answer times achieving the best performance since February 2022. 67.6% of calls were being answered within 60 seconds (although this remained significantly below the target of 95%.

The Red 8-minute response performance for October 2023 was 47.2%, a slight drop when compared to September 2023, below the 65% target and the fourth consecutive month to record a decrease. However, there was another monthly increase in the number of Red incidents that were actually attended within 8-minutes, rising to 2,277 in October 2023.

Initiatives to improve these response times included the Connected Support Cymru service in partnership with St John Cymru, and also the introduction of Community Welfare Responders who are volunteers in the Community providing additional clinical data to clinicians, enabling them to make better decisions in terms of suitable pathways and avoiding the need to transport some patients to hospital.

One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. 23,232 hours were lost during October 2023, a significant increase compared to the already extreme 19,610 hours lost in September 2023 and the fourth monthly increase in a row.

Overall demand for Non-Emergency Patient Transfer Service (NEPTS) continued to increase but remained below pre-pandemic levels. Oncology performance remained below the 70% target in October 2023 (65.4%). Renal performance also decreased to 72.7%, as did discharge journey performance declining slightly to 76% (target 90%).

The Trust produced 122, 050 Ambulance Response unit hours in October 2023, which was an increase from 113, 421 in September. Emergency ambulance unit hours produced (UHP) was 93% in October which was an improvement, but this failed to achieve the 95% target. A factor in the ability to put out more hours was the improvement in sickness absence.

The Performance and Development Review (PADR) compliance rates of 70% for September did not achieve the target of 85%. The Operations Directorate Management Team have been asked to focus on completion of PADR's before the end of December.

Comments:

Lee Brooks commented on the following points:

The percentage of 111 calls answered in Welsh was higher than 1% advising it was probably an issue with scaling and was hopeful there would be an upward trend.

He also commented on the PADR rates adding that a deep dive was due to be undertaken in the People and Culture committee. He added that in readiness for that his staff have been encouraged to make a concerted effort for PADR completion before December.

In terms of the overruns, it had been disappointing to see to see how that's now trending worse now after a period of improvement. The management team in Operations will be focusing on the end of shift experience for staff.

The extraordinary incident declared on the 22 October 2023 was noted. The Committee noted the position with Immediate Release Directives (IRD) and that for October 2023, 173 Red IRDs were accepted and 11 declined, and 1,199 Amber IRDS were accepted and 311 declined. The position was extremely challenging with a 28-hour handover delay at Morriston Hospital being the worst case. Since then, Morriston Hospital have initiated a 10-hour backstop as opposed to the previously agreed 4-hour backstop.

There had also been a Business Continuity Incident recently declared at Cardiff and the Vale University Health Board for which there had been negligible impact on the Trust.

Comments:

Members expressed their disappointment with Immediate Release Directives, in that over 60% of Amber 1 requests were declined, and this clearly had a direct impact on the Trust's 2 highest scoring risks. The Committee also recognised the improvement in the reduction of sickness absences rates, noting the continued improvement in October.

RESOLVED: The Committee considered the September/October 2023 Integrated Quality and Performance Report and actions being taken and determined that it report provided sufficient assurance.

79/23 DIGITAL REPORTING

Jonny Sammut explained that the report was the second publication of the Digital Key Performance Indicators (KPIs) relating to Data and Analytics, ICT systems, Service provision and IMTP contributions covering the period 1 April 2023 to 30 September 2023. There were still some metrics that were currently being developed.

In terms of Data Analytics, the Trust was considering if there was any self-serve capability that could be brought into the new reporting platform as part of the migration plan. With regards to ICT systems the Trust has achieved a green availability status for the last couple of months which was positive.

The use of Robotic Process Automation (RPA) has benefited the Trust, 28 Service desk hours were saved during September. More opportunities were being considered to improve this.

The number of requests for being received by the ICT Service Desk continue to be extremely high and these ranged from password resets to laptop issues. The total received in September was 1,670. A review into the number of requests was being conducted with the intention to share these results at a future meeting.

In terms of key projects, work on the installation of Mobile Data Terminals into vehicles was progressing well. And also, the data linkage work which brings data sets together was in the process of being rescoped.

This month's spotlight was on Directory of Services. There were some existing challenges around a single data feed for pharmacy information which had resulted on poor feedback from users regarding the quality of information. Following liaison with Health Boards, the Trust's application team have integrated another data set to improve the pharmacy information. This will provide better and more accurate patient information which should reduce call backs in to the 111 service. Going forward the Trust was looking to create an all-Wales Directory of Services as part of the wider strategy refresh.

RESOLVED: The Finance & Performance Committee noted the contents of the accompanying report and the trends in metrics presented.

80/23 BUSINESS CONTINUITY ANNUAL REPORT

The Committee were assured that the necessary plans and business continuity arrangements were in place for the most significant risks. The Trust also holds plans for terror attacks, disruption of telecommunications, extremes of weather, flooding, pandemics, and cyber impact amongst others, which have been reviewed and updated.

Incidents such as the cyber-attack on Advanced (the provider of Adastra), telecoms outages affecting EMS-C, and Industrial Action have tested the Trust's preparedness to respond to disruption.

From an exercise perspective the Trust was involved with Exercise Mighty Oak, which simulated a 3-day national power outage session up to and including UK Government level.

There have been several actions identified throughout the report and this includes the need to improve the reporting arrangements of the Business Continuity Steering Group.

The report will be attached to the AAA report from this meeting for the Board's information at its meeting in November. The Committee noted that the recommendations in the report had already been approved by the Executive Leadership Team.

RESOLVED: The Committee RECEIVED the report on business continuity and progress over the last year, noting that the Executive Leadership Team have been asked to approve the recommendations in the paper and the Board will receive a copy for awareness at its next meeting.

81/23 CYCLE OF BUSINESS MONITORING REPORT AND REVIEW OF COMMITTEE PRIORITIES

The report was noted for information.

RESOLVED: The Committee noted the report.

82/23 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

The Chair thanked all authors and presenters for their reports noting there had been some several positives throughout.

83/23 ANY OTHER BUSINESS

None.

Meeting concluded at 12:05

Date of Next Meeting: 15 January 2024.

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
71/23	13 November 2023	Financial Position Month 7	Update on the Financial Plan for 2024/25 A report presenting the approach and assumptions for budget setting for 2024/25 would be brought to the next meeting.	Chris Turley	15 January 2024	Update for 15 January 2024 This will be covered off in the joint paper from Chris Turley and Rachel Marsh regarding next year's IMTP / financial plan, including following on from the issuing of the NHS Wales HB Allocation Letter by WG on 21 December 2023	Open

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.

Trust Board Meeting Date	23 November 2023
Committee Meeting Date	13 November 2023
Chair	Joga Singh

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. During the finance update it was advised that the position with the assumed level of funding of **£5.7m for the 100 WTE had changed and that it was now assumed that the Trust would not receive more than £3.5m; a position which has been confirmed in year.** The associated risk around the receipt of the balance of the £5.7m has therefore been removed, as it is accepted that the balance of this sum will not be received. Members were assured that the Trust is still able to forecast delivery of in year balance however, due to prudent and cautious financial management. The recurring impact of this will be picked up in the 2024/25 financial planning discussions but the current assumption is that the full £5.7m will be required on an ongoing basis. It was indicated that a report presenting the approach and assumptions for budget setting for 2024/25 would be brought to the next meeting.

ADVISE

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

2. Members were updated on progress against developing the **Integrated Medium Term Plan for 2024-27** following a recent board development day where priorities for plan were discussed. The workstreams for the development of the 2024-27 include engagement, gathering intelligence, developing and agreeing priorities, integrated technical planning, writing the plan, and finally, the governance, assurance, and approval processes. Feedback from colleagues across the Trust will be integral to the successful development of the IMTP. The development discussions will be brought back to the Board at its Development Day in December, with a view to seeking final approval in March 2024.

3. A tactical **Winter forecasting and modelling report for 2023/24** was received. The Committee noted the outputs from the latest modelling and implied patient safety risk and noted that the Trust has plans in place to improve response times and mitigate harm where possible. The 'Most Likely Scenario' with the modelling estimates a Red 8-minute performance of 50% for October & November, declining to 45% in December and early January, before recovering in the new year. The modelling estimates that the 65% Red 8-minute target will not be achieved at any point through the winter, with Amber waits also being too long. The Trust has a several short and long-term actions in place to mitigate this position, and a fuller report will be taken to the Trust Board in November outlining the full plans to improve responses and mitigate harm. The continually challenging situation influenced by worsening handover delays and system pressures was noted. The direct relationship between worsening performance and patient safety and outcomes was acknowledged; with the forecasting presented giving rise for significant concern for patient safety risk and avoidable harm during the Winter period. Members were keen to learn the outcome of the discussions of the modelling report at the upcoming meeting of EASC, given the dependency the Trust has on system partners to influence and improve the position.

4. **Value based healthcare update** was received which set out the progress of the key workstreams within its portfolio. The work programme includes the following seven workstreams – Patient Recorded Outcome Measures (PROMS), Patient Data Linkage, Patient Recorded Experience Measures (PREMS), Patient Level Information and Costing System (PLICS), Revenue Business Case Process, Evaluation Framework & Methodology, and Benchmarking. All workstreams are progressing well and the Benchmarking work is due to recommence in November 2023 subject to capacity.

5. Members **reflected** that the financial position of the Trust has a direct impact on the ability of the Trust to deliver a safe service and acknowledged the direct relationship between organisational performance and patient safety and outcomes. The Members were assured that all actions within the Trust's control were being taken to mitigate the risks and issues observed but expressed concern over the continued challenges exacerbated by wider system pressures.

ASSURE

(Detail here assurance items the Committee receives)

6. The Committee received a presentation on the **financial position for Month 7 2023/24** due to the date of this meeting coming close to end of month. The Board will have a detailed paper on the financial position before it for its November meeting. The cumulative year to date revenue position is an underspend against budget of £0.108m, with the year-end forecast being one of break even, based on the assumptions presented. The capital plan is being progressed and current planned expenditure of £20.6m is forecast to be fully spent by the end of the financial year. Delivery of the financial plan for 2023/24 will be challenging, and continued prudent and cautious financial management is required.

7. In line with the savings plans that support the IMTP, gross savings of £4.3m have been achieved against a year-to-date target of £3.7m. The Trust received confirmation from the Welsh Government in early November that it is not required to contribute anything more to the overall NHS Wales deficit. An update was provided on the **Financial Sustainability Programme (FSP)** and this will be a regular quarterly update going forward. Good progress has been made; as of the end of Q2 2023/24 the Trust was targeted to achieve the targeted £6m savings through ongoing efficiency and income schemes, with an overachievement of £419K vs forecast in month 5 which increased to £521K in month 6. This position is likely to be offset by Winter pressure spending, however. There is a commitment across the organisation to consider further income generation opportunities throughout 2023/24 and there is significant engagement and commitment across the Trust on the delivery of the FSP.

8. The **Business Continuity Annual Report** was received. The recommendations in the report had already been approved by the Executive Leadership Team. The Committee were assured that the necessary plans and business continuity arrangements are in place for the most significant risks. The Trust also holds plans for terror attacks, disruption of telecommunications, extremes of weather, flooding etc. The report will be **annexed** to this report for information at its meeting in November.

9. The WAST **Integrated Medium-Term Plan (IMTP) 2023-26** was approved by Welsh Government (WG) on the 12 September 2023 and an update on progress against the plan was received as at the end of Q2, with an interim update on Q3 by exception. The Accountability Conditions for the 2023-26 IMTP have been received and the detail was included in the update. The Trust is expected by WG to deliver its commitments in the IMTP against Ministerial priorities that are relevant to the Trust. These were set out in the related reported appendices. Progress was discussed and areas marked as 'red' will be drawn out in the report to the Trust Board.

10. The Committee received an initial suite of **Digital KPIs from the reporting period 01 April-30 September 2023** that have been developed to provide assurance on the performance, work activities and contribution of the Digital Directorate to the Trust's Strategy and IMTP. This month's spotlight was on Directory of Services with an update received on how the Trust is working with Health Boards have merged a second data feed for Pharmacy Information services with the existing feed, which will more effectively support referrals into community pharmacy services.

11. The **Monthly Integrated Quality and Performance Report** (MIQPR) for September / October 2023 was received and is before the Board at the November meeting. The Committee noted:

    - That there has been sustained improvement of the 111 service throughout 2023 with abandonment rates and call answer times achieving the best performance since February 2022. 67.6% of calls are being answered within 60 seconds (although this remains significantly below the target of 95%.
    - With reference to ambulance response time, the Red 8-minute response performance for October 2023 was 47.2%, which is a slight decrease compared to September, below the 65% target and the fourth consecutive month to record a decrease.

- The actions being taken that are within the Trust's control were detailed in the report and includes additional funding that has been made available to pilot the new Connected Support Cymru service in partnership with St John Cymru.
- Hours lost due to handover delays outside emergency departments was at 23, 232 hours during October 2023. This was a significant increase compared to the already extreme 19, 610 hours lost in September 2023 and the fourth monthly increase in a row.
- Ambulance Care performance for Oncology and Renal were noted, with performance below target. Overall demand for NEPTS continues to increase but remains below pre-pandemic levels.
- The Trust produced 122, 050 Ambulance Response unit hours in October 2023, which was an increase from 113, 421 in September. Emergency ambulance unit hours produced (UHP) was 93% in October which was an improvement, but this fails to achieve the 95% target.
- The PADR compliance rates for September with figure of 70% did not achieve the target of 85%. The Operations Directorate management team have been asked to focus on completion of PADRS before the end of December.
- The extraordinary incident declared on the 22 October 2023 was noted. The Committee noted the position with Immediate Release Directives (IRD) and that for October 2023 173 Red IRDs were accepted and 11 declined, and 1, 199 Amber IRDS were accepted and 311 declined.

12. An update was received on a revised Audit tracker with 37% of management actions closed in the quarter and several historical actions revisited to open discussions on potential revisions of management actions due to the passage of time. There has been excellent engagement on the new process and Members welcomed the revised format. The Committee supported the approach to strengthen scrutiny of the impact of actions when receiving future audit reports by identifying actions within audits as they're received by the Committee.

13. The **Committee priorities** for 2023/24 are on track as is the cycle of business.

RISKS

Risks Discussed: There are eight principal risks within the remit of this Committee with all scores remaining static following ELT review and are current as of 1 September 2023 due to the risks having been reviewed throughout October. The full updates will be presented to the Trust Board on the 23 November 2023. The Committee were assured that the mitigating actions were appropriate, and all relevant risks had been reviewed and Members were assured of new actions were being added to mitigate risks.

Risks 139 (failure to deliver our statutory financial duties in accordance with legislation), **458** (a confirmed funding commitment from EASC and/or WG is required in relation to funding for recurrent costs of commissioning) and **Risk 424** (prioritisation or availability of resources to deliver the Trust's IMTP) scores remain static at 16 (4x4) due to the challenging financial climate.

Risks 260 (a significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems) and **543** (major disruptive incident resulting in a loss of critical IT systems) remain at a score of 15 (3x5). Whilst the majority of mitigating actions are complete, further work is underway to identify further actions, but the score remains the same given the profile of these risks.

Risk 594 (the Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death) remains at 15 (3x5). The operations update provided details on the EPRR multi-agency exercises planned which should further mitigate this action.

COMMITTEE AGENDA FOR MEETING		
Financial position for month 7 2023/24	Financial Sustainability Programme Report	Value Based Healthcare Report
Winter Forecasting and Modelling	Risk Management and Board Assurance Framework	Audit Recommendation Tracker
Integrated Medium Term Plan 2023-26 – confirmed end of Q1/Q2 delivery and assurance position and Q3 interim update	Integrated Medium Term Plan 2024-27 progress in developing the plan	Monthly Integrated Quality and Performance Report
Digital Report	Business Continuity Annual Report	Cycle of Business Monitoring Report and Committee Priorities Update

COMMITTEE ATTENDANCE						
Name	**15 May 2023**	**17 July 2023**	**18 Sep 2023**	**13 Nov 2023**	**15 Jan 2024**	**19 Mar 2024**
Joga Singh						
Kevin Davies	Until 11.30am	Chair				
Bethan Evans						
Ceri Jackson						
Martin Turner		Left at 11.30	Left at 12.00			
Chris Turley		Navin Kalia				
Rachel Marsh		Hugh Bennett				
Lee Brooks	Sonia Thompson	Judith Bryce[1]	Judith Bryce			
Liam Williams	Wendy Herbert			J Turnbull-Ross		
Angie Lewis	Liz Rogers					
Jonny Sammut						
Leanne Smith			Aled Williams			
Hugh Parry						
Damon Turner						
Trish Mills						

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Lee Brooks in attendance for EPRR item

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2023-24 Q3 (October - December 2023)

National Operations & Support

IMTP

Manchester Arena Inquiry Recommendations

The work on the Manchester Arena Inquiry (MAI) recommendations has now been ongoing for 6 months, and a mid-year review was completed in December. This reviewed progress and scope and subsequently recategorized some of the recommendations, all of which have been approved through the SLT governance process as supported by the ELT. 27 of the 68 recommendations are complete with a few others nearing completion. Work is now focussed on the completion of the assessment of our capacity to respond to an incident and the subsequent outline resource case to the Commissioner which specifically connects to one of the recommendations.

The following table is a status reflection of the 68 recommendations that WAST is working on. It should be noted that the RAG coding is to aid areas for focus for the team; they are not used conventionally.

Priority	Number of Recommendations	Status
Red	7	
Amber	19	
Green	10	
Deferred	5	Other organisation dependency
Complete	27	For approval/closure

One of the recommendations from the MAI is the introduction of two new triage tools for mass casualty incidents. Ten Second Triage (TST) is designed to be used by anyone responding to a major incident to provide care to casualties prior to the arrival of clinicians on scene, and the Major Incident Triage Tool (MITT) is for use by NHS Responders at scene. Work has been ongoing to introduce this new tool within WAST with the UK Ambulance Services go-live date set for 1 April 2024.

New Marauding Terrorist Attack (MTA) Joint Operating Procedures have been rolled out through Pan Wales multiagency training courses; this has been the first-time tri-service courses have been delivered on this scale to so many emergency service personnel.

The ELT is to receive a full update on progress in its face-to-face meeting in January 2024, and work will continue to bring to the ELT the case for investment in response to recommendations for consideration in March 2024. Alongside this, it will be necessary to also provide updates to the EASC Management meeting in February 2024.

General Update

Volunteering Conferences

More than 200 volunteers attended two conferences in September and October with one held in Llandudno and one in Swansea. The agenda was varied with keynote speakers including Figen Murray OBE, the mother of one of the victims of the Manchester Arena bombing who spoke candidly about the loss of her son and public site security. Other sessions included Ten Second Triage, wellbeing, safeguarding, and first-hand accounts from our volunteers themselves. Our volunteers were also presented with awards aligned to our behaviours at a gala dinner in the evening of both conferences. We are grateful to all who participated, our speakers, our sponsor, and of course our volunteers who make these events worthwhile.

Community Welfare Responders (CWR) Pilot

Twelve of our CFR teams have been piloting the Community Welfare Responder role across Wales since 16 October 2023. At the time of creating this report it is too early to confirm success, however, early results are promising. The ambition to upscale the pilot quickly is being explored, with a focus on capacity within CSD. The pilot tests the concept of the welfare responder through existing volunteers. It remains our intent to introduce an additional volunteer role to which we will recruit new volunteers.

EPRR - Mass Casualty Exercise

A pan Wales Mass Casualty Exercise took place in September to test the All Wales Mass Casualty Arrangements. All the Health Boards participated with WAST undertaking the lead facilitator role. Learning has been identified from the exercise which will be incorporated into the All Wales Mass Casualty Arrangements. It is regretful that testing the release of ambulances from an emergency department was not included, which has been considered against our associated corporate risk.

Joint Emergency Services Interoperability Programme (JESIP) Assurance Visit

A JESIP assurance visit to Wales took place in November, with the assurance team spending time with South Wales Police, South Wales Fire and Rescue and visited WAST on 15 November. This was a pilot visit to review the feasibility of a national assurance program to

include devolved nations; however, it also gave WAST the opportunity to have the Trust's compliance with JESIP assessed by the national JESIP team. A report following the visit has been received and will be reviewed for any follow up actions.

Review of Key Plans

During Quarter 3, a number of key plans have been refreshed or rewritten as part of the annual review process. These include:

1. **REAP – Resource Escalation Action Plan**
   In November version 4.1 of the Trust's REAP plan was published. This plan provides the ability to manage our response in situations where demand or other significant factors within the service see an increase, and any challenge to the capacity to manage these demands.
   Incident Response Plan (IRP)
   In November, Version 2.0 of the IRP was released. In light of a number of incidents, changes to key pieces of national guidance, and the release of the Manchester Arena Inquiry reports alongside learning from internal debriefs, the IRP underwent a significant rewrite rather than a simple refresh. It was approved by the ELT and will be presented to the F&P Committee in its usual annual assurance.

2. **Clinical Safety Plan (CSP)**
   In December, Version 2.2.1 of the CSP was released. The CSP provides a framework for WAST to respond to situations where the demand for emergency services is greater than the available resources. This update was a relatively minor update reflecting evolutionary change to CSP with a wider review planned for 2024.

Resourcing, EMS Coordination & Quality

Challenges

Resourcing

High abstraction rates across operational areas and governance in relation to financial savings targets have resulted in an increased workload for the Resource Team. Skill mix remains challenging in some areas particularly Powys due to the numbers of NQPs recruited into paramedic vacancies, with the team continuing to work closely with local management teams.

EMS Coordination

As winter pressures increase, the service is seeking to train and recruit 4 EMD cohorts in Q3 with a view to fully rollout by the end of the financial year. The service continues to support London Ambulance Service with call handling since July 2023. The capacity levels allowed the service to assist LAS with 5% of their calls per hour between the hours of 15:00 – 03:00

each Sunday for 12 weeks and concluded on 31/10/23. This provides income to WAST without detriment to our own service levels as these continue to be monitored closely.

Operations Quality

The outstanding tasks sitting with the Operations Quality (OQ) Concerns Team is at 168. This is down from 209 in Q2. The OQ Team continues to work closely with the Putting Things Right (PTR) Team to prioritise work to meet deadlines and requests. The additionality to the Concerns Team will be realised in January 24 as four WTE ISOs have been appointed. Concerns returns within the Tier 1 target time reduced in Oct and Nov 23 to 70.6% and 67.6% respectively, but this was due to a number being sent to OQ a number of days after they had been registered by the Trust and those awaiting consent. December 23 is in a healthier position at 81.3%, and those concerns with no consent will be investigated in time order with other concerns from Jan 24.

Coroner statement demand remains high; however, 17 coroner's statements are outstanding which is down from 24 in Q2. The majority of these statements have been written and are either in QA or with Legal Services for review. It is anticipated that the coroner statement position will continue to improve once the backlog has been fully addressed and an assurance SBAR went to SOT/SLT to update which was received well.

NRIs remain high at 33 outstanding. The International Academies of Emergency Dispatch (IAED) has audited a number of the ineffective breathing calls and plan to review the remaining before Christmas. An approach to address the learning on ineffective breathing is being developed and an SBAR is being prepared for SOT /SLT and CQGG for January 24.

IMTP

Resourcing Rostering Systems Manager

We have welcomed James Roberts to the team in the new post of Rostering Systems Manager. James who was previously an ICT SQL Systems Engineer, returns to resourcing where he began his WAST career in 2009 as a coordinator. James is a welcome addition to the team and will play a key role in system development and improvement, to streamline current manual processes, and improve capacity within the team. Over 34 workstreams have been initially identified in a comprehensive project plan, to include a review of the ESR/GRS interface, GRS Everbridge and GRS CAD.

Resourcing Policy

The relief planning pilot for 5-week roster publication went live on 25 September for rosters published to 30 October. Monitoring and evaluation will take place monthly from November, and evaluation metrics will include a comparison of UHP, abstractions and additional resources at publication (5 weeks vs 4 weeks vs actual post-production)

EMS Coordination Reconfiguration
The current IMTP (legacy) deliverable of reconfiguring EMSC has now been replaced by a proposal for a revised leadership structure, which will also incorporate the original single allocator model and dispatch boundaries recommendations.

Initial work was carried out to progress the boundaries recommendation in early 2023 and it became clear that Project Board were keen to refresh the data to ensure that the original (2017) paper and therefore data remained valid in the current context. As a result, further modelling was carried out by ORH in September 2023 that considered more recent and up to date data (Sept 2022 to May 2023). The revised D&C recommendations (Sept 2023) were considered as part of the wider EMS Coordination Reconfiguration Project and an initial paper has set out a proposed structure that will provide a leadership structure that is fit for purpose but will also address the two outstanding recommendations (noted above) from the original ORH Report in 2017.

The final paper will be submitted to colleagues and will be shared with Trade Union in partners in January and all elements will feature as part of the Organisational Change Process (OCP).

Bryn Tirion Relocation.
On the 9 October 2023, the inaugural Bryn Tirion Project Board was held to explore options available to relocate staff from the Bryn Tirion site. It has been broadly accepted that the site is not fit for purpose and as a consequence, monies have been set aside from this years' Discretionary Capital budget to relocate staff to a more suitable premises. At the Project Board on the 16 November 2023 an options appraisal of three options for potential new locations was undertaken, with Ty Elwy being selected as the preferred relocation site. This was ratified by the Strategic Transformation Programme Board on the 27 November 2023.

It is recognised that the decision to move from Bryn Tirion to Ty Elwy, which is some 25 miles further east, is going to be challenging for some of our staff. As a result, a small space has been identified in the Snowdon House facility in Bangor to accommodate staff who would be unable to move to Ty Elwy. This does not in any way reduce the 111 desk numbers in Snowdon House but does involve some minor alterations to the internal infrastructure to release the additional capacity. An OCP process has been instigated and People Services have been engaged to support staff with identifying the main issues and 1:1 session to scope the impact on individuals.

It is acknowledged that the actual relocation of staff from Bryn Tirion is unlikely to happen before June / July 2024 as there is work required to ensure the space set aside in Ty Elwy meets the specific requirements set out by the teams and to enable the necessary technology requirements to be delivered.

General Update

Death of Michelle Perry, Emergency Dispatch Quality Improvement Manager
In November, we announced the sad death of our colleague Michelle, who died peacefully surrounded by her family. Michelle joined the Trust in 1999 having previously worked for Mid and West Wales Fire and Rescue Service. She progressed from a 999 call handler into dispatch and then into learning and development roles within EMSC before becoming an MPDS Facilitator in 2011. Michelle was much loved and respected by colleagues not only in Operations, Quality and EMS Coordination, but throughout WAST and the International Academy of Emergency Dispatch (IAED) who invited Michelle to become a member of the accreditation panel, such was her expertise. We were fortunate to benefit from Michelle's character and knowledge, and she will be sadly missed.

Culture and Behaviours
The Resource team are to be part of a culture pilot supported by People Services. A questionnaire on team behaviours will be circulated during November, followed by an Insights questionnaire during December with an ambition to facilitate a pan Wales workshop in Q4.

IAED Accreditation
The Trust was awarded reaccreditation for MPDS by the IAED at the UK Navigator Conference. The Trust is now a dual accredited organisation as it was awarded ECNS accreditation for the first time.

EMSC Staff recognition
Members of EMS Coordination in the north were nominated for EMD of the year with one staff member winning, two shortlisted and seven runners up. Four members of EMS Coordination were nominated in the staff awards, all of whom were successful.

Emergency Medical Service

Challenges

Continued System Pressures

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 19,119 hours were lost in July, 19,240 in August, 19,602 in September, 23,222 in October, 20,126 in November, and 22,756 hours in December. The detrimental impact of the resultant pressure is regularly discussed at Committee and Trust Board.

Overtime Controls

Financial savings is on plan, and in some areas had overachieved on modelling and assumptions. As part of this savings plan, EMS Response has continued to control the level of overtime allocation. However, the overtime allocation allowance for December allows for additional resourcing to respond to the expected increased demand in the build up to Christmas and on key dates. Original data identified predicted UHP levels as a result of implementing the savings plans. The reduced overtime allocation commenced on 1 July 2023 and the resultant UHP levels have been extremely close to the original plan predictions (for example, in October UHP modelling predicted 35% abstractions, with an end of month position of 34.77% abstractions, ranging between 30.89% - 38.49% across the Health Board areas), with monitoring through the Senior Operations team and Senior Leadership Team. Despite controls, not all available overtime has been taken up. Overtime allocations have been determined for the rest of the year and will continue to be monitored closely, redistributing money should it be unspent.

Visit from Health Minister, Eluned Morgan

In December, WAST was pleased to host a visit from Health Minister Eluned Morgan. The Minister spoke with operational crews and attended two incidents including a red release to a cardiac arrest call. Following this, the Minister visited Vantage Point House and attended EMS Coordination and CSD spoking with the CSD Service Manager and team about the work of the Clinical Support Desk, and how CSD is supporting patients who have accessed 999 with alternative appropriate opportunities to access care, safeguarding those that may have a significant wait for an ambulance response and providing remote clinical support for non-clinical staff attending scene. The Minister has thanked the Trust for hosting the visit.

IMTP

IMTP deliverables are on target with the current arrival of Big Bang NQPs making a big difference to the rural (Powys, BCU etc) vacancies and rural recruitment. Retention is often a challenge however and so it will be important to monitor transfer requests.

General Update

Winter Planning
Winter Planning progressed well with the Senior Planning Team stood up during November with a remit to oversee all winter planning arrangements, including planning for any impact of the Junior Doctor Industrial Action scheduled for January 2024.

Ambulance Care

Challenges

Net Centre
Call taking via the NET Centre continues to be a challenge. Whilst there has been a good period of stability with performance, retention of staff has had a detrimental effect on the consistency during peak periods of demand.

Demand
Demand for the service continues to increase as NHS planned care services increase activity. This is particularly the case for those patients requiring ambulance conveyance where activity levels are now in excess of those seen prior to the pandemic. It is not clear at present what is driving this shift in accuity.
Of particular note is Renal activity, which continues to trend at a level higher than the historically funded average. Like other areas of the service patients requiring ambulance conveyance seem to be increasing more rapidly, in August Renal patients requiring ambulance conveyance were higher than at any point over the last 5 years.

This is impacting on wider service delivery as the service prioritises renal transport provision. Forecasts from the Welsh Kidney Network indicate that this growth will continue by 5% per annum.

The Ambulance Care senior team are working closely with commissioners to ensure that the appropriate capacity exists to continue the good levels of performance currently seen within the renal transport service.

Volunteer Car Service Capacity
During the pandemic a considerable proportion of the Volunteer Car Service drivers were either requried to or chose to stand down from active volunteering. This reduction in

capacity was offset by a subsequent reduction in demand following reduced planned care activity.

However, as planned care activity increases the ability of the service to absorb additional demand, particularly for Oncology patients, is compromised.

In response, the National Volunteer team is working on increasing VCS driver numbers from 100 to 200 by the end of the financial year. Good progress with recruitment of new volunteer drivers has been made already with 10 new drivers recruited by November and 51 new drivers planned to be in place by end of February 2024.

General Update

CMP (Capacity Management Plan)
The team has reviewed the current Capacity Management Plan, which sets out how the service applies the Welsh Government WHC 2007(005) eligibility criteria for non-emergency transport and the process for managing scenarios where demand for transport exceeds available capacity.

The revised plan, which has been through a EQIA and QIA process, modifies the approach to a position where the service will only take bookings from patients that meet the criteria as per the Welsh Health Circular. Patients who do not meet the eligibility criteria will not be entitled to Non-Emergency Patient Transport and will be signposted to alternative transport solutions only. This plan has been shared with CASC and supported at the DAG meeting.

This refresh will further align the service the Welsh Health Circular, whilst also ensuring that patients that are eligible for transport, in particular those within the enhanced service category, continue to receive the best possible service.

Vehicles development
The delivery and operational roll out of the new B class MAN Ambulances commenced in November. The vehicles will be trialled by UCS colleagues in Barry, Bassaleg and the Grange transfer team. As the vehicles are a very different concept to those currently in service, a full review will be completed and will incorporate colleague feedback and data to help inform decisions on future design.

Integrated Care

Challenges

111

Welsh Language Performance

The 111 Operations team have deployed an action plan designed to improve Welsh call answer performance, specifically the percentage of callers answered in Welsh where this is their chosen language. Performance has been consistently improving and throughout Q3 has remained stable.

Dental Performance

Delivery of the 111 urgent dental care performance indicators has been previously challenged, principally due to the relatively high absence rates within the Dental Advisor Team and vacancies which had been held open in order to support the Directorate savings plan. However, urgent dental care performance is now at 90% as staffing has stabilised.

IMTP

CSD

ECNS Accreditation

The Trust received confirmation on 14 September 2023 that following a review by the Board of the International Academies of Emergency Dispatch (IAED) that the Welsh Ambulance Service was approved as an Emergency ECNS Dispatch Centre of Excellence.

Consult and Close

Work against the consult and close action plan continues. Although consult and close incidents have increased, verified incidents have also increased and therefore percentage of consult and close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with an increase in staffing, which together will enable more triages to take place thus increasing the percentage of consult and close towards the 17%.

General Update

111

Time to Triage

The current 'time to triage' performance is mostly within the KPI standards. However, work has been done to identify opportunities to maintain this performance during the winter season. This was discussed in the 111 Performance Review Group, and as a result, a workshop took place in October. An action plan has been developed, which is overseen by the 111 Performance Review Group.

Business Continuity Exercising

From October, a series of business continuity exercises and training sessions commenced for all 111 operational managers, including Tactical Leads, SCAs, and CHCs. This training involves the EPRR team and the Digital Directorate. Its purpose is to ensure that all 111 managers are well-versed in the 111 business continuity plans and the relevant organizational procedures.

CSD

Police Pilot

Through agreement in the Joint Emergency Services Group (JESG), a second CSD Police Pilot commenced in September 2023. An earlier pilot had low take up, so subsequently the second pilot encompasses a greater geographical area. The trial includes South Wales Police and Gwent police forces and will run for 3 months. The purpose of the trial is to broaden the Remote Clinical Support offer to Police for circumstances where Officers on scene with a patient are waiting for an ambulance response.

Recruitment

Four clinicians joined CSD in September 2023 with a further eight in November. An additional two Mental health clinicians and a trauma desk clinician have also been recruited and the FTE is now at full capacity for the challenging winter months.

Opportunities for promotion within the team have included one PPED colleague being successful in obtaining a position as Senior Practice Educator and a full time Duty Operations Manager position which has also been filled by a member of the team.

AGENDA ITEM No	**7**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

Financial Sustainability Programme Position Paper

MEETING	Finance & Performance Committee
DATE	15/01/2024
EXECUTIVE	Angela Lewis, Director of People and Culture
AUTHOR	Gareth Taylor, Project Manager
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EXECUTIVE SUMMARY

The purpose of this paper is to set out the current position of the Financial Sustainability Programme as of the end of Q3 23/24.

This paper will highlight the progress made against key deliverables within Achieving Efficiency and Income Generation.

As of the end of Q3 FY23/24, the organisation is forecast to achieve the targeted £6m through ongoing efficiency and income schemes, currently exceeding the Month 8 forecast of £4.115m, by £659k.

As noted in the November 2023 Finance & Performance Committee update, work is ongoing to identify and plan for 2024/25 and beyond. Opportunities are being explored to potentially expand the remit regarding income generation, while efficiencies are being scoped and delivered via several well-established schemes.

RECOMMENDED: The Committee is to note the update.

REPORT APPROVAL ROUTE

1. The report was considered by:
   - FSP Lead Executives (22 November 2023)
   - FPC (15 January 2024)

REPORT ANNEXES

None

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

1. Context

1.1. The purpose of this paper is to highlight the progress that has been made in identifying and delivering savings as well as income generation within 23/24 to date, compared with progress made against 22/23.

1.2. A targeted saving of £4.3m for the previous (22/23) financial year was achieved, and subsequently increased by £1.7m to a total of £6m for 23/24 financial year. To achieve this, the organisation took steps to identify a greater range of savings and income schemes via the Financial Sustainability Programme.

1.3. The challenging financial climate within the public sector increases the need for all public sector organisations to deliver sustainable recurrent savings especially based on reducing costs.

1.4. As of December 2023, approximately 101 schemes have been submitted as potential areas of exploration across income generation and achieving efficiency by colleagues across WAST, with 75% scoped and assessed to understand potential benefits, and around 30% in some degree of delivery.

1.5. As highlighted in the Financial Sustainability Update presented to ELT in September, one of several challenges has been moving ideas from innovation to delivery. Resource, capability, market intelligence have all contributed.

1.6. As of the end of Q3 FY23/24, the organisation was forecast to achieve the targeted £4.115m through ongoing efficiency and income schemes. WAST is currently overperforming by £659k as of M8.

1.7. As noted in the November 2023 Finance & Performance Committee update, work is ongoing to identify and plan for 2024/25 and beyond. Opportunities are being explored to potentially expand the remit regarding income generation, while efficiencies are being scoped and delivered via several well-established schemes.

2. Current Progress

2.1. Achieving Efficiency is currently focussing on four key areas of delivery:

- **Service and Provision Reviews**: *This area looks to provide an evidence-base for long-term efficiency across the organisation by undertaking an audit of Administrative and Support Staff provision, and an audit of Service provision across the organisation which will establish the basis for an annual review process.*

- **Short-term Efficiency Savings**: *Identify, scope, and deliver opportunities for cash-related savings in the short-term, contributing to the FY23/24 financial savings target.*

- **Long-term Efficiency Savings**: *Identify, scope, and deliver opportunities for long-term cash-related savings, contributing to targets beyond the FY23/24 financial savings target.*

- **Process Efficiencies**: *Identify, scope, and deliver opportunities for non-cash-related savings opportunities.*

2.2. Income Generation is currently focussing on three key areas of delivery,

- **Income Generation Schemes**: *Scope and deliver 'small-wins' to support the delivery FY23/24 financial savings target.*

- **Commercial Structures and Long-Term Planning**: *Scope potential dedicated structure for delivery and oversight of commercial opportunities beyond 23/24 and to support long-term financial sustainability.*

- **Commercial and Financial Mindsets** – Training and Development: *Explore opportunities for commercial and business training and embed a culture of commercial capability across the organisation.*

3. Achieving Efficiency

3.1. Administrative and Corporate Roles Review, and Service Review Update

3.1.1. The key area focusses on the two in-depth reviews commissioned to assess the efficiency and effectiveness of current provision and structures within WAST and identify opportunities for efficient change.

3.1.2. As noted in the November update, ADLT are currently taking forward recommendations from the Administrative and Corporate Services Review and have developed a 22-point Action Plan accordingly.

3.1.3. To maintain an additional level of scrutiny, this Action Plan will report into the Financial Sustainability Programme via the Achieving Efficiency workstream.

3.1.4. The Service Review is underway and is currently in Phase 1. Following ELT's decision to pursue an Advanced Review, timelines have been reviewed and extended. The proposed date of completion is now April 30th, 2024.

3.1.5. The Service Review lead has completed the organisational structures work, and is now looking to commence the first data collection exercise by December 21st, with a view to beginning data analysis on the 11th January.

3.2. Short Term Savings Opportunities

3.2.1. Progress within this key area has included a deep dive into Fuel Efficiencies, with a Task and Finish Group established to identify and deliver opportunities for reduced fuel spend.

3.2.2. Working with AllStar, fuel spend hotspots have been identified and a baseline determined as of September 2023. Metrics are currently being collated, and a communications plan is still being developed by AllStar. An internal comms package has already gone out accompanied information on every discount fuel site in close proximity to all DGHs in Wales.

3.2.3. The pilot study into consumables waste within ambulance stations has been completed with the findings presented back. The scale of the waste identified within the pilot sites, justifies a wider study of waste nationwide. Work is ongoing to implement digital stock control measures.

3.2.4. Following the lease and hire car audit mandated by the Achieving Efficiencies Group, work has been ongoing to align processes, and identify and mitigate potential areas of Trust Risk surrounding the use of lease and hire cars. As such, a new process for requesting vehicles was implemented in November 2023.

3.3. Long Term Savings Opportunities

3.3.1. This area focusses on the longer-term transformational change programmes, such as Robotics and Process Automation, and efficiency-related behaviour and process opportunities in fleet.

3.3.2. While capacity remains an issue, the Digital team presented an options paper on this topic to the Digital leadership Group for approval in November, and this was subsequently presented to ELT on the 13th December 2023. The proposal includes an outline structure the Robotics and Process Automation delivery structure, a request form for potential processes being submitted for automation, and a proposed panel for approving the processes submitted for automation. The delivery of this structure is based upon adequate resource availability.

3.4. *Process Efficiencies*

3.4.1. Process efficiencies are often a by-product of pursuing financial savings opportunities. Efficiency recommendations from both reviews, as well as the processes automated by the Robotics and Process Automation Scheme will all be recorded as non-cash related benefits.

4. Income Generation

4.1. Commercial Structures and Long-Term Planning

4.1.1. In May 2023, it was raised at a meeting of the FSP Governance Group that the income generation schemes delivering to date were largely BAU, or market-reliant schemes such as Interest Receivable and VAT Rebates, as well as income received for apprenticeship training provision.

4.1.2. Proposed ideas and schemes on transformative service change were discussed and rejected at various stages of discussion often due to risk and resource capacity. The common themes were collated via a deep-dive and presented to STB on the 18th of September.

4.1.3. On the 6th December 2023, a session was conducted during the Executive Team Away Day, which included a proposal paper outlining four potential commercial options, and a case study presented by North East Ambulance Service.

4.1.4. While the session provided a deeper insight regarding what commitment is required from the Trust to pursue each of the commercial options, the session also highlighted the lack of Trust readiness and need for additional expert market analysis, and experienced business intelligence.

4.2. *Income Generation Schemes*

4.2.1. As noted in the previous update, the deep dive identified approximately twenty income generating schemes scoped in detail and deemed non-viable following evidence-based assessment.

4.2.2. Schemes noted in the previous update that are currently being scoped or are potentially viable pending the correct commercial structures include early-discharge support for non-emergency patients, as well as NEPTS Tenders, and the NEPTS Quality Exemplar.

4.2.3. Income generation is largely delivered by interest rates remaining higher than average, asset sales, apprenticeship income, and training income.

4.2.4. While minor progress is made in identifying opportunities, further progress in considering the level of risk appetite is necessary, greater risk appetite and the structures required to deliver income generation is ongoing.

4.3. *Commercial and Financial Mindsets – Training and Development*

4.3.1. Discussions at STB have acknowledged changes required and identified the need to do more to embed a commercial mindset in a public sector organisation like WAST.

4.3.2. Early advice has been sought from Value in Health, Health Trusts, and HEIW around commercial training provision. HEIW is due to provide some example materials, and this will support an appropriate development programme.

4.3.3. Further development in this area will follow the completion of the work around commercial structures in Q4.

5. Current Risks and Issues

5.1. Nine Programme risks remain on the risk register, independent of the risks attributed to each scheme.

5.2. Of these nine, five relate to existing Corporate Risks (Adverse Publicity -201; Statutory Duties – 139; Business Aims – 458; Human Resources - 163, Resource Availability – 424). These are all managed via the Corporate Risk Register, and continuously monitored within the FSP Governance Group.

5.3. The remaining risks refer to engagement during periods of REAP 4 or heightened operational pressures (such as winter pressures - monitored), the Robotics and PA Programme (mitigated by paper to ELT as per update), Service Review delivery (mitigated by identifying project support), and ensuring the clinical assurance of the FSP (mitigated by developing FSP QIA - recently submitted to CQGG)

6. Communication

6.1. With regards to communicating delivery of FSP-related schemes to the wider workforce, consideration is given to how the message is developed and delivered. As an example, the recent Service Review (as well as engaging early with TU partners) developed a communications plan based from previous learning – in this instance the Administrative Review.

6.2. Work to communicate what's already been delivered is also maintained via CEO Roadshows, however further work is required to highlight delivery in a consistent and engaging format.

7. Financial Progress

7.1. As of Month 8, WAST is currently exceeding the forecast savings target by £659k, however this will likely be offset by the additional operational spend anticipated during the upcoming winter period.

7.2. Schemes in the table below are RAG Rated against the following justification,

Current Schemes – Tracked Savings

- Green Schemes – Meeting or Exceeding Planned financial target
- Amber Schemes – Below financial Plan but meeting forecast target and now on-track
- Red Schemes - Below financial Plan, Forecast target and off-track
- Grey – not yet commenced

	Annual	In Month			Cumulative			Forecast			RAG
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
Accident Repair	20	4	8	4	8	8	0	20	20	0	
Acting Up Allowances	11	0	0	0	0	0	0	11	11	0	
Apprentice Income	350	29	7	-22	234	60	-174	350	60	-290	
Asset Disposal (Defib)	225	25	25	0	125	125	0	225	225	0	
Balance Sheet support	200	20	20	0	120	120	0	200	200	0	
CSD - ECNS Non Pay	20	2	2	0	14	23	9	20	29	9	
Decarb	2	0	0	0	2	2	0	2	2	0	
End of Shift Overrun	30	3	10	7	19	188	169	30	231	201	
Fuel (forecourt price saving against budget)	306	15	9	-6	236	395	159	306	476	170	
Fuel (swip, chip & pin and reduction in misfuelling etc)	33	5	2	-2	15	12	-3	33	30	-3	
FYE of 22/23 VERS	66	7	7	0	38	38	0	66	66	0	
Intelligence Routine Platform	100	0	5	5	0	20	20	100	20	-80	
Interest Receivable	500	31	67	36	380	636	256	500	807	307	
MS Office VAT Rebate	250	36	0	-36	108	0	-108	250	0	-250	
Net - Vacancy Management (111 EASC-funded and non frontline)	27	0	0	0	27	27	0	27	27	0	
Net - Vacancy Management (CSD and non frontline)	120	0	0	0	120	118	-2	120	118	-2	
Non Pay Local Schemes	530	46	35	-11	409	373	-36	530	450	-80	
Other local schemes - Non Pay (Travel etc)	26	2	9	7	16	23	6	26	32	6	
Overtime	254	28	56	27	141	278	137	254	500	246	
Private Providers	250	21	21	0	168	168	0	250	250	0	
Reduction in variable pay	38	3	3	0	24	24	0	38	38	0	
Stock Control (MSE etc)	50	5	5	0	23	20	-3	50	48	-3	
Taxi Review	50	4	4	0	28	24	-4	50	46	-4	
Vacancy Management	2,275	164	191	27	1,668	1,866	198	2,275	2,343	68	

Vacancy Management (non frontline)	51	0	0	0	51	55	4	51	55	4	
Vacancy Management (non frontline) Additional	151	10	11	1	111	115	4	151	159	8	
Volunteer Car Drivers	66	5	5	0	30	58	28	66	93	28	
Totals	**6,000**	**465**	**502**	**37**	**4,115**	**4,773**	**659**	**6,000**	**6,335**	**335**	

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

Environment, Decarbonisation and Sustainability Update January 2024

MEETING	Finance and Performance Committee
DATE	15th January 2024
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Jo Williams – Head of Capital Development Lucinda Wassall – Project Manager
CONTACT	Joanne.williams10@wales.nhs.uk

EXECUTIVE SUMMARY

To provide an update on:

- Decarbonisation Programme Board and other wider governance
- WAST Decarbonisation Action Plan update and NWSSP Decarbonisation Co-ordination Reporting (DCR)
- Internal Audit – Decarbonisation
- Capital Investment – EFAB Funding

RECOMMENDATION The Finance & Performance Committee is asked to NOTE this update.

KEY ISSUES/IMPLICATIONS

None

REPORT APPROVAL ROUTE

Capital Management Board – 11th December 2023

Finance and Performance Committee – 15th January 2024

REPORT APPENDICES

Appendix 1 - DCR report – Circulate separately by E Mail

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

WELSH AMBULANCE SERVICES NHS TRUST
Finance and Performance Committee
Environment, Decarbonisation & Sustainability Update
January 2024

SITUATION

1. This paper presents the Finance & Performance Committee with a regular update on the work being undertaken in support of the Trust's Environment, Decarbonisation and Sustainability work programme.

2. It also provides an update on the detailed reporting against the Trust's Decarbonisation Action Plan.

BACKGROUND

3. WAST has produced a Decarbonisation Action Plan (DAP) in response to the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan (*NHSW-DSDP*).

4. The plan has a range of actions which frame the Trust's decarbonisation response and spans all directorates across the Trust. It is vital that all areas of the Trust take ownership for the plan and that work across a potentially complex range of actions is organised appropriately to monitor and demonstrate progress.

ASSESSMENT

Decarbonisation Programme Board and other wider governance

5. The Programme Board last met on 24th October 2023 and considered a range of updates, including a review of the Decarbonisation Action Plan, DCR reporting and highlight reports from the Transport Project Board and EFAB schemes. A detailed risk register is reviewed at each Programme Board meeting. This risk register development is also linked to work on the Corporate Risk Register; work has been ongoing to articulate the level of corporate risk for consideration at Board level. Given the complexity and range of risks within this work, it has now been agreed that a programme level risk management approach is the most appropriate, with specific high level/corporate impact risks escalated as necessary. Risk 542 is currently in development at a CRR level, and further discussion has recently taken place regarding a high level summary risk given that a detailed action plan sits below it.

6. The highest rated specific risks continue to be highlighted to the Programme Board. The summary below details those risks with a score of 25:

a. If there is a failure to secure adequate funding then this would impact on improving the estate/fleet and reducing carbon emissions resulting in an inability to meet the targets set by WG
b. If there is a failure to improve/upgrade leased buildings then this would prevent building being brought up to modern standards. This would result in WAST missing DAP targets and the opportunity to lower emissions from a significant part of the estate
c. If the Trust does not have the correct resource/skill sets assigned to Decarbonisation projects then they will not deliver the solutions required, resulting in the need to spend additional funding to source these externally and greater overall project costs
d. If the Trust is unable to influence NWSSP procurement decarbonisation work, then the Trust will not have control of carbon emissions which come from supply chain. This would result in WAST not reaching identified targets
e. If technology is unavailable to change fleet to full electric, then the Trust will be unable to procure ULEVs resulting in targets being unachievable
f. If the Trust is unable to deliver all of the actions in the DAP then the emissions will not be reduced resulting in not achieving the Decarbonisations emission targets by 2025 and 2030
g. If there is a lack of enough electrical infrastructure or means to upgrade the electrical supply, then the Trust will be unable to install further EV charging capacity resulting in the inability to further progress the charging network and deliver on a full EV fleet.
h. The 2018-19 carbon reporting baseline was calculated using differing methods than those currently used to calculate and report emissions. Therefore, it is difficult to understand our current progress, or success against the set baseline.

7. It should be noted that other risks are identified at a lower but still significant (15 – 20 score rated) level. The risk register will continue to be reviewed and mitigation action accelerated wherever possible. However, some of the mitigation is outside of WAST control, sitting with industry, partner organisations, Welsh Government or within funding constraints currently being experienced.

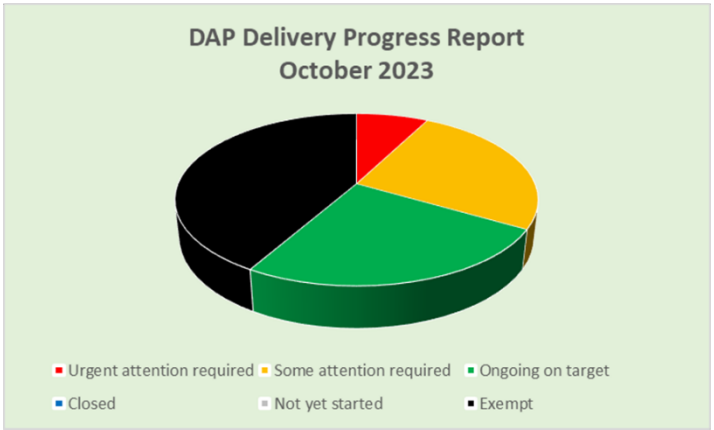
WAST Decarbonisation Action Plan update and DCR Reporting.

8. Capital Management Board (CMB) & F&PC have received regular reporting on action plan progress since September 2022. The reporting follows the standard Strategic Transformation Board reporting, but given the breadth of actions within the report, a "Gateway Review" type scale has been deployed to indicate overall programme rating; it is noted that this continues to evolve and is somewhat subjective but helpful in identifying an overall value. From a starting

point of Red/Amber, the assessment is now Amber and the progress against several of the actions has been recorded as outlined below.

9. NWSSP have now also put in place a new set of reporting requirements within the Decarbonisation Co-ordination Reporting (see below), as such the DAP has been updated to capture the required information. However, given changes to the reporting, this has adjusted the number of actions being reported on, and therefore making a comparison against the previous update provided is now more challenging. It should be noted that progress remains at the same level as previously reported, but the number of actions, and the categorisation of reporting has been amended slightly to comply with the new DCR reporting.

10. The dashboard below outlines the position as reported to the Decarbonisation Programme Board and DCR Team in October 2023 and mid November 2023 respectively.



144	Total actions in DAP
11	Urgent attention required
37	Some attention required
36	Ongoing, on target
0	Closed
0	Not yet started
60	Exempt

11. It should be noted that, at the September 2023 report update to the Capital Management Board and Finance and Performance Committee, a total of 17 actions were marked as red/urgent. Following a deep dive session by the team on 4th September, the total number of red actions has now reduced to 11. Further work is ongoing to undertake a systematic review of the amber actions within the plan. This also includes reviewing the leads for each scheme of work, and ensuring alignment to existing projects in an attempt to avoid any further duplication.

12. The reporting above reflects that which was submitted to the DCR Team in NWSSP for Q2 reporting by the deadline of 14th November, and this is enclosed at **Appendix 1** for information.

Internal Audit – Decarbonisation

13. Regular review continues of the action plan in response to the generic all NHS Wales report Internal Audit which took place during October 2022.

14. A second Internal Audit started on the 06/07/2023 and the draft report has been received by the Trust. Comments and further documentation are being provided back to the audit team currently in support of the draft review exercise. It is anticipated that the final audit report will be received by the Audit Committee at its 1st March 2024 meeting.

Capital Investment – EFAB Funding

15. Delivery is ongoing against a range of WG Estates Funding Advisory Board (EFAB) schemes for 2023/24 and planning has commenced for 2024/25 schemes. As previously noted, the Trust was awarded a proportionally significant amount of the total funding available, with a 30% contribution by WAST within the Capital Expenditure Limit. Schemes range across decarbonisation and infrastructure and an update by scheme is provided below:
    a. AFSRC Wrexham – Decarbonisation: a tender specification for a scheme including PV arrays is now out to tender and closes on 8th December. Previous discussions had also referenced the ability to bid for Asset Collaboration Funding for this scheme given the shared site nature with North Wales Fire Service. Further consideration will be given to this once the costs are received.
    b. Blaenau Ffestiniog Decarbonisation: this scheme is now underway, with a contactor appointed and pre-start meetings having taken place on site.
    c. Cardiff Ambulance Station Decarbonisation: a tender specification for this scheme including PV array is now out to tender and closes in late December
    d. Glynneath – infrastructure and decarbonisation: a tender specification for this scheme including re-roofing and PV array is out to tender and closes in late December
    e. Bryncethin – infrastructure: this re-roofing scheme is out to tender and closes in late December

16. It is currently anticipated that all schemes for 2023/24 will complete by end of March 2024. The delivery of schemes under the EFAB funding scheme is project managed by the Capital Development and Estates Teams and overseen by the Decarbonisation Programme Board. In line with discussions at previous Capital Management Board meetings, project management and capital delivery resource have been identified to progress these schemes.

RECOMMENDATION The Finance & Performance Committee is asked to NOTE this update.

AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Finance & Performance Committee
DATE	15th January 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk/Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the 8 risks that are relevant to Committee's remit for oversight and additionally the Trust's 2 highest scoring risks which are assigned to the Quality, Safety & Patient Experience Committee (QuEST) for oversight.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.

3. The more detailed description contained within the BAF 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. This will assist Members in evaluating current risk ratings supported by the frameworks in Annex 2 of the report.

4. Each of the principal risks will be presented to the Trust Board on 25th January 2024 and are updated as at 13th December 2023 having been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3.

5. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

6. The focus for the forthcoming round of reviews will predominantly be in relation to the mitigating actions identified and taken to support risks to achieve their target score.

7. The Trust's highest rated Risks 223 *the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of*

care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients, scoring 25, remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be closely monitored by management, Board Committees, and at the Trust Board meetings.

8. As reported to the November 2023 Trust Board, whilst good progress has been made on the actions that the Trust can control, the extreme pressure continues. As a result, the likelihood is that the levels of avoidable harm will continue. That does not mean that the Trust is not continually seeking additional actions to mitigate these risks and the actions are articulated in the avoidable harm paper that the Board receive at each meeting.

9. Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance. These two risks will be reviewed closely in conjunction with each other to ensure the synergy between them both and that they reflect the actions from the avoidable harm paper in the same way.

10. Additionally, these risks will be considered further as to how the Trust can approach them by applying the risk appetite methodology as part of the Risk Management Improvement Programme and the most efficient and effective way of managing them internally.

11. As foreshadowed at the last Board meeting; Risk 139 *Failure to Deliver our Statutory Financial Duties* in accordance with legislation has achieved its target risk score of 8 (2x4). The risk has reduced in score from 16 (4x4).

12. The risk has been considered in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to Welsh Government. The score has shown to improve in year as a result, in part due to the Trust being able to resource the remaining cost of the Emergency Medical Service (EMS) staff increase itself in year, whilst further confirmation and assurance has been received from Welsh Government on any pay award funding due. In addition, a recent letter from Welsh Government confirmed that the Trust does not need to contribute anything further to the wider NHS Wales deficit reduction plan or will see any further reduction in its income to do so, providing further confidence that for this financial year, the risk has reduced. It must be noted that even though the level of risk has reduced during this year, the current challenging financial climate for all public sector organisations means that the risk will remain elevated as focus turns towards financial planning for the new financial year, for example, recurrent funding will still need to be agreed with Commissioners for 2024/25 for the 100 wte EMS staff.

13. Because of this, the risk will remain on the CRR and continue to be monitored in month and it is expected that the risk score will increase in the next financial year.

14. 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* has increased in score from 15 (3x5) to 20 (4x5) which reflects Health Board's declining to include the testing of plans to release ambulances in a recent mass casualty exercise. Additionally, the Trust was unable to fulfil its PDA as part of the Manchester Arena Inquiry recommendation due to ambulance being delayed at hospital and Health Boards being unable or unwilling to release them in three out of four scenarios. The lack of assurance has led to the increased risk score.

15. The risk title has been amended on Risk 424 from *Prioritisation or Availability of Resources to Deliver the Trust's IMTP* to *Resource availability (revenue, capital and staff capacity)* to deliver the organisation's Integrated Medium-Term Plan (IMTP). Additional work will be undertaken to ensure that the change is reflected in the controls, assurances, and mitigating actions.

16. Risk 458 *A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning,* the risk is linked to 139; however, the score remains unchanged currently.

17. All original actions are now complete in relation to 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*; however, a review of the recent Cyber Resilience Unit (CRU) assessment is to be undertaken to identify any further actions. On this basis the score remains the same given continued activity by cyber actors due to wider world events. There is a general heightened alert for government and public sector bodies although no specific threat has been identified against NHS bodies.

18. Risk 543 *Major disruptive incident resulting in a loss of critical IT systems* - Most mitigating actions are complete on this risk; however, the score remains unchanged as further reviews of the CE assessor and CRU reports are required to identify any further actions that need to be undertaken.

19. Risks 100 *Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* and Risk 283 *Failure to implement the EMS Operational Transformation Programme* are not due for review until January 2024.

20. A detailed review, discussion and challenge takes place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on these risks monthly.

RECOMMENDATION:

21. **Members are asked to consider the contents of the report and:**
    a) Note the reduction in risk score of Risk 139 to the target score of 8.
    b) The increase in risk score of Risk 594 from 15 to 20.
    c) Note the amendment to the title of Risk 424.

KEY ISSUES/IMPLICATIONS
22. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
23. The BAF was considered by: • ADLT (04 December 2023) • EMT (13 December 2023) All Principal Risks will be considered by Trust Board at its forthcoming meeting on 25 January 2024.

REPORT ANNEXES
• Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - Board Assurance Framework

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →
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.	Director of Operations	**20 (4x5)** ↑ **15 (3x5)**
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	Director of Strategy Planning and Performance	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	IMTP	**THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing		
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage.	Director of Finance & Corporate Resources	**16 (4x4)** →
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	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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		
543 FPC	Major disruptive incident resulting in a loss of critical IT systems	**IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems **THEN** there is a risk of a loss of critical IT systems **RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services	Director of Digital Services	**15 (3x5)** →
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Director of Strategy Planning & Performance	**12 (3x4)** →
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN potential patient harm, deterioration in staff wellbeing and reputational damage		
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	Director of Finance & Corporate Resources	**8 (2x4)** ⬇ **16 (4x4)**

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

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

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/11/2023	TREND	25 (5x5)
		Date of Next Review:	21/12/2023	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death

	Likelihood	Consequence	Score
Inherent	**4**	**5**	**20**
Current	**5**	**5**	**25**
Target	**2**	**5**	**10**

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Quality, Safety and Patient Experience Committee

Risk Commentary Q2 2023/24

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. **In October 2023, over 23,232 hours were lost, equivalent to losing 25% of the Trust's conveying capacity. This is a significant increase on previous months as we approach the winter months. Only Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier.** The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

Improvement actions led by Welsh Government and system partners include: -

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales reduces emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. **REAP is currently undergoing annual review with an updated to be released December 2023.**
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. **On Call cover is reviewed weekly at SLT Performance Meetings.**
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. **The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting.**
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/11/2023	TREND	25 (5x5)
		Date of Next Review:	21/12/2023		

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

	However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. **Clinical Safety Plan is currently under review with a release date December 2023.**
10. Recruitment and deployment of CFRs	10. **CFR numbers have grown during 2022/23 which alongside a cleanse of the volunteer database has realised 500 current active volunteers with an ambition to recruit a further 100 by end of Q4. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).**
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. **ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.**
12. Clinical Contact Centre (CCC) emergency rule	12. **Emergency Rule is incorporated into CSP 999 levels.**
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14. Summer/Winter initiatives	14. Monitoring through SLT and STB. **Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.**
15. CHARU implementation	15. **Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.**
16. Clinical Model and clinical review of code sets	16. Reported through **CPAS and DCR Review reporting through CQGG**
17. Remote clinical support enabling **discharge at scene**	17. Strategic Transformation Board – IMTP deliverable; **Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%**
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	18. Formally documented action plan – actions captured are contained within and monitored via the **Mitigating avoidable harm paper from PIP.**
19. Information sharing	19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
20. Completed EMS Roster Review	20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. **Monitor production** against **the rosters weekly at performance meeting and that provides a level of UHP as a percentage.**
21. **Delivered a reduction in the** number of multiple attendances dispatched to red calls	21. This will increase vehicle availability generally across the Trust **and is monitored through SLT weekly performance meeting.**
22. Transfer of Care	22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
	23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/11/2023	TREND	25 (5x5)
		Date of Next Review:	21/12/2023	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train **(detailed in actions)** following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.	**The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.**
6. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays **(see above)**
18. Access to Same Day Emergency Care (SDEC) for paramedic referrals	**18. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the acceptance of paramedic referrals is low (less than 1%). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.**
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	Extended to March 2024	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
4. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.03.23 Complete	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.
5. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/11/2023	TREND	25 (5x5)
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IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

6. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level.
7. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Complete 21.03.23	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023.
8. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
9. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.
10. New 2023 EMS Demand and Capacity (roster) review	**Assistant Director of Planning & Performance**	**March 2024**	**ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March**
11. Swansea Bay Winter actions	**Assistant Director of Operations, EMS**	**December 2023**	**Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.**
12. Mental Health response pilot	**Assistant Director of Operations, EMS**	**November 2023**	**Pilot to commence in Aneurin Bevan Health Board area Nov 2023**
13. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	**Assistant Director of Quality Governance**		**Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience.** **Phase 1 delivered through St John Ambulance Cymru** **Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.**
14. Maximise the opportunity from Consult and Close – stretch to 17%			**Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates.**
15. Development of new model of care	**Head of Strategy Development**	**2024/25**	**Development of the model remains ongoing**
16. Development of the pathway which connects mental health users connecting via the 999 system to 111 Press 2 services	**Assistant Director of Operations, Integrated Care**	**March 2024**	**Development of the model remains ongoing**

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	10/12/2023	TREND	25 (5x5)
		Date of Next Review:	10/01/2024	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Quality & Nursing	**ASSURANCE COMMITTEE**	Quality, Safety and Patient Experience Committee

Risk Commentary Q2 2023/24

The risk score remains constant at 25 for quarter 2 2023/24 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. **There were 1,888 patient handovers in October 2023 which were over 4 hours**. The target was originally to have zero by September 2022. In October 2023over **23,232 hours were lost, equivalent to losing 25% of the Trust's conveying capacity. Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier.** The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, coronial enquires and redress / claims. The Trust received **three** Prevention of Future Death Reports (Regulation 28) during this quarter. Two reports were issued to the Trust, Betsi Cadwaladr University Health Board and the North Wales Local Authorities due to extended community response and handover of care delays. **To date (Q2 2023/24) the Trust has received 6 Prevention of Future Death Reports, 5 of which relate to delays in response and handover of care issues.**

The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. The Joint Investigation Framework in place to review incidents across the system is now approved and included in the recently published National Policy on Patient Safety Incident Reporting & Management (May 2023). Themes from system partners following review of incidents remains the consequences of high escalation levels in acute care and crowded emergency departments.

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
d) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
e) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer).

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.

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		Date of Next Review:	10/01/2024	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST
9. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (**October 2023** overall 76% - Safeguarding and dementia awareness remains over 91%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board **November** 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of July 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candor Implementation Group and is actively engaged in developing resources. **From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group.**
17. **Clinical Support Desk First in place**	17.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.	1.
2.	2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 38 overdue nationally reportable incident investigations. Shared system learning from the Joint Investigation Framework is currently limited **with no new learning identified to date.**
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In **October** 2023, **23,232** hours were lost with 1,**888** +4 hour delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. Variation pan Wales / England as position not implemented across all emergency departments*.	5.
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
7. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	7.
8. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	8.
9. Transition to ePCR impacting on data temporarily	9.
10. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	10. HIW approve and sign off WAST elements of recommendations.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

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	Likelihood	Consequence	Score
Inherent	5	5	25
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Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Q4 2023/24	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety and health board dashboards.
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Q4 2023/24	• WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
5. Overnight falls service extension	Executive Director of Quality & Nursing	• 31.03.2024	• **Night Car Scheme extension agreed to 31 March 2024 (2 regional resources)** • **Utilization rates continue to be monitoring. Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023); Nighttime falls assistance 66% Utilisation (July – Oct 2023); Daytime utilisation sustained: July -August 58%. September- October 58% utilisation.** • **Optima modelling has now been completed. The modelling clearly identifies that the level two falls' vehicles are the more effective resource. The modelling has identified an estimated need of 48 (38 day and 10 overnight) falls vehicle level 2 12 hours shifts. The modelling is now being built into the strategic (five year) demand & capacity review.**
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded.	Executive Director of Quality & Nursing	• Q3 2023/24	• Monthly updates to progress against actions following the baseline assessment and readiness returns. • RL Datix Dashboards and KPIs under development nationally. • Key policies updated and approved. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	• Q3 2023/24	• Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru • **SJAC funded ended on 31 October 2023.** • **Proof of concept using WAST CFR volunteers as CWRs is underway. Grant funding is being used to put in place roles and processes to recruit and train to new volunteer role.** • **This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data suggesting a 35% consult & close rate for the cohort of patients covered by the pilot.** • **The business case has now been completed and can be made available to key stakeholders. Now awaiting business case approval.** • **The CWR will be modelled as part of the options being considered by the current EMS demand & capacity review.**

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		Date of Next Review:	10/01/2024	➡	

IF	THEN	RESULTING IN
patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q4 2023/24	• OCP commenced 25.09.2023 **and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by April 2024 (taking notice periods into account).**
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	• Q4 2023/24	• Positive meeting held in August 2023 as planned with the Chair of the TVN network. Next steps are for the Patient Safety Team to attend a TVN leads meeting to discuss opportunities for collaborative working and data / information sharing. **Date to be confirmed and there has been good engagement from Health Board Tissue Viability Nurses. Workshop date confirmed in January 2024.**
10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	• Q4 2023/24	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	Executive Director of Quality & Nursing	• Q4 2023/24	• Internal audit in progress. **Delays due to sickness in internal audit team.**

RISK ID 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	Date of Review:	21/11/2023	TREND	20 (4x5)
		Date of Next Review:	21/12/2023		

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 due to vehicles not being released from hospital sites	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

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
Target	2	5	10

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

The challenges across the unscheduled care system **are increasing on the approach to winter with more than 23,000** hours lost to handover delays during **October** 2023. There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. A number of incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services.
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. **REAP is currently undergoing annual review with an updated to be released December 2023.**
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT **with review currently underway with an expected release date in December 2023.**
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift **and cover review at weekly performance meeting**
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. **Cover review at weekly performance meetings**
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. **Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA.**

RISK ID 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	Date of Review:	21/11/2023	TREND	20 (4x5)
		Date of Next Review:	21/12/2023		

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 due to vehicles not being released from hospital sites	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

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
Target	2	5	10

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans	CEO/DOO	3 Jan 2023 Complete	Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
2. Multi Agency Exercise to be arranged	4 x LRF	**October** 2023 **Complete**	This exercise has taken place although Health Boards declined to incorporate vehicle release plans
3. Review of Manchester Arena Inquiry	**Assistant Director of Operations**	Dec 2023	This **programme of** work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios.
4. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration	DOO	Feb 2023 Complete	All Health Boards responded with assurance of plans except BCU.
5. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	Assistant Director Operations	May 2023 Complete	WG have confirmed that they have written to HB EPRR leads.
6. **Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans**	**Assistant Director of Operations**	**December 2023**	

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	08/12/2023	TREND	16 (4x4)
		Date of Next Review:	08/01/2024	➡	

IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	THEN there is a risk that there is insufficient capacity to deliver the IMTP	RESULTING IN delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	4	4	16
Target	1	4	4

IMTP Deliverable Numbers: All

EXECUTIVE OWNER	Director of Strategy, Planning & Performance	ASSURANCE COMMITTEE	Strategic Transformation Board and Finance and Performance Committee

Risk Commentary
Risk score remains currently at 16 as some outstanding gaps in controls and, linked to risk 458, some continued risk with regards to recurrent funding. There are also currently **sickness &** vacancies in the Transformation team resulting in gaps to support delivery of key workstreams **and delivery of mitigations listed in this BAF**, however these are in the recruitment **and managing attendance** processes.
IMTP planning for 2024-2027 underway to refresh our priorities for the next three years, taking into account the external context in which the Trust is working.
This risk will therefore remain under review as we put further controls in place but also taking account of the new commissioning landscape, financial context and our strategic developments.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Prioritisation of IMTP deliverables	1. Prioritisation detailed in IMTP and reviewed and agreed at Strategic Transformation Board
2. Financial policy and procedures	2.
3. Governance and reporting structures e.g., Strategic Transformation Board (STB)	3. IMTP sets out delivery structures and meeting minutes are available
4. Assurance meetings with Welsh Government and Commissioners	4. Agendas, minutes, and slide decks available
5. Transformation Support Office (TSO) which supports the major delivery programmes	5. Paper on TSO to Strategic Transformation Board
6. Project and programme management framework	6. PowerPoint pack detailing PPM
7. Regular engagement with key stakeholders	7. Stakeholder Engagement Framework
8. Financial Sustainability Programme – savings and income work streams	8. FSP programme highlight reports
	Independent Assurance (3rd Line of Assurance) 2. Subject to Internal Audit
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Project and programme management (PPM) framework to be reviewed	1. PPM needs to be reviewed and approved through STB
~~2.~~	2. Benefits have not been fully linked to benefits realisation
3. Lack of a commercial contractual relationship with Commissioners (link to risk 458)	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruit a Head of Transformation	Assistant Director of Planning	30.09.22 complete	Recruited 02.08.22 in post on 01.11.22
2. Review the PPM	Head of Transformation	Extended from 31.03.23 – To 31.06.23 and then to 30.09.23 in line with milestone for delivery Extend to 31.12.23 in line with timescales for sign off. **Extend to 31.01.24 in line with timescales for sign off.**	Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3. Planning Framework approved by STB on 04.07.2023 which sets out the Project Path framework at a high level. Project Path Framework presented at ISPG on 27.10.23 and is scheduled for approval at STB on 27.11.23. **STB reviewed the Project Path Framework and generally good feedback but some alterations to be made and brought back to STB in January 2024 for approval.**
3. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant	Extended from 30.09.22 – to 31.03.23. Further extend to	Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing.

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	08/12/2023	TREND	16 (4x4)
		Date of Next Review:	08/01/2024	➡	

IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	THEN there is a risk that there is insufficient capacity to deliver the IMTP	RESULTING IN delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	4	4	16
Target	1	4	4

	Director, Commissioning & Performance	31.06.23 and then to 30.09.23 in line with milestone for delivery Extend to 31.12.23 as priorities have taken precedence but there is work ongoing in this space. **Extend to 29.02.24 as other priorities have taken precedence but there is work ongoing in this space.**	Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3 as part of Project Path Framework. Work continues with the Commissioning and Performance Team to align performance metrics with programme/IMTP deliverables. An evaluation methodology is being trialled with Swansea University to look at benefits realisation of small, agile projects and PDSA cycles. Work continues on this but will be rolled out as part of the PPF.
4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Director of Finance	31.12.22 – checkpoint date 31.06.23 and then to 30.09.23 Extend to 31.12.23	Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner. A business case panel process has been developed and trialled as part of the development of the project path framework and is factored into the IMTP planning cycle, to give finance colleagues a timelier view of potential developments into the next 3-year cycle. **Extended in line with the roll out of PPF as the business case process is within that framework, however it has been utilised to review the recent CSC Business Case and was found to be helpful and supportive – albeit the model for developing business cases needs to be reviewed further to make the actual output more streamlined**

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services	Date of Review:	14/11/2023	TREND	16 (4x4)
		Date of Next Review:	13/12/2023	→	

				Likelihood	Consequence	Score
IF sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis.	**THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients.	**RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage	**Inherent**	3	4	12
			Current	4	4	16
			Target	2	4	8

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Finance and Corporate Resources	**ASSURANCE COMMITTEE**	Finance and Performance Committee

Risk Commentary

Linked to risk 139, though funding has been sourced internally for the EMS staff, and non-recurrently from EASC, the score remains the same as clarity from Commissioners has still not been provided on **any recurrent funding ask on this topic which** could have a negative **recurrent** impact on the Trusts financial position. Other key item to note is funding for 111, WAST continues dialogue with commissioners of the service and any financial risk is mitigated by operating on a spend and cost recovery basis with commissioners.

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bimonthly to Trust Board
2. Financial policies and procedures in place	2.
3. Setting and agreement of recurrent resources	3.
4. Budget management meetings	4. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly.
5. Budget holder training	5. Diarised dates for budget holder training
6. Annual Financial Plan	6. Submission to Trust Board in March annually
7. Regular financial reporting to EFG & FPC in place	7. Diarised dates for EFG and FPC with full financial reports
8. Regular engagement with commissioners of Trust's services	**External** **Management (1st Line of Assurance)** 1. Accountability Officer letter to Welsh Government 3 and 8 EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised. 9. Monthly monitoring returns
9. Welsh Government reporting monthly	**Independent Assurance (3rd Line of Assurance)** 2. Internal Audit reviews of financial policies & procedures as part of their audit plan
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of clarity regarding EASC/Welsh Government commitments with respect to recurrent funding	1. Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control)

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	Executive Leadership Team	31.3.24	Update: 23/24 Recurrent **funding remains an issue for the 100 WTE £6m funding from commissioners**. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.
2.Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.3.24	Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	06/12/2023	TREND	15 (3x5)
		Date of Next Review:	29/12/2023		

IF	THEN	RESULTING IN
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	there is a risk of a significant information security incident	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

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Digital Services	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

The **latest National Cyber Security Centre (NCSC) assessment indicates that the** threat of Cyber-attacks remains unchanged with activities of state actors and criminal gangs still high. Whilst the Trust and wider NHS Wales organisations have in place several layers of technology to protect the Trust and its information systems, there is still a risk that users will be fooled by phishing emails which are becoming ever more sophisticated. To raise user awareness of cyber threats the Trust ICT department run regular phishing exercises as well as short security training packages, reporting the results and uptake through IGSG and into FPC.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g., CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g., penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
15. **Cyber/Info Security KPI are reported to senior management and committees**	**15. Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group, ELT, IGSG and FPC**
16. Regular cyber awareness campaigns are conducted	**16. Cyber training is provided to staff and regular phishing campaigns are conducted. These are reported as part of the KPI reports**
17 IT recovery Plan does not include a cyber response	**17. Cyber response incorporated into IT Disaster Recovery Plan**
	External Independent Assurance

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	06/12/2023	TREND	15 (3x5)
		Date of Next Review:	29/12/2023		

				Likelihood	Consequence	Score
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	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14

GAPS IN CONTROLS	GAPS IN ASSURANCE
1.	1.
2. Lack of understanding and compliance with policy and procedures by all staff members	2. Information Security Policy refreshed and in Trust wide consultation
3. No organisational information security management system in place	3. **SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy**
4.	
5. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects, and procurement and this has a cyber security, information governance and resource impact	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establish Cyber and Information Security KPIs	Director of Digital Services	31.03.23 complete	KPI format agreed and will be produced from Q1 2023-24 with a retrospective annual report produced for 2022-23.
2. Discuss how cyber risk is reviewed and frequency of review	Director of Digital Services	28.10.22 Close – now Business as Usual	a. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources. b. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
3. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	28.10.22 Complete	The Trust has run two exercise Joshua & Joshua 2 to test departments readiness
4. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 **-** Complete	Exercise reports being drafted.
5. Formalise Cyber Incident Response Plan	Head of ICT	30.06.23 – complete Checkpoint Date 31.**03**.202**4**	Cyber Incident Response Plan adopted, and CRU Assessment conducted during May 2023 with report expected by end June 2023. **Implementation ongoing of** CRU Cyber assessment action plan in response to any recommendations.
6. Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	30.06.23 – Complete Checkpoint Date **31.03.2024**	Additional learning modules purchased, and both will be rolled out from Q1 2023-24. **Drive up staff compliance of IG & Cyber training**

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	06/12/2023	TREND	15 (3x5)
		Date of Next Review:	29/12/2023		

IF	THEN	RESULTING IN
IF there is an unexpected or uncontrolled event e.g., flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems	THEN there is a risk of a loss of critical IT systems	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

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of Digital Services	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

The risk remains static as work continues to **migrate services to the new** infrastructure. In addition, controlled cut over of key systems to backup sites was undertaken during this quarter. Maintenance works has been undertaken by estates on power systems supporting key ICT sites which will provide additional assurance for sites in the event of incoming mains disruption. Further desktop exercises are being considered to test both department BCP and ICT recovery plans. Internal audit have **completed an** audit on **ICT** system resilience which **was rated as reasonable assurance.** Work **will be undertaken to address the recommendations**.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Trust Incident Response Plan and Department Business Continuity Plans	1. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. Annual schedule of testing of BCPs.
2. IT Disaster Recovery Plan	2. Recent ICT tabletop exercise undertaken
3. Recovery/contingency plans for critical systems	3. Reports from tabletop exercises
4. Service management processes in place	4. Documented and approved service management processes in place
5. Incident Management Policy, Procedure and Process	5. Incident Policy and Procedure put in place in February 2022. This would be required annually and if there is a system change, the review would be earlier
6. Regular data back ups	6. Daily report on status of backup and fully automated process. Log kept of where restores are undertaken
7. Resilient and high availability ICT infrastructure in place	7. 04/08/23 – New back-up system ordered with the aim of implementation before the end of Nov23.
8. Robust security architecture and protocols	8.
9. Diverse IT network (both data and voice) delivery at key operational sites	9.
10. Regular routine maintenance and patching	10. 04/08/23 – Ongoing continual update of servers and replacement of out-of-date equipment
11. Environmental controls	11.
12. Intelligence gathered from suppliers with respect to future tool sets and enhancements	12. Via email and webinars
	External **Independent Assurance** • 2021_16 Internal Audit review of IM&T Control Assessment – baseline exercise • 2021_19 Internal Audit review of ICT Disaster Recovery – Limited Assurance • **WAST_2324-14 Internal Audit review of ICT Technical Assurance – Reasonable Assurance** • NIS Directive internal audit report 2022 – Reasonable Assurance (covering controls 1-12)

GAPS IN CONTROLS	GAPS IN ASSURANCE
Non identified	Undertaking Cyber Essentials assessment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	31.12.22 extend to 30.06.23 now complete	Suite of exercise available via BC teams' channel.
2. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 extend to 30.06.23 now complete	Joshua and Joshua 2 reports produced and circulated.
3. Cyber Essentials assessment to be completed.	Head of ICT	30.06.23 Extend to 31.03.24 - ongoing.	Evidence submitted to assessor – further works required to meet requirement. **Implementation of** action plan in response **to CRU Cyber assessment** recommendations
4. **Implement recommendations of IA Technical resilience audit**	**Head of ICT**	**30.06.2024**	**Implementation of recommendations from the internal audit technical resilience**

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	25/10/2023	TREND	12 (3x4)
		Date of Next Review:	25/01/2023		

IF	THEN	RESULTING IN
WAST fails to persuade EASC/Health Boards about WAST ambitions	there is a risk of a delay or failure to receive funding and support	a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

IMTP Deliverable Numbers: 2, 3, 4, 6, 11, 14, 29, 34

EXECUTIVE OWNER	Director of Strategy, Planning & Performance	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

The ambition is appropriate levels of patient safety and good working conditions for our staff. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels being around 20,000. EASC has an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which looks very unlikely, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust is not fully funded on these rosters either. The Trust is not fully funded for the CHARU roster lines, with an identified shortfall of -89.5 FTEs. The Trust has made the decision to transfer staff from emergency ambulance roster lines to CHARU roster lines, which is almost complete, but does not add more staff. Similarly, the Trust has made the decision to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned reduction in emergency ambulance numbers.

The 2023 EMS Demand & Capacity Review is live with an estimated completion date of Christmas. This strategic review will enable the Trust to articulate the type and level of resource that optimises response and conveyance to deliver appropriate levels of patient safety and good working conditions for our staff i.e., the ambition. Health boards are clearly under substantial financial pressures, so whether EASC can then support the ambition as articulated by the review, remains to be seen. The Trust has largely delivered on its side of the bargain, with the focus clearly shifting to health boards and handover improvement. The one area that the Trust needs to address is abstractions (including sickness), which are materially above the benchmark of 30%.
If further funding is not forthcoming, post the 2023 EMS Demand & Capacity Review, the risk may need to be revise its score upwards.

CONTROLS	ASSURANCES
	Internal & External Management (1st Line of Assurance)
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between CASC/CEO	3. Meetings are diarised every week
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established	5. Formal meeting with agendas, minutes, and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. It exists and has had its first meeting
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. EASC meetings focus largely on EMS and cursory note of NEPTS	1. NEPTS is covered in the WAST Provider Report to EASC.
2. Governance coordination between NCCU and WAST to be improved.	2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface. Actioned but has lapsed due to capacity and resourcing in NCCU team. HB to reboot.
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	3. Ministerial direction on handover reduction
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	4. Strategic demand and capacity review being undertaken with output due to be reported to EASC in Jan-24.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	25/10/2023	TREND	12 (3x4)
		Date of Next Review:	25/01/2023		

IF	THEN	RESULTING IN
WAST fails to persuade EASC/Health Boards about WAST ambitions	there is a risk of a delay or failure to receive funding and support	a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	02/08/23 Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure. 28.07.23 Funding secure for 23/24, but not recurring.
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	02/08/23 Checkpoint Date	30.09.22 4-hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture. 02.05.23 Continued worsening picture with almost 29,000 lost in March 2023. 28.07.23 There has been some reduction, but levels remain extreme.
3. Increased understanding of NEPTS by EASC	Director of Strategy Planning and Performance	02/08/23 Checkpoint Date	30.09.22 "Focus on" session in May 2022 EASC and NCCU represented on Ambulance Care Programme Board. 12/01/23 F&P Deep Dive made available to NCCU. 02.05.23 Continued attendance by NCCU at Ambulance Care Transformation Programme. 28.07.23 EASC want WAST to develop a LTS for NEPTS, which will increase the focus on it.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU.
5. Utilising the engagement framework to engage with the stakeholders	Director of Partnerships & Engagement AD Planning & Transformation	02/08/23 Checkpoint Date	30.09.22 Significant engagement through roster review briefings. 12/01/23 Engagement on roster review largely concluded, with some political interest continuing in a few areas. 02.05.23 Continued interest from various stakeholders as the roster review concludes. 28.07.23 New engagement manager appointed linked to inverting the triangle work.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	25/10/2023	TREND	12 (3x4)
		Date of Next Review:	25/01/2023		

IF	THEN	RESULTING IN
there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	potential patient harm, deterioration in staff wellbeing and reputational damage

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Strategy Planning & Performance	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

The EMS Operational Transformation Programme is the Trust's strategic delivery response to the 2019 EMS Demand & Capacity Review. The programme has now largely been delivered e.g., closure of relief gap (recruitment of +300 staff), increase consult & close above the 10.2% benchmark, re-roster EMS, ensure that there was sufficient fleet and estate to support these changes and roll out the new CHARU resource. The main area outstanding is the reconfiguration of EMSC, which was initially delayed by the pandemic and then further delayed by the need to update the data used to ensure the recommended actions were still correct. This update has just been completed, so the focus is now on finishing the EMSC project within this programme.

Whilst the programme has largely delivered on its agreed outputs, it has not delivered the required levels of patient safety and staff working conditions for two main reasons: extreme handover (20,000 lost hours v the 6,000 that the programme was predicated on) and abstractions (37% v the 30% benchmark).

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership	1. Minutes and papers of Implementation Programme Board
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board
3. Programme Manager and Programme support office in place (for delivery of the programme)	3. Same as 2
4. Programme risk register	4. Highlight reports showing key risks reported to STB every 6 weeks
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks	5. Highlight reports presented to STB every 6 weeks
6. Programme budget in place (including additional £3m funding for 22/23)	6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks and letter received from CASC on £3m funding for 22/23
7. Programme documentation and reporting is in place to Programme Board every 3 weeks and STB receives highlight report.	7. PID and Programme Plan Summary kept up to date**.** PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks.
8. Regular engagement with the Commissioner and Trade Unions and representation	8. Commissioner and TU participation at the Implementation Programme Board
9. Management of external stakeholder and political concerns	9. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders
10. Secured specialist consultancy to support decision making	10. Reports and contractual compliance
	External **Management (1st Line of Assurance)**
	a. Deputy Ambulance Services Commissioner sits on the Implementation Programme Board
	b. Emergency Ambulance Service Committee Management Group receives a highlight report every two months
	c. EASC receives an update every 2 months on the programme as part of the WAST Provider Report

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Current controls on workforce buy in are not sufficient due to changes in working practices	1. Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position. The PID has been updated for 2023/24 and reflects the budget, commissioning intentions and IMTP.
2. System pressures – patient handover delays at hospitals (link to risks 223 & 224)	2. No prompts from STB for programme PID or risk register updates. The SRO continues to provide the HLR, but the PID needs to be signed off by the Executive Sponsors. This can be done outside of STB.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	25/10/2023	TREND	12 (3x4)
		Date of Next Review:	25/01/2023		

IF there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	THEN there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	RESULTING IN potential patient harm, deterioration in staff wellbeing and reputational damage

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	**02.08.23 Checkpoint Date**	30.09.22 Significant engagement through roster review project. 12/01/23 Largely complete. 02.05.23 There remains some minor engagement as the project concludes.
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	**02.08.23 – Checkpoint Date**	30.09.22 Transition plan not funded, but +100 FTE agreed. 12/01/23 Recurrent funding not secure. 02.05.23 this has not been forthcoming, and handover lost hours are offsetting all of the gains that the Trust has made. 03.08.23 More capacity unlikely within current financial pressures, but Trust has recently started the next iteration of the strategic EMS Demand & Capacity Review.
3. Engage with key stakeholders to reduce handover delays	CASC	**02.08.23 – Checkpoint Date**	30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend. 02.05.23 handover hours remain extreme. 28.07.23 Increasing focus through ICAP meetings, with C&V showing notable progress and early signs of progress in some other health boards.
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	**02.08.23 Checkpoint Date**	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 10% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment. 02.05.23 the Trust achieved 7.99% in Feb-23, but levels are higher in Operations. Continued focus into 2023/24 to reach 6% by 31/03/23. 28.07.23 Abstractions, which includes sickness now less than 35% with benchmark to 30%
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	**02.08.23 Checkpoint Date**	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB. 02.05.23 PID has been updated but needs to be signed off by Executive Sponsors. 28.07.23 PID updated and programme aligned to new arrangements required by HoT.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	14/11/2023	TREND	8 (2x4)
		Date of Next Review:	13/12/2023		

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	

	Likelihood	Consequence	Score
Inherent	3	4	12
Current	2	4	10
Target	2	4	8

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	**ASSURANCE COMMITTEE**	Finance and Performance Committee

Risk Commentary Q4 2022/23

The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG. The score has improved in year as a result, in part due to WAST being able to resource the remaining cost of the EMS staff increase itself in year, whilst further confirmation and assurance has been received from WG on any pay award funding due. In addition, a recent letter from WG confirmed that the Trust does not need to contribute anything further to the wider NHS Wales deficit reduction plan or will see any further reduction in its income to do so, providing further confidence that for this financial the risk has reduced. It must be noted that even though the risk has reduced for this year, in the current challenging financial climate for all public sector organisations the risk will remain elevated especially as focus turns towards financial planning for the new financial year e.g., recurrent funding will still need to be agreed with Commissioners for the new financial year for the 100 WTE EMS staff.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at **FPC**, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.	
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	a) Monthly monitoring returns to ADLT, EFG, ELT and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, ELT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	14/11/2023	TREND	8 (2x4)
		Date of Next Review:	13/12/2023		

				Likelihood	Consequence	Score
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	**Inherent**	3	4	12
			Current	2	4	10
			Target	2	4	8

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	1. None identified.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 – Checkpoint Date	**In line with the recent WAST financial position and monthly monitoring letter sent to WG, WAST can resource the cost of the EMS staff itself. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.**
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/24 – Checkpoint Date	The Financial Sustainability workstreams that were launched in May 2023 have now been rebranded as the Financial Sustainability Program (FSP) and the work of the program underpins the need of the organisation to deliver transformative savings via the Achieving Efficiencies and Income Generation subgroups. **WAST is currently over delivering against its savings plan.**
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/24 – Checkpoint Date	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. WIIN support for procurement, savings, and efficiencies	WAST Improvement and Innovation Network group	31/03/24 – Checkpoint Date	WIIN ideas are regularly communicated across to the Achieving Efficiencies subgroup of the FSP.
5. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 – Checkpoint Date	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales.

AGENDA ITEM No	**10**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER 2.0 – DECEMBER 2023

MEETING	Finance and Performance Committee
DATE	15 January 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

2. The Audit Tracker has been updated in Quarter three following its complete revision in Quarter two again there has been excellent engagement from Directorates. C.30% of audit recommendations are presented as closed in quarter in this report and there are actions with a change in date proposed (marked in blue), many of which are due to be closed in Quarter four or Quarter one of 2024/25.

3. With respect to the Committee's responsibility to scrutinise the impact of actions, in November the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.

4. The current version of the tracker is now open for Directorate review for actions due in January, February, and March. These updates will then be reported to the Committee at its meeting in May 2024.

5. Due to the timing of reporting for Committee in January 2024 there are some actions which were due in December 2023 which may not have complete updates or where there may be a further update available for the Committee at its meeting in March 2024.

RECOMMENDATION

6. The Committee is requested to:

   (a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are: -
      - Estates Assurance – Estates Condition;
      - 111 Service Commissioning Arrangements (advisory);
      - Technical Resilience (to be received in closed Committee).

   (b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue); and

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Tracker presented to ADLT via email in December 2023.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 October - December 2023 for Committee Reporting

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

SITUATION

7. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

BACKGROUND

8. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised to include Audit Wales content.

9. The Handbook includes roles and responsibilities for the various stakeholders including:

    - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.

    - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.

    - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.

10. The Tracker has been updated in Quarter three following its complete revision in Quarter two. Members will receive a copy of the Tracker by email and are invited to filter the excel sheet to their particular Committee to view the relevant audit actions. A copy of the Tracker is also reproduced at Annex 1 filtered to the actions assigned to this Committee for oversight.

11. Very good progress has been made on the development of the SharePoint solution for Tracker 3.0 with colleagues in Digital Health and Care Wales Centre of Excellence. It is intended that this solution will be ready to implement / use early in the 2024/25 financial year.

ASSESSMENT

12. The Handbook notes that it is the responsibility of a Board Committee (other than Audit 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.

13. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter three, with the result that c.30% of audit recommendations are presented as closed in quarter in this report.

14. Some actions have had a change in date proposed (marked in blue), many of which are due to be closed in Quarter four.

15. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Q4 with a view to closing down or revising as many as possible.

16. With respect to the Committee's responsibility to scrutinise the impact of actions, in November the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.

17. The current version of the tracker is now open for Directorate review for actions due in January, February, and March. These updates will then be reported to the Committee at its meeting in May 2024.

18. Due to the timing of reporting for Committee in January there are some actions which were due in December 2023 which may not have complete updates or where there may be a further update available for the Committee at its meeting in March 2024.

RECOMMENDATION

19. The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are: -
   - Estates Assurance – Estates Condition;
   - 111 Service Commissioning Arrangements (advisory);
   - Technical Resilience (to be received in closed Committee).

(b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Respons e No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
382	20/21	FPC	Clinical Contact Centres - Performance Management	Reasonable	Deborah Armstrong	Liam Williams	Medium		5. Review coaching and training arrangements within NHSDW/111 to ensure mechanisms are in place for all staff to receive regular feedback, coaching and training going forward.		5b. Following recruitment, a review of other aspects of training will be undertaken; It should be noted however that without outsourcing aspects of training and delivery for the new system, an overlap with Salus roll out may delay 'regular' coaching and training until at least Autumn.	Jan-22	Not Met	Nov-23			Closed in Quarter	11.12.23: There has been a vast improvement in the ratio of coaching sessions offered to staff across all operational sites. This can be evidenced through the data submitted and reviewed at the 111 Quality Meeting, which includes every coaching session booked and those which didn't go ahead/why they didn't go ahead i.e., high demand/sickness. It should be noted however that various pressures including accelerated recruitment and induction, and the upcoming updating of the CAS system, will impact on the ability of the team to do this with the regularity they would otherwise wish to. Proposed for closure on the basis that the team are achieving coaching/training and that there is a mechanism to review this at the 111 Quality Meetings. Board Secretary has reviewed the Education Professional and Clinical Practice Team Data Dashboard from Nov 23 with coaching and training elements. Last update 30/06/2023 SALUS is now planned for Go Live in November 2023. There has been an improvement in delivery of CPD to more staff but this remains a risk as will be put on hold when Salus needs to be trained to all. External Provider assistance may be required. A risk has been identified previously due to a number of unfunded posts in the training team that may not be made permanent however this risk has recently been reduced for someof the unfunded posts to be funded.
383	20/21	FPC	Clinical Contact Centres - Performance Management	Reasonable	Deborah Armstrong	Liam Williams	Medium		5. Review coaching and training arrangements within NHSDW/111 to ensure mechanisms are in place for all staff to receive regular feedback, coaching and training going forward.		5c. The risk relating to the lack of education, coaching and supervision is currently captured on the QSPE Directorate risk register. This risk will be reviewed and updated and if necessary escalated to the corporate risk register.	Apr-22	Not Met	May 23	Nov-23		Closed in Quarter	11.12.23: Risk 409 was not escalated to a Corporate Risk therefore it was reviewed at the Senior Quality Team Meeting on 15 November 2023. Given the evidence provided in Trust Ref 382, it was agreed by the Senior Quality Team that this risk would close and the Senior Quality Leadership Team were advised on 28 November 2023 via the AAA. The risk may reoccur as the workload and workforce changes (but is currently no longer present). Propose for Closure (Board Secretary reviewed AAA) Last update 30/06/2023 CPD for 111 operational staff. New CPD year 2023/24 commenced April 2023 and is currently strong however important to note that indicative date for Salus training and implementation (Aug-Nov) will impact on ability to maintain other aspects of education and training.
420	21/22	FPC	Service Management	Reasonable	Aled Williams	Leanne Smith	Medium		WAST should develop their Service Management framework and once complete, the Service Catalogue should be published and communicated to all appropriate stakeholders.		Agreement has been reached to employ consultants to undertake a review of current position and to develop ITIL based procedures covering the whole service management disciplines. This work is expected to commence during September 2021. A deliverable of this work will be a refreshed service catalogue which can then be published and communicated.	Mar-22	Not Met	Dec22	Sep-23	Apr-24	Open	Last Updated: 10/10/23 - There is limited capability to support Service Catalogue in Service point and an attempt was made to develop one in Excel see attached draft. Whilst this could be completed and shared with stakeholders it would not be particularly user friendly. We are now close to procuring a replacement for Service Point where there will be a central service catalogue available to digital staff and the users within the system. Aim is to get new system operational by Mar-24.
470	21/22	FPC	Asset Management - RAM System	Reasonable	Jill Gill	Chris Turley	Medium		The Trust should consider the requirement to use the proposed RFID system to validate assets not included in its current processes (e.g. stretchers, defibrillators, suction units, emergency lifting cushions and oxygen delivery systems) against the RAM Asset Management system and review and update its procedures as appropriate.		The Trust has considered the potential of linking RAM and an RFID system, however this would not be practical as RAM is updated on a quarterly basis and the RFID system is a live system with constant streaming updates. These two products would not align in a manner that would deliver a safe and valued output. The proposed solution will be a quarterly download from the RFID system that will be reconciled into RAM and variances investigated. RFID is currently in development, however due to operational pressures the rollout is unlikely to be completed before December 2022.	Mar-23	Not Met	Mar-24			Open	Last updated 25.09.23 This work cannot be taken any further forward until the RFID system is fully implemented and quarterly reports become available to reconcile to RAM, this is as per the management response. The RFID system needs to be implemented at pace by the Trust, work is progressing with Fleet in the North and SE to tag items however currently a separate ICT resource is required in C&W to complete, following the previous update the ICT lead has now left the Trust, in addition ICT currently has circa 10 vacancies and is experiencing difficulties in recruiting to these posts, this is resulting in other schemes having to be prioritised over this scheme to ensure core systems function. The previous completion date of Mar 2023 shows as it is unclear due to the recruitment issues faced by ICT exactly when this action will be completed, Mar 2024 put as estimate by ICT dept.
501	21/22	FPC	Waste Management	Limited	Richard Davies / Nicci Stephens	Chris Turley	High		1. The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The Trust should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements.		1. Agreed as the key priority, recommendation and action for immediate further improvement from this review. From which the response and resolution for many of the other actions will naturally follow. To progress many of these, it has been jointly agreed at Exec level that a task and finish group (TFG) will be immediately created with representatives from the following departments: • Estates and Facilities • IPC • Health and Safety • Operations • ICT • Fleet • Corporate Services • Training • Finance • Medical directorate (for drug management issues) • Clinical equipment and logistics • TU rep The TFG will develop a National Waste policy to cover both domestic waste and clinical waste. The policy will identify the management structure for both sections of waste (which will be different) and therefore a reporting structure, including through to Board Committees (likely to be by exception) and therefore Trust Board itself. It will also identify training needs and all compliance and audit obligations.	Sep-22	Not Met	Sep-23	Nov-23	Mar-24	Open	Target date moved in Quarter 3 Update 201223. Discussions have now been held at Exec level, including with CEO on any required realignment of Exec level responsibilities, part of which links to changing Exec portfolios from 01/01/24. Following this, all remaining items to conclude the new waste management policy will be progressed at pace in January 2024, with a view for ensuring formal sign off before 31/03/24. Updatd 180923: Waste management policy is drafted however discussions regarding Director level responsibility for clinical waste are being held. The SOPs that form part of the master list of waste in the policy have been implemented however it is the overarching policy that brings them together with roles, responsibilities and governance structures that is out for consultation. Given the clinical waste ownership discussions, it is proposed that this action be moved to November 2023 for the policy to be presented back to the Policy Group to enable those discussions to be held. The policy will thereafter be approved by the FPC. Last updated 13/07/23 Waste Management Policy out to consulation and due to be approved by FPC in September 2023
505	21/22	FPC	Waste Management	Limited	Nicci Stephens	Chris Turley	High		5.1 The Trust should review the arrangements in place for the transfer of clinical waste and seek to gain assurance that the current arrangements as detailed are in keeping with the requirements of WHTM-07-01.		5.1 – The WHTM 07-01 was amended from HTM 07-01 in 2013, this predates the separation of HCS from WAST. Under its current form WAST is not able to comply with this particular section of the document as WAST does not have a direct contract with the current clinical waste contractor. NWSSP FS, the documents authors, have been contacted regarding this point. The WHTM is due for review. However, those confirmed under the TFG as clinical waste lead will produce an annual hazardous waste transfer note for Denbigh Stores and Pontypool Ambulance Station for completion by HCS, therefore compliant with current hazardous waste legislation.	Jun-22	Not Met	Sep-23	Jan-24	Mar-24	Open	Target date moved in Quarter 3 to align to update in 501 i.e. these will come to FPC with the Waste Mangement Policy in March 2024. Update 180923: WAST does not have a contract with HCS regarding clinical waste. A hazardous waste transfer note was sent to HCS but they have not signed it, stating it was not required. Natural Resources Wales have also confirmed that we have an exemption for transferring clinical waste to HCS and that the only agreements that need to be in place are between HCS and Stericycle (which they are). The only body to whom WAST could have a contract that satisfied WHTM 07-01 is NWSSP (the authors of that WHTM) and they have declined to do so. Propose that this item is closed when a paper is taken to the Finance and Performance Committee setting out the ways in which the risk regarding the absence of a contract for clinical waste for WAST is mitigated. It is proposed that the timing for this is when the Waste Management Policy is taken to FPC (January 2024) so that director responsibilities for clinical risk are clear. Last Updated: 13/07/23 A paper to be prepared and shared at an appropriate forum detailing the current status and the proposals to manage the risk.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
505(a)	21/22	FPC	Waste Management	Limited	Nicci Stephens	Chris Turley	High		6. WAST should contact the respective Health Boards on an annual basis to obtain a duty of care transfer note covering handover of clinical waste from Ambulances at Health Board sites, in keeping with the requirements as stipulated in WHTM 07-01.		6. The WHTM 07-01 was amended from HTM 07-01 in 2013. HTM 07-01 is the English management of waste in healthcare technical note. On amending the HTM to the WHTM this section should have been replaced. As a commissioned service to the health boards clinical waste sits with the patient and therefore the health board. NWSSP FS, the documents authors, have been contacted regarding this point. However, to further add to the assurance of this, it is also now requested that the TFG will propose the production of an annual hazardous waste transfer note for each Health board, therefore compliant with current hazardous waste legislation. This will be included in the national waste management policy.	Sep-22	Not Met	Jan-24	Mar-24		Open	Target date moved in Quarter 3 to align to update in 501 i.e. these will come to FPC with the Waste Mangement Policy in March 2024 Reopened September 23 followng 22/23 Follow Up Audit. Update: Only two HBs have not returned the duty of care transfer. CVUHB are awaiting the appointment of their waste manager to sign the document. BCUHB did not sign it based on improvements being required on WAST segregation methods. WAST has held fortnightly meetings with local mangers in the HB region, as well as BCUHB management and conducted waste management audits in the area. WAST has identified issues and put in place mitigations and have written to BCUHB indicating as much and seeking their agreement to the duty of care transfer note. It is proposed that this action is closed when the paper which encompasses matter arising 5 and the Waste Management Policy are presented to the FPC in January 2024 Update 02/09/22. WTN have been written and sent.
512	21/22	FPC	Service Reconfiguration	Reasonable	Mark Harris / Deborah Kingsbury	Rachel Marsh	Medium		1.1 We recommend that the service specification is finalised and reissued for the period beginning June 2022, reflecting any amendments to the model that post-implementation service reviews have indicated. This is particularly significant because of the contribution this project may make to an upcoming all-Wales model to cover similar service reconfigurations. Future service change SLAs must be signed before the renew date.		1.1 The timescale is dependent on commissioners agreeing the longer term commissioning agreement. Meetings with commissioners (ABUHB and NCCU leading) have commenced to take forward the recommendations of the GUH Evaluation and this should include the agreement on the next commissioning agreement. However this may need to be backdated.	Sep-22	Not Met	Apr-24			Open	4.12.23:Requirement is related to an operational issue around the service specification at The Grange - Planning is assisting with the work and it should be finalised before the review date of April 2024. Update 101023: After initial exchange as noted on 030523 update, Pending receipt of something formally. Informal conversations indicate that based on activity review and remodelling work ABUHB will be looking to reduce peak capacity Currently 10 crews at 1400 hrs daily to 6 Crews. ABUHB will also be redefining the service purpose in the SLA refresh to take out what is believed to be mission creep example Step Across and Discharge activity. WAST will be undertaking its own modelling to corroborate Health Borad modelling and also to ensure there are no unintended consequences or at least the stakeholders are appraised of the risks if any. ABUHB has also indicated that they will be disinvesting from the Paramedic resource it commissioned under this contract and will be looking to increase the Transfer Practitioner resource (TP) instead. The single system project that is looking to move all ACA2 activity under the GUH inter site transfer service on to Cleric CAD system is being progressed with this assumption in agreement with ABUHB 03.05.23 Initial exchange on SLA undertaken, response from WAST considered by ABUHB who are preparing a report to their Execs, advised by NCCU that they will facilitate a further meeting to discuss, likely to be in June. Acknowledged that SLA will not be able to progress until requirements clear from ABUHB. 25.01.23 NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation of the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model. Last updated: 02/11/22 Enabling pieces of work are scheduled to be completed for discussion with NCCU and AB in December, NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation no the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model.
502	22/23	FPC	Immediate Release Directions	Reasonable	Caroline Miftari	Liam Williams	High		3.1 Datix incidents should be reviewed and closed in a timely manner and any lessons learned should be shared with the relevant parties.		It remains challenging for the Trust to investigate and subsequently close Datix as refusal to comply with an Immediate Release Direction is a Health Board Decision and so any harm that subsequently occurs, requires the Health Board to lead on a joint investigation, with the same principle being expected by the Trust where harm has not explicitly been identified. A new Joint Investigation Process is being piloted under the leadership of the NHS Wales Delivery Unit, which commenced in November and that will run until March 2023. IRD requests that have been declined and where harm has been identified or is considered to have occurred, will form a part of this Pilot and a decision to recommend changes to the process will follow this pilot.Of note the Duty of Candour, that comes into place on 1 April 2023, further regulates the need for openness and transparency with families across the NHS.	Mar-23	Not Met	Apr-23	Dec-23	Jan-24	Open	Target date changed in quarter. 14.12.23 The SOP for the management of all incidents reported over Datix Cymru is currently in final draft on the new Directorate template, feedback from patient safety to be incorporated. The Quality Management Group have received and considered a presentation on open incidents within the incident module on Datix Cymru. As part of the presentation, Immediate Release Declines reported via Datix was also reviewed. A draft SBAR for Immediate Release Decline has been discussed at QMG with a view to looking at an alternative process for the management of immediate release declines that are not considered, adverse incidents, near misses and/or hazzards as per the Adverse Incidident Policy 2023. Further discussions are planned in December 2023. As the SBAR for an alternative process for reporting Immediate Release Declines has not yet been shared with or approved by SOT, we request a revised date of January 2024 for completion 121023: The SOP developed is a QSPE SOP which relates to the management of records through datix as opposed to the SOP in 504 which is the guidance from EMS Coordination in relation to live management of incidents. The review undertaken by the delivery unit in relation to the joint investigation process did not specifically pick up any additional learning regarding immediate release declines however there is now a 'standing agenda' item in the quarterly PTR report regarding serious incidents linked to declines so that we have a method to capture incidents and identify thematic activity. TBC at next review if this now closes this item. Update: 26.09.23 - Standard Operating Procedure for Datix drafted to step out expectations for managers. Review currently ongoing for how datix is used with proposals to be drafted to more easily identify those IRD records where harm has occurred. Proposed revised date of 31.12.23 to allow datix team to provide analysis and proposols for change. Reason for proposed revised date is due to capacity within team. Senior QUality Governance lead now in place, OCP completed for department but 1 vacancy still remains. Last update: 14.04.23 Delayed due to management capacity and impacts of industrial request for extensiont to end of April 23 - coaching bulletin drafted
503	22/23	FPC	Immediate Release Directions	Reasonable	Caroline Miftari	Liam Williams	High		3.2 Noting the capacity issues above, the Trust should review the requirement to investigate all Amber 1 declined directions and consider introducing a streamlined mechanism of reporting. The Trust's SOP should then be updated accordingly to reflect the outcome of this review.		The Trust will agree a process to record all Amber 1 declined IRDs and report occurrence thematically based on UHB and clinical code sets. Where thematic analysis identifies additional areas of concern, these will be taken forward on a 'task and finish' basis by the Trust with the appropriate UHB and clinical representation.	Feb-23	Not Met	Apr-23	Dec-23	Jan-24	Open	Target date moved in quarter. 14.12.23 A draft SBAR for Immediate Release Decline has been discussed at Quality Management Group with a view to looking at an alternative process for the management of immediate release declines that are not considered, adverse incidents, near misses and/or hazzards as per the Adverse Incident Policy 2023. Further discussions planned in December 2023 therefore we request a revised date of January 2024 for completion Update 121023: Given that the action is to include the process to record all Amber 1 declined IRDs and report thematically, with TFGs being estabisherd where areas of concern identified, we will close this when the SOP (the SOP is different to that in item 504) has been approved as that will close off the action. The action was not to embed processes. Propose extending to Dec 23 on that basis. All Amber 1 declined IRDs are now recorded through datix. There may be further tweaks to the process as we continue to develop our quality management system. Update 26.09.23: Linked to Ref 502 review now ongoing for how datix is used which will include recommendations on how themeatic anaysis can be provided. Quality Management Group now commencing which will allow for review of thematic analysis to support quality improvement planning and subsequent T&F tasking. Proposed revised date of 31.03.24 to allow recommendations to be approved and QMG to embed processes, pre-requisite for Ref 502 to be completed before this action can be recommended for closure. Reason for delay is due to capacity within team. Senior Quality Governance lead now in place, OCP completed for department but 1 vacancy still remains. Last update: 14.04.23 Delayed due to management capacity and impacts of industrial request for extensiont to end of April 23 - coaching bulletin drafted
522	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Medium		1.1 A report (template) catalogue should be created and maintained. It should list all reports available, their purpose, the data fields they contain, and the parameters that can control the actual report production e.g. period, location etc. This can be supported by the MI on report production; if it has not been produced for over 12 months is it still needed, should it be archived?		A report catalogue is already in development. We will also set up a small selection of report templates to help speed up development, make self-serve easier for consumers, and streamline this report cataloguing effort.	Apr-23	Not Met	Dec-23	Feb-24		Open	Last updated 22/11/23: A specialist 'Reporting Analyst' secondment position was created and successfully recruited into to support this work. Progress has been made since this appointment in Oct-23, with a goal of finalising and publishing Jan-24. Update 28/06/23: Capacity in the analytics team means although progress has been made against this action, it is not yet complete. The report catalogue now exists, but cycles of review for the reports contained within it have not yet commenced.

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523	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Medium		1.2 The process of requesting a new or modified report should be formalised. It should include reference to the catalogue at 1.1 so that specialised analyst time is not wasted reproducing existing reports		The recommendation is welcomed, and we will look to expand on the existing request process with a formalised (potentially guided self-serve) check of existing functionality, and an ability to decline requests if the content already exists in other places, or if not aligned with organisational priorities.	May-23	Not Met	Dec-23	Feb-24		Open	Target date moved in quarter. Last updated 22/11/23: This work is on-track, and the proposed process is waiting review by the data and analytics leadership team. Changed date requested. Update 28/06/23: The new report catalogue has been embedded within HI processes: when new requests for intelligence are received a check is made whether a report already exists which could allow the requestor to self-serve the information before the task is actioned. Due to capacity constraints within the team, the request mechanism is still to be amended to ensure alignement with WAST strategic priorities in 2023-24.
524	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Medium		1.3 Data on report production and usage should be maintained, and feedback from the requestor obtained. This should be used to maintain and limit the reports available to a manageable number of reports with their usage and priority recorded.		We do already obtain some feedback on service and products, but will look to formalise the collection of this and the embedding of findings within the development cycle process, as well as create management KPIs around these metrics to take through Digital governance routes. However, a dependency here is the management of the HI HelpDesk inbox, and work to converge this with the ICT ServiceDesk inbox.	Jun-23	Not Met	Dec-23	Feb-24		Open	Target date moved during quarter. Last updated 22/11/23: This action is linked to the catalogue work of action 522. We have gathered intel on all available data products and are now grading reports. Expected to be able to complete early 2024 - propose date change to Feb-24. Update 02/10/23: Report usage data is routinely collected and used on an ad-hoc basis, but we don't currently obtain much feedback from requester/users. We are beginning to implement a report review cycle for all reports. Linked to 522.
525	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Low		2.1 There should be a series of Entity Relationship Models available covering all of the tables in the data warehouse.		We will develop an ERD library, including meta-data, starting with **EMS CAD.** We will plan out a roadmap for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.	Mar-23	Not Met	Mar-24			Open	191223: Update from LS: Role being interviewed for this week.The ability to meet the March date will therefore depend on the notice period and start date of the appointed candidate. Leave as Mar-24 for now and review if required in January. Last updated 22/11/23: Recruitment is in progress to bring in a principal data engineer to bolster capacity in the team, but also support oversight on this project from March-24. Update 28/06/23: The EMS CAD Data diagram is now complete. Deadline for full ERD library is unrealistic, suggest this is reviewed against other priorities. This work will ultimately be used within Digital and not wider Trust stakeholders. There has been a Principal Data Engineer vacancy since Jun-23 and as part of the savings plan, there is no intention to backfil for this post in the short-term.
526	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Low		2.2 All tables should have a completed meta-data table describing their contents		We will develop an ERD library, including meta-data, starting with EMS CAD. We will plan out a **roadmap** for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.	Jul-23	Not Met	Dec 23	Mar-24		Open	Target date moved in quarter 3. 191223: Update from LS: Update from LS: Role being interviewed for this week. The ability to meet the March date will therefore depend on the notice period and start date of the appointed candidate. Move to Mar-24 for now and review if required in January. Target date moved during quarter 2. Last updated 22/11/23: Recruitment is in progress to bring in a principal data engineer to bolster capacity in the team, but also support oversight on this project from March-24. Update 02/10/23: As per update of item 525. A sequence of design for the ERD library has been agreed within Digital, but timelines for completion are not yet available due vacancies in the team (recruitment is underway). The EMS CAD item is complete, with goal of achieving ePCR diagram by December 2023 (followed by CAS then NEPTS in Spring 2024).
527	22/23	FPC	Data Analysis	Reasonable	Aled Williams	Leanne Smith	High		3.1 A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		**A risk-assessment** will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - **due March 23**. In the meantime, there is already a programme of work to migrate reports and dashboards to **PowerBI.** However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time - due March 24.	Mar 24	Not Yet Due				Open	Last Updated 02/10/23: Risk assessment completed and in Datix. A 12-month secondment has been created for a PowerBI specialist to start the work of migration from Qlik before decommissioning. March-24 is likely unrealistic, but a roadmap will be developed once the secondment begins (November-23). Previous update 27/06/23: Qlik is considered a low IS risk. Work is already ongoing to move reports into powerBI but due to capacity constraints within the team will take most of 2023-24 to complete
531	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Low		5.1 A defined quality (accuracy) level should be established for all data fields, so that particular focus can be made on those determined as being key, e.g., patient identifiers have to be 100% accurate.		It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.	Aug-23	Not Met	Dec 23	Jun-24		Open	Target date moved during quarter 3. Last updated 22/11/23: propose that the target date be moved out 12 months to enable review of the policy in 2024-25 and a data quality assurance plan to be created with appropriate resource secured to support the work. **The approval of the policy will close this action.** Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.). Date for approval of the Data Quality Policy aimed at November 2024 QUEST.
532	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Low		5.2 Acceptable error rate(s) should be agreed and processes put in place or improved, so that Trust data reaches the agreed accuracy levels.		It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.	Aug-23	Not Met	Dec 23	Jun-24		Open	Target date moved during quarter 3. Last Updated 22/11/23: propose that the target date be moved out 12 months to enable review of the policy in 2024-25 and a data quality assurance plan to be developed with appropriate resource secured to support the work. **The approval of the policy will close this action.** Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.) Date for approval of the Data Quality Policy aimed at November 2024 QUEST
533	22/23	FPC	Major Incidents	Reasonable	Clare Langshaw	Lee Brooks	High		2.1 The Trust should consider options to support more frequent testing of incident plans, this should also consider the location of exercises to ensure equal opportunity for Commanders across the territories.		2.1 The Trust accepts this recommendation. As the pandemic period closes, the Trust has resumed ongoing work with partner agencies to increase the frequency of plan testing on a multi agency basis. The EPRR team will also develop an internal programme of plan testing, which will be on a Pan Wales basis. Monitoring and reporting will be made through the Senior Operations Team (SOT) and for assurance through to Senior Leadership Team (SLT). Any exercising will be subject to available funding.	Mar-23	Not Met	Mar-24			Closed in Quarter	BS noted evidence of SOT report indicating EPRR team developed a record sheet that will record the details of each exercise commanders within the Trust take part in and will identify the plans that are tested during the exercise. Also reporting to FPC on MAI. Update 27.09.2023 Developed tracker, annual EPRR report to Welsh Government has been predominantly favourable in the number of excersises we have undertaken, this action has also be superseaded by the Manchester Arena recommendations therefore this action is recommended for closure. Last updated: 26.06.23 - The EPRR team has developed a tracker to record commanders who have undertaking exercising. An exercise plan has been put in place but is limited by available budget and capacity within the EPRR Team so this is currently only available via Teams. Further development is required to enable hybrid table top and live exercises across the Trust to deliver this the EPRR Team requries a dedicated exercise budget and increased capacity within the team.
554	22/23	FPC	Fleet Maintenance	Reasonable	Dave Holmes	Chris Turley	High		3.1 The Trust should review fleet maintenance expenditure and ensure that the procurement rules have been adhered to.		3.1 Agreed. The Fleet Management Team will review all suppliers against fleet maintenance expenditure in partnership with our procurement colleagues in NWSSP. Action arising for the review will be implemented at the earliest opportunity. All expenditure with suppliers exceeding the financial threshold will be tendered for and/or framework agreements / contracts awarded.	Nov-22	Not Met	April 23	Jun-23	Aug-23	Closed in Quarter	Last updated 27/09/23 Work has been undertaken with our partners in NWSSP. Suppliers/services identified as requiring a procurement exercise have now been completed as follows. MOT services-Tender awarded. Gearbox specialist services -awarded. Windscreen services-completed. Service maintenance repair North Wales is to re added to the next Pan Wales SMR tender as advised by IA at NWSSP. This action is now complete - Board Secretary has reviewed trail of emails with NWSSP.

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558	22/23	FPC	IMTP Delivery	Reasonable	Heather Holden	Rachel Marsh	Medium		1.1 The PDDs of the sample programmes should be enhanced to include a Quality Management element to assure the quality of the programme and its deliverables.		This recommendation is accepted. We will define the quality standards to be implemented across all projects and programmes as part of the development of the project and programme management framework and will consider how we define quality measures for project deliverables for the delivery of the next iteration of the IMTP. This will commence with a framework workshop by the end of April to determine the actions required to put this in place.	Apr-23	Not Met	Jun-23	Nov-23	Feb-24	Open	Target date moved in quarter 3. 4.12.23: It was stated that this would come through the Project Path Framework document which will be updated and brought back to STB on 15th January 2024. **This item will be closed when the pathway framework document is approved by the Strategic Transformation Board.** Target date moved in quarter 20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. This will include a revised Programme Definition Document that includes a Quality Management section. Following approval, the current programmes will be transitioned to the new templates and the QM sections will be populated. Last Updated: 17.04.23 Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed.
560	22/23	FPC	IMTP Delivery	Reasonable	Kelsey Rees-Dykes	Rachel Marsh	Medium		2.1 The G2C programme board should implement a programme level deliverables plan to assure the management of dependencies in the event of individual project / workstream slippage or other development; and that this is universally implemented across the transformation programmes of the Trust.		Currently programme level plans are included within the overarching reporting via STB. With specific plans developed at project level. We will therefore develop a detailed G2C Programme Action Plan (Milestone timeline aligned to IMTP deliverables) with project Gantt charts feeding into this timeline.	Mar-23	Not Met	Jun-23	Nov-23	Feb-24	Open	Target date moved in quarter 3. 4.12.23 - Key milestones under each of the projects that sit in G2C to be updated - revised date of February 2024 required. Confirmed that all Project Managers need to ensure there is an overarching deliverable plan for all projects so dates can be seen by SRO in one place. 20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. **This item will be closed when the pathway framework document is approved by the Strategic Transformation Board.** A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. RAID (Risk, Action, Issues, Decision) logs are part of the standard suite of documentation. Last updated: 17.04.23 Focus of March planning and transformation was landing the IMTP which required additional attention from the team to meet the challenging outlook for 2023/24. Following a review of the governance and reporting into STB we are now re-setting the programme plans in line with the 2023-26 IMTP so this will form part of that work.
562	22/23	FPC	IMTP Delivery	Reasonable	Heather Holden	Rachel Marsh	Medium		3.1 Programme documentation should incorporate a standard benefit realisation plan that includes the methods to assess the identified benefits, the timing of the benefit realisation work and the criteria that will be applied to measure success.		We would consider there to be a benefits plan in place for EMS Operational Transformation. For other programmes, this has been something that we have intended to do for some time, as we awaited the appointment of a new Head of Transformation. We recognise the need to clearly articulate and plan programme benefits and will review all programmes to determine whether current benefits plans meet the requirement of a benefits realisation plan and will identify dates to hold benefits planning workshops to finalise benefits realisation plans for each programme where this is required.	Apr-23	Not Met	Jun-23	Oct-23	Feb-24	Open	Target date moved in quarter 3. 4.12.23: Project Path Framework includes Benefits Realisation Plan headings for use across the Trust. To be signed off on 15th January 2024 at STB. REQUEST REVISED DATE OF Feb-24 20.09.23 - A Benefits Realisation Plan template has been developed and will be rolled out across the existing programmes. Due October 2023. Will propose closure once action complete Last Update: 17.04.23 Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed.
566	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		1.1 The Trust should engage with Welsh Government to update the content within the SLA to recognise that HART capabililites and include reference, where appropriate to National Standards		The Trust accepts this recommendation, recognising that the SLA is proivded to WAST by Welsh Government who procure the services from WAST. We will therefore seek to agree the content of the SLA	Mar-22	Not Met	Mar 23	Sep-23	Mar-24	Open	Update 22.11.2023 Confirmed March 2024 is a reasonable date for SLA Target. Update 27.09.2023 new SLA in draft and agreement with Welsh Governmanet that the new SLA will come into 2024/2025 financial year. Last Updated: 26.06.2023 - Agreement obtained that Welsh Government will review the SLA and the process has commenced. EPRR Team has commenced the review of SLA. Proposed completion date changed from Sep23 to Mar24 as an extensives amount of work needs to be undertaken.
567	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		2.1 The Trust should undertake a self-assessment agains the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken		The Trust accepts this recommendation and is committed to undertaking a self-assessment aginst the NARU review document	May-23	Not Met	Mar-23	Mar-24		Open	Update 22.11.2023 We are looking to undertake an internal review carried out by the Specialist Operations Locality Manager against the same criteria that the English Trusts are reviewed against to ensure interoperability is maintained. Update 27.09.2023 NARU still unable to support due to capacity limitations. HART uplift currently rolled out in england which is NARU's current focus. To ensure this action is undertaken an internal review will now take place in line with this action. Last Updated: 26.06.2023 NARU has been approached, but they are not able to support this at the moment due to staff shortages. Although they are supportive of the Trust in this. Proposed completion date changed from Mar23 to Mar24.
568	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		3.1 The Trust should establish a single process to collating and maintaining the HART service asset register. NARU guidance indicates this must include any regulatory requirements associated with the equipment		The Trust accepts this recommendation and will ensure that relevant fields are updated and included on Proclus. Regular updating on Proclus will also be maintained.	Apr-22	Not Met	Sep-23			Closed in Quarter	Update 22.11.2023 Single Tender Waiver completed, Suggest action to CLOSE as the asset register on Proclus for HART is being updated and maintained. Number of items on register currently stands at 1,942. Specialist Ops LM will be providing assurance in monthly 1:1 meetings to assure that proclus compliance is maintained going forward. Board Secretary reviewed screen grab of Proclus including the detail of one of the assets (there are over 1000). POTENTIAL REVISED DATE REQUIRED Update 27.09.2023 process in place to put the asset onto proclus however a waiver needs to be implemented to pay for the licence. Procurement to agree on the single tender waiver. Last Updated: 26.06.2023 - Meeting held with Proclus on 30.03.23 to discuss and agree a plan to progress this matter. This is a significant piece of work but on track for completion by end of Sept23.
570	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		5.1 The Trust should consider undertaking a periodic review of the CAD codes assigned to prompt specialist response, or establishing a link between the group and HART for its input into ongoing reviews.		The Trust accepts this recommendation and will undertake a review of CAD codes to ensure they are applicable to HART capabilities and also maximise the use of HART deployments. Any changes will be subject to CPAS approval and we will engage with CPAS to reflect this work on their work programme.	Jun-23	Not Met	May-23	Oct-23	Apr-24	Open	Target date moved in Quarter 3 Update 22.11.2023 Suggest revised date to change to April 24 to account for the expected winter pressures in the coming months and EMSC capacity to support. Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support. Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
573	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		8.1 The Trust should make arrangements to update and finalise the MOU with Fire and Rescue services		The Trust accepts this recommendation and will ensure that the MOU with Fire and Rescue Services is updated appropriately	May-23	Not Met	May-23	Dec-23		Closed in Quarter	28.11.23 - WAST have provided input to the JESG MOU which supercedes this action. The MOU incorporates how the emergency services work together and FRS have agreed that a seperate MOU for HART is not required. Currently the Police have refused to sign this JESG MOU. There is therefore no further action for WAST to take here as any resolution is beyond the scope of this recommendation. CLOSURE PROPOSED 29.09.2023 - following discussion at SLT, and in line with the update on the 1st August 2023, this recommendation is recommended for closure. The JESG document is in development with JESG and is unconnected with this action. CLOSURE PROPOSED. 27.09.2023 - The action will not be closed untill JESG doc approved 2nd revised date for December 2023. Update: 01.08.23 - SWFRS are unable to locate this document. A review of the need for this document, taking into account the content of the document now being outdated, as it was orginally intended to aid the start up of HART and the length of time this document has been pending with no serious untoward incidents. I recommend this action is closed as it is no longer relevant. On 8/8/23 the SLT approved document 'Requests for Assistance and/or Support MoU between WAST, Police Forces and Fire & Rescue Services'. This document is due to be approved by JESG and establishes support arrangements between services. Update: 11.04.2023 - SWFRS who own the MOU have confirmed that they have the document and are in the process of reviewing it. Response from SWFRS will be progressed during Apr23 in order to aim for completion of this recommendation by end of May23 as planned.
595	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		6.1 HART management should undertake periodic comparison of data extracted from the CAD system to compare against activity reported on PROCLUS to support ongoing efforts to improve data recording on that system		The Trust accepts this recommendation and will undertake a comparison of CAD data to Proclus, with a view to improving the accuracy and system of reporting on Proclus in the future.	May-23	Not Met	May-23	Oct-23	Apr-24	Open	Target date moved in Quarter 3 Update 22.11.2023 Suggest revised date to change to April 24 to account for the expected winter pressures in the coming months and EMSC capacity to support. Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support. Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation.
622	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Medium	1.1	WAST should schedule a physical stocktake to ensure the asset register is 100% accurate.	1.1	With the majority of corporate staff remote working since Covid it has been difficult to conduct a physical audit. Also given the range of equipment provided to staff for home working (laptop, dock and monitors) we will have to develop a new way of undertaking a physical audit.	Apr-24	Not Yet Due				Open	
623	22/23	FPC	IM&T Infrastructure	Reasonable	Robert Walker	Leanne Smith	Low	2.1	The contract management SOP should be appropriately reviewed and authorised and communicated to relevant staff.	2.1	The Contract Management SOP has been approved at ICT SMT and will now be presented to Digital Leadership Group for approval, following which it will be communicated to staff across the Trust	Sep-23	Not Met	Dec-23			Closure Proposed (pending evidence)	Last updated 06/12/23: approved by DLG comms to go out Trust-wide on Siren in Dec-23. Board Secretary reviewed DLG action/decisions log. **Awaiting Siren notice for full closure.**
624	22/23	FPC	IM&T Infrastructure	Reasonable	Wyn Morris	Leanne Smith	Medium	3.1	The process for clearing all PRTG/system alerts should be formalised and documented. It would typically include •A shared mailbox, all alerts go to one place •Prioritisation guidelines for all calls. •Scheduled review times for technicians and managers. •Process for storing cleared alerts for periodic analysis to	3.1	Agreed, will look to formalise the process and provide some ownership to the defined process	Dec-23	Not Met	Jun-24			Open	Target date moved in quarter 3 Last Updated 06/12/23: Technical solution still to be designed but likely solution superceded by implementation of new Service Desk platform which will address this need in core requirements. Timeline June 2024. 18/12/23: Contract for new service desk software signed 15/12/23, Draft implementation plan produced with full implementation expected to take 6 months, individual modules are yet to be priortiesed
625	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.1	Switches should be identified within the asset register.	4.1	This work was underway prior to the audit but the member of staff is on long term sick. As our switches are configured not to respond to general network sweeps it is a manual task to collate and add this information to the CMDB.	Mar-24	Not Yet Due				Open	
626	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.2	A process for patching of unpatched switches or other network components should be established.	4.2	We will look to develop a risk based patching procedure for network switches and devices	Mar-24	Not Yet Due				Open	
627	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.3	A mechanism to deal with/isolate equipment that cannot be brought up to the required security specification should be defined.	4.3	This will be included in the above patching procedure	Mar-24	Not Yet Due				Open	
628	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Low	5.1	Consideration should be given to how long the switch to the disaster recovery site will take and if automation is a practical option.	5.1	There are differing requirements for fail over of Trust systems in DR terms with some also only supporting a manual failover process to the DR site. The Trust infrastructure is being refreshed during 2023-2024 and we will look to areas where it can improve failover where practicable or required.	Dec-23	Not Met	Jun-24			Open	Target date moved in quarter 3. 22/11/23: CAD will always have aspects that need manual intervention with MIS. Trust infrastructure refresh in the process of migrating (Dec-23) which will improve capability for failover. Next to agree failover requirements, during annual review Business Impact Analysis (BIA). CONSIDER REVISED DATE TO JUN-24 DEP ON 111 project solution.
629	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Medium	6.1	A review should be undertaken to ensure that the assessment of the criticality of the services is still valid. The backup site capacity should then be reviewed to ensure all the required services can be hosted and what	6.1	The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to align capacity and to improve failover where practicable and affordable	Mar-24	Not Yet Due				Open	
643	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	1.1	Guidance should be developed to clearly outline: - Roles and Responsibilities (including assessments, approvals, monitoring and reporting arrangements). - Documentation to be used within the savings process to ensure that key elements are included, e.g. impact, risks, success measures, timescales, etc. - Escalation process to be followed (when, to whom and actions to be taken) where savings are not	1.1	Guidance on roles and responsibilities, documentation and escalation to be developed and shared by Financial Sustainability Programme.	Jul-23	Not Met	Dec-23	Feb-24		Open	Target date moved in quarter. Update 12.12.23 - Draft Financial Sustainability Programme Delivery Strategy document developed which covers off guidance on roles and responsibilities, documentation and escalation - to be shared with relevant stakeholders over the coming months. Action to be closed off when document presented to STB on 15.1.24
645	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.1	A formal programme of financial training should be provided to budget holders to allow them to effectively carry out their role.	2.1	Key objective for WAST FM Team (and wider Finance teams) for 23/24 will be to undertake a series of Finance Training to Board Members, Budget Holders and other non-financial staff. This will be delivered by several methods such as face to face training, TEAMS sessions and induction.	Dec-23	Not Met	24-Mar			Open	Target date moved in quarter. Update 12.12.23 - this has commenced with formal training to board members / TU partners taken place in April 23 and training sessions held with Operational Managers in November 23. Training to budget managers will now be captured in Quarter 4 to include any potential updates to finance system rollouts being undertaken by NHS Wales. In the interim all budget managers have assigned Senior Finance Business Partners who support and informally train on all finance related matters.
646	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.2	Training records should be maintained to confirm attendance, which should be monitored to identify non-attendance so this can be followed up.	2.1	Schedule of Training and who has attended to be recorded.	Dec-23	Not Met	24-Mar			Open	Target date moved in quarter. Update 12.12.23 - As per audit ref 645, formal training has commenced and a log of attendees has commenced and this will be further updated during quarter 4 roll out of formal training to budget managers

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647	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (a)	Savings and efficiency plans should be enhanced using SMART criteria to define success and provide realistic timescales.	3.1 (a)	Will be evidenced by project management principles being applied to every individual savings schemes as it is identified and its ongoing monitoring.	Mar-24	Not Yet Due				Open	
648	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (b)	Noting the expected future financial challenges, there should be prioritisation and recording of recurring funding against one-off savings to assist with financial sustainability.	3.1 (b)	Impact of Non-recurring schemes in 23/24 will be addressed by FSP and as part of WAST Financial Plan for future financial years.	Mar-24	Not Yet Due				Open	
649	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (c)	A log should be implemented to enhance the current process recording changes to the savings programme, during the financial year, from that originally approved.	3.1 (c)	Schedule of 23/24 agreed plans and any additions will be controlled through FSP.	Mar-24	Not Yet Due				Open	
622	22/23	FPC	Estates Condition	Limited	N/A	Chris Turley	Medium	1.1	Management should consider the advantages and disadvantages of specialist capital expertise provided by a Non-Executive Director to oversee the capital programme.	1.1	Noted. The capital programme is overseen by the Capital Management Board and reported to the Finance and Performance Committee where both non execs and executive directors attend. Further consideration may be undertaken in relation to a NED champion role on the Board if such an	Complete	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
623	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	1.2	The Trust should advise NWSSP:SES that the "designated person" will be re-allocated to an appropriate Board member in accordance with WHEN 07-02.	1.2	Designated named persons will be updated to appropriate board members.	Dec-23	Not Yet Due				Open	Update 181223: Designated person will be updated by end of December.
624	22/23	FPC	Estates Condition	Limited	N/A	Chris Turley	Medium	2.1	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) based on the current configuration of the estate, and to inform a financial model for required revenue support.	2.1	Agreed. And due to the completion of a recent OCP, this has already been undertaken	Complete	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
625	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	2.2	Future estate workforce reviews should acknowledge the refreshed Estates Strategy ensuring that it adequately reflects any delays in the associated investment programmes informing the capacity, skill set and future requirements of the service.	2.2	Agreed	N/A	Met				Closed in Quarter	Marked as closed as it relates to action 2.1 which was marked as complete when the audit was submitted to Internal Audit
626	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	3.1	Management should review and confirm the accuracy of published backlog maintenance data with consultation with NWSSP: Specialist Estates Services.	3.1	Agreed, however guidance will need to be sought from NWSSP to ensure accuracy of backlog maintenance for the unique ambulance service estate within NHS Wales. Action will be closed once such guidance is sought.	Mar-24	Not Yet Due				Open	
627	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	4.1	The Trust should review the risk categorisation within the EFPMS and engage with NWSSP: SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures.	4.1	Agreed, however again guidance will need to be sought from NWSSP to ensure risk categorisation within EFPMS is appropriate for the unique ambulance service estate within NHS Wales. Action will be closed once guidance is sought.	Mar-24	Not Yet Due				Open	
628	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	5.1	The Trust should engage with NWSSP: SES to ensure that the survey approach is appropriate noting the need for a consistent all-Wales assessment of the estate.	5.1	Agreed, noting that the service followed the six-facet approach to ascertain the condition of the estate, engagement is therefore required with NWSSP to further highlight the unique ambulance estate within NHS Wales. Action will be closed once this is done.	Mar-24	Not Yet Due				Open	
629	22/23	FPC	Estates Condition	Limited	N/A	Chris Turley	Medium	5.2	Planned disposals should be removed from backlog maintenance data in accordance with guidance.	5.2	Agreed	Complete	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
630	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	6.1	Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets.	6.1	Agreed, backlog maintenance will be reported through the Finance & Performance Committee annually in line with the EFPMS submission.	Jun-24	Not Yet Due				Open	
631	22/23	FPC	Estates Condition	Limited	Richard Davies Joanne Williams Edward Roberts	Chris Turley	High	7.1	The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	7.1	Agreed, a refreshed Strategic Outline Programme is required upon receiving guidance from NWSSP as detailed within recommendation 4.	Sep-24	Not Yet Due				Open	
632	22/23	FPC	Estates Condition	Limited	Richard Davies Susan Woodham Edward Roberts	Chris Turley	Medium	7.2	Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	7.2	Agreed, noting that this would form part of managing facilities and through pre planned maintenance contracts to ultimately reduce high and significant backlog maintenance.	Sep-24	Not Yet Due				Open	
634	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	8.1	Statutory, "high", and "significant" risk backlog maintenance items that remain unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of	8.1	As noted at MA 4, additional advice will be taken in respect of "high" and "significant" risk classifications, which may largely remove this issue. Further consideration of any residual reporting through the Corporate Risk Register will then be considered.	Mar-24	Not Yet Due				Open	
634	22/23	FPC	Estates Condition	Limited	N/A	Chris Turley	Medium	9.1	Management should confirm to Welsh Government, via appropriate surveys, the absence or extent of Reinforced Autoclaved Aerated Concrete.	9.1	Actioned since audit fieldwork and ahead of the audit being completed A structural surveyor has now affirmed that appropriate surveys has been undertaken & Welsh Government have been advised that RAAC is not present within WAST buildings.	N/A	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
635	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	1.1	Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust).	1.1	A new Joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24.	Apr-24	Not Yet Due				Open	
636	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	1.2	A copy of the previous signed version of the National Collaboration Agreement should be retained in a central location and monitored to ensure roles and responsibilities are fulfilled.	1.2	The previously signed version will apply until the new version is agreed, so the Trust will seek to obtain and retain a copy until recommendation 1.1 is enacted.	Dec-23	Not Yet Due				Open	
637	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	1.3	The Trust should ensure that it has finalised versions of the terms of reference for forums and groups where it participates within the NHS 111 Wales governance structure.	1.3	The responsibility for up-to-date terms of references rests with 111 commissioners, but the Trust will collaborate with commissioners and seek to ensure all relevant terms of reference are updated. The Trust will feedback to commissioners on the National Urgent Primary Care (Out of Hours) Forum and	Jan-24	Not Yet Due				Open	

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638	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Hugh Bennett	N/A	2.1	Management should ensure that all operational policies and procedures that relate to NHS 111 Wales service delivery, are updated as soon as possible.	2.1	The Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. The reviews will be completed and the old versions of policies removed and replaced.	Feb-24	Not Yet Due				Open	
639	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Hugh Bennett	N/A	2.2	Once approved, policies and procedures should be circulated to all staff.	2.2	Updated policies to be placed on Siren and accompanied by Siren communications and more direct staff briefings, where appropriate e.g. fire evacuation procedure.	Feb-24	Not Yet Due				Open	
640	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	3.1	Develop a mechanism to enable post-implementation learning of benefits, lessons learnt and impact to service delivery to be completely captured.	3.1	Proceed with the planned "time out" for Executives who interface with the commissioning arrangements, 111 Senior Leadership Team and other Assistant Directors/Heads of Service who support the commissioning arrangements.	Feb-24	Not Yet Due				Open	
641	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Chris Turley	N/A	4.1	Key outcomes from meetings that Trust employees attend on commissioning arrangements should be appropriately recorded and reported to ensure that there is appropriate oversight of key discussions held.	4.1	Action notes/minutes for the Finance Group are the responsibility of 111 commissioners. The Trust will discuss with 111 commissioners and seek a formal record of each meeting.		Not Yet Due				Open	
642	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	4.2	Progress with delivering the commissioning framework should be reported within the Trust.	4.2	The Trust does report progress on the commissioning framework i.e. commissioning intentions, but recognises that internal reporting is more intermittent. Re-establish regular reporting of the commissioning intentions (every quarter) to the Trust's Strategic Transformation Programme Board.	Feb-24	Not Yet Due				Open	
643	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	4.3	The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure.	4.3	A letter will be collaboratively drafted and agreed between the 111 Board Chair and Trust CEO to formalise the informal escalation arrangements that do currently exist.	Jan-24	Not Yet Due				Open	
644	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	5.1	The Trust's Corporate Risk Register should be amended to capture risks relating to the NHS 111 Wales commissioned arrangement or service delivery.	5.1	The Trust's Corporate Risk Register commissioning risks to be updated to reflect that 111 is now also a commissioned service.	Jan-24	Not Yet Due				Open	
645	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	5.2	The Gateway to Care Programme Board's risk register should be reviewed and updated to ensure that the risks documented remain current and there are appropriate mitigating controls in place.	5.2	Gateway to Care Programme Board's risk register to be reviewed and updated.	Jan-24	Not Yet Due				Open	

Estates Condition
Final Internal Audit Report

November 2023

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Report status:	Final Report
Fieldwork commencement:	2nd June 2023
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Draft report issued:	14th August 2023
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Management response received:	17th November 2023
Final report issued:	20th November 2023
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Chris Turley, Executive Director of Finance & Corporate Resources
Distribution:	Navin Kiala, Deputy Director of Finance & Corporate Resources Richard Davies, Assistant Director of Capital & Estates Susan Woodham, Head of Estates & Facilities Management Joanne Williams, Head of Capital Development Edward Roberts, Head of Financial Business Intelligence & Capital Planning
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Corporate Governance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Welsh Ambulance Services NHS Trust no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Welsh Ambulance Services NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable estate strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the aging estate in Wales.

The latest nationally reported data (2021/22) for the Trust confirmed a total backlog maintenance requirement of £10.6m.

The audit sought to evaluate the arrangements put in place by the Trust to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

Overview

Backlog has almost halved since 2017/18 (from circa £13.6m). As of 2022/23, the Trust had an assessed backlog of circa £7.3m. However, "high" and "significant" backlog had increased to circa £4m of this sum (i.e., 54% of the total).

Key to understanding the challenge is the accuracy of the baseline data. A six-facet survey was undertaken in 2021. However, while recognising the simple nature of the estate (with limited need for invasive surveys), the audit identified the need for a targeted programme of surveys to supplement the non-invasive nature of the six-facet survey.

Further issues have been raised on the comparability of the data, given the significantly varied methods of computation by each NHS Wales organisation.

The Trust set out its vision to eliminate backlog maintenance over a 10-year period within its 2017 Estates Strategy. (It is recognised that in the period to date, Covid may subsequently have had some impact on investment plans).

In the short to medium term, the Trust uses a combination of all Wales capital funding, targeted EFAB funding, planned and reactive maintenance,

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary [1]

Assurance objectives		Assurance
1	Governance	Reasonable
2	Baseline information	Reasonable
3	Estates strategy	Limited
4	Funding strategy	Limited
5	Monitoring & reporting	Reasonable
6	Risk management	Limited

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Assurance Objective	Priority
1.1	Management should consider the advantages and disadvantages of specialist capital expertise provided by a Non-Executive Director to oversee the capital programme.	*1*	Medium
1.2	The Trust should advise NWSSP: SES that the "designated person" will be re-allocated to an appropriate Board member in accordance with WHEN 07-02.	*1*	Medium
2.1	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets	*4*	Medium

and discretionary funding to address identified high-priority areas as follows, e.g.:

- All-Wales capital funding (£8m) was secured for a new facility at a site in Pontprennau for a make ready depot. A new workshop facility was also developed in Merthyr, facilitating the return of the Blackweir facility to Cardiff City Council.
- The Trust successfully secured EFAB funding of £2.18m across 2022/23 & 2023/24 to address estate priorities.

Reductions in the backlog maintenance required were to be primarily achieved by disposal and replacement of older sites. However, a refresh of this strategy in 2021 showed that capital requirements had increased from £89m to £107m over a re-based 10-year period.

With the current limitations of available investment, progress has stalled. The approved values of current and forward investments do not presently match the approved plans to eliminate "high" and "significant" risk backlog.

Matters requiring management attention included the need to confirm appropriate levels of investment, with an appropriately resourced maintenance team, to assess and address backlog maintenance. There was also a need to ensure effective monitoring and reporting against targets. This should be supported by effective reporting of "high" and "significant" risks; an appropriate methodology for the annual update; and accurate performance indicators.

Other recommendations / advisory points are within the detail of the report.

An overall **limited assurance** has been determined noting that identified estate risks cannot be managed within existing funding. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues have further increased the risk profile of the NHS Wales estate. At the time of reporting the Trust had confirmed to Welsh Government that appropriate RAAC surveys had been undertaken and confirmed the absence of RAAC within the Trust's estate.

	required) based on the current configuration of the estate, and to inform a financial model for required revenue support.		
3	Management should review and confirm the accuracy of published backlog maintenance data by consultation with NWSSP: Specialist Estates Services.	*2*	Medium
4	The Trust should review the risk categorisation within the EFPMS and engage with NWSSP: SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures.	*2, 6*	Medium
5.1	The Trust should engage with NWSSP: SES to ensure that the survey approach is appropriate noting the need for a consistent all Wales assessment of the estate.	*2*	Medium
5.2	Planned disposals should be removed from backlog maintenance data in accordance with guidance.	*2*	Medium
6	Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets.	*3,4,5*	Medium
7.1	The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	*4*	High

7.2	Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	*4*	Medium
8	Statutory, "high", and "significant" risk backlog maintenance that remains unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of mitigating actions.	*6*	Medium
9	Management should confirm to Welsh Government via appropriate surveys the absence or extent of Reinforced Autoclaved Aerated Concrete (RAAC).	*6*	Medium

Future Assurance Matters[2]		Assurance Objective	Priority
2.2	Future estate workforce reviews should acknowledge the refreshed Estates Strategy ensuring that it adequately reflects any delays in the associated investment programmes informing the capacity, skill set and future requirements of the service.	*4*	Medium

[2] Future assurance matters are for management action at future (appropriate) projects. Noting current action cannot be taken, the Audit Committee is requested to exclude from the audit tracker and the matters arising included in this report for management information. They have, however, been taken into consideration when determining the assurance rating at this report.

1. Introduction

1.1 This audit forms a part of the 2023/24 operational plan agreed with the Trust.

1.2 The audit was undertaken to evaluate the processes and procedures put in place by the Trust to support the management, condition, and performance of the estate.

1.3 The effective and efficient management of the NHS Wales estate is essential for the delivery of quality health care services.

1.4 The potential risks considered in the review were as follows:

- The Board may be unaware and/ or may not be adequately informed to effectively assess and manage the risks associated with backlog maintenance (particularly statutory requirements);
- Appropriate funding may not be in place;
- The status and value of backlog maintenance may not be adequately defined, and the probability and impact may not be fully understood;
- Information may not be interrogated to ensure focus is prioritised on the key risks; and
- Performance in addressing identified priorities may not be monitored, potentially impacting organisational objectives.

1.5 The Estates and Facilities Performance Management System (EFPMS) records a range of estates measures including:

- Function and space of assets;
- Age of assets;
- Quality of Buildings; and
- Estates Maintenance.

1.6 Within the Quality of Buildings section, the total estate backlog figures were categorised on a risk basis, based on national guidance i.e. ranging from High, Significant, Moderate to Low risk.

1.7 The EFPMS enables the Trust to submit an annual declaration on key data to Welsh Government. The Trust reported position over the last three years, against NHS Wales averages, was as follows (also showing targets of the Trust Estates Strategy):

Table 1

	Estates Strategy Target	2019/20	2020/21	2021/22	2022/23
Trust Cost to eradicate High Risk Backlog (£)	Eliminate	2,419,647	2,465,575	667,468	283,153
Trust Cost to eradicate Significant Risk Backlog (£)	Eliminate	5,819,905	5,871,468	2,855,208	3,669,780
Trust Total Backlog Cost (£)	Eliminate	12,559,894	12,596,981	10,629,409	7,288,001
NHS Wales average: Total Backlog Cost (£)		78,098,898	97,385,329	113,007,158	
Trust Risk Adjusted Backlog Cost (£)		9,758,028	7,759,073	7,184,233	4,649,810
Trust Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)		17.27	24.91	28.48	
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)		23.86	27.43	28.77	

1.8 The WAST EFPMS Data for 2022/23 had not been fully compiled at the time of the audit, and all Wales figures had yet to be published.

1.9 Additional estate performance data across NHS Wales is presented at **Appendix B,** taken from the NHS Estate Dashboard Report for 2021/22 (published by NWSSP: Specialist Estates Services).

1.10 Our audit work was reliant on the above information. We have not sought to provide assurance over the accuracy of supplied information; however, we have commented within the body of this report on the consistency in approach with other NHS Wales Organisations.

2. Detailed Audit Findings

2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in **Appendix A**.

Governance: *To obtain assurance that robust governance arrangements were applied to ensure the organisation stays abreast of matters and associated risks relating to the estates condition.*

2.2 Effective governance was in place, with structures ensuring that the Trust's Executive Board was appropriately informed. This oversight included Non-Executive Directors.

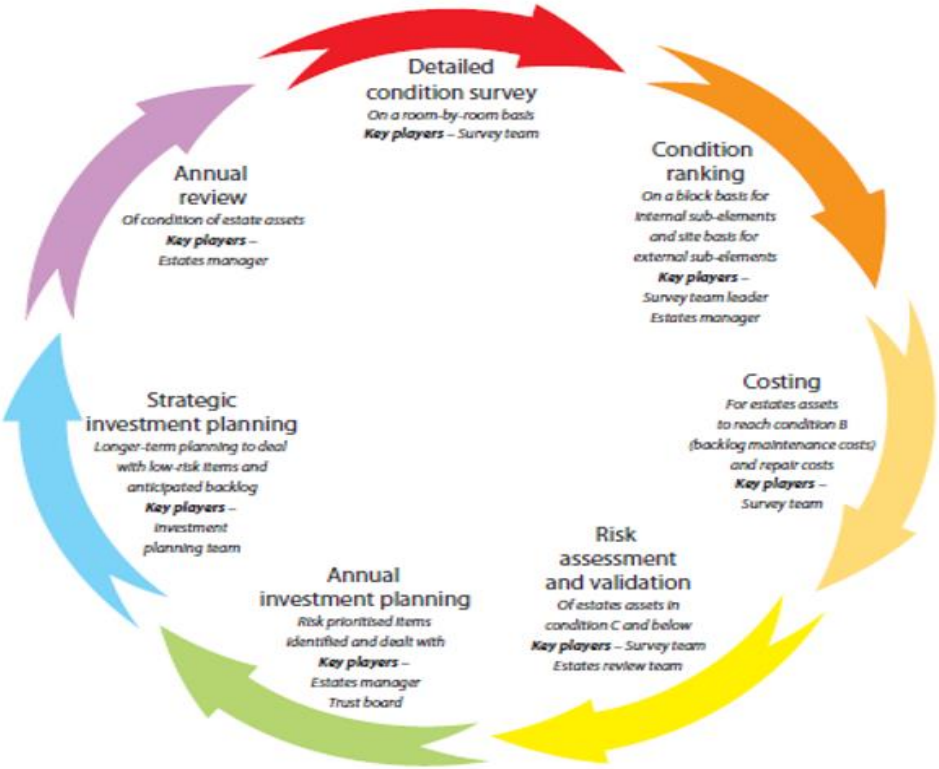
2.3 The Estates Strategy indicated that the Executive Director of Finance & Corporate Services *"will act as formal programme sponsor and will ensure that the programme meets its overall objectives and delivers its expected benefits"*. WHEN 07-02 additionally requires a designated Board lead for technical Estates matters. However, the nominated person as recorded at the NWSSP: SES "Health Board and Trust Designated Persons" list is currently the Assistant Director of Capital & Estates (not a Board attendee) (**MA 1**).

2.4 The allocation of capital/estate responsibilities to an appropriate Non-Executive Director to champion estates issues has additionally been recommended for consideration (**MA 1**).

2.5 Sound decision making is predicated upon the quality of management information and these matters are further considered at subsequent sections of this report. Noting these matters, **reasonable assurance** has been determined in relation to project governance.

Baseline information: *To obtain assurance that the Trust has detailed assessments of the condition of the estate based on a combination of robust condition surveys and risk assessments. The information was managed and retained within robust management systems that are subject to regular review.*

2.6 The extant guidance in relation to assessing backlog maintenance: '*A risk-based methodology for establishing and managing backlog,'* (updated March 2013) describes the steps involved in establishing and managing backlog, as follows:



2.7 In respect of the detailed condition survey, the guidance recommends that[1]:

> *"NHS organisations carry out a detailed survey of their assets on a five-yearly basis[1]."*

2.8 A six-facet survey of the estate was conducted in 2021, in accordance with the above guidance. This provided management with a detailed, risk-assessed picture of the condition of the estate and compliance with statutory / mandatory requirements (e.g., fire safety), along with the indicative costs for undertaking the remedial works.

2.9 The remit and associated caveats for the six-facet survey were not provided, limiting associated assurance as to the robustness of its data. It is understood that the WAST survey was non-invasive, a fact which has significantly limited the robustness of data across Wales. However, it is recognised that the infrastructure at the WAST is less complex than in clinical/acute hospital settings. Management have commented that for WAST there were few access limitations, such as full access to server rooms, clinical contact centres, and roof voids.

2.10 However, some data anomalies were evidenced at EFPMS returns at percentage compliance figures. There was therefore a need to ensure data accuracy (**MA 3**).

2.11 Additionally, noting differences in approach to inflation, surveys, interim updates, and risk categorisation across Wales, this has resulted in inconsistencies in EFPMS figures between different health bodies. To appropriately benchmark and compile consistent data, health bodies would therefore benefit both from peer review and consultation with/advice from NWSSP: Specialist Estates Services (**MA 4**).

2.12 It is important that the baseline of the six-facet survey is kept up to date to enable effective monitoring, reporting, and investment planning. The guidance recommends that:

> *"You should update the findings of your detailed survey on an annual basis. This will inform your investment planning process and ensure your assets are safe and fit for purpose.4*

2.13 While management advised that interim updates were undertaken, a robust methodology for delivering the same was not evidenced (i.e., to demonstrate accordance with NHS guidance). Recent increases in "high and significant" backlog had been attributed to "better intelligence" (**MA 5**).

[1] A risk-based methodology for establishing and managing backlog (publishing.service.gov.uk) (Applies in Wales)

2.14 Whilst recognising the need to confirm accurate data the six-facet survey undertaken in 2021, and the simple nature of the estate, **reasonable assurance** has been determined in relation to the baseline information.

Estates strategy: *To obtain assurance that a tailored estates strategy was in place including linkage to major investment, estates condition, statutory compliance, decarbonisation requirements, service needs etc. The strategy also reflected emerging risks.*

2.15 It is important that long term Estates strategies are re-evaluated for on-going applicability and sustainability.

2.16 Health Building Note 00-08 'Estatecode' (2018) highlights that:

> *"Once a comprehensive analysis of the condition and performance of the existing estate has been completed, the organisation will have the baseline data used when developing an estate strategy.*
>
> *An estate strategy should .. provide the strategic framework for the provision of an efficient, sustainable and fit-for-purpose estate that is both safe and secure... improving efficiency and rationalising occupancy whilst reducing ongoing revenue and capital commitments.*
>
> *The estate strategy should be reviewed annually using EFPMS data and the information from the five-facet survey. The clinical strategy should be the driver of the estate."*

2.17 The Trust's Estates Strategy (a 10-year Strategic Outline Programme - SOP) was endorsed by Welsh Government in 2017 outlining a proposed 10-year capital investment programme.

2.18 This was informed by a Demand & Capacity review, providing a strategic framework for the development of services and associated estate (including backlog maintenance) requirements. This updated an earlier SOP delivered in 2013, and in turn, was further refreshed in 2021 in accordance with good practice (also noting the intervening Covid emergency, and availability of capital, impacting on planning).

2.19 The SOP also contained a backlog target, and an associated ten-year investment plan. Key amongst these was the aim that "*current backlog maintenance will be largely eliminated and there will be a planned preventative maintenance regime to ensure properties are maintained to appropriate standards*". However, the strategy primarily addressed service reconfiguration rather than specifically detailing the resultant backlog reduction.

2.20 The 2017 SOP required £89m investment over 10 years, increasing to £107m at over 10 years at the 2020/21 re-fresh. (Management have stated this to be due to both inflation and an increased footprint in the estate for Covid social distancing).

2.21 It was not evident whether this additional requirement arose from lack of funding in the earlier years, or from additional service needs (**MA 6**).

2.22 However, the total funding received from Welsh Government (against the SOP required investment above) was not reported at SOP updates, as these only reported forward planning. This impeded understanding of the increased capital investment requirements.

2.23 Data published at the Estates and Facilities Performance Management System showed the WAST as the lowest ranked health body for functional suitability & condition of the estate.

2.24 Partly as a result of disposals and capital investment, the WAST had made positive inroads into its estates backlog to 2021/22.

2.25 However, as of 2022/23, while overall backlog has continued to reduce, "high" and "significant" risk backlog maintenance is now increasing, and the effective implementation of the Estates strategy has therefore stalled. This matter is further considered within the Funding Strategy section below.

2.26 The Estates Strategy itself represents a comprehensive assessment of targeted service reconfiguration with clear objectives, supported by detailed and dynamic investment / divestment plans. However, noting the need for an associated backlog strategy, supported by accurate data, **limited assurance** has therefore been determined in relation to backlog Estates Strategy.

Funding strategy: *To obtain assurance that there was a co-ordinated approach to the targeting of All-Wales, Estates Funding Advisory Board (EFAB) and Discretionary funding to implement the estates strategy.*

2.27 There has been historical under-investment across Wales in this area, resulting in a deterioration of the NHS estate condition. The cost of the Trust's backlog maintenance was estimated at £13.6m in 2017/18.

2.28 As at ***Table 1***, as of 2022/23, backlog stood at £7,288,001 – almost halved from prior levels.

2.29 The Trust has published detailed funding plans, drawing on both Welsh Government and discretionary finance.

2.30 More recently, this has been supplemented by the availability of EFAB funds, where a range of bids have been approved in the sum of £2.18m (relating to works to address fire safety, infrastructure, and decarbonisation). This evidenced appropriate review and consideration of funding options.

2.31 The 2017 SOP required over £89m investment to maintain an effective estate. As from 2020/21 (year 4) this assessment was refreshed and increased to £107m for the next ten years (including £67.5m reliant on WG discrete approvals of capital business cases, and the remainder from discretionary allocations).

2.32 The endorsement of the SOP, however, is not a commitment to expenditure by Welsh Government, which would be subject to the submission and approval of

individual business cases - assessed against other competing NHS investment priorities across Wales. There remains therefore a material risk that the Estates Strategy and capital investment plan was unaffordable, noting the current financial climate and considering total funding requirements across NHS Wales

2.33 As previously noted, the total funding received from Welsh Government was not reported at SOP updates, as these only reported forward planning (**MA 6**).

2.34 The Trust's total backlog has reduced over the period 2019/20-2022/23 (see **Table 1**). This reduction has primarily been achieved though the disposal and rationalisation of the Trust's older estate i.e., 8 of a potential 28 sites across Wales disposed of during the period – driven by a more efficient hub and spoke service re-configuration; co-location with service partners; and regional centralisation of the non-operational premises.

2.35 The delivery of the Trust's Estates Strategy (including to "*largely eliminate*" backlog maintenance requirements) will require continued capital investment and support from Welsh Government.

2.36 The Estates Strategy currently plans the disposal of a further 20 sites, and over the next three years targeted £67.374m of investment. Excepting annual funding of circa £4m from discretionary allocations, approvals for such spending were not in place. There was therefore a need to match funding against backlog reduction within a revised Estates Strategy. Revisions to the Estates Strategy should also include maintenance targets to avoid future escalation (**MA 7**).

2.37 The Estates and Facilities Performance Management System (EFPMS) is an annual return that the Trust makes to Welsh Government; a part of this return categorises the "Total Building & Engineering Maintenance Cost per Occupied Floor Area" over recent years as highlighted below.

Table 2

Measure	2019/20	2020/21	2021/22
Trust Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	17.27	21.41	28.48
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77

2.38 Subject to the accuracy of the above, when compared to 2019/20 reported figures, the Trust's expenditure now aligns with national averages of spend per occupied floor area. However, whilst recognising the simpler WAST estate (e.g., offices, and ambulance depots etc., compared to acute hospital sites), the Welsh average level of investment has been insufficient to prevent a deterioration in the condition of the NHS estate across Wales.

2.39 Local and national resource constraints are a theme across Wales. At the time of the current review, the Trust was carrying vacancies within its Estates staffing establishment. A resource plan was required to provide assurance relating to the future demands of the service (e.g., to effectively identify and address backlog) (**MA2**).

2.40 An appropriate range of funding had been utilised, deriving from an endorsed investment strategy. However, at the most recent data "high and significant" risk backlog had increased, similarly required investment to address the same had increased. There remains a material risk that the Estates Strategy and capital investment plans are unaffordable, and that backlog will again increase. Noting the absence of a funded strategy to reduce / eliminate backlog maintenance, the audit therefore concluded **limited assurance** in respect of the funding strategy.

Monitoring and reporting: *To gain assurance that appropriate management information was presented with regularity on key issues, including the estate condition and progress to implement the estates / funding strategy. Monitoring and reporting included an assessment of the success of the combined strategies in improving estates condition (and reducing risk exposure), and confirmation that expenditure of funding was in line with agreed conditions.*

2.41 The Estates Strategy (Strategic Outline Programme – SOP), was approved by the Trust Board in March 2017, and endorsed by Welsh Government in August 2017.

2.42 An updated SOP was submitted to the Trust Board in March 2021, though the associated approvals / endorsement by the Trust Board and Welsh Government respectively, were not evidenced.

2.43 This provided a prioritised plan to address Estate's needs. Key reporting included a periodic update of the Estates Strategy, with associated updates and approval of a medium-term plan, and annual discretionary programme.

2.44 Formulation of these matters was via the Estates (SOP) Delivery Group, with a review by the Capital Management Board and oversight and approval by the Finance and Performance Committee.

2.45 While the Estates Strategy contained targets, there was a need for variance reporting of associated outcomes. As highlighted previously, there was also a need to report funding variances of prior years within the SOP, in addition to re-calibration of the forward plan (**MA 6**).

2.46 While recognising the reduced need for formal reporting relevant to the size/nature of the organisation, the 2021 SOP update represented the only formal reporting relating to backlog maintenance requirements identified since 2017.

2.47 A key facet within the SOP impacting on backlog has been disposals of older properties. However, the level of backlog maintenance associated with these was

not reported. Similarly, the impact of investments (e.g., whether service enhancements, or replacements of older estate), was not identified.

2.48 However, it is recognised that reporting to the Executive is risk based. Additionally noting that management were well informed of risk backlog via EFPMS data, **reasonable assurance** has been determined in relation to monitoring and reporting.

Risk management: *To obtain assurance that risks were appropriately logged and escalated through the corporate risk reporting arrangements. The risk exposure of the Trust in relation to estates condition was clearly reported.*

2.49 The 2021 survey provided overall totals for each risk priority. Following the categorisation of backlog maintenance requirements into "high", "significant", "moderate" and "low", associated risk scores were utilised as part of a wider risk assessment. This included scoring of strategic fit (e.g., with the Welsh Government approved demand and capacity review), in accordance with best practice. This facilitated the objective assessment of the best organisational investment / divestment choices.

2.50 However, the resultant statutory, "high" and "significant" risk backlog left un-addressed by such decisions was not reported. While the corporate risk register has included certain issues, there was the potential for a further review following a re-appraisal of estates risks. There was also a need to assess the holistic estates backlog maintenance risk position (**MA 8**). Management have commented, that for context, in line with (**MA 4**) above, that following re-appraisal of risk ratings, few or no "high" or "significant" risk items may remain. They also noted that backlog had almost halved since 2019/20, and as such would not have a high corporate profile.

2.51 It is important that management understand both unaddressed statutory maintenance and potential single points of failure (**MA 4** & **8**). As such, it was noted that the WAST included items such as leaking skylights within non-critical areas as "high" risk backlog. In the context of having no in-patient facilities, and comparability of data with Health Boards, it is therefore recommended that the WAST seek guidance and review their risk prioritisation. This could provide scope for further reduction in the "high" and "significant" risk backlog figures (**MA 4**).

2.52 At the time of audit, there was also a need to conclude reporting to confirm initial conclusions that the Trust does not have Reinforced Autoclaved Aerated Concrete (RAAC) (which can cause structural issues over time) (**MA 9**). This matter was addressed subsequent to audit fieldwork.

2.53 The recent reduction in the profile of backlog risks is therefore recognised. However, noting limited reporting of residual risks, including "high" priority (and potentially statutory) issues, **limited assurance** has currently been determined in relation to risk management.

Appendix A: Management Action Plan

Matter Arising 1: Non-executive scrutiny and challenge (Design)	**Impact**
NHS Wales utilises both expert Non-Executive Directors and Board leads as key elements of its governance and scrutiny arrangements. Welsh Health Circular (WHC/2021/002) issued in January 2021 (expiry/review date of March 2023), discontinued the role of the estates board champion. At the time of reporting, there had been no update issued in line with timescales. However, whilst noting the above, in the period since 2021 the profile of the NHS estate has increased significantly at a national level. Through our thematic reviews undertaking throughout NHS Wales, good practice has been evidenced within other organisations; where Non-Executive Directors or Independent Members had been specifically allocated areas of representation associated with capital and estates. Capital Planning was progressed via a Capital Management Board – with assigned responsibility for the implementation of the Estates Strategy. There was onward accountability to the Finance and Performance Committee led by the Executive Director of Finance & Corporate Services (DOF) – with assigned responsibility for delivery of the Estates Strategy. While this committee also included expert scrutiny, it did not include a Non-Executive Director with specialist estates and capital management knowledge (to champion estates matters). All Wales guidance (WHEN 07-02) requires that the lead for technical Estates matters be a designated Board member. However, NWSSP: SES has been notified that this role rests with the Assistant Director of Capital & Estates (as per the "Health Board and Trust Designated Persons" list - see extract at **Appendix C**).	Potential risk that: • The programme is not appropriately scrutinised and challenged.
Recommendations	**Priority**

1.1 Management should consider the advantages and disadvantages of specialist capital expertise provided by a Non-Executive Director to oversee the capital programme.	**Medium**
1.2 The Trust should advise NWSSP:SES that the "designated person" will be re-allocated to an appropriate Board member in accordance with WHEN 07-02.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
1.1 Noted. The capital programme is overseen by the Capital Management Board and reported to the Finance and Performance Committee where both non execs and executive directors attend. Further consideration may be undertaken in relation to a NED champion role on the Board if such an opportunity arises but, noting that this is not a mandatory requirement, and the alternative assurances provided as to the scrutiny and oversight of such matters undertaken at committee and board level, it is not deemed required or indeed feasible at this stage.	Already completed	N/A
1.2 Designated named persons will be updated to appropriate board members.	31st December 2023	Assistant Director of Capital & Estates

Matter Arising 2: Resource (Operation)	**Impact**
In April 2022, the Welsh Government Deputy Director of Estates and Capital Planning, wrote to all Heads of Estates across Welsh Health Bodies to assess the adequacy of Estates resource. This letter particularly referenced a desire to reduce outsourcing, stating: "*The central intention is to keep NHS Wales as a public service and to only outsource contracts and services when there is no in-house alternative or where there is a time limited job that requires specialist input to be completed*". Appropriate staffing levels are required to ensure the on-going assessment and maintenance of the estate (in accordance with WG guidance). The need includes not only the assessment of staffing numbers and grades, but of an adequate range of specialisms to assess and address the various aspects of backlog maintenance (e.g., fire, water, asbestos, and medical gas safety). Any new or refurbished estate is likely to deteriorate in the future without a change in the level of investment. An inadequate internal maintenance resource can contribute to an increasing backlog position i.e., reduced ability to address reactive and planned maintenance. The WAST initiated a re-appraisal of required roles within the Capital Development and Estates departments in March 2021. This identified the need to increase staffing from 11 to 16 whole time equivalent staff e.g., including the need for environmental officers. However, as of April 2023, three roles remained un-filled, including a facilities officer, and an estates compliance officer. The need for a decarbonisation specialist was also subsequently identified but was yet to be appointed. An initial £67m investment was targeted within the first three years of the current Estates Strategy. However, this had not been secured (**MA 7**). Any review of associated maintenance staffing requirements would need to consider the impact of the same.	Potential risk that: • The programme is not appropriately resourced.

The Trust therefore has challenges in recruiting and retaining skilled labour to enable effective estates service provision and meeting the needs and risks of an aging property portfolio (noting restricted investment). Noting these matters, and the dynamic nature of estates management and the regulatory environment, there is therefore an on-going requirement to refresh the assessment of future estates requirements (including skills, qualifications, and in-house versus contracted out provision).		
Recommendations		**Priority**
2.1 The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) based on the current configuration of the estate, and to inform a financial model for required revenue support.		**Medium**
Future Assurance 2.2 Future estate workforce reviews should acknowledge the refreshed Estates Strategy ensuring that it adequately reflects any delays in the associated investment programmes informing the capacity, skill set and future requirements of the service.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Agreed. And due to the completion of a recent OCP, this has already been undertaken	Already completed	N/A
2.2 Agreed	N/A	Assistant Director of Capital & Estates

Matter Arising 3: Data accuracy (Design)	**Impact**
Backlog is defined as the value of the estate falling below category "B". However, several key indicators of the estate, including the percentage below category "B" had not changed in recent years despite considerable reduction in declared backlog (as published at the Estates and Facilities Performance Management System), returned to Welsh Government annually (***Table 1***). These figures also declared that only 48% of the estate was in a compliant physical condition. The remaining 52% of the value of the estate therefore was not compliant. This would indicate that the backlog maintenance figure should be much higher than the £10,629,409 published. Management advised that in the case of this Key Performance Indicator (KPI), a building was recorded as deficient where it contained defects e.g., where £10 - £30k backlog maintenance applied, the entire value of the building was added to the value of the defective estate for purposes of the KPI. While noting there was no guidance for completion of the KPI's, this approach was not replicated across Wales, effectively meaning that EFPMS data was not comparable. There was a need therefore to confirm the accuracy of published data.	Potential risk that: • Data is inaccurate.

Recommendations	**Priority**
3 Management should review and confirm the accuracy of published backlog maintenance data with consultation with NWSSP: Specialist Estates Services.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
3 Agreed, however guidance will need to be sought from NWSSP to ensure accuracy of backlog maintenance for the unique ambulance service estate within NHS Wales. Action will be closed once such guidance is sought.	31st March 2024	Assistant Director of Capital & Estates

Matter Arising 4: Data consistency – All Wales approach (Design)	**Impact**
In 2004, NHS Wales published "*A risk-based methodology for establishing and managing backlog*" (mandatory in Wales) as guidance for the consistent compilation of EFPMS data. The six-facet survey of the estate undertaken in 2021 resulted in a significant change in the percentage of the estate meeting acceptable physical compliance standards, while dropping from 82% to 65% in one year. There was also no consistent approach agreed across Wales relating to the uplift for inflation e.g., some NHS bodies have utilised professional estimates ranging from 3% to over 16%, while others have applied cost indices. Uplifts for fees, overheads and profits have similarly varied. At the WAST, while an uplift to the works costs of 49% was applied, no addition was made for inflation (i.e., inflation was assessed at 0%). Management have advised that they have now secured professional estimates for works inflation at 3%, which would be applied to future data. The approach to risk prioritisation also varied across Wales, with some organisations assessing matters as high risk, where whole asset classes had reached the end of their useful life, while others took account of the ability to safely maintain its condition (in accordance with guidance). Other examples of "high risk" areas across Wales, included, lack of expert staff to undertake assessments, and at the WAST included leaking skylights in non-critical areas. There was also a need for some health bodies (including the WAST) to remove estate areas where there were approved plans for disposal within five years (in accordance with guidance). Additionally, the completion of Key Performance Indicators such as Physical Condition did not seem to be completed on a consistent basis within backlog data. Associated guidance was not available. Current guidance would indicate the prioritisation of single critical points of failure which cannot be readily recovered. It was not evident that any of the identified "high" risk backlog items would present such a risk to continuity of operations. In the event of these being present, they should be included within a business continuity / disaster recovery document.	Potential risk that: • Backlog data is inaccurate. • Backlog figures are not comparable across Wales.

These matters therefore raise questions as to the comparability of figures across Wales. However, it is recognised that the nature of the WAST estate may be simpler, and easier to survey than many of the Health Boards, and that both "high" risk and overall backlog figures may not be materially impacted by these adjustments.		
Recommendations		**Priority**
4 The Trust should review the risk categorisation within the EFPMS and engage with NWSSP: SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
4 Agreed, however again guidance will need to be sought from NWSSP to ensure risk categorisation within EFPMS is appropriate for the unique ambulance service estate within NHS Wales. Action will be closed once guidance is sought.	31st March 2024	Assistant Director of Capital & Estates

Matter Arising 5: Annual update (Design)	**Impact**
In 2004 NHS Wales published "*A risk-based methodology for establishing and managing backlog*" (mandatory in Wales). This recommended a six-facet survey every five years, and that "y*ou should update the findings of your detailed survey on an annual basis".* A six-facet survey of the estate was conducted in 2021. However, the remit and associated caveats of this survey were not provided, limiting associated assurance as to the robustness of its data. Across Wales, surveys at some other health bodies have been heavily caveated, notably as to their non-invasive nature, meaning that significant sums relating to e.g., mechanical, electrical, and asbestos issues may not have been assessed. While the infrastructure at the WAST is less complex than in acute hospital settings, it is understood that the WAST survey was also non-invasive, similarly qualifying the resultant data. Management advised that interim updates of the survey (backlog) data by Trust Estate's staff included the removal of estate disposals and the addition of items notified as requiring maintenance (though these systems were not evidenced/tested at this audit). At other health bodies, the approach to interim updates was typically more pro-active and variously included: • the addition of items at the end of their useful life & no longer serviceable; and • rolling surveys of the full estate (typically targeted at older / higher risk estate). However, there was a need to confirm the effective update of surveys (as outlined above and in accordance with NHS guidance). There was also a need to remove redundant Estate from the backlog maintenance data i.e., where there were agreed disposal plans (in accordance with national guidance). However, it is recognised that the 2021 survey did not result in any material amendments to previously published figures.	Potential risk that: • Backlog is not appropriately recognised.

Recommendations		Priority
5.1 The Trust should engage with NWSSP: SES to ensure that the survey approach is appropriate noting the need for a consistent all-Wales assessment of the estate.		**Medium**
5.2 Planned disposals should be removed from backlog maintenance data in accordance with guidance.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
5.1 Agreed, noting that the service followed the six-facet approach to ascertain the condition of the estate, engagement is therefore required with NWSSP to further highlight the unique ambulance estate within NHS Wales. Action will be closed once this is done.	31st March 2024	Assistant Director of Capital & Estates
5.2 Agreed.	Already Completed	N/A

Matter Arising 6: Delivery - reporting (Operation)	**Impact**
A Strategic Outline Estates Programme was submitted to and endorsed by Welsh Government in August 2017. This targeted capital investment of circa £89m over 10 years (with £35m targeted by year 3). This was aimed largely at providing an enhanced service model, but also with the stated intention eliminate backlog maintenance requirements. The endorsement of the programme, however, was not a commitment to expenditure/funding by Welsh Government. Approved funding would be subject to the approval of individual business cases submitted by the Trust and would be assessed against competing NHS priorities across Wales. The updated SOP produced in 2021, included increased capital investment requirements revised to £107m for the next ten years (including £67.5m subject to the submission and approval of capital business cases via Welsh Government, and the remainder from discretionary allocations). The updated SOP did not provide an assessment of the increased investment requirements compared to the original SOP (and / or interim investment received) - variances between budgeted and approved funding were not profiled. Reporting could also usefully include inflationary adjustments, reductions due to direct/indirect investment, benchmarking information, newly discovered backlog maintenance.	Potential risk that: • The programme is not effectively monitored.

Recommendations	**Priority**
6 Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
6 Agreed, backlog maintenance will be reported through the Finance & Performance Committee annually in line with the EFPMS submission.	30th June 2024	Assistant Director of Capital & Estates

Matter Arising 7: Estates Strategy - update (Operation)	**Impact**
The current Estates Strategy (a 10-year Strategic Outline Programme – approved by the Trust Board in March 2021) included plans for circa 20 capital investment schemes requiring additional Welsh Government funding, typically averaging circa £3.4m each. Together with discretionary funding (circa £4m p.a.) this required £107m of investment. The plans included closure of over 20 premises (which would reduce backlog maintenance requirements). Planned funding over the next 3 years was profiled as: **(£'m)** / **2022/23** / **2023/24** / **2024/25** / **Three year total** Total funding / 22.932 / 22.501 / 21.941 / **67.374** Excepting discretionary allocations, the above would require additional funding approvals from Welsh Government of circa £18m p.a. No such approvals were in place for 2022/23 funding, and business cases were not funded or in progress for 2023/24 and 2024/25. The Estates Strategy did not therefore represent a funded programme to address Estate's needs. Revisions to the Strategy could usefully include measures that the Trust would put in place to ensure refurbished buildings are maintained in the future, thus, ensuring that any future backlog maintenance can be managed appropriately.	Potential risk that: • The Estates strategy does not match funding to backlog reduction targets.
Recommendations	**Priority**
7.1 The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	**High**

7.2 Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
7.1 Agreed, a refreshed Strategic Outline Programme is required upon receiving guidance from NWSSP as detailed within recommendation 4.	30th September 2024	Assistant Director of Capital & Estates / Head of Capital Development / Head of Financial Business Intelligence & Capital Planning
7.2 Agreed, noting that this would form part of managing facilities and through pre planned maintenance contracts to ultimately reduce high and significant backlog maintenance.	30th September 2024	Assistant Director of Capital & Estates / Head of Estates and Facilities Management / Head of Financial Business Intelligence & Capital Planning

Matter Arising 8: Risk reporting (Design)	**Impact**
The Trust has a defined Risk Management and Board Assurance Framework which provides guidance on the management of strategic and operational risks within the organisation (as reported to the Board in March 2023). While Estates risks were not included within top Trust risks, this assessment pointed to linkage with the Intermediate Medium-Term Plan and associated Estates Strategy (which in turn was informed by supporting risk assessment from the 2021 Survey of the Estate). Following the categorisation of backlog maintenance into "high", "significant", "moderate", and "low", associated risk scores were utilised as part of a wider risk assessment. This included scoring of strategic fit (e.g., with the demand and capacity review), in accordance with best practice (as part of the approved Estates SOP refresh). This facilitated the objective assessment of the best organisational investment / divestment choices. However, internal reporting did not highlight or summarise the "high" and "significant" risk backlog maintenance not being addressed by these options. The deferment of "high" and "significant" backlog maintenance to future years, should be an objective choice, with associated risks owned by the Board. Similarly, any deviation from the approved SOP Estate's Strategy (targeting the elimination of backlog maintenance across a ten-year period), should be approved in the manner as the original strategy. It is also important that management understand both statutory maintenance that remains un-addressed and potential single points of failure. Key remaining risk issues should be reflected within the corporate risk register. While the corporate risk register has included certain issues, there was potential for review following a re-appraisal of the estate's risks. Management have commented, in line with **MA 4** above, that it is recognised that there are differing views on what constitutes "high" risk, and that more guidance would be welcome. Accordingly, for context, few or no "high" or "significant" risk items respectively may remain following such re-assessment.	Potential risk that: • Management is not sighted on accepted risks. • Annual investment decisions are contrary to approved strategy.

Recommendations		Priority
8 Statutory, "high", and "significant" risk backlog maintenance items that remain unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of mitigating actions.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
8 As noted at **MA 4**, additional advice will be taken in respect of "high" and "significant" risk classifications, which may largely remove this issue. Further consideration of any residual reporting through the Corporate Risk Register will then be considered.	31st March 2024	Assistant Director of Capital & Estates

Matter Arising 9: RAAC (Operation)	**Impact**
Welsh Government have written to respective NHS Wales Chief Executives requesting confirmation of any issues relating to Reinforced Autoclaved Aerated Concrete (RAAC) at health premises. This type of concrete, common in floor and ceiling panels in prior decades of construction, has been assessed as having the potential to cause structural issues over time, requiring strengthening (e.g., via pillars), or replacement. At the WAST, it was not thought that RAAC was present at any of its properties. At the time of reporting management confirmed that this position had been assessed by a chartered surveyor, but remained subject to formal confirmation by a structural engineer in accordance with revised requirements issued by NHS Wales Shared Services: Specialist Estates Services (NWSSP: SES) on behalf of Welsh Government.	Potential risk that: • the assessment of backlog maintenance is mis-stated.

Recommendations	**Priority**
9 Management should confirm to Welsh Government, via appropriate surveys, the absence or extent of Reinforced Autoclaved Aerated Concrete.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
9 Actioned since audit fieldwork and ahead of the audit being completed A structural surveyor has now affirmed that appropriate surveys has been undertaken & Welsh Government have been advised that RAAC is not present within WAST buildings.	N/A	N/A

Appendix B: Estates Facilities Performance Management System (EFPMS)

NHS ESTATE DASHBOARD REPORT 2021/2022

HEALTH BOARD / TRUST ESTATE PERFORMANCE BREAKDOWN 2021/2022

National Key Performance Indicators

Percentage of the estate which is of reasonable standard and therefore falls within Estatecode category 'B'/'F' or above:

	Physical Condition (%)	Statutory & safety compliance (%)	Fire safety compliance (%)	Functional suitability (%)	Space utilisation (%)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	94	93	85	98	91
BETSI CADWALADR UNIVERSITY HEALTH BOARD	62	74	64	74	93
CARDIFF & VALE UNIVERSITY HEALTH BOARD	78	86	87	66	81
CWM TAF UNIVERSITY HEALTH BOARD	96	89	95	100	97
HYWEL DDA UNIVERSITY HEALTH BOARD	88	89	65	91	99
POWYS TEACHING LHB	67	80	72	71	86
SWANSEA BAY UNIVERSITY HEALTH BOARD	51	47	47	55	97
VELINDRE UNIVERSITY NHS TRUST	65	95	95	88	99
WELSH AMBULANCE SERVICES NHS TRUST	48	90	90	36	99

Backlog Maintenance Costs

...o be agreed

	High Risks (£)	Significant Risks (£)	Moderate Risks (£)	Low Risks (£)	Risk Adjusted Cost (£)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	37,754,428	16,518,352	45,488,017	49,807,323	98,296,321
BETSI CADWALADR UNIVERSITY HEALTH BOARD	91,809,773	142,498,091	68,658,155	45,421,260	239,955,528
CARDIFF & VALE UNIVERSITY HEALTH BOARD	32,033,876	85,487,856	28,777,072	5,537,518	101,262,019
CWM TAF UNIVERSITY HEALTH BOARD	31,261,530	31,963,352	22,345,412	1,519,250	64,046,747
HYWEL DDA UNIVERSITY HEALTH BOARD	0	89,509,339	9,432,673	6,802,904	90,679,218
POWYS TEACHING LHB	5,075,437	23,998,187	12,931,568	10,039,954	30,117,985
SWANSEA BAY UNIVERSITY HEALTH BOARD	9,057,000	46,516,759	41,835,883	4,598,390	56,464,069
VELINDRE UNIVERSITY NHS TRUST	139,220	1,894,312	5,002,211	2,719,910	1,875,521
WELSH AMBULANCE SERVICES NHS TRUST	667,486	2,855,208	3,170,304	3,936,411	7,184,233

The complete dataset upon which this report is based is accessible from the NHS Wales Shared Services Partnership - Specialist Estates Services intranet and internet sites

Appendix C: Contact Details for Health Board and Trust Designated Persons (extract)

CONTACT DETAILS FOR HEALTH BOARD AND TRUST DESIGNATED PERSONS **January 2023**
(AS DEFINED IN WHTM 00 AND REQUESTED IN FSN 12/05)

Health board and Trust Designated Persons are at **board level** with responsibility for one or more of the technical disciplines listed below as specified in the following guidelines:

WHTM 01 – Decontamination

HTM 02 – Medical Gases

HTM 03 – Heating and ventilation systems

W HTM 04 – Water systems

WHTM 05 – Fire safety

HTM 06 – Electrical services

HTM 07 – Environment and sustainability

HTM 08 – Specialist services

Trust	Designated Person	Discipline	Contact details
Welsh Ambulance Services NHS Trust **Vantage Point House** **Vantage Point Business Park** **Ty Coch Way** **Cwmbran** **NP44 7HF**	Mr Richard Davies *Assistant Director of Capital & Estates*	All services except for: *Decontamination* and *Specialist Services*	Richard.Davies16@wales.nhs.uk Tel: 01633 626228

Appendix D: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
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CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

NHS 111 Wales Service Commissioning Arrangements

Final Advisory Review Report

December 2023

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Report status:	Final
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Fieldwork completion:	7 November 2023
Draft report issued:	10 November 2023
Draft report meeting:	14 November 2023
Management response received:	12 December 2023
Final report issued:	13 December 2023
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Lisa Harte, Internal Audit Manager
Executive sign-off:	Rachel Marsh, Executive Director of Strategy, Planning & Performance
Distribution:	Hugh Bennett, Assistant Director of Commissioning & Performance
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose	The objective of this review was to assess the effectiveness of the new commissioning arrangements and structures for the NHS 111 Wales service, to ensure there is a sustainable and improved patient quality experience provision with appropriate resourcing and finance mechanisms.
Report opinion	This is an **advisory review** therefore we have **not provided an assurance rating**. We have identified learning and provided suggestions for opportunities to strengthen and improve the current commissioning arrangements (see Appendix A). Limitations to the scope of our review and associated risks are detailed in Appendix B.

Overview

The arrangements put in place for the national NHS 111 Wales service are still evolving and the improvements identified as part of the review will assist in strengthening the current framework for delivery but will also provide focus when inputting into the design of arrangements effective from April 2024 (see para 1.5). Putting in place a robust mechanism to capture post-implementation learning will form a key aspect of this to confirm that the expected outcomes and benefits have been achieved, and identify any lessons learnt.

Roles and accountabilities of partners are currently unclear within the latest draft version of the National Collaboration Agreement, which remains unsigned by the Trust. We have been unable to obtain a copy of the previous signed version, to confirm responsibilities, escalation and funding arrangements, or the finalised versions of the terms of reference to clarify roles and responsibilities for the Joint Operational & Performance Group, Finance Group or National Urgent Primary Care GP (OOH) Forum.

A governance structure for NHS 111 Wales has been established and we have evidenced an appropriate level of discussion and scrutiny of agenda items has been undertaken from our review of meeting minutes. Enhancements noted to further strengthen arrangements include ensuring that there is effective oversight of key discussions arising within the groups and forums in the structure; providing clarification on the process where matters should be referred to for escalation; and putting in place a robust mechanism to ensure that conflicts of interest are appropriately declared and recorded.

There is frequent performance reporting on the NHS 111 Wales service delivery to Welsh Government, the Trust's Board and its various committees; and opportunities have also been identified to strengthen reporting of the commissioning arrangements, including to the Strategic Transformation Board. Within the NHS 111 Wales governance structure, to comply with the Commissioning Framework, the Trust supplies a provider report and monitors progress on the commissioning intentions (see Appendix C). During quarter 4, the Trust is due to report progress against the care standards and core requirements and work is ongoing to develop national quality indicators.

Review of the NHS 111 Wales commissioning arrangement has noted that it would benefit from having a designated strategy to assist with developing a sustainable service provision, which would help to enable the appropriate identification of longer-term funding. Currently, key areas such as the roster review (to assess the demand and capacity of the service) and the website development have been impeded due to a lack of funding and resource. However, we note that development of the strategy is the responsibility of the Commissioner.

Key strategic, financial, and reputational risks have been identified and are escalated appropriately, but the commissioning risks that are recorded on the Trust's Corporate Risk Register need to be amended to incorporate the NHS 111 Wales commissioning arrangements.

1. Introduction

1.1 During 2015/16, NHS Wales, supported by Welsh Government, confirmed their intention to collaborate and implement a NHS 111 Service across Wales. A 111 National Programme Board oversaw the implementation of the model, which integrates the telephone service provided by NHS Direct Wales (a core service of the Welsh Ambulance Services NHS Trust ('the Trust')) and Urgent Primary Care (GP out-of-hours) provided by health boards. The national rollout of the programme was completed in March 2022.

1.2 Now the national NHS 111 service has been fully implemented across Wales, a new commissioning framework ('Quality & Delivery Assurance (Commissioning) Framework') has been developed, which details the role of the Trust, as a provider organisation, in the delivery of the NHS 111 Wales services, e.g. call handling and clinical assessment functions. It aims to improve the delivery of urgent primary care by providing a single access point to help patients get urgent help when they need it, as well as reducing service inefficiency and improving access to health information and advice. Quality & Delivery standards have been designed to provide assurance on the service quality provided.

1.3 The NHS 111 Wales Service is closely aligned to Goal 2 (signposting people with urgent care needs to the right place, first time) of the Welsh Government's 'Six Goals for Urgent and Emergency Care 2021-2026' ('Six Goals Programme'). The Programme aims to support improvement in the urgent and emergency care system and contributes to the delivery of the Minister for Health and Social Care's priorities.

1.4 The Trust's Integrated Medium-Term Plan (IMTP) 2023-2026 sets out in strategic objective 1 ('for providing the right care or advice, in the right place, every time') the need to focus on improving clinical metrics and patient experience within NHS 111 Wales. This includes setting out a clear 'quality & delivery commissioning framework' for the service, improving performance and patient experience, and continued development of the 111 Wales website.

1.5 A review commissioned by Welsh Government ('*Independent Report into a review of National Commissioning Functions*' May 2023), concluded that the national commissioning arrangements currently undertaken by the Welsh Health Services Commissioning Committee (WHSCC), The Emergency Ambulance Services Committee (EASC) and the National Collaborative Commissioning Unit (NCCU) should be combined into a single entity and form a single Joint Committee. While the NHS 111 Wales Service commissioning arrangement was not part of the original scope, the review recommended that the new body should be responsible for commissioning this service. The Trust's Chief Executive is on the NHS Implementation Board to provide input on the development of new arrangements.

2. Detailed Audit Findings

Objective 1: There is an appropriate framework designed for the commissioning arrangement that covers the aims, principles and outcomes that will be achieved, the roles and accountabilities of each partner; and is adequately supported by procedures.

2.1 A Quality & Delivery Assurance (Commissioning) Framework for the NHS 111 Wales service has been approved by both the National Director (NHS 111 Wales) and the Trust's Chief Executive. This details the objectives and principles of the NHS 111 Wales Service, provides an overview of governance arrangements, but is primarily focused on outlining the performance mechanisms for providing assurance on the quality of service provided.

2.2 The Commissioning Framework refers to the National Collaboration Agreement (the Agreement) that was developed to support the rollout of the NHS 111 Wales National Programme across health boards. It details that the Agreement, "*sets out principles of collaboration, roles and responsibilities for NHS Wales organisations who deliver elements of NHS 111 Wales.*" Partners were initially given until March 2023 to provide feedback on the revised version of the Agreement with the expectation that the Interim NHS 111 Wales Board would approve the finalised version in May 2023.

2.3 Terms of reference for the Interim NHS 111 Wales and Urgent Primary Care (Out of Hours) Board detail that one of their core delivery priorities is, "*ensure an 'NHS 111 Wales National Collaboration Agreement' for NHS 111 Wales is agreed by all stakeholders.*"

2.4 The Trust has not signed the latest version as more clarity was needed in relation to roles and responsibilities; and we were unable to obtain a copy of a previous signed version of the Agreement to confirm roles and accountabilities of each partner. The latest version of the Agreement has been discussed with the Commissioners and also at Executive Leadership Team (ELT) in April 2023, but it has not been amended (see **Matter Arising 1**).

2.5 The commissioning arrangements did not require any specific documented policies and procedures to be put in place, but a core requirement of the Commissioning Framework is for the Trust to ensure that "*policies and procedures are in place to support staff in the carrying out their duties*". From our review of the SharePoint intranet site, three operational procedures have missed their review dates (Clinical Safety Plan - due 21/05/22; Fire Evacuation Procedure 111 NHS Wales VPH 1st Floor Clinical Contact Centre – due 18/11/22; and a Standard Operating Procedure for the Management of NHS Direct Wales/111 Service and Ambulance Calls during Planned System Outage or System Failure - due 11/07/21). There were also three business impact analysis documents (for business continuity planning within the NHS 111 Wales) dated February 2017 that did not detail a review date.

2.6 The Head of 111 Service confirmed that two of these operational procedures were currently being reviewed (Clinical Safety Plan and Fire Evacuation Procedure), but

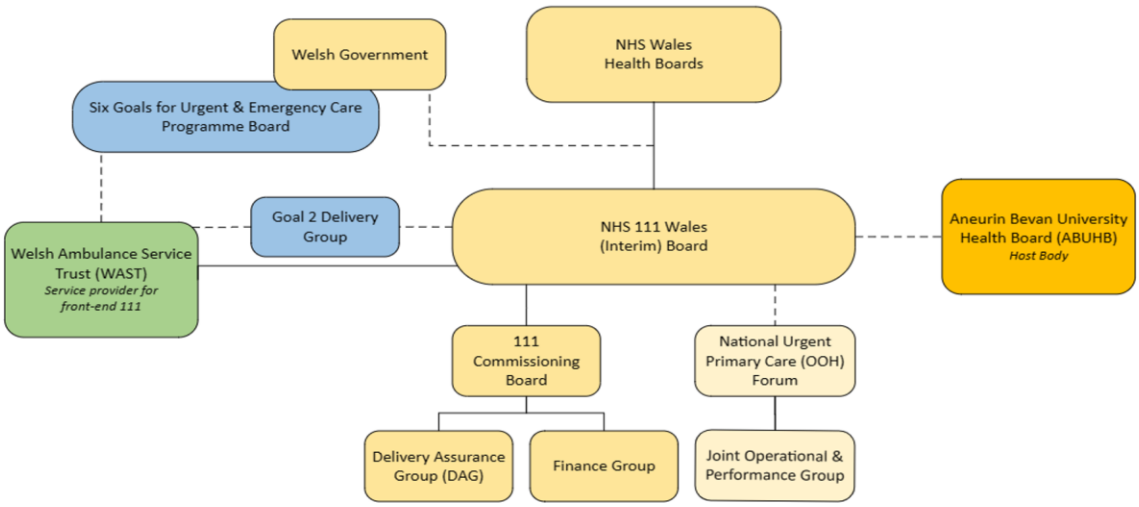
the other documents were no longer 'live' (see **Matter Arising 2**). The Operations Directorate have recently put in place a document tracker to record the review dates of key procedures to strengthen arrangements going forward. We note that policy reviews have been impacted by the Covid-19 pandemic across the Trust.

2.7 It remains early days in terms of embedding the NHS 111 Wales commissioning arrangements, and while there have been opportunities to reflect through Board development days and inputting into the independent review commissioned by Welsh Government, there is no robust mechanism to capture post-implementation learning including the views of operational staff involved (see **Matter Arising 3**). This would be beneficial in terms of focussing on the development of the new arrangements that will take effect from April 2024 (see para 1.5).

Objective 2: Decision-making structures are clear and transparent, with due regard given to potential and perceived conflicts of interest which risk compromising the integrity of decision-making.

2.8 The Commissioning Framework details the following governance structure for NHS 111 Wales:

NHS 111 Wales Governance Structure



2.9 The revised version of the draft Agreement also details the above governance framework, but only includes as appendices the draft terms of reference for some of the boards and forums. We have not been able to obtain finalised versions of the terms of reference for the Joint Operational & Performance Group, Finance Group or National Urgent Primary Care GP (OOH) Forum (see **Matter Arising 1**). While we understand that the Trust does not have responsibility for the administration of governance arrangements, it should ensure that it has received finalised versions of terms of reference to clarify roles and responsibilities and ensure appropriate oversight.

2.10 Our review focussed on the commissioning element below the NHS 111 Wales (Interim) Board (111 Commissioning Board, Delivery Assurance Group (DAG), and Finance Group). The level of discussion and scrutiny of agenda items was evident from our review of meeting minutes for both the 111 Commissioning Board and DAG. Meeting minutes are not taken for the Finance Group, so we are unable to ascertain the key outcomes arising from their discussions (see **Matter Arising 4**).

2.11 The 111 Commissioning Board receives regular updates on the financial position and commissioning arrangements, and DAG reporting included performance and workforce metrics and complaints, but at some meetings, there were verbal updates provided rather than written reports due to staff pressures, which would need to be approved by the Chair. However, we note that arrangements are embedding, and written reports are increasingly being provided.

2.12 Governance arrangements could be strengthened by providing clarification on the process where matters should be referred to for escalation. The draft Agreement details escalations and disputes, but this version remains unsigned (see para 2.4). Terms of references for the groups and forums, that were available for audit review, do not cover the escalation process although DAG carries out regular highlight reporting to the 111 Commissioning Board that provides an opportunity to capture this information (see **Matter Arising 4**).

2.13 There is also no process for dealing with perceived conflicts of interest to ensure that they are declared appropriately and recorded. The independent review commissioned by Welsh Government (see para 1.5) identified that some Chief Executives were placed in a difficult position of being both a commissioner and provider and therefore have a potential conflict of interest. The independent review recommended that substantive declarations of interests should be stated at the start of committee meetings where issues could directly affect the organisations involved. Therefore, we have not replicated a recommendation in this report. There is a similar issue within the NHS 111 Wales service commissioning arrangement noting that Aneurin Bevan University Health Board continues to host the National 111 team as commissioner, but also provides the Clinical Support Hub. This will be addressed by the new commissioning body being in place from next year.

Objective 3: 111 commissioning arrangements are being reported on and embedded within the Trust core processes, e.g. IMTP

2.14 Elements of the NHS 111 Wales Service form part of the remit of several executive directors within the Trust. A RACI (Responsible, Accountable, Consulted, and Informed) document is in place to detail roles and responsibilities amongst executive directors for activities within the service. The Executive Director of Strategy, Planning & Performance is responsible for the commissioning arrangement and the collaboration agreement (roles and responsibilities and schedules).

2.15 Commissioning arrangements have been detailed within the Trust's IMTP 2023-26, which refers to the Commissioning Framework. Trust Board reporting (27 July 2023) also noted that the new governance arrangements began in May 2023.

2.16 The Commissioning Framework details commissioning intentions (see Appendix C) that have been designed to deliver service improvements and these were shared with the Gateway to Care Programme Board (that reports into the Strategic Transformation Board) in June 2023. A report was submitted to Finance & Performance Committee (18 September 2023) on the outcome of the national review of commissioning functions (see para 1.5).

2.17 However, while there is frequent reporting to the Trust Board and various committees on risks and the performance metrics with the NHS 111 Wales service delivery, progress with delivering the commissioning arrangements has only been reported if it forms part of the IMTP delivery. The plan was for the commissioning intentions to be included in quarterly reporting to the Strategic Transformation Board (STB), but this has not always happened and is recognised as an area for improvement (see **Matter Arising 4**). Management has advised that proposed annual reporting for 2023-24 will incorporate compliance with the standards and commissioning intentions.

Objective 4: Performance is monitored appropriately with clear standards and benchmarking.

2.18 The Commissioning Framework details the quality assurance arrangements for assessing service delivery, including the commissioning intentions; care standards and core requirements provide assurance on the quality and safety of service delivery.

2.19 Commissioning intentions (see Appendix C) are reported quarterly to DAG and the 111 Commissioning Board. The latest progress report (October 2023) detailed 18 actions with none having a red RAG status; 8 recorded as amber; 9 green; and one action had been closed. Of the amber rated actions, four had missed their timescales and these were impacted because of delays with the system implementation or roster reviews. We note that the commissioning intentions for 2024-25 have been drafted and are currently with the Trust for consultation.

2.20 The Trust is due to report progress against the care standards and core requirements during Quarter 3 using the self-assessment templates provided although this has been postponed until Quarter 4 due to staff capacity issues. Additionally, there is also a bi-monthly 111 WAST provider report. The latest report (20 September 2023) provides the 111 Commissioning Board with an overview of current quality and performance within the service. Key reporting points note that call answering performance was improving but highlighted concerns about capacity and service resilience into the winter. The report also details that a 111 Measures Task & Finish Group has been established, with representation from the Six Goals Programme, the Trust and Digital Health and Care Wales (DHCW) to focus the development of National 111 Quality Indicators as required by Welsh Government. As work is ongoing to take this forward, we have not raised a recommendation.

2.21 Welsh Government representatives attend the NHS 111 Wales (Interim) Board as well as the bi-monthly Integrated Quality, Planning and Delivery (IQPD) meeting where performance and service developments are discussed. There is also regular

oversight and monitoring of performance within the NHS 111 Wales service through reporting to the Quality, Patient Experience & Safety Committee (QuEST), People & Culture Committee, Performance & Finance Committee, and the Board.

2.22 The report presented to QuEST (31 October 2023) outlined progress with performance in August and September 2023:

Top Monthly Indicators	Target 2023/24	2 Year Average	August 2023	September 2023	RAG
NHS 111 Call Handling Abandonment Rates	<5%	15.0%	3.2%	3.4%	G
111 Clinical Triage Call Back Time	90%	96.7%	99.2%	99.0%	G
NHS 111 % of Total Calls Answered in Welsh	Increasing Trend	0.44%	0.92%	0.88%	G
NHS 111 Dental Calls	To Be Determined	5,877	7,603	6,750	TBD

2.23 The report also noted that staff sickness absence reduced within the service, continuing a longer-term trend in this direction; and 65.4% of calls were answered within 60 seconds during September 2023, although this remains significantly below target (95%). The following remedial actions were identified to address this:

- The Commissioners have agreed to fund 198 WTE call handlers in 2023/24 but is currently 21.25 FTE short of establishment. The Trust is aiming to address this in quarter three.
- Improving sickness absence in line with an IMTP aim of reducing to 6%.
- Carrying out a roster review, in collaboration with the 111 commissioners, to ensure that capacity is aligned to demand, but the review has been impacted by funding.
- Reviewing the use of the Clinical Advice Line (for call handlers requiring clinical advice while on a call to the patient).

2.24 Evidence was provided of regular performance reporting operationally, e.g., there is a fortnightly group that reports into the Operations Directorate Performance Group, which replicates the information reported to the various committees. A Learning Experience Group has recently been established to enable further analysis of performance data and to identify themes and trends and the performance framework is currently being revised.

2.25 A revised audit tool has been developed to monitor the performance of calls and the quality of the advice provided, but, at the date of audit fieldwork, had not been implemented. Management advised they were awaiting a decision on the 111 Wales triage and clinical assessment platform required within the NHS 111 Wales Service, as this may already have an integrated audit tool.

2.26 Complaints can come from three main sources – Putting Things Right, when the caller is on the phone, and from other healthcare professionals. Any negative feedback is reported to the line manager and to the operational Quality Assurance Group and DAG. The latest report (September 2023) noted that there had been a decrease in the number of concerns raised (ten concerns were raised in June 2023 and this has reduced each month to only one concern being raised in September 2023).

2.27 The report presented to QuEST (31 October 2023) detailed the outcomes from patient experience surveys for September 2023 (based on four responses):

111	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	66
Did you follow the advice given to you by NHS Direct Wales?	85	100
Would you consider using NHS 111 Wales again	85	100
Overall experience of NHS 111 Wales Online today	57.14% Good	14.29% Poor
Overall experience of Integrated Care (NHS 111 Wales telephone line only) today	100% Good	0% Poor

2.28 Benchmarking of performance has been carried out but is at an early stage. At the date of audit fieldwork, due to concerns over data sharing, discussions were ongoing as part of a wider review within the Trust on utilising benchmarks.

Objective 5: Key strategic, financial, and reputational risks have been identified and are regularly monitored.

Risk Management

2.29 There are no specific risks in relation to the NHS 111 Wales Service commissioning arrangement or service delivery recorded on the Trust's Corporate Risk Register (CRR). However, there are two risks in relation to commissioning that need to be amended to incorporate the 111 Service (see **Matter Arising 5**):

- Risk 458 – *A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning*; and
- Risk 100 - *Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.*

2.30 The Risk Management & Board Assurance Framework report presented to Trust Board (28 September 2023) notes that work continues to consider the development of a risk that includes the triage and clinical assessment platform, symptom checkers, website, clinical workforce training and funding, and may

require inclusion on the CRR in future. This has been highlighted at both Gateway to Care Programme Board and ELT.

2.31 There is also periodic risk reporting at 111 Commissioning Board, and 111 risks are also recorded on the Gateway to Care Programme Board's risk register. Progress with updating the programme's risk register has been impacted by resourcing issues and we note that some risks have not been updated since October 2022 (see **Matter Arising 5**).

2.32 Service risk registers also record risks in relation to NHS 111 Wales service delivery and evidence was provided demonstrating that risks had been appropriately escalated, where required.

Sustainable Service

2.33 The delivery and sustainability of the national service model that will link services delivered by NHS 111 Wales with Urgent Primary Care services is noted as a key objective within the draft National Collaboration Agreement; but development of the NHS 111 Wales Service has been impacted in some areas.

2.34 While performance is improving (see para 2.20), the planned roster review (see para 2.23) has been paused due to funding issues, and the website development and symptom checker have been impacted by both funding and resourcing issues (see para 2.30).

2.35 The Patient Experience & Community Involvement Bi-Annual Report (April - September 2023), presented to QuEST (31 October 2023), outlined the outcomes of a website experience survey, which 195 people completed between April and September 2023. It was reported that *53% of respondents could not easily find information on the NHS 111 Wales website and 49% of people rated their overall experience of using the website as 'Poor' or 'Very Poor'*. It further conveyed the risks posed with the website content not being updated and no ongoing assurance processes for clinical content, including the online symptom checkers.

2.36 Strategic workforce planning has been identified as a commissioning intention (see Appendix C) as part of the Commissioning Framework and is at an early stage; although management advised that the project plan details that work will be completed by Quarter 4 (2023/24). The Head of Workforce Planning, who is assisting with developing the NHS 111 Wales service workforce plan, sits on the Integrated Technical Planning Group, which assesses the wider impact of decisions to the Trust. The Group is chaired by the Assistant Director of Commissioning & Performance who was a facilitator at a session in November 2023 on horizon scanning as part of workforce planning for the NHS 111 Wales service.

2.37 There has been a focus on NHS 111 Wales staff recruitment and retention. The Head of Workforce Transformation chairs the 111 People and Culture Group, which has been looking at making rostering more agile, in line with flexible working requests, and developing a multi-disciplinary team. Innovative recruitment campaigns have also been carried out using social media. There is limited data corporately to understand why people are leaving the Trust and a 'Moving on

Interview' process has been developed to address this (this will be explored as part of our Recruitment and Retention audit within the 2023/24 Internal Audit plan). However, the report presented to DAG (16 June 2023) provided a high-level overview of staff retention within the service and identified themes in relation to rostering, not having face-to-face contact with patients and support after training in the first year of practice.

2.38 Further support for staff during their first year of practice is currently being developed. There is a structured induction and training programme in place with self-directed learning through accessing a dedicated library and reflective practice opportunities where clinicians work through a patient scenario. A training matrix is currently being developed recording the skills required for each role in the service compared to the training the Trust provides.

2.39 While the NHS 111 Wales service is included in the Trust's IMTP 2023-26, there is no separate strategy to assist with longer term planning (aligned to the timescales of the Goal 2 priorities, referred to in the Six Goals Programme (see para 1.3). This would ensure that appropriate funding is allocated for the delivery and transformation of the service. However, we note that the strategy would have to be developed jointly with the Commissioner and therefore, no recommendation has been made.

Financial Resources

2.40 The Commissioning Framework refers to a cost and recovery finance methodology for 2023/24, which will remain in place until such time that a consistent future service model has been jointly agreed. While there is reference to funding arrangements within the latest draft National Collaboration Agreement, it has not been signed by the Trust (see para 2.4) and we have not been able to obtain further documentation to outline more explicitly the funding arrangements and ensure that costs can be recovered where necessary (see **Matter Arising 1**).

2.41 The cost and recovery finance methodology removes the risk of overspending as NHS 111 Wales Service costs are forecasted at the start of the financial year, and the Finance Group, as part of the NHS 111 Wales Governance structure (see para 2.8) meet monthly to agree costs incurred by the Trust that will be invoiced to the Commissioner. Historically, the Trust has been underspending because of recruitment and retention challenges. However, we were informed that the methodology, which differs from the block contract/resource envelope commissioning approach for Emergency Medical Service (EMS) and Non-Emergency Patient Transport Service (NEPTS), is limiting the Trust in being able to develop the 111 service, e.g., assessment of capacity so staff can be effectively rostered to meet demand, proactively undertake website development, etc.

Appendix A: Management Action Plan

Matter arising 1: Clarity over Roles and Responsibilities (Operation)	Impact
111 Commissioning Board meeting minutes (28/02/23) note that, "*within the existing agreement, there had been a commitment to update and refresh the Collaboration Agreement when the national programme had concluded and 111 moved to a national operational service*." Both the draft National Collaboration Agreement and the Commissioning Framework detail that, "*all Parties acknowledged and agreed there would be an opportunity to reassess the existing collaboration arrangements once the programme rollout had concluded, however, there was an expectation that the majority of the existing agreement would remain extant and apply to a nationally recognised model*." The Commissioners had met with board secretaries on revisions to the existing agreement with an initial feedback deadline of 17th March 2023. 111 Commissioning Board meeting minutes (18/04/23) record that no response had been received from the Trust. Reporting to Executive Leadership Team (ELT) on the 19 April 2023 noted that the Interim NHS 111 Wales Board were seeking to approve the Agreement at their meeting at the end of May, but there was a need to have greater clarity over roles and responsibilities of partners detailed within the Agreement and the Clinical Governance Framework section within Schedule 1 (the Trust's Delivery of NHS 111 Wales Call handling & Clinical Nurse Triage) had not been completed. ELT agreed that comments in relation to the Agreement would be conveyed in writing to the Commissioners. The Agreement remains unsigned by the Trust. We requested a copy of the previous version of the Agreement to ascertain what was detailed within there on the roles and accountabilities of each partner. However, this was not provided by the conclusion of our review. The draft National Collaboration Agreement details that the Commissioners will receive funding directly from Welsh Government and a proportion will be transferred to the Trust in relation to "*the initial front end call handling/ nurse clinical assessment element of the service along with proportionate costs for additional operational and technical support including education and training for staff*". For any additional funding, the 111 Board may request financial investment for transformational activities. However, we have not been able to obtain further documentation to outline more explicitly the funding arrangements while the latest version of the Agreement remains unsigned. The Commissioning Framework details the NHS 111 Wales governance structure, but we were unable to obtain finalised versions of the terms of references for forums and groups within the structure (draft copies were provided for the National Urgent Primary Care (Out of Hours) Forum, Finance Group, and the Joint Operational & Performance Group). While we understand that the Trust does not have responsibility for the administration of the governance	Potential risk of: • Unclear roles and responsibilities could result in poor decision making and a lack of accountability and oversight. • Resources being used inefficiently if partners duplicate in their undertaking of roles and responsibilities

arrangements, it should ensure that it has final version of the terms of reference to confirm roles and accountabilities and that decision making is appropriate at each level of the governance structure.

Recommendations		Priority
1.1	Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust). Opportunities should be provided for partners to reflect on their roles and functions regularly so that the Agreement can be amended to reflect any changes.	**N/A – this is an advisory review**
1.2	A copy of the previous signed version of the National Collaboration Agreement should be retained in a central location and monitored to ensure roles and responsibilities are fulfilled.	
1.3	The Trust should ensure that it has finalised versions of the terms of reference for forums and groups where it participates within the NHS 111 Wales governance structure.	

Management response		Target Date	Responsible Officer
1.1	A new Joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24.	01/04/24	Executive Director of Strategy, Planning & Performance
1.2	The previously signed version will apply until the new version is agreed, so the Trust will seek to obtain and retain a copy until recommendation 1.1 is enacted.	31/12/23	Executive Director of Strategy, Planning & Performance
1.3	The responsibility for up-to-date terms of references rests with 111 commissioners, but the Trust will collaborate with commissioners and seek to ensure all relevant terms of reference are updated. The Trust will feedback to commissioners on the National Urgent Primary Care (Out of Hours) Forum and the Joint Operational & Performance Group) but considers these outside of the formal commissioning arrangements.	31/01/24	Executive Director of Strategy, Planning & Performance

Matter arising 2: Out-of-date policies and procedures (Operation)	Impact
While no specific policies and procedures were required by the NHS 111 Wales commissioning arrangement, our review of policies and procedures relating to the operational delivery against the commissioning intentions noted the following issues: • the Clinical Safety Plan – records a review date of 21st March 2022 (the document tracker notes the date as 21 May 2022); • the Fire Evacuation Procedure 111 NHS Wales VPH 1st Floor Clinical Contact Centre – is dated 18/11/21 and does not detail a review date, but the document tracker records this as 18/11/22; • there are three business impact analysis documents (Thanet House, Vantage Point House, and Snowdon House) that are dated 2017 but do not record a review date; and • the '*Standard Operating Procedure for the Management of NHS Direct Wales/111 Service and Ambulance Calls during Planned System Outage or System Failure*' records a review date of 11/07/21. The Head of the 111 Service explained that both the Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. We note that Audit Wales ('*Structured Assessment 2022 – Welsh Ambulance Services NHS Trust'* (January 2023)), which included reviewing the Trust's governance arrangements, has highlighted a wider issue across the Trust with policy reviews being impacted by the Covid-19 pandemic and the capacity of the Office of the Board Secretary. A policy prioritisation exercise has since been undertaken by the Trust, which has resulted in a programme of work being established to bring the organisation's key policies up to date.	Potential risk of: • Outdated arrangements which are not compliant with legislation and cause confusion to staff.

Recommendation		Priority
2.1	Management should ensure that all operational policies and procedures that relate to NHS 111 Wales service delivery, are updated as soon as possible.	**N/A – this is an advisory review**
2.2	Once approved, policies and procedures should be circulated to all staff.	

	Management response	Target Date	Responsible Officer
2.1	The Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. The reviews will be completed and the old versions of policies removed and replaced.	29/02/24	Assistant Director of Operations (Integrated Care)
2.2	Updated policies to be placed on Siren and accompanied by Siren communications and more direct staff briefings, where appropriate e.g. fire evacuation procedure.	29/02/24	Assistant Director of Operations (Integrated Care)

Matter arising 3: Post-Implementation Learning (Design)	Impact
There have been opportunities to reflect on current commissioning arrangements, e.g., discussions at executive director level, Strategic Transformation Board, Gateway to Care Programme Board, etc. However, there needs to be a robust mechanism to capture these reflections in one place and to encapsulate the views of staff involved with the operational service delivery. This would be beneficial to determine not only benefit realisation and lessons learnt, but also assist with providing input to the new commissioning arrangements that will take effect from April 2024.	Potential risk of: • Lack of organisational learning in respect of service delivery or being able to effectively input into the development of new commissioning arrangements.

Recommendation		Priority
3.1	Develop a mechanism to enable post-implementation learning of benefits, lessons learnt and impact to service delivery to be completely captured.	**N/A – this is an advisory review**

Management response		Target Date	Responsible Officer
3.1	Proceed with the planned "time out" for Executives who interface with the commissioning arrangements, 111 Senior Leadership Team and other Assistant Directors/Heads of Service who support the commissioning arrangements.	29/02/24	Executive Director of Strategy, Planning & Performance

Matter arising 4: Governance Oversight (Operation)	Impact
While we acknowledge that the governance arrangements for the national NHS 111 Wales service are embedding, the following gaps have been identified to ensure that the Trust has adequate oversight: • A signed version of the previous National Collaboration Agreement could not be provided by the conclusion of our review to confirm effective oversight of its content, agreed roles and responsibilities of each partner and escalation arrangements (see **MA1**). • Key outcomes arising from meetings of the Finance Group are not documented. • We were unable to establish the level of oversight of the Joint Operational and Performance Group and the National Urgent Primary Care GP (OOH) Forum as meeting minutes and reports were not provided (however, we understand that these groups do not form part of the commissioning element of the governance structure). • Progress against performance measures detailed in the Commissioning Framework are not reported within the Trust. It was planned for commissioning intentions to be included in quarterly reporting to the Strategic Transformation Board (STB), but this has not always happened. This has been recognised as an improvement as part of the Quality & Performance Framework and detailed on the workplan for Audit Committee (30 November 2023).	Potential risk of: • Unclear governance and reporting arrangements leading to a lack of accountability and oversight.

Recommendation		Priority
4.1	Key outcomes from meetings that Trust employees attend on commissioning arrangements should be appropriately recorded and reported to ensure that there is appropriate oversight of key discussions held.	**N/A – this is an advisory review**
4.2	Progress with delivering the commissioning framework should be reported within the Trust.	
4.3	The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure.	

	Management response	Target Date	Responsible Officer
4.1	Action notes/minutes for the Finance Group are the responsibility of 111 commissioners. The Trust will discuss with 111 commissioners and seek a formal record of each meeting.	31/12/23	Director of Finance and Corporate Resources
4.2	The Trust does report progress on the commissioning framework i.e. commissioning intentions, but recognises that internal reporting is more intermittent. Re-establish regular reporting of the commissioning intentions (every quarter) to the Trust's Strategic Transformation Programme Board.	31/01/24	Executive Director of Strategy, Planning & Performance
4.3	A letter will be collaboratively drafted and agreed between the 111 Board Chair and Trust CEO to formalise the informal escalation arrangements that do currently exist.	31/01/24	Executive Director of Strategy, Planning & Performance

Matter arising 5: Risk Management (Design)	Impact
Any risks associated with a commissioned arrangement should be captured in the Trust's risk register. Funding and resourcing limitations have been highlighted that are impacting the NHS 111 Wales service development in line with the Trust's ambitions, however this isn't currently captured within the two risks on the Trust's Corporate Risk Register that relate to commissioning: • Risk 458 – A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning. • Risk 100 – Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience. The Risk Management & Board Assurance Framework report presented to Trust Board (28 September 2023) notes that work continues to consider the development of a risk that includes the triage and clinical assessment platform, symptom checkers, website, clinical workforce training and funding, and may require inclusion on the CRR in future. This has been highlighted at both Gateway to Care Programme Board and ELT. NHS 111 Wales risks are also recorded on the Gateway to Care Programme Board's risk register, but its review has been impacted by resourcing issues, and some risks showed a review date of October 2022.	Potential risk of: • Risks are not identified and managed effectively and impact adversely.

Recommendation		Priority
5.1	The Trust's Corporate Risk Register should be amended to capture risks relating to the NHS 111 Wales commissioned arrangement or service delivery.	**N/A – this is an advisory review**
5.2	The Gateway to Care Programme Board's risk register should be reviewed and updated to ensure that the risks documented remain current and there are appropriate mitigating controls in place.	

Management response		Target Date	Responsible Officer
5.1	The Trust's Corporate Risk Register commissioning risks to be updated to reflect that 111 is now also a commissioned service.	31/01/24	Executive Director of Strategy,

			Planning & Performance
5.2	Gateway to Care Programme Board's risk register to be reviewed and updated.	31/01/24	Executive Director of Strategy, Planning & Performance

Appendix B: Terms of Reference

Scope and Objectives

Scope	To assess the effectiveness of the new commissioning arrangements and structures for the 111 service, to ensure there is a sustainable and improved patient quality experience provision with appropriate resourcing and finance mechanisms. The review will examine the following areas: 1. There is an appropriate framework designed for the commissioning arrangement that covers the aims, principles and outcomes that will be achieved, the roles and accountabilities of each partner; and is adequately supported by procedures. 2. Decision-making structures are clear and transparent, with due regard given to potential and perceived conflicts of interest which risk compromising the integrity of decision-making. 3. 111 commissioning arrangements are being reported on and embedded within the Trust core processes, e.g. Integrated Medium-Term Plan (IMTP). 4. Performance is monitored appropriately with clear standards and benchmarking. 5. Key strategic, financial, and reputational risks have been identified and are regularly monitored.

Limitation of scope

Limitations to scope	The review is limited to assessing the effectiveness of arrangements from the Trust's perspective. The Gateway to Care Programme will not be considered in detail as this was covered in our audit of IMTP Delivery (final report issued February 2023) nor did we assess the delivery of new digital platforms as this is planned within the ICT Contract Management audit.

Associated Risks

Associated risks	• Ineffective arrangements resulting in wasted resources, failure to deliver strategic objectives, poor patient experience, and a lack of value for money; and • Failure to deliver required service levels resulting in patient harm

Appendix C: Commissioning Intentions 2023-24:

Agreed commissioning intentions detailed within the Commissioning Framework

Commissioning intentions focus on delivering service improvements which will improve staff and patient experience and overall service performance - supported by a suite of actions. WAST will work collaboratively with the National NHS 111 Wales team, through the Delivery Assurance Group (DAG), to deliver its Commissioning Intentions. WAST will be required to develop action plans with key activities and timelines to deliver the following Commissioning Intentions:	
Ci.1 - Optimise performance, improve outcomes & ensure value for money by further developing the WAST service model.	
Ci.1A	Undertake a review of the current model using evidence of effectiveness to establish 'what good looks like' for NHS 111 Wales
Ci.1B	Develop the model to reduce the number of hand-offs, consider the concept of 'one & done'
Ci.1C	Review the current workforce skill mix and ratios of non-clinical vs clinical staff based on future service models and UK benchmarking
Ci.1D	Evaluate roles that have been created as pilots and report on the impact & outcomes achieved
Ci.1E	Consider the opportunities for creating enhanced roles – enhanced call handler, autonomous nurse practitioner, in the future delivery model
Ci.1F	Support the National Programme for Urgent & Emergency Care (Goal 2) transformational workstreams, specifically the development of 'Enhanced Clinical Pathways': • Urgent Dental - Map out the existing pathways for HBs (4) and review in the context of developing a National Urgent Dental Pathway to support all HBs • Palliative Care pathway development
Ci.2 - Enhance performance through the improvement of call abandonment rates (Step 2).	
Ci.2A	Undertake a review of calls to understand disposition/outcomes including self-care rates, number of touchpoints and flows into OOH
Ci.2B	Undertake a review of abandonment after 60 secs to understand at what point in the call, abandonments are occurring
Ci.2C	Review IVR messaging to determine which messages have greatest impact in diverting calls to website /other services
Ci.2D	Review the correlation of days/ times to peaks in demand and levels of staffing rostered during those times and undertake the necessary action to ensure staffing meets demand patterns
Ci.3 - Staff experience a great place to work, where they are engaged and their wellbeing is promoted (Core Requirement 6).	

Ci.3A	Develop a strategic workforce plan to ensure effective workforce planning arrangements are in place with the capacity to meet service demand. Ensure the plan links to wider National workforce plans
Ci.3B	Ensure workforce planning arrangements are in place to identify staffing requirements and action plans such as recruitment & training plans to meet those requirements
Ci.3C	Undertake a workforce & training review to establish where training can be more efficient and effective
Ci.3D	Undertake a rostering review and ensure effective rostering practices are implemented to ensure shift fills, rota management and rostering to levels of demand
Ci.3E	Develop a staff education & training matrix to ensure staff are appropriately trained, educated & qualified to undertake their role and deliver the services provided
Ci.3F	Ensure the requirement to work predominantly out of hours, is a key feature in contractual agreements
Ci.3G	Review sickness absence rates and undertake the necessary action to ensure sickness absence is in line with National targets
Ci.3H	Monitor turnover rates and undertake exit surveys to identify the reasons why staff leave the service

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

Integrated Medium-Term Plan (IMTP) 2023 – 2026
Q3 Delivery & Assurance

MEETING	Finance & Performance Committee
DATE	15 January 2024
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Planning and Transformation Deborah Kingsbury – Senior Planning & Performance Business Partner Gareth Taylor – Senior Project Manager
CONTACT	alex.crawford@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide Finance & Performance Committee with the progress and delivery of actions in the IMTP 2023-26. A full delivery and assurance report is included as an appendix to this paper, alongside a detailed assurance report in relation to the Trust Strategy Development.

RECOMMENDED:

That the Finance & Performance Committee:

1. Notes the overall delivery of the IMTP detailed in this paper.
2. Note the update against the ministerial priorities that are relevant to WAST in Appendix 1
3. Advise of any further assurance required for the Trust Board.

KEY ISSUES/IMPLICATIONS

Due to current reporting cycles, IMTP Delivery Programme Boards may be impacted by the Christmas Period when providing updates ahead of the deadline for papers.

This report was compiled week commencing 18th December using updates from the following,

Gateway to Care – November STB Assurance Report. Programme Board 10th January. Assurance will be provided via Strategic Transformation Board on the 15th January due to a later deadline for papers.
EMS Operations – Programme Board 22nd December.
Ambulance Care – Programme Board 21st December.
Financial Sustainability Programme – December Cycle (Separate Assurance Report - Agenda Item 7)
Clinical Transformation – November STB Assurance Report. Programme Board due 18th December stood down due to assurance provided at last Programme Board 29th November.

Appendix 2 is a full delivery and assurance report which includes a written update from each of the IMTP Delivery Programmes due to be presented at Strategic Transformation Board on the 15 January (subject to Gateway to Care additions following Programme Board):

- EMS Operations Programme
- Ambulance Care Programme
- Gateway to Care Programme
- Clinical Transformation Programme
- Financial Sustainability Workstreams

Appendix 3 provides a further update on the Trust's Strategy Development Work. As with Gateway to Care, the deadline for papers on the 5th precedes TSAG on the 10th, whereby a more comprehensive update will be provided. As such an updated version will be presented to STB on the 15th for assurance and noting.

Appendix 2 also includes updates by exception on the IMTP Enabling Programmes:

- People and Culture
- Digital
- Infrastructure
- Fundamentals (including Quality Safety & Patient Experience, and Corporate Governance)

The majority of enabling actions will be reported through the main IMTP delivery programmes and will be managed and monitored in Directorate Plans. However, where there are discrete, Directorate-led IMTP work packages, assurance will be provided to STB, including progress against agreed milestones.

IMTP Delivery Programmes

EMS Operations Programme

Overall RAG Status: AMBER

4 Amber, 1 Green, 1 Red:

- The EMS Response Roster Review completed implementation last year, and the project evaluation has been drafted. First Draft to be taken to EMS Programme Board for approval on the 2nd February 2024, and to STB at the end of February.

- The rightsizing of EMS Response is **Red.** The EMS Operations Programme aims to run a post-roster change relief gap, to be agreed between WAST CEO and Chief Ambulance Services Commissioner on numbers and unit hours production.
- The EMS Control Reconfiguration Project is currently recorded as Amber across all three workstreams. The EMS Coordination restructure paper was initially presented in November 2023, and following amendments will be presented to formal SLT on the 9th January 2024.
- CHARU work is also rated Amber as there continues to be a vacancy rate of 38.61FTEs. Recruitment advert went out again in December. Utilisation rates currently differing from ORH modelling, and investigation underway.

Ambulance Care Programme

Overall RAG Status: AMBER

10 Amber, 3 Green, 3 Complete, 2 Paused, 2 Not Started, 1 Red:

- 1 **Red** deliverable relates to the revision and implementation of the new eligibility criteria which is subject to further dialogue with Commissioners and WG. Internal measures to manage demand and capacity have been taken through CQGG, EMT and QuEST.
- Implementation of the new NEPTS roster pan-Wales is paused, as is a funding bid for 12FTEs in the NET Centre Project. No funding identified to date.
- The Urgent Care Service (UCS) Demand and Capacity review is now complete and was presented to the UCS Steering Group. Recommendations approved by ELT 13/12/23, and transition planning now underway.
- Transfer and discharge currently working on options following ORH review of demand and capacity modelling having been completed, with final options being taken to STB in Q4.
- Implementation plan regarding improved performance parameters for NEPTS completed with actions underway.
- Plurality model proposal approved by Operations Senior Leadership Team on 12th December 2023 and opportunities to expand ambulance car service sought, although none identified to date.
- The development of a CAD Business Case is Amber due to the need for greater cross-organisational coordination.

Gateway to Care Programme

Overall RAG Status: GREEN/AMBER

1 Amber/Red, 3 Amber, 1 Green, 4 paused, 1 complete:

- **SALUS;** Scoping exercise complete to determine different approaches and system options to replace CAS in the absence of SALUS being ready. Review and scoring matrix conducted which has secured Ministerial Approval to the preferred WAST approach.
- Improvements to the 111.Wales website are also currently paused due to ongoing resource envelope discussions with 111 commissioners.
- Remote clinical support strategy closure report accepted at G2C Programme Board
- 111 re-roster also paused pending outcome of funding decisions.

- Work to identify booking and pathway opportunities across CSD and 111 ongoing in parts with direct booking trial due to start in December in Cardiff.

Clinical Transformation Programme

Overall RAG Status: GREEN

1 Red, 1 Amber, 13 Green, 1 Paused:

- 1 **Red** relates independent prescribing, this is dependent on the capacity for clinical supervision which has been flagged as a risk and workforce review being undertaken based on HEIW JD publication. Clinical Supervision Policy due to be presented at QUEST in February 2024, with a workplan in place to implement in Q4.
- APP Navigator Pilot now standard agenda item on ACPDG, and HDUHB Phase 2 Pilot on-going with a completion date of 31st December 2023.
- The BCU breathing and chest pain pathway pilot is currently noted as PAUSED as BCU proposed revisions to the operational scope, BCU discussions on hold.
- Initial falls modelling reviewed, being updated; awaiting report back from Optima (expected December 2023). Ongoing discussions with Commissioners on L1 Falls commissioning arrangements going forward. Specific discussions with BCU to extend coverage across North Wales. Funding received for an additional Level 2 Falls team in AB through RPB and additional L1 night service in addition to existing services in AB.
- Funding for Mental health response vehicle approved for AB. Some delay in go live due to availability of ABUHB mental health practitioners; working with AB to support and go live during January.
- Slight delay in the evaluation of the RITA dementia friendly reminiscence therapy, now expected in January 24
- Clinical Audit Plan developed and being delivered so now moved into BAU.
- Phase 2 of SBRI Challenge Fund bids - application received by both businesses regarding SBRI funding (Fujifilm and LUSCII). Evaluation and scoring completed. WAST not leading on any Fujifilm projects. Plan for LUSCII Discover Phase programme with ABUHB and BCUHB.

Financial Sustainability Programme - Income Generation

Overall RAG Status: GREEN/AMBER
Overall Position Against Savings Target: GREEN (Exceeding Financial Forecast)

Commercial Structures and Long-Term Planning - ***Scope potential dedicated structure for delivery and oversight of commercial opportunities*: GREEN**

Income Generation - *Identify, scope, determine viability of ideas and schemes for delivery*: AMBER

Commercial Mindset *Identify, assess, and deliver opportunities for commercial and financial training and Development*: PAUSED

- Following a deep-dive into barriers and threats to income generation, presented to STB on the 18th September, commercial options where scoped and presented to ELT on the 6th December during a commercial scoping session. Case Studies from elsewhere in the UK were presented.
- Following the session, the lack of organisational readiness to pursue income generation on a greater scale than is currently being delivered was noted, and a request made to undertake a market analysis exercise before the end of the Financial Year.
- The Income Generation workstream continues to scope available opportunities as and when they arise. Recent examples include Early Discharge, and outsourcing consultancy opportunities.
- NEPTS Tender and Quality Examplar initiatives are paused pending the outcome of the commercial structures work.

Financial Sustainability Programme – Achieving Efficiency

Overall RAG Status: GREEN/AMBER
Overall Position Against Savings Target: GREEN (Exceeding Financial Forecast)

Reviews: GREEN

Short Term Savings Opportunities (Cash Releasing / Spend Avoidance): GREEN

Long Term Savings Opportunities (Cash Releasing / Spend Avoidance): GREEN

Other / Non-cash releasing Savings / Process Efficiencies: AMBER

- Having completed the Administrative Review, a proposal on next steps and recommendations was presented to ADLT and EMT for consideration. Ownership of recommendations now sits with ADLT, with additional updates via the FSP. Recommendations are being taken forward via a 22-point Action Plan
- The Services Review is now in entering Phase 1 of data collection and analysis, with collection due to be completed by the 20th December, and analysis to commence on the 11th January. Timeframe for completion currently sits at April 30th 2024 following a decision by ELT to pursue an Advanced Review with a longer associated timeframe for completion
- An internal project lead has been identified to take forward Robotic Process Automation, and a proposal paper went to ELT 13th December regarding process and approval frameworks.
- Short term savings being targeted via fuel efficiencies, utilties, and consumables waste.
- Process efficiencies are being delviered via schemes such as hire car, and the Administrative Review, however a formal proces to record as benefits yet to be developed, meaning key deliverable noted as Amber.

IMTP Enabling Programmes (by exception only)

People & Culture

The People & Culture portfolio is monitored through a local Directorate Plan, with actions aligned to IMTP Objectives. The Directorate Plan has been reviewed and updates provided by exception:

CULTURE

Develop and articulate our target culture: GREEN/AMBER

On track overall, however there is an **Amber** status against rollout of EQIA training due to limited training capacity; online video tutorials and Share Point information created as interim solution. EQIA form being trialled.

Refresh TU partnership working arrangements: GREEN/AMBER

On track overall, and ACAS action plan has now been developed and agreed in partnership with TUPs. Implementation of the plan is underway, but timelines have been updated in the context of IA with work due to commence in Sep-23.

CAPACITY

Develop our employee offer: GREEN/AMBER

Delivery against our commitment to address the 3 biggest issues facing staff (flexible working, shift overruns, and digital experience) continue to progress.

1. **Shift Overruns** – Pilot for shift overruns undertaken in Swansea Bay and an SBAR was presented to Operations Senior Leadership Team (Ops SLT) (21/08) highlighting the positive impact on staff wellbeing but flagging that the costs to deliver this at scale could be prohibitive. Since then, a facility has been re-introduced at some hospital locations in line with the Trust's winter resilience planning and is showing signs of working well to improve end of shift for our people.

2. **Flexible Working Policy** – Developments around flexible working include,

    a. Reviewing current policy.
    b. Establishing a clear understanding of current processes and impacts of flexible working arrangements across frontline services.
    c. Reviewing current research for frontline flexible working across NHS& Emergency services.
    d. Engaging with wider Ambulance Sector to understand flexible working practices across UK.
    e. Developing coaching / process material.
    f. Exploring ESR functionality for requesting and recording agreed / declined flexible working requests.
    g. Engaging with WAST colleagues to understand perceptions views on flexible working options and evaluate after changes are implemented.
    h. Continuing to establish a pathway of support for Carers within the organization.

3. **Digital Experience** – Work ongoing with the EqIA process, in order to make this more digitally accessible. Regarding Digital Literacy Skills, the development of accredited and non-accredited education programmes is underway, as is the implementation of LMS365. Also within this commitment is the expansion of Learning Launchpad content.

CAPABILITY

Promote personal responsibility: GREEN/AMBER

On track overall, however there is a **Red status against increasing Apprenticeship provision**, due to inability to draw down previously secured funding (income), the financial implications of which have been highlighted. These financial implications have been partially mitigated by residual funding.

Digital

The Digital portfolio is monitored through a local Directorate Plan, with actions aligned to IMTP Objectives. The Directorate Plan has been reviewed and updates provided by exception:

National Data Resource Programme Support: GREEN/AMBER

All planned activities are complete, however longer-term funding has not been agreed.

Upgrade 999 Telephony Platform: AMBER

Supplier on site (Q3) SAT Testing. Delivery planned October/November 2023.
User interface remains relatively the same. Go Live planned Q4 February 2024.

Digital Experience of Staff: GREEN /AMBER

High Level Market engagement ongoing. Current risks around Cost/Funding to be agreed. Security risks to be mitigated against.

Operations Communication Programme: GREEN

The MDVS project has begun deployment of the replacement technology into the WAST operational fleet (EMS), as of W/C 18.12.2023 176 vehicles have been installed with 1420 staff trained and self-certified. The NEPTS NMA application development has slipped by c7 weeks with live pilots now scheduled to begin W/C 05.02.2024.

Fundamentals

These portfolios are monitored through a local Directorate Plan, with actions aligned to IMTP Objectives. Directorate Plans have been reviewed and updates provided by exception:

Risk Management: GREEN / NOT STARTED

Risk Management Framework in draft – due for approval at Audit Committee March 2024

Welsh Language Policy: GREEN/AMBER

Policy is in draft and on track for approval in 2024, however the policy continues to require regular revisions to incorporate new Welsh Government elements. More than Just Words Year 1 Report submitted to Welsh Government, and Year 2 looks to conduct a Welsh language skills gap analysis as part of strategic workforce development plan. The Annual Report regarding Delivery of the Welsh language Standards completed and Approved at Trust Board 28/09/2023, and a monitoring process to gauge compliance is now being developed. WAST Trust Policy on use of Welsh Language in draft – due for approval in 2024. New translator commenced August

2023 and translation service currently in soft launch phase with an expected hard launch during January 2024.

Quality Management System Implementation: AMBER
Quality Management Group regular meetings being held. (meeting 4 to date).
TOR approved. QPMF Self-Assessment pilots concluded - end of Q3.
Review of ISO standards 9001:2015 completed to support development of robust QMS.
Presentation to ADLT provided, 6th December. Risk to delivery remains dependant on QMF functioning with Ops engagement/risk capacity to attend. Ops have since engaged risk reduced to low.
Duty of Quality page updated with links and communications strategy drafted to launch DoQ e-learning across organisation. Training needs analysis completed collaboratively to develop packages for supervisory/leadership roles. MIQPR now available via SIREN Sharepoint as first phase of Always on reporting.
QPMF now available via SIREN Sharepoint to support development of local QMS Frameworks.
Website presence for Duty of Quality now complete (bilingual) to provide point of presence for future Annual reporting externally.

Ministerial Priorities

Appendix 1 sets out an assessment of our progress against Ministerial Priorities for 2023/24 that are relevant to WAST.

REPORT APPROVAL ROUTE

ELT 03.01.2024

REPORT APPENDICES

Appendix 1 – SBAR Assessment of progress against ministerial priorities
Appendix 2 – 1501 – IMTP Delivery Assurance Report Jan24
Appendix 3 – Strategy Development Highlight Report (27-11-23)

REPORT CHECKLIST

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

Appendix 1- Assessment of progress against ministerial priorities

Situation

1. The purpose of Appendix 1 is to set out an assessment of delivery against the Welsh Government (WG) accountability conditions that accompanied approval of the WAST IMTP, with particular attention to delivery against Ministerial Priorities.

Background

2. WAST submitted its last IMTP (2023-26) to WG on 31st March 2023 following Board approval. Welsh Government recently approved WAST's IMTP on 12th September 2023. Following approval the Director General issued accountability conditions on which our approval is based on 2nd October 2023 as follows:

   - Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximise its improvement trajectory and develop robust mitigating actions to manage financial risks.
   - Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.
   - Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.
   - Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.

   These four financial areas will be monitored by the NHS Executive, Financial Planning and Delivery Team on a quarterly basis, and assurance on our financial position is provided to the Committee and the Board through the finance reports on these agenda. There was also a paper regarding Value Based Health Care on the Finance and Performance Committee agenda which provided assurance on our progress in this area. This paper therefore will focus on delivery against ministerial priorities.

3. Despite financial challenges for NHS Wales, WAST is expected by WG to deliver its commitments in its IMTP, particularly against the ministerial priorities that are relevant to WAST. Furthermore, it is expected that the Board scrutinises the IMTP and ensures that progress is monitored effectively over the forthcoming year, in particular against the Ministerial priority templates that were submitted (these are summarised below in the table at paragraph 5).

4. WAST is also required to refresh its Minimum Data Set (MDS) on a quarterly basis as part of its internal review of plans. The requirements of paragraph 3 and 4 are monitored by the Health and Social Services Group Planning Team. Further risks are communicated to WG through IQPD meetings and JET.

Assessment

5. The assessment against ministerial priorities is as follows:

Priority	**Milestones Q3**	**Progress**
Primary care access to services: Improved access to dental services	• Roll-out of the 111 service to patients with urgent dental care needs across Wales – likely to be phased rollout and timescales to be determined with 111 Board (therefore Q3 as a place marker at this stage)	Plan to pilot an Urgent Dental Line in Betsi Cadwalader in Q4 however due to technical issues actions relating to urgent dental will need to rollover into the 2024-27 IMTP.
Urgent & Emergency care: Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales to support improved access and GMS sustainability (aligned to Goals 1, 2 &3)	• Increase the capacity and capability of the clinical teams • Voluntary fixed rosters, improved recruitment of new call handlers	We are meeting IMTP requirements that we set ourselves around clinical capacity and capability, however it should be noted across all work in 111 that the focus in Q4 will need to be on CAS implementation, which will draw resources from our clinical team. Recruitment to call handler posts is now BAU in terms of process. However discussions ongoing about the level of both clinical and call handler capacity, the number for which have been adjusted by the commissioner within the resource envelope available. This will form part of the remit of the new commissioning arrangements in 2024/25 and WAST would hope for some stability in the resource envelope whilst allowing for support and clinical leadership roles to be developed. Fixed rosters continue to be rolled out but a formal roster review on hold There continues to be work on pathway development

Priority	Milestones Q3	Progress
		including into Urgent Primary Care Centres and Palliative Care.
Urgent & Emergency care: Implementation of Same Day Emergency Care services that complies with the following:	• Growth in SDEC referrals locally	An action for Q3 was to consider 111 referrals through ICAPs. However, at this stage focus for SDEC referrals has been on growth in community referrals from EMS. This remains challenging. Conveyance to an SDEC unit throughout Wales has remained consistent with a 12 Month average of 0.16%. However, December 2023 conveyance rates dropped by 0.3% compared to December 2023 (0.15%), despite a modelled potential of 4% of incidents that could be suitable for SDEC. WAST clinical colleagues continue to work with WG, Health Boards and the Six Goals programme teams to develop and open up the pathways into SDEC as a priority for WG and the minister.
Urgent & Emergency care: Health boards must honour commitments that have been made to reduce handover waits *(NB whilst our actions and milestones for handover are reliant on a system co-ordinated response, we put forward a set of actions and milestones for ways in which*	Generally, handover is still extreme as set out in the MIQPR. Ongoing work with Health Boards at all levels to reduce handover delays, this report sets out two specific milestones set out at the beginning of the year. • Expansion of Falls and Frailty Services	Falls modelling v1 provided and evaluated, model to be re-run with different parameters. Currently 1x L1

Priority	Milestones Q3	Progress
WAST can support people more effectively outside of hospital)	• Proposal re labour line to HBs and WG	commissioned by WAST for BCU, however demand spread across 3 localities with reduced ability to cover Northwest. Engaging with HB regarding direct commissioning for SJAC response, with continuation of WAST operational support. This presents an opportunity to address gap in L1 dedicated provision in Anglesey and Gwynedd and regional night-time provision. Funding has been made available by Gwent RPB for expansion of level 2 Falls services. Scoping is complete and we are awaiting a decision on priorities for phase two of the MatNeoSSP and secondment of MatNeo champion beyond March 2024. In the meantime there continues to be implementation of improved guidance, training and Learning and Development which includes updated JRCALC guidance and training in relation to breech birth.
Cancer recovery: NEPTS oncology performance	• No Q3 milestones for NEPTS and Ambulance Care against this priority – however there is an action to work with health boards on the development of an enhanced hub, merging the renal hub with oncology call handling	The work to develop an enhanced hub is ongoing for delivery in Q4 in line with the Q4 milestones in our plan

Priority	Milestones Q3	Progress
Mental health and CAMHS	• No specific milestones for WAST in Q3	Whilst there were no specific milestones set out in our Ministerial Templates, there is a commitment within WAST to continue to improve Mental Health response and funding has been received through Gwent RPB to trial a Mental Health Response Vehicle. There are some capacity issues to navigate in terms of availability of Mental Health practitioners to support the variety of requirements across the spectrum of mental health services. However, a plan has been developed with Aneurin Bevan to take this pilot forward, giving valuable learning as we develop our next IMTP.

Recommendation

6. The Committee is asked to:

    - Note the contents of this paper and the update against the ministerial priorities that are relevant to WAST

Welsh Ambulance Services NHS Trust

IMTP Delivery – Q3/Q4 Assurance Report

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

IMTP Delivery – IMTP Delivery Assurance Report
Version 1.0
Released: December 2023

by Transformation Support Office

IMTP Delivery Programmes

- EMS Operations
- Ambulance Care
- Gateway to Care
- Clinical Transformation
- Financial Sustainability
- IMTP Enablers & Fundamentals

Use hyperlinked section headers to navigate to each section

Use the arrows to progress through the report

EMS Operations Programme

Hugh Bennett

EMS Operations Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Hugh Bennett
Dec-23	Amber	Amber	For Noting	Business Partner:	-
				Project Manager:	Richard Baxter

Objectives	Current Position	RAG	Work to be completed
EMS Response Roster Review	**Complete part 1 evaluation:** Draft of the evaluation has been written. Final review at the Roster Review Project Team meeting in January 2023.	G	1. Take to EMS Operational Programme Board on 2nd February 2024 for approval. 2. Take to STB in February 2024.
	Rightsizing following roster changes: Run a temporary relief gap as agreed by WAST CEO and Trade Union Partners. WAST CEO in the process of writing to the Chief Ambulance Services Commissioner on the numbers and unit hours production.	R	Agree the particulars on running a temporary relief gap.
EMSC Reconfiguration Project	**EMSC Roster Review Workstream:** A new EMS Coordination structure papers was presented in late November to SLT, with a number of minor amendments / additions required to finalise the paper. In the weeks following the original paper a number of further developments came through that identified a potential source of funding that would need to be added to the paper, including some additional funding for EMSC. Further discussion took place and as a result a final paper will be presented to Formal SLT on Tuesday 9th January 2024, which will then be included in an update to ELT. In advance of that paper TU partners will be consulted on the final proposal before it goes into SLT. It is hoped that the proposed structure will provide the necessary infrastructure to support EMSC for the longer term.	A	It is also envisaged that in the weeks following the SLT meeting on the 9th January that we will be in a position to resume the Project Board and Working groups on the key elements such as Organisation Change Policy will commence, and consultation will take place.
	Broader Ways of Working Workstream: A new EMS Coordination structure papers was presented in late November to SLT, with a number of minor amendments / additions required to finalise the paper. In the weeks following the original paper a number of further developments came through that identified a potential source of funding that would need to be added to the paper, including some additional funding for EMSC. Further discussion took place and as a result a final paper will be presented to Formal SLT on Tuesday 9th January 2024, which will then be included in an update to ELT. In advance of that paper TU partners will be consulted on the final proposal before it goes into SLT. It is hoped that the proposed structure will provide the necessary infrastructure to support EMSC for the longer term.	A	It is also envisaged that in the weeks following the SLT meeting on the 9th January that we will be in a position to resume the Project Board and Working groups on the key elements such as Organisation Change Policy will commence, and consultation will take place.
	Boundary Changes Workstream: A new EMS Coordination structure papers was presented in late November to SLT, with a number of minor amendments / additions required to finalise the paper. In the weeks following the original paper a number of further developments came through that identified a potential source of funding that would need to be added to the paper, including some additional funding for EMSC. Further discussion took place and as a result a final paper will be presented to Formal SLT on Tuesday 9th January 2024, which will then be included in an update to ELT. In advance of that paper TU partners will be consulted on the final proposal before it goes into SLT. It is hoped that the proposed structure will provide the necessary infrastructure to support EMSC for the longer term.	A	It is also envisaged that in the weeks following the SLT meeting on the 9th January that we will be in a position to resume the Project Board and Working groups on the key elements such as Organisation Change Policy will commence, and consultation will take place.
Cymru High Acuity Response Unit (CHARU) Workstream	Target 153 with 101.7 staff in post including 12.69 WTE SP contribution. Vacancy rate at 38.61 FTEs. Recruitment advert to go out again at the end of December. Recognising concerns regarding utilisation versus what was modelled by ORH. CHARU T&F investigating including feedback from CHARU Paramedics. There does appear to be an issue being sort including looking at dispatch criteria.	A	Continue to recruitment to target. Expected completion date Q1 24/25. Review utilisation levels verses modelling

Ambulance Care Programme

Mark Harris

Programme Summary Q3

Report Month:	Current RAG	Previous RAG		
Dec-23	Amber	Amber	SRO:	Mark Harris

Objective	Q1	Q2	Q3	Q4	RAG	Latest Update
NEPTS Roster Project (MH)					P	
Implement the new roster pan Wales (NEPTS)					P	• Paused, no funding to support
NET Centre Project - AO					A	
Seek funding for 12 FTEs for planning and day control as per the NEPTS D&C					P	• No funding identified, hold
Re Roster NET Centre (c/f from 22/23)					A	• Work has commenced to align resources and shift patterns.
Urgent Care Transformation – MH					A	• Updated RAG status
Complete the UCS demand and capacity review					C	
Review the recommendations from the D&C review					A	• Approved by EMT 13/12/23. ITPG commence planning & Implementation.
Develop a transformation plan for UCS					A	• Currently working on developing the details.
Transfer & Discharge - AC					A	
Understand commissioning response to proposed high level concept on All Wales T&D Model					A	• Working on final options. Further discussions with commissioners
Review modelling of transfer demand to determine scope of any business case					A	• Final options being taken to STB in Quarter 4
Work collaboratively with NCCU on any business case					NS	• Delayed awaiting final report.
Develop an implementation plan (subject to commissioning)					NS	
Transport Solutions – MH (Interim pending new Head of Service for Ambulance Care Co-ordination)					A	
Implement refreshed performance parameters that focus on improving patient and customer experience					G	• Developed implementation plan and actions underway
Revising and implementing the new eligibility criteria (subject to further dialogue with Commissioners & WG)					R	• Been to CCQG, EMT and QuEST.
NEPTS Plurality Model – AE (Interim)					A	• Update overall RAG to Amber
Continue to drive forward the Quality Assurance agenda					A	• Proposal approved by SLT 12.12.23.Present to CQGCX on 24.01.24
Identify opportunities to expand use of the ambulance car service					A	• Opportunities sought, none identified.
CAD – AE (Interim)					A	
Establish cross Organisational project to consider the requirements of systems to support service delivery for patients					A	• Meeting on 18.12.2023 with Heads of Service EMSC and 111.
Completion of BJC for a new CAD system					G	
NEPTS Operational Improvement - KH					A	
Review resource downtime (previously referred to as post-production lost hours)					C	
Work with a local hospital to maximise the usage of the discharge lounge, to reduce cancellations.					A	• Engagement with CTMUHB to improve flow.
Finalise the National Standardised guidance and risk assessments.					C	
Continue to roll out the refresh of the ambulance care fleet mix					G	• Ford Customs data to be reviewed.

NEPTS Roster Project

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
Dec 23	Paused	Paused	Note the issues	SRO:	Mark Harris
				Project Lead:	

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Implement the new NEPTS roster pan Wales enabling the service to better match demand		P	• Explored an opportunity around funding for the roster keys to recommence this work. Following review, it was felt there was little value on refreshing the roster keys due to the spend required and the commitment to deliver. Funding bid was submitted and if approved with an ask of it would have been a commitment into 2024/25. At present the organisation cannot support this commitment due to the current financial position.	• To review in the Q4 to see about opportunities on accessing any finances at year end due to underspend. • To review again once in new financial year.

Key Decisions	Issues	Risks
	• Lack of funding to support implementation • Paper submitted to SLT regarding additional funding requirement, decision made by SLT to pause until funding available to support.	

NET Centre Project

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
DEC-23	Amber	Amber	For Noting	SRO:	Mark Harris
				Project Lead:	Anita Owen

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Seek funding for 12 FTE for planning and day control as per the NEPTS D&C	• Raise with commissioners	P	• Commissioners indicated no funding available	
Re roster NET Centre	• Relief capacity establishment to be completed by end of November 2023.	A	• Explored additional funding opportunities and submitted a bid for a refresh of the original keys. However, due to an ongoing commitment for £100k+ next year if we proceeded with the refresh, funding approval was not provided. • Work has commenced to align resources and shift patterns following Optima modelling. • Working groups have been set up. Core Principles have been drafted and awaiting sign off. • Expressions of interest have been sent out to Service Managers for inclusion onto regional and national workshops. • New roster for Team Leaders has been created and begun to be implemented.	• Set up staff surgeries to allow staff the option to discuss and raise questions or issues. • Implementation of new rosters for NETS Centre

Key Decisions	Issues	Risks
	• No funding available to support 12FTE for planning & day control as per NEPTS D&C	

Urgent Care Transformation

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
DEC-23	Amber	Green	• Note progress and update RAG status.	SRO:	Mark Harris
				Project Lead:	

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Complete the UCS demand and capacity review	***(C/F from Q1)*** • Final version of report to be completed. • UCS Steering Group to consider the final report	C	• Completed the review and presented to UCS Steering Group, agreed preferred future direction • Agreed that ITPG will be the group to oversee the delivery of the recommendations • Engaged with senior TU reps on proposals	• Comms and engagement with staff on the final outcome
Review the recommendations from the D&C review	• To gang corporate approval to proceed with professional outcomes. • Finalise Transformation Plan	A	• Presented to EMT on 13th December and approval provided for ITPG to commence detailed planning and implementation.	• Review outcomes form EMT. • Finalise Transformation Plan.
Develop a transformation plan for UCS **(Q3)**	• To develop the detail around the action required.	A	• Currently working developing the details.	• To have developed the details to deliver the actions required.

Key Decisions	Issues	Risks
		• Ongoing delays regarding corporate approval

Transfer & Discharge

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
Dec-23	Amber	Amber	Note reprofile due to an ask for ORH to do a further review.	SRO:	Alex Crawford
				Project Lead:	Deb Kingsbury

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Understand the commissioning response to the proposed high-level concept of the All Wales T&D Model	• Continued liaison with Commissioners on commissioning position	A	• Working on final options for further discussion with Commissioners.	• Liaise with Commissioners and agenda for future meeting.
Review modelling of transfer demand to determine scope of any business case	• Finalise ORH report and finalise options with associated costs • Share with Executives	A	• Final options being taken to Strategic Transformation Board (STB) in Quarter 4.	• Finalise options for consideration at Transfer and Discharge, Ambulance Care Transformation Programme Board and Strategic Transformation Board.
Work collaboratively with the NCCU on development of a business case	• Need to understand from Commissioners perspective post EASC Management Group and NEPTS DAG.	NS		
Develop a plan for Implementation – fleet, workforce, estates, clinical etc dependent on outcome of the business case		NS		
Develop interim plans to support system/ strategic service changes prior to commissioning of All Wales Service	• Final Implementation Plan for MTPS, roll out with internal and external partners. • Engaging with Health Board transport groups. • Review the project structure and phasing to focus on delivery of interim improvements	A	• Implementation plan in draft. • ACCTS session taken place. • Medications and Equipment session completed. • Project Structure approved. • Review MTPS status and priority codes completed • Dispatch cross reference completed.	• Training Plan • Implementation Plan – During Quarter 4.

Key Decisions	Issues	Risks
		• Capacity to deliver MTPS in EMSCC due to competing priorities

NEPTS Plurality Model

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
Dec-23	Amber	Green	For noting	SRO:	Mark Harris
				Project Lead:	Aaron Evans (interim)

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Continue to drive forward the Quality Assurance agenda	• Finalise the dashboard to award the Third Q and for the dashboard to be signed off. • Hold engagement sessions with providers around the third Q.	A	• WAST Quality team have prepared the reviewed dashboard. • 100% of PAS providers have attended the engagement sessions and have been afford the opportunity to give feedback. • Duty of Quality Standards- SBAR Completed • Proposal approved by SLT on 12/12/23. To be presented to CQGG on 24/01/2024.	• SBAR to be taken via Senior Operations Team (SOT) then Operations Senior Leadership Team (SLT) • Proposed roll out of for Quarter 4.

Key Decisions	Issues	Risks

Transport Solutions

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
Dec 23	Amber	Green	For noting	SRO:	Mark Harris
				Project Lead:	

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Implement refreshed performance parameters that focus on improving patient and customer experience	• Embed through the development of an implementation plan against themes identified	G	• Developed implementation plan and actions underway	• Completion of implementation plan
Revising and implementing the new eligibility criteria (subject to further dialogue with Commissioners & WG)	• Engage with Llais • Complete impact assessment • Agreement from EMT to progress • Active by end of Q2	R	• Has been taken to CCQG, EMT, QuEST 31/10/2023	• Formal engagement with patient reps required

Key Decisions	Issues	Risks

New CAD

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
Dec 23	Amber	Amber	Escalate issue for organisational discussion regarding CADs	**SRO:**	Mark Harris
				Project Lead:	Aaron Evans

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Establish cross organisational project to consider the requirements of systems to support service delivery for patients	***(C/F from Q1)***	**A**	• Meeting arrange 18th December with Head of Service for EMSC and 22nd with Head of Service for 111.	
Completion of BJC for a new CAD system **(Q3)**				
Continued development of existing cleric system	***Cleric Online user report set up – allows configuration to target area, mobility groups, online user name so on. Report can be used to target quality checks on bookings made via online. Further projects to improve system identified thought Ambulance Care Workshop.***	**G**	• Started Work on Further Developments identified from Ambulance Care workshop. Meeting Set up with Cleric 15/12/2023 to run through the priority list.	•Identify projects from the list and to start development in priority order.

Key Decisions	Issues	Risks
	• Procurement for both CADs – how do we align across organisation?	

Opportunities for Ambulance Car Service

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
Dec-23	Amber	N/A	For noting only.	SRO:	Mark Harris
				Project Lead:	Karl Hughes

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Identify opportunities to expand the use of the ambulance car service (local and wider are vehicles)	***(C/F from Q1)*** •Share at senior ops meeting, agenda.	A	• Ambulance Car Service -business case and evaluation completed and benefits identified along with optimal deployment opportunity. Service delivery team will continue to look for opportunities to utilise. As no longer a transformation action, recommend closure of action.	

Key Decisions	Issues	Risks
• Closed action and transfer to business as usual.		

NEPTS Operational Improvement

Report Month:	Current RAG	Previous RAG	Ask from ACT Programme Board		
Dec-23	Amber	Green	Change request regarding the B-class vehicle review move to end of Q4	SRO:	Mark Harris
				Project Lead:	Karl Hughes

Objective	Q3 Milestone	RAG	Updated Position	Work to be Completed Next Period
Work with local hospital to maximise the usage of the discharge lounge, to reduce cancellations	***C/F from Q1***	A	• WAST currently engaged with CTMUHB regarding improving flow. Will be discussing the opportunity to trial at this Health Board.	• Agree to trial in CTMUHB and identify specific sites for a trial.
Continue to roll out the refresh of the ambulance care fleet mix	Embed B class vehicles in to operations and commence reviews. Review Customs feedback survey and feed into replacement schedule, vehicle amendments.	G	• Ford Customs data has now been reviewed. • Final and approved by the FSDG Business Case Submission.	• Review the B-class vehicle once in service, same user audit tool used for ford custom. Mid Quarter 4. • Evaluation B-Class and feedback to be collated and feedback to into FSDG and Ambulance Care Senior Team. This will determine suitability/future requirements. • Once review is completed, results to be considered and recommendations submitted through the appropriate governance route • Decision to continue with the Ford Custom to be finalised.

Key Decisions	Issues	Risks

Gateway to Care Programme

Rachel Marsh

Gateway to Care Programme Summary

Objectives	Milestone Status Q1	Q2	Q3	Q4	Current Position
Deliver a safe and high quality service, providing an excellent patient experience					
Re-roster call handlers and clinicians	G	G/A	P		Paused Pending funding - progress paused - project still very much required
Develop clinically confident and competent workforce	G	G			Elements of project on hold due to SALUS
Access to high quality remote clinical assessment					
Identify opportunities to increase consult & close rates from the 999's	G	G	A/R		60% of consult and close action plan delivered Will not reach 17% due to multiple issues: 1. Resourcing 2. Telephony reporting (Lack Off) - Potentially feb 24 (Delayed once already) 3. High triage durations
Develop a clinical specialty educational and career framework for Remote Clinical Decision-making (RCDM)	G	G	A		- Awaiting an update on the WAST apprenticeship - Led by People and culture team - Work still to start on the newly qualified nurse option - 'What does this look like' - Advance Practice Education – 111 & CSD Group established and required to review use of additional skill set, role design advance Practitioner B7, and HR aspect. Next steps currently being mapped out, JDs in draft and review of structures for these new roles in review.
Develop a remote clinical support strategy	G	G	C		Closure report accepted at G2C
Seamless transfer of callers to further specialists or face to face assessment					
Implement 999 Triage system Emergency Communication Nurse System (ECNS)	A	A	A		Text and email functionality outstanding; meeting w/c 03/07 to scope options for email functionality and share API with Supplier. Awaiting quote for configuration. Benefits realisation to be commenced prior to delivery of text/email functionality in response to the recommendations from the recent NCCU review of the CSD. SC and HH to meet w/c 02/10 to discuss.
Implement the new 111 system; SALUS	A	A/R	P		Scoping exercise complete to determine different approaches and system options to replace CAS in the absence of SALUS being ready. Review and scoring matrix conducted which has provided a recommended way forward. Review underway of procurement options.
Develop and expand direct booking and pathway opportunities within CSD and 111	G	G	G		Pause on pilot due to some changes to the model - looking to commence Dec/Jan Direct booking into UPCC's trial due to start December in Cardiff - agreement to expand into BCU. January for HD. Agreed UPCC's are more suitable for 111 patients then SDEC. Funding has been agreed to continue 111 press 2, awaiting on Capita to complete model.
Increasing numbers using digital frontend to meet patient's routine and urgent care needs / More people accessing 111 as their preferred port of call to meet their healthcare needs					
Deliver an improved Directory of Services	A	G	P		No Current funding continuing conversations with 6 GOALS team.
Improve 111.Wales website, and enable better digital self-service	A	A	P		Ongoing resource envelope discussions with 111 commissioners.
Standardise information architecture and common approach to data and analytics					
Develop a data dashboard for G2C/Power Bi reporting to drive decision making through data and analytics	A	A	A		Digital team working through backlog of dashboard requests so an interim solution may be required using reports available through the MIQPR which is currently being developed.

Slide 1 of 3 – Next Slide

Gateway to Care Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh
Nov-24	Green/Amber	New FY23/24 Reporting Cycle	For noting.	Business Partner:	Kelsey Rees-Dykes
				Project Manager:	Lydia Hutton

Objectives	Upcoming Key Milestones	RAG	Current Position
Deliver a safe and high-quality service, providing an excellent patient experience	**Re-roster for 111:** 1. Update procurement framework	A	Procurement scoring was complete – however funding is now on pause - Stephen James drafting paper for 6 goals to secure funding.
	Clinically confident and competent workforce: 1. Redesign of the call review audit tool trial to be completed (Aug-23) 2. Clinical Supervision for staff policy to be signed off 3. Discussions to take place with CAPITA on SALUS quality dashboard for managing call quality indicators 4. 6-monthly shift model to commence (Sep-23)	G	Conduct multidisciplinary team (MDT) styled tabletop exercise, along with tabletop evaluations and dashboard reporting indicators has been delayed due to SALUS. 6 monthly shift model for clinicians observing clinical areas outside of their own speciality to start in Sept once SBAR and recommendations signed off.
Access to high quality remote clinical assessment	**Increase consult & close rates from the 9's:** 1. Explore more patient pathways to increase opportunities for patient flow following CSD telephone triage 2. Review success rate of 999 call types (MPDS codes) and propose codes for most successful conversion 3. Improve effectiveness of triages carried out in CSD through practice education support and learning	G/A	A 30-action draft plan is in development to support the 17% target. Action plan agreed and implemented - Operations leadership team review on a weekly basis. 50% delivered
	Develop a clinical specialty educational and career framework for Remote Clinical Decision-making (RCDM) 1. Collate survey results (Sep-23) 2. Circulate survey results for discussion and feedback (Sep-23)	G	Funding agreed to support integrated care clinicians to undertake bridging modules to bring their education level up to the required level for stepping onto Masters level courses.
	Develop with commissioners a remote clinical support strategy 1. Strategy document and Closure report to be approved	G	Strategy document and Closure report have been tabled for discussion at the next G2C Board in Sep-23. Agreed to close.

Gateway to Care Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh
Nov-24	Green/Amber	New FY23/24 Reporting Cycle	Note the risk around SALUS delivery; delays in completion of UAT presents further barriers to WAST training in preparation for go-live.	Business Partner:	Kelsey Rees-Dykes
				Project Manager:	Lydia Hutton

Objectives	Upcoming Key Milestones	RAG	Current Position
Seamless transfer of callers to further specialists or face to face assessment	**Implement 999 Triage system Emergency Communication Nurse System (ECNS):** 1. Quote from Supplier for text and email integration 2. Plan and timescales for implementation	G/A	Text/email functionality - potential solution identified for testing and WAST ICT are configuring a unique SMS presentation ID (Alpha Sender). Once complete, testing will be arranged with the Supplier.
	Implement the new 111 system; SALUS 1. Continued development of the core operating solution along with delivery of supporting Programme Workstreams	R	Working group set up to look at potential systems to take us beyond CAS provider. Tender process on going.
	Develop and expand direct booking and pathway opportunities within CSD and 111 1. SDEC PID to be finalised 2. Dental PID to be signed off 3. Palliative care evaluation to be finalised	G	SDEC to be potential offer in ICAPs;. Pan-Wales urgent Dental pathway being piloted in two health boards. Palliative Care patient trial of silent press 0 option implemented and evaluation underway.
Increasing numbers using digital frontend to meet patient's routine and urgent care needs & More people accessing 111 as their preferred port of call to meet their healthcare needs	**Deliver an improved Directory of Services:** 1. Funding options to be explored for National DOS	G	Potential for funding through the Further Faster Programme. WAST & DHCW are engaging with 6 Goals team.
	Improve 111.Wales website, and enable better digital self-service: 1. Funding to be secured for updating legacy content management system	A	Ongoing resource envelope discussions with 111 commissioners
Standardise information architecture and common approach to data and analytics	**Develop a data dashboard for G2C/Power Bi reporting which drives decision making through data and analytics** 1. Explore potential for G2C data dashboard	G	Digital team is currently working through backlog of dashboard requests so an interim solution may be required using reports available through the MIQPR which is currently being developed.

Clinical Transformation Programme

Brendan Lloyd

Programme Summary

IMTP Objectives	Milestone Status				Position
	Q1	Q2	Q3	Q4	
Optimising Care Group – Advanced Clinical Practice					
Evaluate the APP Navigator and if appropriate look to expand via a spread and scale	A	G	G		
Review the APP dispatch criteria to maximise skillset to patient need	G	G	G		
Develop WAST Principles of Advanced Practice document	G	R	G		**RISK:** Note capacity for clinical supervision infrastructure
Evaluate the impact of the Independent Prescribing programme	R	R	R		As above
Optimising Care Group – Optimising Conveyance					
Deliver the WAST clinical elements of the 6 Goals	G	A	Paused		BCU proposed revisions to the operational scope could render the model inviable for WAST
Digitalisation of current and future pathways and referrals	R	G	G		**RISK**: Not all primary care has current and monitored email address or digital pathway infrastructure.
Develop Pre-Dispatch Outcome Risk Stratification Tools linking CAD & ePCR data	R	G	G		
Clinical Intelligence Assurance Group					
Deliver Clinical Indicator Plan and design a suite of future Clinical Indicators	A	G	G		
Older Persons & Falls					
Evaluate Powys Care Home PDSA and consider opportunities for spread and scale	A	G	G		
Expand the Falls & Frailty Response (inc. Level 1 and 2) across Wales	R	A	G		
Mental Health & Dementia					
Pilot use of Mental Health Response Vehicles	G	A	G		
Evaluate impact of Mental Health Practitioners in CSD	G	G	G		
Establishing optimal configuration for dementia friendly ambulance environments	G	G	A		Some slippage in evaluation, should be completed in Q4
Connecting Support Cymru					
CSC Project Scoping and Development	N/A	A	G		
CSC Volunteer Scoping and Development	N/A	G	G		**ISSUE:** Pilot; capacity within CSD & EMSC and impact on performance
Deliver 'testing' phase of the Small Business Research Initiative	N/A	A	G		Challenging timescales to evaluate applications

Optimising Care Group

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Dec 23	Green/Amber	Amber	To note the risk around Clinical Supervision capacity. Multifaceted barrier to upscaling of APP workforce and extension of APP scope of practice.	Business Partner:	Deborah Kingsbury
				Project Manager:	Richard Ashby

Objectives	Q3 Key Milestones	RAG	Current Position
Optimising Care Group – Advanced Clinical Practice	**Evaluate APP Navigator:** 1. Evaluate Phase 1 App Navigator pilot 2. Undertake Phase 2	G	ACPDG established and APP Navigator Pilot included as standard agenda item to maintain focus and momentum. HDUHB phase 2 pilot on-going scheduled to be finished by 31/12.
	Review the APP dispatch criteria (APP Perfect Day PDSAs): 1. Complete PDSA1 Evaluation Report 2. Undertake PDSA2 and evaluate 3. Commence planning for PDSA3	G	PDSA2 evaluation completed. PDSA3 completed 05/10. PDSA3 initial evaluation to be completed and then presented to ACPDG (05/12) and OCG (11/12). PDSA4 planning discussed, is dependant on outcomes from CSD Early Clinical Screening TOC and PDSA. Aiming for Q4.
	Develop WAST Principles of Advanced Practice: 1. Approval for the Clinical Supervision Policy 2. Commence writing the Principles of Advanced Practice document	G	Clinical Supervision Policy to be presented at QUEST in Feb 2024. Workplan is in development to implement the Policy during Q4, however there is no current implementation plan for the Clinical Supervision Plan.
	Evaluate Independent Prescribing Programme: 1. OCG will identify a solution to Independent Prescribing training challenges	R	HEIW generic job description published - workforce review being undertaken.
Optimising Care Group – Optimising Conveyance	**Deliver WAST clinical elements of 6 Goals:** 1. Engage with BCU on PTAS/SICAT	P	PID developed for BCU pathway pilot providing an ED alternative for Code 6 (Breathing) and Code 10 (Chest Pain). BCU proposed revisions to the operational scope are being considered but could present a barrier to the pilot. BCU discussions on hold.
	Digitalisation of current and future pathways and referrals: 1. Deliver automated non-injured falls pathway in ePCR 2. Work with primary care to implement resolved epilepsy and hypoglycemia pathways	G	Non-injured falls pathway still under-going further testing as issues with Local Government boundaries for automated system. New TerraPACE app and portal update (04/12)-updated WAST Pathways module to allow fully automated referrals. To work with nominated GP lead to develop information requirements for Primary Care.
	Develop Pre-Dispatch Outcome Risk Stratification Tools: 1. Set clinical criteria for Code 6 (Breathing), Code 10 (Chest Pain), and Code 28 (Stroke)	G	High Risk Marker Power BI dashboard now in operation. Clinical criteria for rest of Amber 1 call stack to be determined once sufficient amount of data collected for each code set. Review codes and level of EA response once sufficient ePCR data collected and reviewed.

Clinical Intelligence Assurance Group

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Dec 23	Green	Amber	To note the risk around Clinical Supervision capacity. Multifaceted barrier to upscaling of APP workforce and extension of APP scope of practice.	Business Partner:	Deborah Kingsbury
				Project Manager:	Richard Ashby

Objectives	Q3 Key Milestones	RAG	Current Position
CIAG	**Data & Analytics Development** 1. Appoint Principle Clinical Information Officer 2. Develop criteria for 3 clinical indicators	G	3 indicators identified and work commenced; older fallers, paediatric trauma/pain management being scoped, APP practice (condition specific) initial meeting planned. All 2 indicators now agreed. Stroke & STEMI metric agreed and now reported
	Develop & Deliver existing Clinical Audit Plan	C	Note milestone closed, as BAU. Overall CIAG deliverable Green
	Deliver PowerBI Dashboard	G	CI dashboard operational, work underway on version 2. Version 2 progressing slowly, aim to be delivered by end of Q3 HRM dashboard now operational.

Mental Health and Falls

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Dec 23	Green	Amber	To note the risk around Clinical Supervision capacity. Multifaceted barrier to upscaling of APP workforce and extension of APP scope of practice.	Business Partner:	Deborah Kingsbury
				Project Manager:	Richard Ashby

Objectives	Q3 Key Milestones	RAG	Current Position
Mental Health & Dementia	**Pilot Mental Health Response Vehicles:** 1. Develop protocol for MHRV pilot 2. Gain HB commitment to deliver collaborative pilot(s)	G	Protocol completed. Funding for ABUHB pilot to run Nov/Dec until end Mar 24. Staffing challenges in ABUHB delayed go live, working with ABUHB on joint solution to go live during Jan 24, final date to be confirmed
	Evaluate impact of Mental Health Practitioners in CSD: 1. Build Mental Health dashboard with HI 2. Build and implement ECNS Mental Health assessment algorithm	G	Dashboard has been finalised and is on the list of works waiting to be completed by HI. MHP Performance Report has been completed. ECNS algorithm has been agreed internally and externally – to be discussed at SOT & CQGG. In discussion with ops to implement
	Explore Dementia friendly ambulance environnements: 1. Complete Phase 1 Pilot: Reminiscence/Rehabilitation & Interactive Therapy Activities (RITA) and evaluate 2. Commence Phase 2: Ambulance Environment	A	Evaluation expected in January 2024. There has been partnership working with Cardiff & Vale HB to explore ED dementia admissions to improvements to the handovers, training and environments.
Older Persons & Falls	**Evaluate Powys Care Home PDSA and explore spread and scale:** 1. Complete Powys PDSA evaluation and present to OCG 2. Undertake Swansea Bay iStumble pilot and complete evaluation	G	Evaluation being undertaken and when completed to be presented to OCG. Planned to be completed by Q4 due to the low numbers of clients involved.
	Expand Falls and Frailty response across Wales: 1. Undertake forecast modelling for system-wide response 2. Engage with BCU re: L1 and L2 commissioned service 3. Complete Community Falls Pathway Referral Rate Audit	G	Modelling v1 provided and evaluated, model to be re-run with different parameters - awaiting report back from Optima (12/23). Engagement through Associate Director for Emergency Care and USC Programme Director - Transformation and Improvement to explore L1 commissioning arrangements. Currently 1x L1 commissioned by WAST, however demand spread across 3 localities with reduced ability to cover Northwest. Engaging with HB regarding direct commissioning for SJAC response, with continuation of WAST operational support. This presents an opportunity to address gap in L1 dedicated provision in Anglesey and Gwynedd and regional night-time provision. Significant funding from ABUHB to fund 1 additional Level 2 falls vehicle (day) and 1 SJ falls assistant (nights) on top of existing services until March 25. Ongoing discussions regarding recruitment into the team. Level 1 (night) operational from 05/12, contract renewal from Sept 24. Therapist recruitment discussions continue with aim to be operational from Mar 24.

Connecting Support Cymru

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Dec 23	Green	Amber	For noting.	Business Partner:	Deborah Kingsbury
				Project Manager:	Richard Ashby

Objectives	Q3 Key Milestones	RAG	Current Position
Connecting Support Cymru	**CSC Project scoping and development:** 1. Undertake a twenty-week feasibility project 2. Finalise PID 3. Business Case development and EMT approval	G	Rota position now shared as part of daily running sheets/control room sheets via ODU/CSD DOMS/POC. Termination date SJAC 31/10/23 – completed. Present to CTPB once evaluation completed. Evaluation within Business Case, will write out a separate document for circulation. Phase 2 application received by both businesses. Evaluation and scoring to be completed by the 28/07/23. Evaluation completed. WAST not leading on any Fujifilm projects. Plan for LUSCII Discover Phase programme with ABUHB and BCUHB. SJAC commissioned to provide a further evaluation of the project. SJAC funded for 3000 hours, discussions ongoing. Revise PID following Business Case approval. Discussions commenced with Communications Team to develop Communication Plan. Business Case delivered awaiting feedback and approval.
	CSC volunteer scoping and development: 1. Readiness for Phase 1 of the Volunteer pilot 2. Develop and procure volunteer kit bags 3. Recruit to B4 training positions	G	Role profile drafted and awaiting approval. Further discussions required with SJAC CWR work stream to develop appropriate next steps. Go Live Q3. Will link in with SBRI work-stream to incorporate digital-solution as part of the 'kit bags' following decision. Funding will be applied for within business case. Will be using current CFR responder bags as an interim solution. Interviews taken place 3 posts appointable, further 1 post to be re-advertised. In progress, with some details to work through. Need to ensure sufficient capacity within CSD to support. Plan to be developed alongside Business Case. Plan being reviewed by project board.
	Deliver testing phase of SBRI (Health Tech) initiative: 1. Deliver 'testing' phase of the Small Business Research Initiative	G	Phase 2 application received by both businesses. Evaluation and scoring to be completed by the 28/07/23. Evaluation completed. WAST not leading on any Fujifilm projects. Plan for LUSCII Discover Phase programme with ABUHB and BCUHB.

Financial Sustainability Programme

Angie Lewis

Financial Sustainability Programme

Report Month:	Previous Milestone RAG	Current Milestone RAG	Current Financial RAG	FY23/24 Target	STB Action Required	SRO:	Angie Lewis
Jan-24	Amber	Green/ Amber	Green Exceeding Financial Forecast	Green Exceeding Financial Forecast		Workstream Chair:	Navin Kalia
						Project Manager:	Gareth Taylor

Objectives	Upcoming Key Milestones	RAG	Current Position
Income Generation	**Commercial Structures and Long-term Planning –** *Scope potential dedicated structure for delivery and oversight of commercial opportunities* 1. Undertake deep dive into barriers and challenges to delivering income generating schemes 2. Collate justifications for scheme rejections 3. Present findings to STB (18th September) 4. Determine long-term plan for Income Generation	G	• Four options developed and presented to ELT on the 6th December during Executive Away Day in Swansea against a sliding scale of risk. 1. No Risk – Remove Income Generation 2. Low Risk – Remain with current structures 3. Medium-high Risk – Internal commercial structure 4. High Risk – Commercial Subsidiary • Case Study from NEAS presented, and risk attitudes were mapped. • Business Intelligence exercise to be undertaken
	Income Generation Schemes – *Identify, scope, determine viability of ideas and schemes for delivery* 1. NEPTS Tenders – Complete options paper, draft service delivery model, and present paper back through Ambulance Care Informal for approval. 2. Quality Exemplar – Assess viability of scheme and market demand. 3. Apprenticeships – Assess impact of loss of funding stream 4. Other – Continue to monitor ongoing schemes, and scope new ideas.	A	1) Scoping complete as reported to November STB. No further progress on beginning programme of commercial delivery until commercial strategy and relevant structures determined. 2) SBAR drafted and agreed via SOT 3) Complete – target amended, but residual funding will decrease offset lost revenue, alongside new income streams via HEIW. 4) Continuing and on-track. Opportunities within the last reporting period have included Early Discharge / Home from Hospital schemes (linking in with Connect Support Cymru), and a proposal is currently in draft around using the volunteer workforce to generate income as is done in other Ambulance Trusts.
	Commercial and Financial Mindsets – *Identify, assess, and deliver opportunities for commercial and financial training and Development*: 1. Identify development opportunities 2. Draft plan for enhancing commercial and financial understanding 3. Identify metrics for measuring success	P	No progress – paused while assessing commercial options

Additional Progress

- Majority of work since last reporting period (three weeks) focussed on delivering Commercial Options
- Strategy Workshop for Future Ambulance Care Vision also included assessment of commercial appetite.
- Little progress on developing commercial mindsets since last reporting period.
- Financial Planning underway for FY2024/25 and scheme list and costings being developed.
- Completed first draft of the Financial Sustainability Programme Delivery Framework.
- Further detail surrounding commercial and financial development opportunities.

Forward View

- Following the Commercial Options session, appetite was largely in favour of exploring a commercial team ahead of the new Financial Year.
- Next steps to scope and cost a market intelligence exercise to determine cost-viability.
- Complete scheme list as part of 2024/25 financial planning

Financial Sustainability Programme

Report Month:	Previous Milestone RAG	Current Milestone RAG	Current Financial RAG	FY23/24 Target	STB Action Required	SRO:	Angie Lewis
Jan-24	Green/ Amber		Green Exceeding Financial Forecast	Green Exceeding Financial Forecast	None.	Workstream Chair:	Liz Rogers
						Project Manager:	Gareth Taylor

Objectives	Upcoming Key Milestones	RAG	Current Position
Achieving Efficiencies	**Reviews:** 1. Complete Administrative and Support Service Review and present findings and recommendations to ELT by Aug 1st 2. Identify Project lead, and commence Service Review	G	1. Complete - Following presentation of recommendations presented to both ELT and ADLT, 22-Point Action Plan developed. Action plan to be reported via Achieving Efficiency Group with ADLT Chair present. 2. Service Review well underway, entering first round of data collection w/c December 11th . 3. SPOCs for each business area being identified, and data collection due to be completed ahead of data analysis w/c 8th January
	Short Term Savings Opportunities (Cash Releasing / Spend Avoidance): 1. Initiate Fuel Efficiencies Task & Finish Group 2. Wider Trust expenditure reviews; 1. Utilities 2. Consumables 3. People Spend 4. Hire/Lease Car Spend 3. Identify and scope further non cash-releasing savings opportunities	G	1. Complete - Fuel Efficiencies T&F Group now underway. 'Missed Opportunity' data analysed, hotspots identified, and advice sought from AllStar. Metrics have been identified and a baseline set, in order to measure success of T&F Group. Comms package created by AllStar to be circulated 2. Ongoing - Several workstreams underway reduce avoidable spend in key areas. Sustainability Lead has identified hotspots and work ongoing to assess opportunities regarding utilities spend. Pilot to explore consumables wastage has completed, and results to be presented to Achieving Efficiency Group in November. Group to be established to scope series of savings opportunities across People Services. Fleet team are currently working through an audit of lease car agreements, following merger of Fleet and Lease Teams. 3. Ongoing - Further quick-win, non-cash savings opportunities to be identified via schemes and reviews. These include increased efficiency and robustness regarding processes in areas such as lease car management, re-fuelling, driver accident reporting.
	Long Term Savings Opportunities (Cash Releasing / Spend Avoidance): 1. Digital - Robotics and process Automation Programme 2. Process & Behaviours	G	1. Assistant Director of Digital compiling business case and proposal to follow recommendations from Support Service Review. Proposal discussed at ELT 13th December and process proposed for process automation approval. RPA Framework currently being developed to outline process, principles, and structure regarding automating existing WAST process 2. Communications package being developed for Fuel Efficiencies, band opportunities around developing driver training opportunities being explored with Training Team
	Other / Non-cash releasing Savings / Process Efficiencies 1. Identify and record non-financial efficiency benefits of FSP	A	1. Ongoing. Both reviews set to provide recommendations on amended services and process efficiencies. 2. Financial schemes also set to deliver process efficiencies (improved SOP for lease car process, and improved behaviours around vehicle use and re-fuelling). 3. As above, RPA programme currently developing a framework to determine process efficiencies prior to automation. 4. Mapping progress slowed since last reporting period

Additional Progress

- Service Review Milestones agreed
- Analysis of Pilot Study into consumable waste ongoing
- Proposal outlining the direction of travel regarding Robotics and PA presented to ELT 13th December
- Completed first draft Financial Sustainability Delivery Framework.
- Draft Financial Scheme Tracker for FY 2024/25 ongoing

Forward View

- Complete scheme list as part of 2024/25 financial planning
- Complete Service Review data collection (Phase 1) by December 21st, and commence Data Analysis (Phase 1) by 11th January
- Circulate AllStar Diesel Savings comms package
- Complete analysis of Consumables Pilot
- Determine ELT appetite for Robotics and PA Process, and confirm framework for process approval.

Savings Progress – Month 8

Below forecast target and off-track
Below or meeting forecast target but on-track
Exceeding forecast target
Not yet commenced

	Annual	In Month			Cumulative			Forecast			RAG
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	
Accident Repair	20	4	8	4	8	8	0	20	20	0	
Acting Up Allowances	11	0	0	0	0	0	0	11	11	0	
Apprentice Income	350	29	7	-22	234	60	-174	350	60	-290	
Asset Disposal (Defib)	225	25	25	0	125	125	0	225	225	0	
Balance Sheet support	200	20	20	0	120	120	0	200	200	0	
CSD - ECNS Non Pay	20	2	2	0	14	23	9	20	29	9	
Decarb	2	0	0	0	2	2	0	2	2	0	
End of Shift Overrun	30	3	10	7	19	188	169	30	231	201	
Fuel (forecourt price saving against budget)	306	15	9	-6	236	395	159	306	476	170	
Fuel (swip, chip & pin and reduction in misfuelling etc)	33	5	2	-2	15	12	-3	33	30	-3	
FYE of 22/23 VERS	66	7	7	0	38	38	0	66	66	0	
Intelligence Routine Platform	100	0	5	5	0	20	20	100	20	-80	
Interest Receivable	500	31	67	36	380	636	256	500	807	307	
MS Office VAT Rebate	250	36	0	-36	108	0	-108	250	0	-250	
Net - Vacancy Management (111 EASC-funded and non frontline)	27	0	0	0	27	27	0	27	27	0	
Net - Vacancy Management (CSD and non frontline)	120	0	0	0	120	118	-2	120	118	-2	
Non Pay Local Schemes	530	46	35	-11	409	373	-36	530	450	-80	
Other local schemes - Non Pay (Travel etc)	26	2	9	7	16	23	6	26	32	6	
Overtime	254	28	56	27	141	278	137	254	500	246	
Private Providers	250	21	21	0	168	168	0	250	250	0	
Reduction in variable pay	38	3	3	0	24	24	0	38	38	0	
Stock Control (MSE etc)	50	5	5	0	23	20	-3	50	48	-3	
Taxi Review	50	4	4	0	28	24	-4	50	46	-4	
Vacancy Management	2,275	164	191	27	1,668	1,866	198	2,275	2,343	68	
Vacancy Management (non frontline)	51	0	0	0	51	55	4	51	55	4	
Vacancy Management (non frontline) Additional	151	10	11	1	111	115	4	151	159	8	
Volunteer Car Drivers	66	5	5	0	30	58	28	66	93	28	
Totals	**6,000**	**465**	**502**	**37**	**4,115**	**4,773**	**659**	**6,000**	**6,335**	**335**	

IMTP Enablers & Fundamentals

- People & Culture – Angie Lewis
- Digital – Leanne Smith
- Fundamentals – Trish Mills and Liam Williams

N.B. *Infrastructure is not included within this report as IMTP delivery is managed through the Capital Management Board. Verbal updates to be provided to STB by exception only. Capital Management Board papers will be routinely added to STB meeting folders for information.*

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People & Culture

Report Month:	STB Action Required	Executive Lead:	Angie Lewis
Dec-23	N.B. The People & Culture portfolio is monitored through a local Directorate Plan, with actions aligned to IMTP Objectives. The Directorate Plan has been reviewed and updates provided by exception.	Business Partner:	Sarah Davies

Objectives	Q1	Q2	Q3	Q4	Current Position
Culture – *Create an environment where colleagues have autonomy in their work, feel a sense of belonging, and are confident to make decisions, put forward ideas and raise concerns*					
Develop and articulate our target culture	G	G/A	A		*Broadly on track with the identified culture related initiatives. The Amber status refers to a delay in engaging with the Culture Champions (CC) network via an initial survey and with external organisations to identify best practice, due to competing priorities and capacity in the team. A HIVE survey now scheduled to go out to CC network early Jan and team are identifying best practice examples from external organisations for the purpose of applying learning where appropriate*
Sustain our focus on improving wellbeing	G	G	G		On track and on target overall.
Increase levels of psychological safety	G	G	G		On track and on target
Improve disciplinary and resolution processes	G	G	G		On Track and on target
Refresh TU partnership working arrangements	A	A	A		See below:
On track overall, and ACAS action plan has now been developed and agreed in partnership with TUPs. Implementation of the plan is underway, but timelines have been updated in the context of IA with work due to commence in Sep-23. Plan shared with TU lead for feedback and shared at WASPT. Activity includes development of relationships through joint sessions with managers and TU reps to promote a mutual understanding of each other's challenges balancing TU duties against operational delivery. **AT RISK:** STB are asked to note the ongoing challenges with relationships which may interrupt or stall progress.					
Amplify employee voices	G	G	G		On track and on target
Capacity – *Ensure we have the right people in the right roles, at the right time, with the right skills, to enable WAST to realise its ambitious service redesign plans*					
Develop our employee offer	G	G	G		On track and on target
Improve organisational onboarding processes	NS	NS	G		On Track and on target regarding developing onboarding process.
Improve people related policies and processes	G	G	G		On Track and on target
Develop Strategic Workforce Plan	G	G	G		On Track and on target
Deliver Managing Attendance Programme	G	G	G		On Track. Further work to be undertaken via Deep Dive and streamlining.
Capability – *Ensure our people are suitably skilled and qualified, can work at the highest level of their scope of practise and are comfortable to make decisions within their control.*					
Build on our learning and development offer	G	G	G		On Track and on target
Promote personal responsibility	G	G/A	A		On track overall, however there is a **Red** status against increasing Apprenticeship provision, due to inability to draw down previously secured funding (income), the financial implications of which have been highlighted.
Improve talent management approach	NS	NS	N/S		Not yet started
Enhance change capacity and expertise	G	G	G		On Track and on target
Respond to legislative changes	G	G	G		On Track and on target

People & Culture - Commitments

Report Month:	STB Action Required	Executive Lead:	Angie Lewis
Jan-23		Business Partner:	Sarah Davies

Commitments	Q 1	Q2	Q3	Q4	Current Position
Digital Experiences					
• EqIA: making this more digitally accessible • Digital Literacy Skills: development of accredited and non-accredited education programmes • Implementation of LMS365 • Expansion of Learning Launchpad content	G	G	G		On track and on target
Shift Overruns					
As per MIQPR Pilot for shift overruns undertaken in Swansea Bay and an SBAR was presented to Operations Senior Leadership Team (Ops SLT) (21/08) highlighting the positive impact on staff wellbeing but flagging that the costs to deliver this at scale could be prohibitive. Since then, cohorting has been re-introduced at some hospital locations in line with the Trust's winter resilience planning.	A	A	A		
Flexible Working					
• Review current policy • Establish a clear understanding of current processes and impacts of flexible working arrangements across frontline services • Review current research for frontline flexible working across NHS& Emergency services • Engage with wider Ambulance Sector to understand flexible working practices across UK • Develop coaching / process material • Explore ESR functionality for requesting and recording agreed / declined flexible working requests • Engage with WAST colleagues to understand perceptions views on flexible working options and evaluate after changes are implemented • Continue to establish a pathway of support for Carers within the organisation	G	G	G		On track and on target

Digital

Report Month:	STB Action Required		
Jan -23	N.B. Digital (including HI) is a critical enabler for many FY23/24 IMTP actions and is reported through relevant programme boards. An update has been provided against the digitally-led IMTP objectives.	**Executive Lead:**	Jonny Sammut
		Business Partner:	Rhonwen Jones

Objectives	Upcoming Key Milestones	RAG	Current Position
National Data Resource Programme	**National Data Resource (NDR) Programme Support:** 1. Confirm FY23/24 funding to progress longer-term NDR activities	G/A	**AT RISK:** All planned activities are complete, however longer-term funding has not been agreed. No further update.
Operations Communications Programme	**Mobile Data Vehicle Solution (MDVS):** 1. Integration CRS/MDVS 2. Testing due to complete/pending outcome. 3. Finalise application testing and pilot for NEPTS fleet 4. Commence Mass Deployment	G	The MDVS project has begun deployment of the replacement technology into the WAST operational fleet (EMS), as of W/C 18.12.2023 176 vehicles have been installed with 1420 staff trained and self-certified. The NEPTS NMA application development has slipped by c7 weeks with live pilots now scheduled to begin W/C 05.02.2024.
999 Platform Upgrade	**Upgrade 999 Telephony Platform:** 1. Supplier readiness (level of confidence) to test 999 platform solution during Q2 2. Q2 - testing Jul/Aug 999 platform solution	A	Supplier on site (Q3) SAT Testing. Delivery planned October/November 2023. User interface remains relatively the same. Go Live planned Q4 February 2024.
Digital Experience of our Staff	**Digital Single Sign on** 1. Nadex Integration **User Experience Assessment** 1. Supplier Microsoft (Android) 2. Supplier Apple (iPAD)	G/A	AT RISK: High Level Market engagement ongoing. Current risks around Cost/Funding to be agreed. Security risks to be mitigated against. November meeting with Supplier – Apple – Risk appetite for improving single sign on & reducing security to facilitate.

Fundamentals

Report Month:	STB Action Required		
Nov-23	N.B. These portfolios are monitored through local Directorate Plans, with actions aligned to IMTP Objectives. Directorate Plans have been reviewed and updates provided by exception	Executive Lead(s):	Trish Mills/Liam Williams
		Business Partner(s):	Deborah Kingsbury/Rhonwen Jones

Objectives	Milestone Status				Position
	Q1	Q2	Q3	Q4	
Risk Management					
Develop and deliver a risk management framework including policy and procedures	G	G			Policy in draft – approval due at Audit Committee March 2024
Transition to a strategic BAF reflecting strategic objectives and risks	NS	NS			Work due to commence Q3
Develop and deliver programme of training and education for the Trust	NS	NS			Work due to commence Q3/Q4
Deliver Board education on risk management	NS	NS			Work due to commence Q3/Q4
Welsh Language					
Centralised translation service	G	G			New Translator started in post on 30/08/23. Translation service currently in soft launch phase with an expected hard launch during January 2024.
More than just words 2022-27 action plan	G	G			More than just words year 1 report submitted to WG. Year 2 - conduct a Welsh language skills gap analysis as part of strategic workforce development plan.
Welsh Language Policy	A	G/A			Policy in draft – this policy will focus on the positive steps the Trust can take to develop our use of Cymraeg - approval due 2024. Policy drafted - development of accompanying implementation plan.
Delivery of the Welsh Language Standards	G	G			Annual Report completed and approved at Trust Board on 28/09/23 . Development of a Trust wide standards monitoring process to gauge compliance.
Quality, Safety, & Patient Experience					
Working Safely Plan	G	C	N/A	N/A	Programme now Closed. Closure Report to be shared with members.
Quality Management System (QMS) Implementation	A	A	A	A	Quality Management Group regular meetings being held. (meeting 4 to date). TOR approved. QPMF Self-Assessment pilots concluded - end of Q3. Review of ISO standards 9001:2015 completed to support development of robust QMS. Presentation to ADLT provided, 6th December. Risk to delivery remains dependant on QMF functioning with Ops engagement/risk capacity to attend. Ops have since engaged risk reduced to low. Duty of Quality page updated with links and communications strategy drafted to launch DoQ e-learning across

Welsh Ambulance Services NHS Trust

Strategy Highlight Report

Report period up to Nov-23

(1) Organisational Strategy Development
(2) Ambulance Care Strategy Development
(3) EMS Transformation Programme 'Inverting the Triangle'

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

Organisational Strategy Development

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO	Rachel Marsh
Nov-23	On Track	On Track	Note the progress reported. No issues / risks to escalate.	Head of Strategy:	James Houston
				Project Manager:	Sarah Parry / Lauren Price

Description	Status	Current Position	Forward View
Review of WAST Organisational Strategy & Future Service Model	**On Track**	• Consensus the strategy is still fit for purpose (Board Development & SLT review July/August) • 'Bold refresh' required of clinical model and digital ambition • Handling Plan to be developed • Initial discussions held with TSAG (Oct) & Board Development (Oct)	• Future Service Model workshop planned for 7th Dec. • Develop draft model for wider internal discussion and debate (Dec / Jan)
Internal Audit – Strategy Development	**Paused**	• Fieldwork and data collation completed (August) • Fieldwork & Assessment paused due to capacity issues within Audit Team. Due to re-commence in Dec.	• IA Fieldwork & Assessment (Dec / Jan) • De-brief (TBC) • Audit Committee (TBC)
Purpose Statement	**Complete**	• Communications video launched in October (Yammer & Siren)	

Ambulance Care (NEPTs): Future Vision Development

Report Month:	Current RAG	Previous RAG	STB Action Required
Nov-23	**On Track**	**On Track**	Note the progress reported. No issues / risks to escalate.

Description	Status	Key Progress / Items for Highlighting	Forward View
Future Vision Development	**On Track**	▪ NCCU planning to hold a collaborative workshop with WAST, Commissioners and wider stakeholders in Jan/Feb to discuss future vision for the service. ▪ Internal planning workshop arranged for the 30th November with internal leads to discuss future vision / aspirations.	▪ Internal WAST planned for workshop 30th Nov. ▪ Proposal document to be developed to summarise key findings and organisational position. ▪ Support preparation for external event (Jan/Feb)

Transforming Care: Inverting the Triangle (Key Highlights)

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh / Andy Swinburn
Oct-23	On Track	On Track	Note and discuss work streams reporting (amber)	Head of Strategy:	James Houston
				Project Manager:	Sarah Parry / Lauren Price

Description	Status	Key Progress / Items for Highlighting	Forward View
Inverting the Triangle	**On Track**	▪ **Future Service Model:** o Initial discussions held with TSAG (Oct) & Board Development (Oct) ▪ **Internal Communications:** o Initial (month long) internal Communications Campaign undertaken in Oct /Nov. Including 5 x videos & request for feedback. ▪ **External Engagement:** o Strategy Discussion with EASC (21st Nov) o SECamb strategic discussion / Strategy discussion with EASC. ▪ **Test of Change**: o APP Flooding PDSA 3 completed o Preparatory work for PDSA 4 (CSD Screening initial evaluation undertaken 20th Nov). o CSC Business Case developed / being reviewed in readiness for submission. ▪ **Evaluation Framework:** o Logic Model framework identified following discussion with Swansea University.	**Service Model:** Future Service Model workshop planned for 7th Dec. Wider engagement **Internal Communications:** Further promotion, analyse feedback. Develop detailed Communications Plan. **Engagement:** refinement of Engagement Delivery plan in readiness for structured engagement (Feb onwards) **Test of Change:** PDSA 4 to be undertaken (early Dec). Plans for PDSA 5 in new year. CSC Business Case completed.
	Issues	• **Case for Change**: • Detailed feedback provided to PWC (Oct) • PWC confirmed capacity / capability to deliver a quality product (Mid Dec)	**Case for Change:** Detailed report & Executive Slide deck to be completed (Mid-Dec). * To note no 'new' work as part of commission, case for change will remain aligned to ITT conceptual model.

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Integrated Medium-Term Plan (IMTP) 2024 – 2027
Progress in developing the plan

MEETING	Finance & Performance Committee
DATE	15 January 2024
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance Chris Turley – Executive Director of Finance and Corporate Resources
AUTHOR	Alexander Crawford - Assistant Director of Planning and Transformation
CONTACT	Alexander.crawford2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide Finance & Performance Committee with an update on the progress and actions required to develop the next iteration of WAST's Integrated Medium Term Plan for 2024-27.

RECOMMENDED: That the Finance & Performance Committee:

1. **Note the overall progress in developing the IMTP;**
2. **Note the financial and budget setting assumptions following issuing of the Health Board allocation letters;**
3. **Note the approach and timelines set out in the report;**
4. **Advise of any further assurance required during the final stages of the planning cycle.**

KEY ISSUES/IMPLICATIONS

1. It is a legal requirement that NHS Health Boards and Trusts in Wales must submit to Welsh Government an IMTP covering three years, refreshed annually. However, importantly for WAST it is also the way in which we set out the priorities over the next three years for achieving our long term strategic objectives and deliver the transformation that needs to happen to improve our services, but closely aligned to the commissioning intentions for EMS, NEPTS and 111.

2. WAST's IMTP planning cycle runs from June 2023 to March 2024. Planning happens alongside delivery, making the plan dynamic and a live document. The key to good

planning is not in the final written plan but in the processes, conversations and engagement that go into developing the plan.

3. Welsh Government has issued its Planning Guidance in letters from the Minister to Chairs and followed by more detail from the Director General to Health Board and Trust Chief Executives on 18th December 2023. Furthermore following the 2024/25 draft budget for Welsh Government released on 19th December 2023, Health Boards have received their allocation letters for the 2024/25 financial year on 21st December 2023. Whilst this does not directly confirm funding for WAST, it does provide insight as to the level of funding our commissioners will receive and some assumptions can be made over the impact on the Trust, including the assumption from the CASC, as reported at EASC Management Group on 14th December 2023, that any uplift in Health Board allocations will be passed on in full to EASC.

4. Planning is going well, with lots of work being undertaken in the 'gathering intelligence' and 'engagement' workstreams which will lead to discussions over the coming months on our key priorities, and the scope and pace of change that is possible in an ever changing context in which the NHS is working.

REPORT APPROVAL ROUTE
Finance and Performance Committee – 15 January 2024

REPORT APPENDICES
Appendix 1 – SBAR Appendix 2 – Summary of the NHS Wales Planning Framework 2024-27

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

Appendix 1

Approach to Developing the 2024-27 WAST IMTP

Situation

1. The purpose of this paper is to provide Finance & Performance Committee with an update on the progress and actions required to develop the next iteration of WAST's Integrated Medium Term Plan for 2024-27.

Background

2. It is a legal requirement that NHS Health Boards and Trusts in Wales must submit to Welsh Government an IMTP covering three years, refreshed annually. However, importantly for WAST it is also the way in which we set out the priorities over the next three years for achieving our long term strategic objectives and deliver the transformation that needs to happen to improve our services, but closely aligned to the commissioning intentions for EMS, NEPTS and 111.

3. WAST submitted its last IMTP (2023-26) to Welsh Government (WG) on 31st March 2023 following Board approval. Welsh Government approved WAST's IMTP on 12th September 2023. Following approval the Director General issued accountability conditions on which our approval is based as follows:

    - Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximise its improvement trajectory and develop robust mitigating actions to manage financial risks.
    - Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.
    - Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.

4. WAST is also expected by WG to deliver its commitments in its IMTP, particularly ministerial templates and the focus for the next planning round will need to consider a more robust approach to these templates, as these are the means by which the minister seeks assurance against her priorities.

5. WAST's IMTP planning cycle runs from June 2023 to March 2024. WG Planning Guidance for the next round of plans requires that an accountable office letter will need to be submitted to the Director General by 16th February 2024 if the organisation is unable to produce a financially balanced IMTP. The plan itself then needs to be submitted by 29th March 2024, following Trust Board approval on 25th March 2024.

6. In November the Committee was assured that the planning process would take a more holistic approach this year building the plan from floor to board in like with our Quality and Performance Management Framework organisational requirements. Planning has also taken account of the challenge from the Board to really focus in on what the organisation will look

like in 1 – 3 years time, in line with the further development of our Trust long term strategy and the articulation of the ambitions set out in the strategy.

As an 'integrated plan, the planning approach needs to take account of the workforce, fleet, estate, digital and financial resources required to deliver the IMTP. At the same time it takes account of the system wide developments which impact on WAST's ability to deliver services to the quality, the influence WAST can have on the system and performance standards we hope to achieve through our own plan.

7. Our IMTP is developed at the same time as Commissioner plans and commissioning intentions, as well as key priorities for the Minister. Welsh Government will continue to scrutinise the extent to which the assumptions that underpin our planning (activity, income etc.) align with those of Commissioners, key partners and the Ministerial priorities for NHS Wales.

8. WG Planning Guidance was issued by the Minister in letters to NHS Chairs and further supported by a letter from the Director General to Chief Executives on 18th December 2023. The requirement is to submit clear narrative plans set over three years, showing clear progression over those three years, together with templates setting out how organisations are delivering against the minister's key priorities for the NHS and aligned to a Minimum Dataset (activity and performance trajectories, workforce plans and financial plan).

9. Whilst the Planning Guidance is heavily weighted towards issues that affect Health Boards, some of the key issues set out by the Minister and Director General in the guidance is as follows (and summarised by the Assistant Directors of Planning network in Appendix 2):

9.1 Value and Sustainability

The minister has been clear within the Value & Sustainability agenda her expectation that for 2024-25 there must be a consistent and significant impact in the following areas on both a local and national basis:

- Continued progress in reducing the reliance on high-cost agency staff.

- Ensuring strengthened 'Once for Wales' arrangements to key workforce enablers such as recruitment, and digital.
- Maximising opportunities for regional working.
- Redistributing resources to community and primary care where appropriate and
- maximising the opportunities offered by key policies such as Further Faster.
- Reducing unwarranted variation and low value interventions.
- Increasing administrative efficiency, to enable a reduction in administrative and
- management costs as a proportion of the spend base

Whilst this will inevitably present challenges for the Trust, it also presents opportunities, particularly in the resource focus around primary and community care and WAST's strategic offers to the system. A key area of challenge will be digital enablers and our ability to deliver transformation in this space due to both financial and workforce constraints.

9.2 Ministerial Priorities

The Minister expects plans that demonstrate clear milestones, actions, risks and outcomes set out in a set of consistent templates issued to all NHS organisations across the following areas:

- Enhancing care in the community, with a focus on reducing delayed pathways of care
- Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.
- Urgent and Emergency Care, with a focus on delivery of the 6 goals programme.
- Planned Care and Cancer, with a focus on reducing the longest waits.
- Mental Health, including Child and Adolescent Mental Health Services (CAMHS), with a focus on delivery of the national programme.

WAST plays a role in all of these areas, including planned care and cancer through its NEPTS service in particular and a workshop on 11th January will spend some of its agenda looking at how we ensure we have clear milestones in place in 2024/25 to address these priorities.

9.3 Further developments and enabler in the NHS in 2024

There are a range of national developments that will impact across the NHS in 2024 that should be taken into account when developing the IMTP:

- A Healthier Wales Accountability Review.
- The new NHS Wales Joint Commissioning Committee.
- The continued work of Value and Sustainability Board.
- Phase two of the NHS Executive

Furthermore new legislation will be coming into force and/or requires strengthening:

- Social Partnership and Public Procurement (Wales) Act 2023 – complements the Wellbeing of Future Generations (Wales) Act (WBFGA) 2015 and will require NHS bodies to refresh their wellbeing goals in light of the new requirements – as a potential named body under the WBFGA, WAST will need to be clear on its wellbeing goals.

- The Health Service Procurement (Wales) Bill is intended to gain royal assent in December 2023 and for associated regulations and statutory guidance to be laid in summer 2024. This legislation will give organisations such as the NHS and local authorities the ability to implement more flexible procurement practices when sourcing services provided as part of the health service in Wales.
- Strengthening our compliance with the Duties of Quality and Candour, ensuring our plans set out how we will deliver improvement in the safety and quality of services.

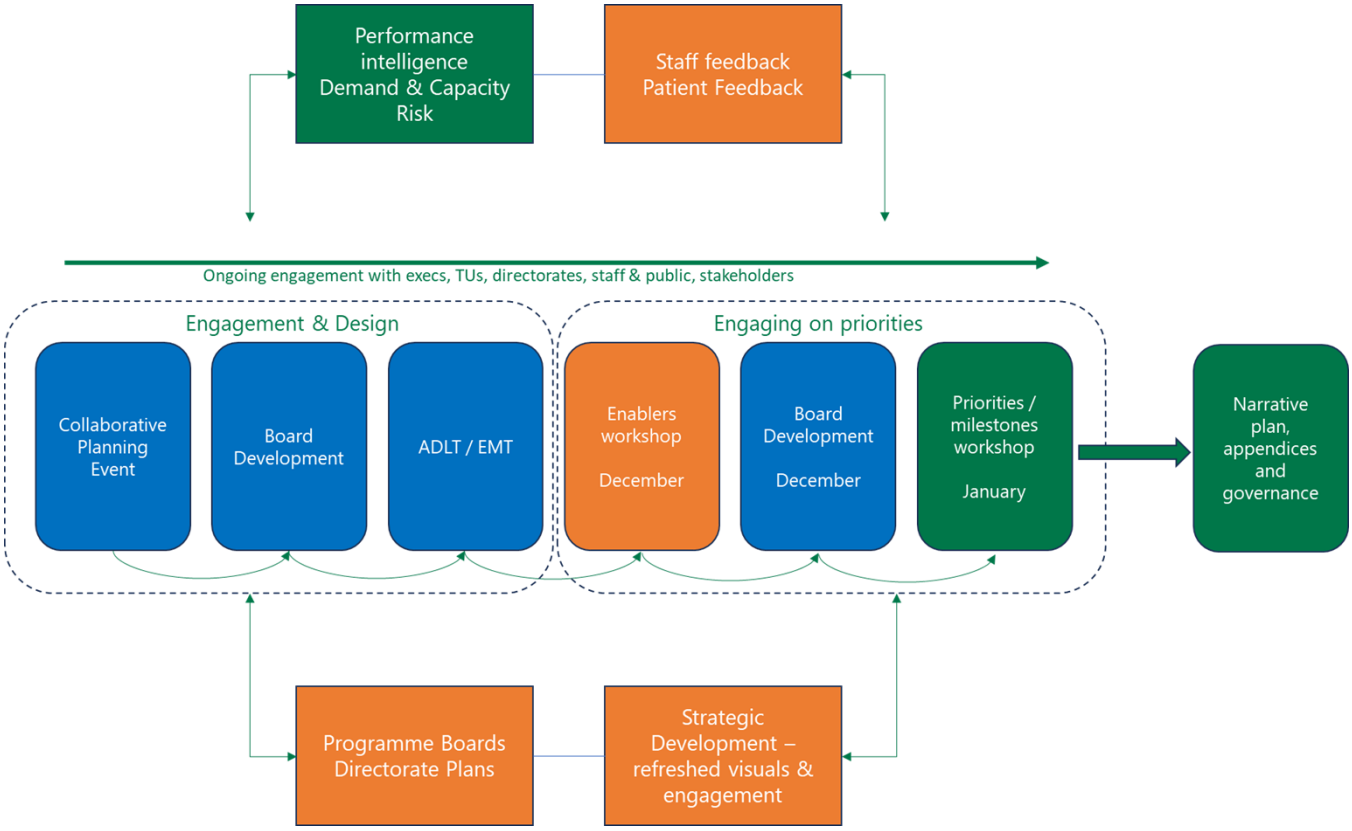
10. The aims for achieving a Board Approved Plan in readiness for 2024-2027 are as follows:

- Refresh of the current 3-year IMTP with a focus on how we are working towards our strategy, whilst also maintaining control of our spend in the challenging financial environment;
- To be clearer about our milestones across the whole period in years 1,2 and 3 – this is the direction set by the Board and WG;
- Ensure the IMTP meets the needs of patients, colleagues and the wider public and our people;
- That it showcases our commitment to delivering our statutory obligations and commissioning intent.

11. The approach to developing the IMTP this year as with previous years is through phases, or workstreams. The key workstreams are as follows:

- **Engagement** – with our people, public and patients, trade unions, commissioners and key partners;
- **Gathering intelligence** – through our performance data, NHS Wales data and information, risks, understanding the strategic and socio-economic context we are working in
- **Developing and agreeing priorities**, using a business case approval process as required
- **Integrated technical planning**, which considers fleet, estate, digital, workforce and financial consequences of our IMTP
- **Writing the plan**
- **Governance, assurance and approval**

The high level approach can be seen in the following diagram.



Assessment

12. The following paragraphs set out the process and progress to date in developing the next iteration of the WAST IMTP, by workstream.

Engagement

13. Since the last update to the Committee in November we have collated the feedback from our collaborative planning event and Board development sessions where we undertook PESTLE (political, economic, social, technical, legal, environmental) analysis and from staff gathered particularly through the CEO Roadshows, but also through our Transforming Care surveys.

14. As well as some of the well understood issues such as population health and demographic change, system pressures, and policy direction in Wales the PESTLE analyses led us to understand that we have both challenges and opportunities in respect of technological advances, but with the risk that we may not have the resources to embrace the opportunities, as well as a growing concern around the ability to prevent climate change and what we now need to do to adapt through planning to the changing environment around us.

15. Some of the key feedback from **our people** that we need to take account in the IMTP includes:

- Financial strain and cost of living impacting on them
- System pressures and demand and how it is taking its toll on staff

- Digital transformation – both the pace of change needed but also continued concerns about digital literacy and experience
- Staff well-being and mental health continues to be a key theme and accounts for just under 3% of staff being absent from work
- Public expectations and communication with the public about our services
- Climate change and sustainability became a new theme and the concern over the changing environment was a key issue in many discussions
- Career progression and training opportunities
- Collaboration and whole-system approach
- Media impact and public perception of WAST services

16. We continue to engage **patients and the public** notably through our PECI team. As set out in previous reports to committee:
    a. We have a lot of data and information from patient engagement QUEST reports, as well as data from Putting Things Right, serious incident reporting and National Reportable Incidents. We will use this to inform the IMTP as we have done in previous years;
    b. Patient Stories also give us valuable and personalised information to help us develop our priorities;
    c. We are awaiting feedback from the first phase of the Bevan Commission Big Conversation, which asked the public for feedback about the future of the NHS in Wales;
    d. Continuous PECI engagement will give us data and information on what is important to the public; and
    e. We are awaiting any feedback from targeted engagement.

17. We are still analysing the feedback from staff on our transformation journey. Whilst the response rate was not high there are some valuable messages that we will follow up on. However it is clear that our people who did respond understand the key drivers for change, including a strong message that we have no choice but to do things differently to address the challenges we face.

18. The transformation communication campaign is just the beginning of what will be a continuous engagement approach that will use a range of different approaches including methods such as video messaging, staff briefings, podcasts and further opportunities for colleagues to get involved and share feedback and ideas. This will be a key component of the IMTP deliverables in 2024-27 around our strategic ambitions and transformation journey.

19. We continue to engage with our **Commissioners** through the usual 111 and EASC commissioning meetings. We have now received 111 and EMS commissioning intentions. NEPTS commissioning intentions will be developed later in this planning cycle as there is a need for our Commissioners to work with WAST on the future vision for Ambulance Ca

20. We will continue to have regular touch point meetings with the NCCU, as well as collaborative discussions with HEIW and DHCW on areas such as workforce planning and digital, to complement the plans set out by commissioners in their commissioning

intentions. We also continue to engage directly with Health Boards through ICAP meetings and through the Directors of Planning and Assistant Directors of Planning networks.

21. As well as direct engagement with staff we maintain open engagement on the IMTP through the Welsh Ambulance Services Partnership Team (WASPT) and its Corporate Partnership Forum sub-group. **Trade Unions** (TUs) are also part of Board Development sessions and the building up of the plan through our programmes.

22. We maintain engagement with **partners** across the health and care system and information flows through a framework approach into Integrated Strategic Planning group (ISPG) and Strategic Transformation Board (STB). This includes our joint engagement sessions with Digital Health & Care Wales (DHCW) and Health Education and Improvement (HEIW). We are now also represented on all Regional Partnership Boards.

Gathering Intelligence

23. We are currently compiling the data pack which will be a 'compendium' of key challenges and opportunities as an Appendix to the IMTP and this will inform draft one of the plan which will be developed by the end of January 2024.

Developing and agreeing priorities

24. The Planning Team has undertaken a gap analysis against the feedback received through planning workshops, roadshows, PESTLE analyses and commissioning intentions to ensure that our emerging priorities have not missed anything. However, it is important to note that we have to be realistic about the scale and pace of our ambition in the current financial context and within the resources available to WAST. Thus it is important to prioritise our work along the full three years of the plan.

25. In order to write the first draft and undertaken prioritisation, we now have intelligence from our key programmes and directorates about their view of priorities for 2024 and beyond. We have also undertaken internal workshops to consider the future shape of our service offer in the next 1, 3 and 7 years, a visioning workshop for Ambulance Care services in preparation for a joint workshop with commissioners around Non Emergency Patient Transfer Services (NEPTS) in the new year, and we will be undertaking a horizon scanning session for 111 on 12th January 2024. The IMTP will bring together these pieces of work into an integrated view of what we need to do to achieve progress against our strategy, in line with commissioning intentions and system wide programmes over the next 3 years.

26. It can be seen in the diagram above that the planned 'Enabling Workshop' is marked as amber. Alongside the technical planning set out in paragraph 29 below, we had intended to hold a workshop to discuss the priorities for our people and culture, digital, infrastructure and partnership plans. However, this has been pushed back, and it is important that we understand what the key priorities for our service transformation is over the next three years to understand the resources and priorities required across our enabling functions.

27. It will be important to combine this workstream with the plan to engage with stakeholders on the emerging priorities so that we are able to finalise and confirm priorities through January.

Integrated Technical Planning

28. The Integrated Technical Planning Group which reports into ISPG (which is responsible for overseeing IMTP development) meets regularly throughout the year and will provide the technical planning which considers our priorities in the context of fleet, estates and digital requirements. It also informs our workforce and financial planning (both revenue and capital). The agenda for the meetings has now been extended to ensure we have clear focus on the IMTP at every session between now and the end of March.

Financial Plan and key Budget setting assumptions

29. As noted above, the NHS Wales Health Board Allocation Letter for the 2024/25 financial year was issued by the Minister for Health and Social Services in Wales on 21st December 2023, providing some key insights to the levels of funding our commissioners will be receiving in the coming financial year. Whilst we are not directly funded through this allocation, being a commissioned organisation our funding is then agreed via (currently) Emergency Ambulance Services Committee (EASC), it does provide some key assumptions for our 2024/25 financial plan.

30. The main headlines within the HBs allocations were as follows:

    a. An additional £330m being allocated to HBs for 2024/25, on top of that recurrently provided part way through the 2023/24 financial year;
    b. This includes the recurrent impact of current year forecast energy costs being fully funded. This does include an amount for WAST of c£450k;
    c. On top of this the recurrent costs of the 2023/24 pay award, plus that to be agreed for 2024/25, plus the recently announced changes to the minimum and real living wage (RLW) values will be separately and fully funded to all NHS Wales organisations;
    d. This all results in a residual general uplift for inflationary and other cost pressures for 2024/25 of 3.67%;
    e. An expected minimum of 2% cost avoidance / containment and savings plan across all NHS Wales organisations.

31. Whilst the settlement for health across the NHS in Wales is therefore arguably significantly better than may have been expected, given the continuing levels of service demand, impact and cost pressures within the wider system, this is still being framed as an allocation for stability and inflationary pressures rather than being a budget for investment and growth. However, given the level of funding able to be made available, and subject to some of the remaining risks highlighted below, this should allow for the Trust to work towards being able to present a balanced financial plan for 2024/25.

32. Work will now continue over the coming weeks to translate the expected impact of the HB funding allocations on that expected to be applied to our financial plan, including:

a. Ensuring that, as previously indicated and in line with previous financial years, the general uplift for 2024/25, now agreed at 3.67% is fully passed on to us by commissioners. To help with this the covering narrative which accompanied the allocation tables states "*Health Boards and the Welsh Health Specialised Services Committee are expected to pass on an appropriate level of funding for relevant non-pay inflationary cost increases in the Healthcare Agreements for services provided by other Boards and NHS Trusts,* ***equivalent to the additional funding provided to commissioners****";*
b. Ensuring such uplifts are applied to all of the Trust's funding streams, including those for NEPTS and 111;
c. Ensuring that identified within the HB allocations as energy funding for WAST is similarly passed on in full, and
d. Ensuring in year that the actual costs incurred for pay awards and RLW impacts is funded in full.

33. Discussions will now continue with the Chief Ambulance Services Commissioner (CASC) and / or wider commissioners to seek to confirm the above financial planning and funding assumptions for 2024/25 as soon as possible.

34. Whilst the likely settlement and funding increase for the coming financial year is therefore greater than may have been expected, no financial plan is risk free and there inevitably remains a number of risks and challenges that will need to be worked through over the coming weeks in order to finalise the financial plan and budget for 2024/25. This include the following:

    a. As above, ensuring all of the funding expected to be confirmed to the Trust, from a variety of sources, is fully recovered;
    b. Agreeing with commissioners any other levels of outstanding recurring funding being made available, the impact or not on this of the 2024/25 funding and management of any residual costs / gaps;
    c. Some recurrently committed levels of spend already made in 2023/24 and ensuring these are fully recognised and managed within the 2024/25 financial plan and budget setting;
    d. Despite the additional funding provided, some cost elements are still hard to predict through the coming 15 months and may remain volatile, with a clear indication from WG that no further funding will follow in year in 2024/25 to manage any such variations;
    e. The need to ensure a savings plan delivery, predominately via our Financial Sustainability Programme, of at least a minimum 2% increase in 2024/25, noting that an element of our 2023/24 delivery is non recurring;
    f. How elements of our planned transformation journey, including that needed to mitigate service, demand and activity pressures and risks, may be able to be agreed from some of that now available;
    g. Whilst hopefully relatively a low risk, there is also in 2024/25 a planned increase in the Trust's baseline depreciation charge, for which funding has been allocated to HBs and for which we will similarly need to ensure the money for this flows to us via EASC;

h. The need to ensure no negative financial impact on the Trust of any upcoming changes to commissioning arrangements, potentially in particular in relation to 111. Discussions will continue with 111 commissioners over the level of funding required for the service, including that needed non recurrently for the implementation of the agreed new CAS system. Included in these discussions will be the continuing basis on which we are funded for the 111 service. For the first time now a quantum of value for this has been specified in the HB allocation letter but we need to also work through how the 2024/25 uplift is applied to this, what impact, if any, the wider funding uplift may have on this service and what impacts there may be to having to maintain a resource envelope in line with previous years and that which has been able to be managed non recurrently in some cases as an addition to this;
i. That the upcoming proposed changes in commissioning have no wider impact on the Trust financially, including in relation to how it is currently funded for EMS, NEPTS services, etc;
j. Whilst the current allocations deal with revenue costs and funding only, indications from WG is that capital funding for 2024/25 is not likely to be any greater than in the current financial year, which could impact on a number of key enablers to our plan;
k. All of that provided so far is with a 1 year financial planning horizon, 2024/25, with any elements of the Trust's 3-year financial plan having to again be presented in this context.

35. As in previous years at this stage, all of this is likely to initially be presented over the next few weeks through a range of potential scenarios, fully discussed and hopefully agreed with commissioners, so that a final plan can be presented through the final drafts of the IMTP in March. At this stage it is hoped that this will be able to present a balanced financial plan for 2024-27.

36. Further updates on how all of this develops will be provided to F&PC and Trust Board, including anything further progressed by the time of the F&PC meeting on 15 January 2024.

Writing the plan

37. Given the timing of the planning framework and allocation letters and the work to undertake prioritisation in January (workshop on 11th January), it is intended that a slide deck of key priorities for the plan will be brought to Trust Board in its January meeting, with a draft document circulated and further discussion enabled through development meetings with Non-Executive directors as well as in trade union meetings.

38. Areas such as People & Culture, Quality, Research & Innovation etc. may take specific development of their aspects of the IMTP into their relevant committees (i.e. People and Culture committee, QUEST, Academic Partnerships committee).

39. During this workstream we will develop the detailed appendices which will include Ministerial Templates, our MDS, detailed finance plan, and Decarbonisation Action Plan.

Governance, assurance and approval

40. As set out in paragraph 31, certain aspects of the plan go through relevant committees for guidance and endorsement. However, the key governance routes are as follows:

- **Strategic Transformation Board (STB)** (or Executive Leadership Team (ELT)) depending on timing) in 15 January 2024 - update on progress and presentation on key priorities informing the first draft of the IMTP
- **Finance & Performance Committee** 15 January 2024 – update on progress in developing the plan
- **Corporate Partnership Forum** (TU engagement) 22 January 2024 – ongoing engagement with TU partners on development of the IMTP
- **Trust Board** 25 January 2024 - update on progress and presentation of first draft of the IMTP
- **Emergency Ambulance Services Committee (EASC) Management** sessions January tbc – presentation of priorities and draft plans
- **111 Commissioning Board** sessions January tbc – presentation of priorities and draft plans, and endorsement in March 2024
- **EASC/ Welsh Health Specialised Services Committee (WHSSC) joint committee** 30 January 2024 – requirement at full committee tbc
- **STB** 26 February 2024 – updated draft
- **ELT** March 2023 – final draft for comment, amendment and endorsement
- **EASC/ (WHSSC) joint committee** 19 March 2024 – final draft for endorsement
- **Finance & Performance Committee** 19 March 2024 – scrutiny and assurance of final draft and endorsement for approval at
- **WASPT** March 2024 tbc – engagement on the final draft plan
- **Trust Board** 28 March 2024 - final version of the IMTP for sign off prior to submission to Welsh Government (WG)
- **WG Submission** - 28 March 2024

Recommendation: Finance & Performance Committee is asked to:

- **Note the overall progress in developing the IMTP;**
- **Note the financial and budget setting assumptions following issuing of the Health Board allocation letters;**
- **Note the approach and timelines set out in the report;**
- **Advise of any further assurance required during the final stages of the planning cycle.**

Appendix 1

NHS Wales Planning Guidance 2024 - 2027

Planning Framework received **18 December 2023**

Statutory requirement for approvable plans (Integrated Medium Term Plan/ IMTP) which comprises the duty to break-even, whilst setting out the improvements to services and their future sustainability within the resources available to reduce inequalities and to improve the health outcomes of the population served.

General Requirements
(Director General & Minister's Letters)

- ❑ Plans targeted to pressures:
  - Challenging financial outlook;
  - Impact on CYPs and other disadvantaged sectors.
- ❑ Recovery and sustainability
  - Optimisation of resources to deliver the best care and treatment for the people of Wales;
  - Reduction in inequalities and improving health outcomes – focus on gaps in service provision;
  - Stabilisation of the NHS.

Golden Threads

- ✓ Recognition of external factors being the most challenging circumstances since the inception of the NHS; recognition that this is likely to continue;
- ✓ Improving population health outcomes – impact of burden of disease modelling and focus on prevention – incl. weight management and diabetes;
- ✓ Children's access to specific and universal care and services;
- ✓ Quality and value-based approaches to care – reduction in waste, harm and unwarranted variation;
- ✓ Shift to primary & community focused care;
- ✓ Role of the NHS as an **Anchor institution**;
- ✓ Foundational economy;
- ✓ Wellbeing of Future Generations (5 Ways of Working);
- ✓ Climate change;
- ✓ Plans to show clarity of delivery commitments – assessment and aggregation against *A Healthier Wales.*

Plans to include in year priorities with route map to medium term, in 3 years context, with longer term ambitions.

Ministerial Priorities (Planning Framework): The national programmes will continue to support the delivery of services, whilst reinforcing best practice (quality, efficiency and patient experience) and not driving costs. ***Accountability Conditions for these programmes were issued in September 2023 and will provide continuity between 2023/24 Plans.***

Enhanced Care in the Community
➢ Focus on reducing delayed pathways of care

Primary and Community Care
➢ Focus on improving access and shifting resources into primary and community care

Urgent and Emergency Care
➢ Focus on delivering the 6 Goals Programme

Planned Care and Cancer
➢ Focus on reducing the longest waits

Mental Health, including CAMHS
➢ Focus on delivery of the national programme

Thematic Workstreams (Value & Sustainability Board)
To support and provide guidance, the VSB has agreed five workstreams to **maximise resource utilisation** across the system.
These thematic areas cover:

i. Workforce – continue reduction on reliance of high-cost agency staff; 'Once for Wales' arrangements for recruitment strengthened
ii. Medicines Management
iii. Continuing Healthcare (CHC) / Funded Nursing Care (FNC)
iv. Procurement and non-pay, and
v. Clinical Variation / Service Configuration – reduction in unwarranted variation and low-value interventions

The Board has already issued a range of requirements in relation to low value interventions, prescribing and continuing health care that must be implemented to ensure a consistent approach across Wales.

Further Requirements & Considerations
(Director General & Minister's Letters)

Process & governance arrangements
- Consolidation of plans and ensuring collective progression against sustainability agenda and delivery of ***'A Healthier Wales'***
- More detailed expectations are being produced – i.e. PHW mandate letter – follow in 2024.
- Three-year plan – incl. ***Firm, indicative, Outline*** levels of detail with clear progression captured.
- Detail of operational delivery, management of risk and financial sustainability.
- Agile and dynamic planning to adapt to changing environment.

Inclusions
- Quality, prevention, health inequity, impacts on CYPs particularly;
- Anti-Racism Action Plans – employment and service delivery;
- Duty of Quality – 12 Health and Care Quality Standards.

Financial
- Unprecedented level of financial deficit – continue to reduce funding deficits and ensure financial sustainability – driving down financial risk.

Integrated Arrangements
- Performance Framework will be issued ASAP and will reflect **key performance information,** complementing the Minimum Data Set (MDS)
- Templates – focus on areas of risk;
- Collaboration across HB and public sector boundaries.

Enablers & Influencers
- ✓ A Healthier Wales – Accountability Review
- ✓ NHS Wales Joint Commissioning Committee
- ✓ Value & Sustainability Board
- ✓ NHS Executive – phase two
- ✓ Social Partnership & Public Procurement (Wales) Act 2023
- ✓ Health Service Procurement (Wales) Bill
- ✓ Duty of Quality and Duty of Candour

Core Supporting Functions & Triangulations
Plans must take advantage of transformation, innovation, partnership/regional working and digital opportunities.

- ✓ Embrace the Accelerated Cluster Development and Regional Partnership Board Plans;
- ✓ Strengthen 'Once for Wales' arrangements for digital;
- ✓ Maximise opportunities for regional working;
- ✓ Redistribution of resources to community & primary care;
- ✓ Maximise opportunities offered by **key policies** – i.e. ***Further Faster;***
- ✓ Increasing administrative efficiency, to enable a reduction in administrative/management costs as proportion of the spend base.

AGENDA ITEM No	13
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – November 2023

MEETING	Finance and Performance Committee
DATE	15th January 2024
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning & Performance Mark Thomas – Commissioning & Performance Manager Melanie O'Connor - Commissioning & Performance Officer
CONTACT	Hugh.bennett2@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Melanie.O'Connor@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **November 2023.**

2. The indicators used at this high-level show a decrease of system pressure with handover hours lower in November compared to the previous month, however, November normally sees a reduction and therefore this reduction should not be used as a guide to December. The Trust has modelled handover at 25,000 for December 2023, which is lower than last year, but still extreme, with a consequent severe impact on patient quality, safety, and experience (long waits and unmet demand). The Trust's focus into winter is on boosting ambulance unit hours production (all resource types). Production was good in November and Emergency Medical Services (EMS) abstractions were 30.74%, almost achieving the pre-pandemic benchmark of 30%. The Trust has also identified with senior stakeholders the need to achieve its Integrated Medium Term Plan (IMTP) ambition of 17% consult and close. Performance had dipped earlier in the year, but has now started to improve again, rising to 14% in November. Cymru High Acuity Response Unit (CHARU) utilisation is below 30% and an area of focus.

3. 111 is showing continued improvement and is in a more resilient place than last winter. Senior stakeholders have been provided with day-by-day call handler production estimates for December, which are positive.

4. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, with both oncology and renal performance achieving their targets.

5. The Trust continues to focus on its people, with a range of tactical actions in place linked to winter planning e.g., reducing shift overruns, welfare vehicles etc., whilst it also continues with the more strategic focus on the People & Culture Plan. Sickness absence was 8.79% in November 2023 (9.41% rolling 2-year average).

6. Overall, the picture remains one in which the Trust can demonstrate clear improvement over things it controls, but a more mixed picture where there are system dependencies e.g., handover lost hours. For those areas that it controls in the 999 pathway, the Trust has identified: further improvement to its consult and close rate; maintaining the improvement in abstractions; and improving CHARU utilisation, as key.

RECOMMENDATION

FPC is asked to: - Consider the November 2023 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 is required, or
c) Further remedial actions are to be undertaken through Executives.

REPORT APPROVAL ROUTE

Date	**Meeting**
9 January 2024	**Executive Director Strategy, Planning & Performance**
15 January 2024	**Finance and Performance Committee**

REPORT APPENDICES

Appendix 1 – Top Indicator Dashboard

REPORT CHECKLIST

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

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **November 2023.**

BACKGROUND

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

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

3. These four areas of focus broadly correlate with the Quadruple aims set out in '*A Healthier Wales*'.

4. As previously agreed, the metrics which form part of this committee/Board report will be updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (Integrated Medium-Term Plan - IMTP) and strategies. A revised set were recently agreed, which are now being built into the report on an iterative basis.

ASSESSMENT

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

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

6. **999** call answering times, having been challenging at the end of last year, improved significantly, achieving the 6 second answering target during the early part of 2023, however, in the second half of the year the 95th percentile has begun to worsen; in October 2023 it was 27 seconds with an improvement to 18 seconds in November 2023. The 65th percentile and median performance remains very good.

7. **111 call answering is improving,** with the call abandonment target of <5% being achieved again in November 2023 (3.9%) and 61.6% of calls being answered within 60 seconds, although this still remains significantly below target (95%). Negotiations with commissioners have indicated that funding is available for 198 call handlers this year and recruitment has been underway to secure this number,

but there remain a number of vacancies. It was agreed to recruit another cohort in November, with the aim of getting closer to the 198 level (current estimate for December is 181 Full Time Equivalent (FTE)s, which is further boosted by bank and overtime). It should be noted that the Trust is anticipating a reduction in the commissioned level of FTEs next year. Significant improvement work has been undertaken on improving production and increasing productivity. There is also improved ICT in place since last winter. Senior stakeholders have been provided with day by day estimates of call handler production through December, which are positive. A priority was a commissioning intention to re-roster 111 (including demand & capacity work). The funding for this has been withdrawn.

8. **111 Clinical response:** the Trust continues to see achievement of the clinical call back time target for the highest priority 111 calls (P1CT – 99%). P2 and P3 was close to the 90% performance target in November 2023, with the respective figures being 83.7% and 86%. The previous improvement has been driven by more efficient working practices and the alignment of capacity to demand. The numbers of clinicians are now broadly at agreed establishment levels (recently agreed as 102 Whole Time Equivalents).

9. **Ambulance Response** (safety / patient experience): the Red 8-minute response performance for November 2023 was 49.48%, a slight improvement when compared to October 2023, remaining below the 65% target. However, there was a slight monthly decrease in the number of Red incidents that were actually attended within 8-minutes, dropping to 2,274 in November 2023. The actual number of Red incidents attended within 8-minutes has seen a general increase over the past two years with the monthly average in 2023 being 2,070 compared to 1,921 in 2022 and 1,813 in 2021. The Amber 1 median was 1 hour 8 minutes (ideal 18 minutes) and the Amber 1 95th percentile was 4 hours 44 minutes. These long response times have a direct impact on outcomes for many patients. Actions within the Trust's control include:

   Capacity:
   - Recruitment: The Trust currently has 97% of commissioned front-line posts in place. There is no significant recruitment planned over the next few months as forecasts identify that there is good coverage until March 2024.
   - Some additional funding was made available to pilot the new Connected Support Cymru service in partnership with St John Cymru (SJA). This funding has now ended; however, the Trust is continuing with this project through the volunteer Community Welfare Responders, which is producing some positive early results.

   Efficiency (rosters, abstractions/sickness absence and post-production lost hours)
   - The Managing Attendance Programme continues, delivered through this year's ten-point plan. There was a reduction in overall sickness levels during the early part of 2023, and although increases have been seen over the past two months,

further work is still on-going to reduce to 6% during 2023/24. There remain risks associated with delivery of this level of improvement especially in the context of winter viruses and Covid, as well as the impact of other winter pressures and handover delays.

Demand Management

- The increase in Clinical Support Desk capacity has meant that the Trust has been able to increase its consult and close rate over the last 12 months, however, it has declined in recent months, with an upturn to 14% in November (IMTP ambition 17% by quarter 4). The Trust has been asked by senior external stakeholders what it can focus through the winter, with the Trust identifying the 17% ambition as key, along with ambulance production (linked to targeted overtime and reduced abstractions).

Red Improvement Actions

- The full roll out of the Cymru High Acuity Response Units (CHARUs). Recruitment and training is being undertaken at pace with the aim to fully populate the CHARU rosters keys (153 full time equivalents), with the current estimated staff in post of 125 FTEs.
- Red review. This is being undertaken within additional resource, when possible, but ideally, as previously identified, would require additional FTEs. The resource requirement will be considered further through the 2023 EMS Strategic Demand & Capacity Review.
- A more efficient response logic, which went live on 19 June 2023, is reducing the number of multiple attendances to certain categories of red call, releasing resource to respond to other calls.

10. One of the key factors in relation to response times is the capacity lost to **handover outside Emergency Departments**. 21,110 hours were lost during November 2023. These levels remain so extreme that all the actions within the Trust's control cannot mitigate or offset this level of loss. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, with other health boards reporting that they are seeking to learn lessons. Wales Immediate Release figures for November 2023 were: Red 130 accepted and 4 declined; and Amber 1, 162 accepted and 302 declined. There has been some challenge from health boards on the accuracy of requests, with the Trust engaging in a workshop organised by the National Collaborative Commissioning Unit (NCCU). Two business continuity incidents were declared on the 7th and 29th November 2023 in two separate Health Boards. Ambulance production was good and there was no demand spike.

11. **Ambulance Care (formally NEPTS) (Patient Experience)**: Oncology performance exceeded the 70% target in November 2023 at 70.43%. Renal performance increased in November 2023, and remained above target at 73.62%. Advanced discharge & transfer journey booked in advance performance improved

compared to the previous month (81%); however, remaining below the 95% target. Overall demand for NEPTS continues to increase but remains below pre-pandemic levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: improved procurement through the plurality model, aligning clinic patient ready times to ambulance availability, re-rostering (NET Centre and NEPTS transport) and addressing oncology performance.

12. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported three NRIs to the NHS Executive in November 2023, a slight increase from the two reported in October 2023; and 22 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide. In November 2023 complaint response times increased to 38% and remained significantly below the 75% target, with cases remaining complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust has put more capacity into the Putting Things Right (PTR) team, which has had a positive impact for the Legal Team until periods of long-term sickness absence. The Concerns Administrators responding to patients and families continue to have lengthy and repeated calls due to protracted response times in the community, compounded by an inability to always respond in a timely manner to their concerns and questions. The Trust is concerned for the welfare of the team, given the nature and volume of the PTR work across all functions and a number of supportive actions are progressing/planned for both the corporate team and EMS Coordination & Resourcing.

13. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 77.9% in November 2023, a slight increase from the 76.4% seen in October 2023, but remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) compliance rate increased to 22.2% in November compared to 17.1% in October 2023.

14. For the first time, the Trust is now able to report on call to door times for Stroke and STEMI patients. These show in November call to hospital door times of 2:06 for stroke patients and 2 hours 15 minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls as a result of the pressures and issues outlined in this report.

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

15. **Hours Produced**: The Trust produced 121,349 Ambulance Response unit hours in November 2023, a slight decrease from the 122,047 produced in October 2023 (longer month). Emergency ambulance unit hours production (UHP) was 96% in

November 2023, thus improving and achieving the 95% target. CHARU UHP increased to 142% (note this is of the commissioned level, not full roll out). Key to the number of hours produced are roster abstractions, which remain above benchmark, but are reducing i.e., improving (see below).

16. **Response Abstractions:** EMS abstraction levels decreased to 30.74% in November 2023 and is now very close to the 30% benchmark. EMS Response sickness abstractions stood at 9.40% (benchmark 5.99%).

17. **Trust sickness absence:** the Trust's overall sickness percentage was 8.79% in November 2023, a slight decrease on the 8.65% recorded in October 2023. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan.

18. **Staff training and Personal Appraisal and Development Reviews (PADR)s:** PADR rates did not achieve the 85% target in November 2023 (76.59%), while compliance for Statutory and Mandatory training increased slightly to 76.56%.

19. **People & Culture Plan**: The Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working and the introduction of a staff pulse survey tool. The Executive Leadership Team have undertaken a pan-Wales round of CEO Roadshows in November 2023. Feedback from attendees identifies workloads as the main cause of stress and pressure.

Finance and Value

20. **Financial Balance**: The reported outturn performance at Month 8 is a surplus of £108k, with a forecast to the year-end of breakeven.

Partnerships/ System Contribution

21. **Shift left:** much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 14% in November 2023, an increase from the 13.8% seen in October 2023, but below the Trust's 2023/24 IMTP ambition of 17%. However, in relation to increasing the numbers conveyed to places other than a main Emergency Department, little progress has been made through the year. Work continues with health boards on gaining access to their Same Day Emergency Centres.

22. In November 2023, 9,586 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 164 callers. A formal programme to take forward "inverting the triangle" has been

established. The Trust has proceeded with growing the numbers of Advanced Paramedic Practitioners (APP)s in training. The current focus is on developing a "strategic case for change", a stakeholder engagement process and simulating the inversion through the 2023 EMS Demand & Capacity Review.

Summary

23. The indicators used at this high-level highlight a decrease of system pressure, in particular, handover lost hours; however, November normally sees a reduction before a further increase in December. Clearly, the level of handover is having a serious impact on the quality, safety, and patient experience that the Trust can deliver (long waits and unmet patient demand). 111 is continuing to show improvement with abandonment rates continuing to achieve better than target levels. Ambulance Care, in particular, NEPTS performance has been relatively stable. Overall, the picture remains one in which the Trust can demonstrate clear improvement over some things it controls, but a more mixed picture where there are system dependencies e.g., handover lost hours, and these pressures are beginning to increase as the Trust heads into winter.

RECOMMENDATIONS

FPC is asked to: -

- **Consider** the November 2023 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 is required, or
  c) Further remedial actions are to be undertaken through Executives.

Welsh Ambulance Services NHS Trust

Monthly Integrated Quality & Performance Report

November 2023

Annex 1 – Top Indicator Dashboard

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: January 2024

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2023/24	2 Year Average	Oct-23	Nov-23	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	11.8%	2.9%	3.9%	G
111 Clinical Triage Call Back Time (P1)	90%	97.3%	99.0%	99.0%	G
999 Call Answer Times 95th Percentile	00:06	00:40	00:27	00:18	R
999 Red Response within 8 minutes	65%	50.5%	47.2%	49.5%	R
999 Amber 1 Median	00:18	01:22	01:23	01:08	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	73.5%	65.4%	70.4%	G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	84.9%	78.0%	81.3%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	18.6%	17.1%	22.2%	A
Stroke Patients with Appropriate Care	95%	77.4%	76.4%	77.9%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:27	2:18	2:06	A
Acute Coronary Syndrome Patients with Appropriate Care	95%	43.4%	53.5%	42.6%	R
National Reportable Incidents reports (NRI)	Reduction Trend	5	2	3	A
Can't Send & Cancelled by Patient Volumes	Reduction Trend	10904	10535	8819	A
Concerns Response within 30 Days	75%	38.8%	21%	38%	R
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	95%	93%	96%	G

Top Monthly Indicators	Target 2023/24	2 Year Average	Oct-23	Nov-23	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	9.41%	8.73%	8.79%	R
Mental Health Absence Rates	Reduction Trend	2.38%	2.59%	N/A	A
Staff Turnover Rate	Reduction Trend	10.34%	9.10%	9.34%	A
Statutory & Mandatory Training	>85%	79.69%	76.43%	76.56%	R
PADR/Medical Appraisal	>85%	69.49%	73.0%	76.6%	R
Number of Shift Overruns	Reduction Trend	3778	4106	4021	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.1%	1.4%	1.5%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	32%	27.2%	25.3%	R
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.42	2.36	2.29	A
NEPTS on the Day Cancellations	Reduction Trend	19.6%	19.4%	25.3%	A
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	13.1%	13.8%	14.0%	R
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.4%	10.72%	11.81%	A
Number of Handover Lost Hours	15,000	22,963	23,232	20,110	R
NHS111					
NHS111 Dental Calls	Increasing Trend	6,117	7,107	6,996	A
Consult & Close Volumes by NHS111	Increasing Trend	1,131	940	1,260	A

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

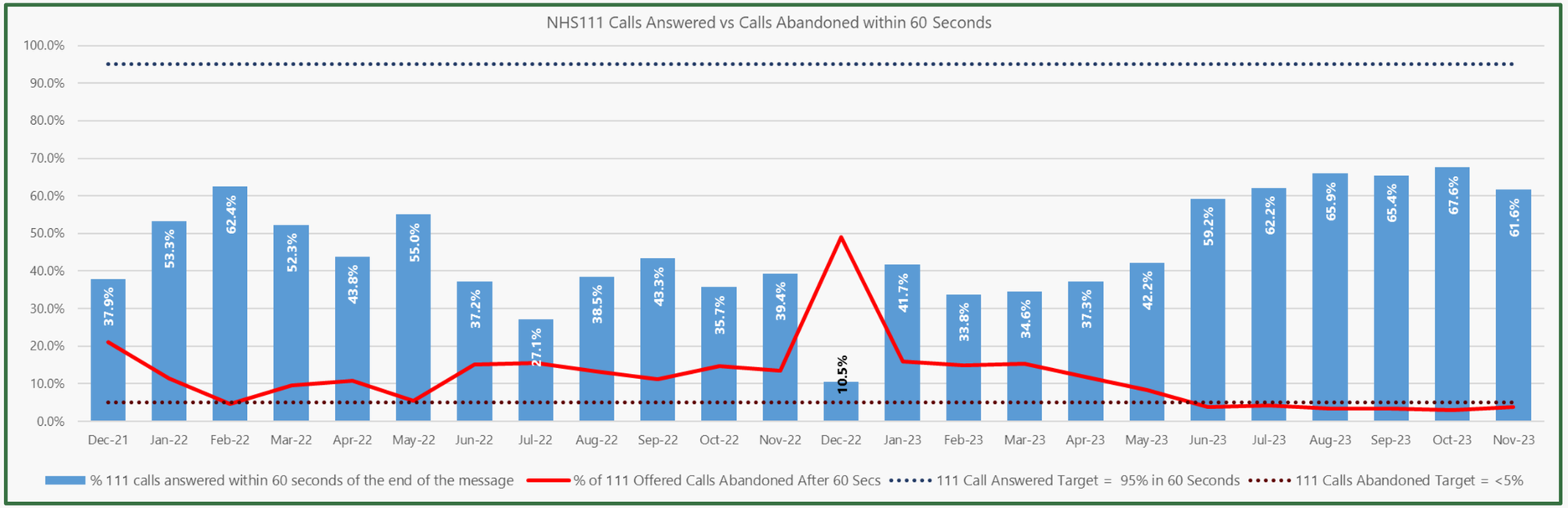
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

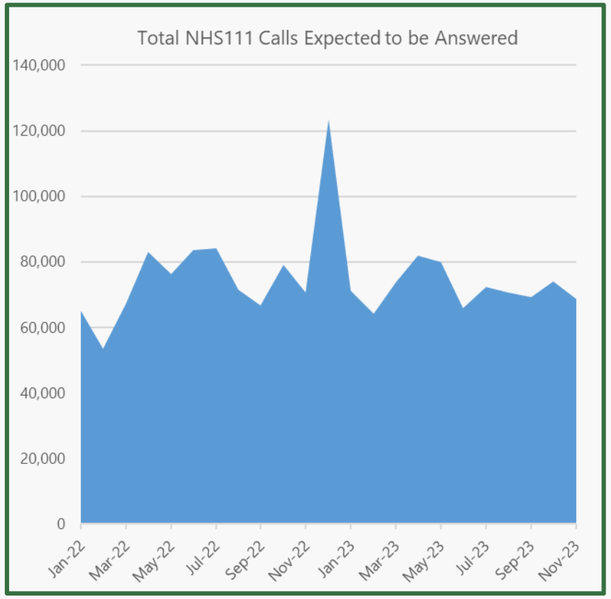
(Responsible Officer: Lee Brooks)

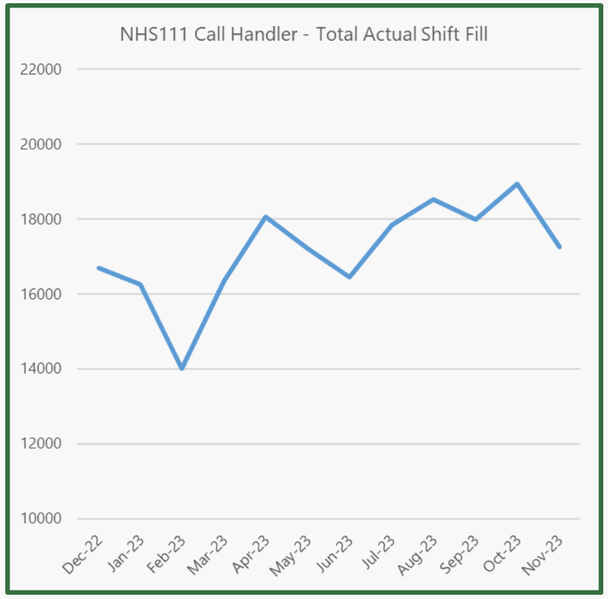
Abandonment Rate G

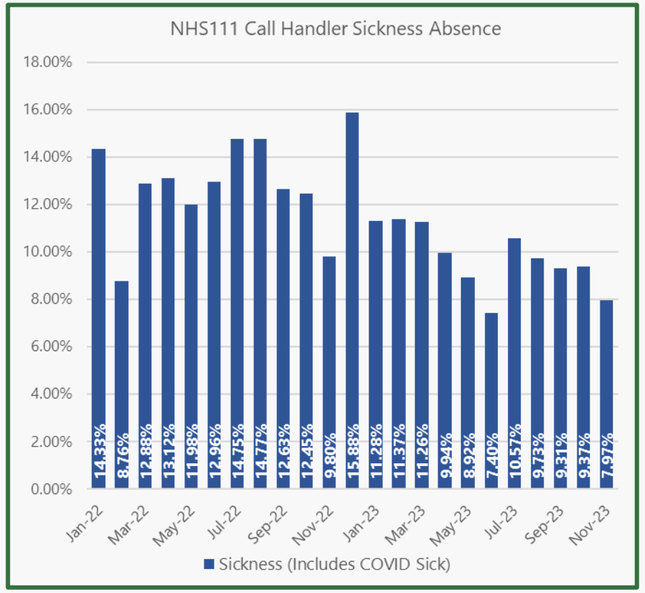
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

111 call abandonment is a key patient safety indicator for the service. November 2023 saw an **abandonment rate of 3.9%,** remaining below the 5% target, however an increase from 2.9% in October 2023.

The percentage of 111 calls answered within 60 seconds of the end of the message in November 2023 reduced to 61.6%, which although remaining below the 95% target, is a decrease compared to October 2023 (67.6%).

The percentage of 111 calls answered in Welsh increased from 1.15% in October 2023 to 1.25% in November 2023.

Abstractions due to sickness absence decreased slightly, reinforcing the longer-term downward trend. 111 abstractions are lower (better) than benchmark.

Remedial Plans and Actions

The key to improving call answering times is having the right number of call handlers, rostered at the right time to meet demand, and to maximise efficiency.

- Agreement has been reached with commissioners that 198 WTE call handlers will be funded in 2023/24. The Trust is currently 21.25 FTE short of establishment. The Trust is aiming to address this in quarter three. The Trust is expecting the 111 resource envelope to reduce in 2024/25.
- Work continues on sickness absence in line with the Trust's managing absence work programme with an IMTP aim to get organisational sickness down to 6%
- A roster review in three parts is due to start, in collaboration with the 111 commissioners to review rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week. Funding has been withdrawn, so this project is now paused.

Expected Performance Trajectory

The Trust is now moving into the winter period. The Trust has improved ICT, compared to last winter, and improved processes and is recruiting up towards the commissioned FTE totals. In December 2022 there was a very severe spike in demand, not seen the previous winter.

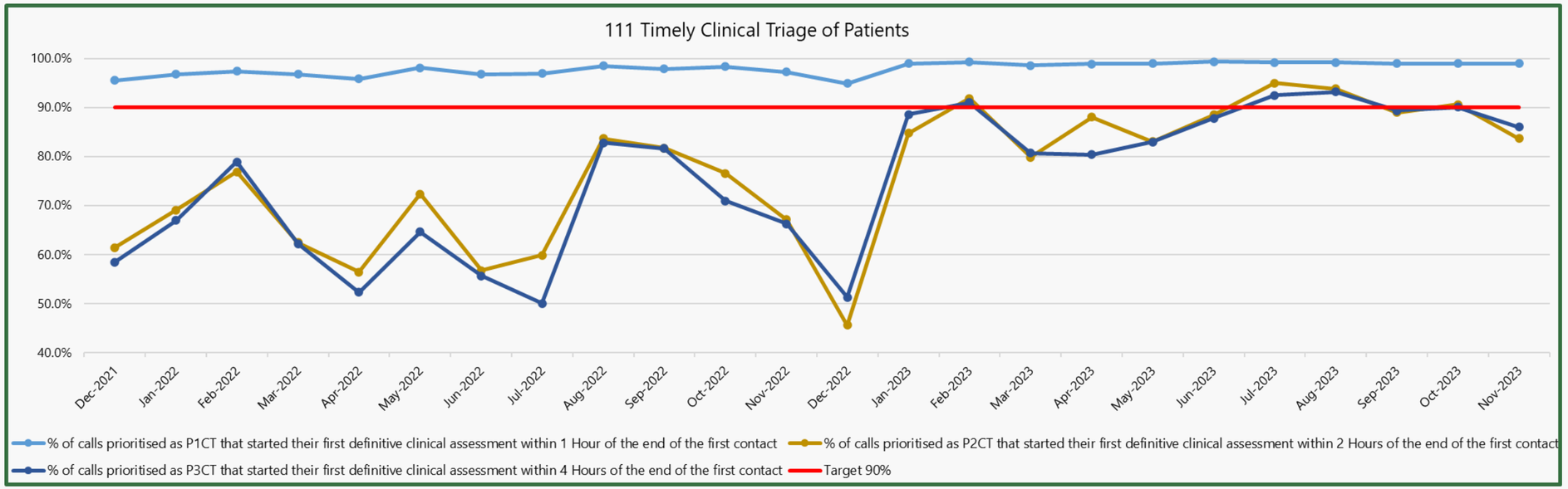
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

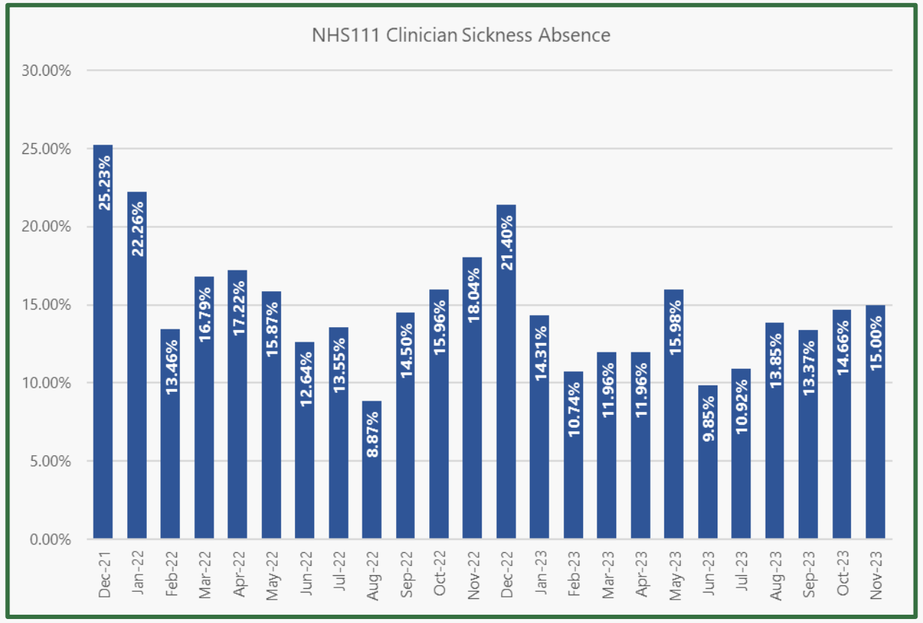
(Responsible Officer: Lee Brooks)

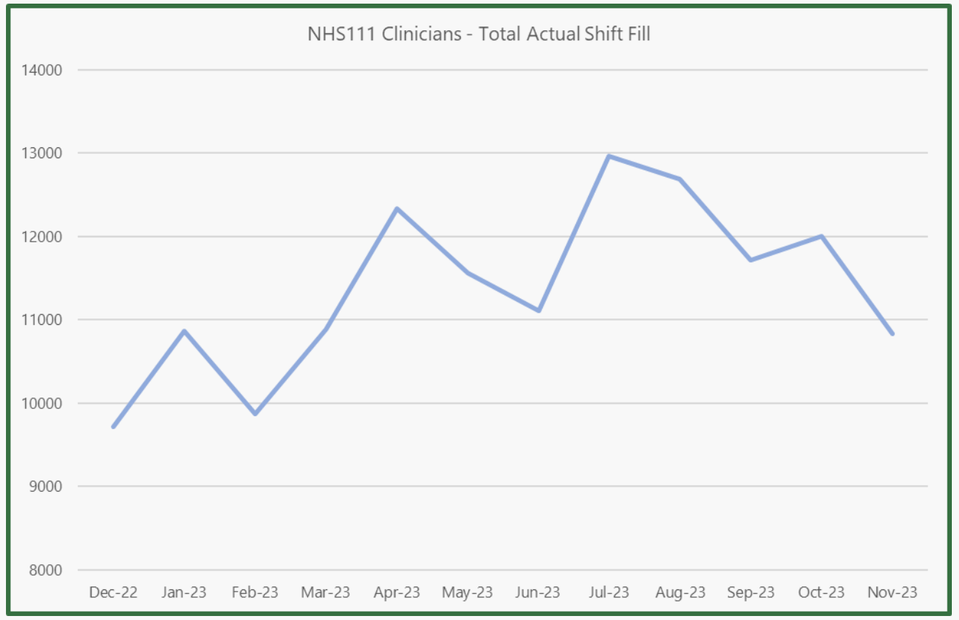
P1CT G

FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

The highest priority calls, P1CT, continues to achieve the 90% target (99%).

For lower category calls P2CT decreased to 83.7% in November 2023 compared to 90.6% in October 2023, while P3CT also decreased to 86% in November 2023 compared to 90.1% in October 2023.

Clinical staff capacity decreased to 10,838 hours during November 2023, a drop of 1,162 hours when compared to October 2023. Clinician sickness absence increased to 15% in November 2023 from the 14.66% reported in October 2023.

Remedial Plans and Actions

The main driver for improved performance will be the correct number of clinicians in post to manage current and expected demand. At present 100.71 FTE (Sep-23) nurses and paramedics are in post, and commissioners have indicated that they have funding available for 102 WTE., albeit this could change next year. ORH however have indicated that 140 FTE are required to achieve the KPIs.

Expected Performance Trajectory

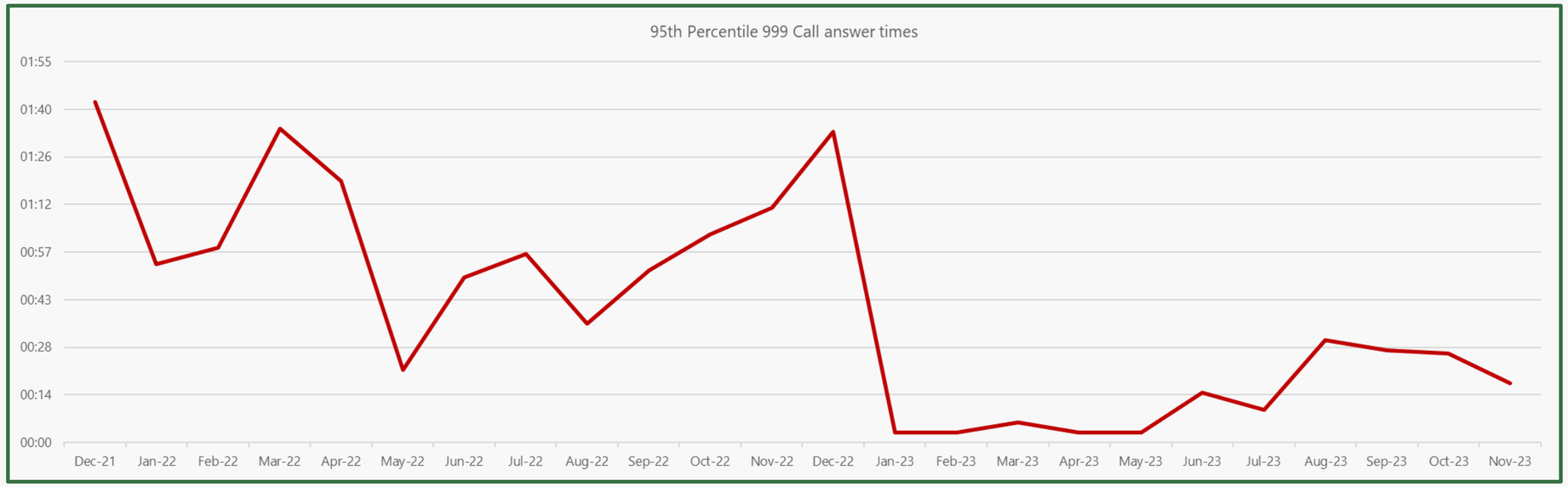
The Trust is now moving into the winter period. The Trust has improved ICT, compared to last winter, and improved processes and is recruiting up towards the commissioned FTE totals. In December 2022 there was a very severe spike in demand, not seen the previous winter. Some in year capacity has been provided by 111 commissioners regarding maintaining the 111 website, in particular, the symptom checkers.

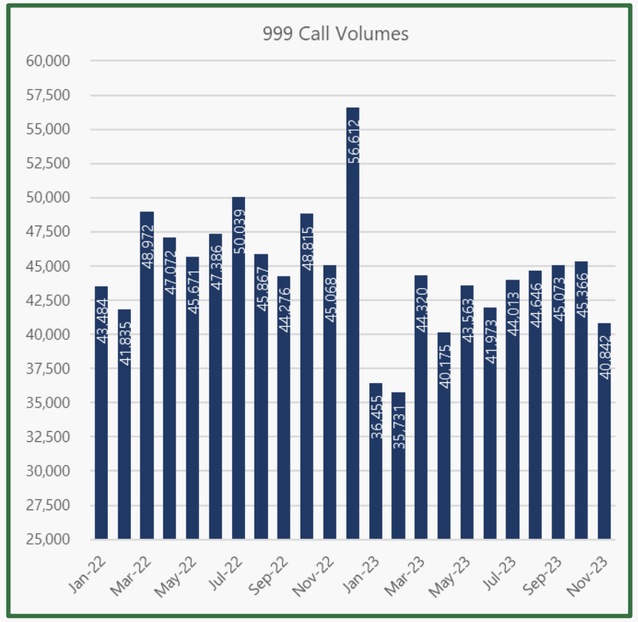
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

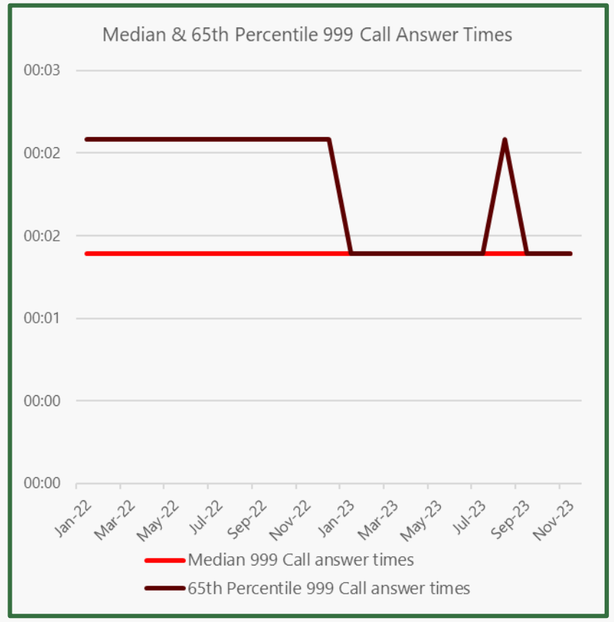
(Responsible Officer: Lee Brooks)

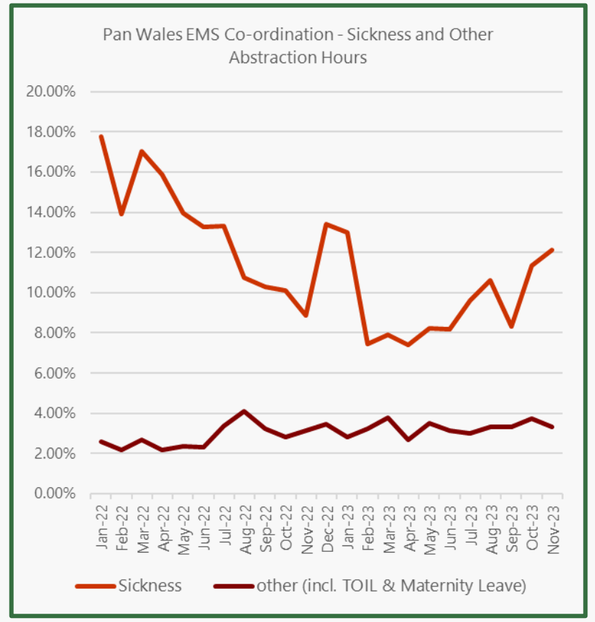
999 R | FPC | CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance improved to 18 seconds in November 2023, down from 27 seconds in October 2023 but remained above the 6 second target. The median call answer time for the 999-service remained consistent at 2 seconds.

The Trust received 40,842 emergency 999 calls in November 2023, a decrease from the 45,366 calls received during October 2023, the first month since May 2023 demand has decreased.

Overall sickness abstractions within the EMS Coordination have risen over the past four months, after being on a downward trajectory till April 2023, rising to 12.11% in November 2023.

Remedial Plans and Actions

- EMD FTE is currently 119.89 against a funded establishment of 111.76; however, this includes new starters still in the sign off period. Once qualified, experienced staff will be re-aligned to vacant dispatcher posts.
- Intelligent Routing Platform is now in operation following configuration changes.
- A cohort of 12 went live the end of September with a further cohort of 9 commencing in North at the end of October go live end of November, and a further course of 12 arranged for November with go live 25 December; however, the teams are still experiencing attrition.
- Three workstreams are being progressed through the EMS Reconfiguration project (the complete reconfiguration has not commenced due to cost pressures required to fund the agreed model approved by ELT). This is on hold currently but will re commence in the next few weeks pending outcome and approval of a proposed new Structure for EMSC. This will require consultation.

Roster Review. Having successfully implemented an EMD roster review in February 23 the project has now progressed to commencing a dispatch roster review for Allocators and Dispatchers. About to restart subject to revised structure being agreed at Operations SLT in January 2024.
Boundary changes. EMS Coordination intend to realign dispatch. boundaries to balance workload and pressures for individual dispatch teams About to restart as above..
Broader Ways of Working. This project is looking to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and lack of variation across centres. About to restart as above.

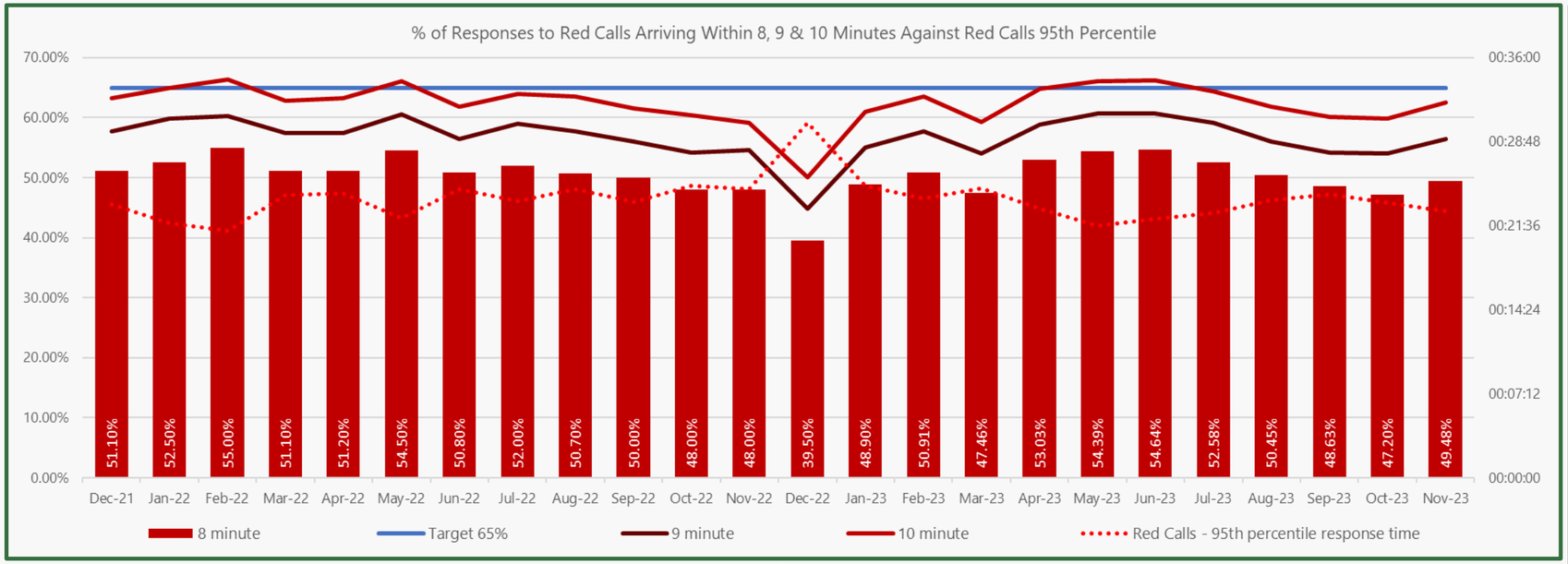
Expected Performance Trajectory
Performance is expected to remain on track, subject to continued good work around capacity management.

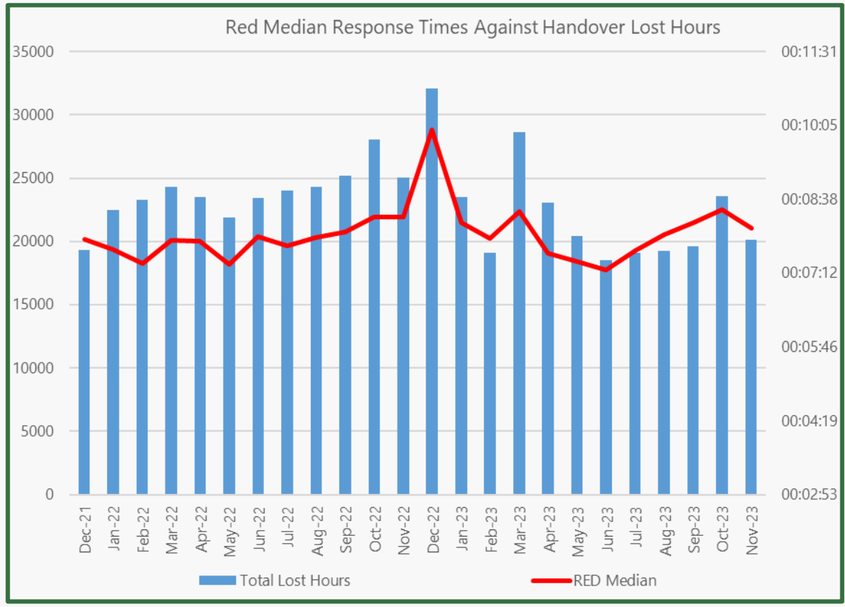
Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

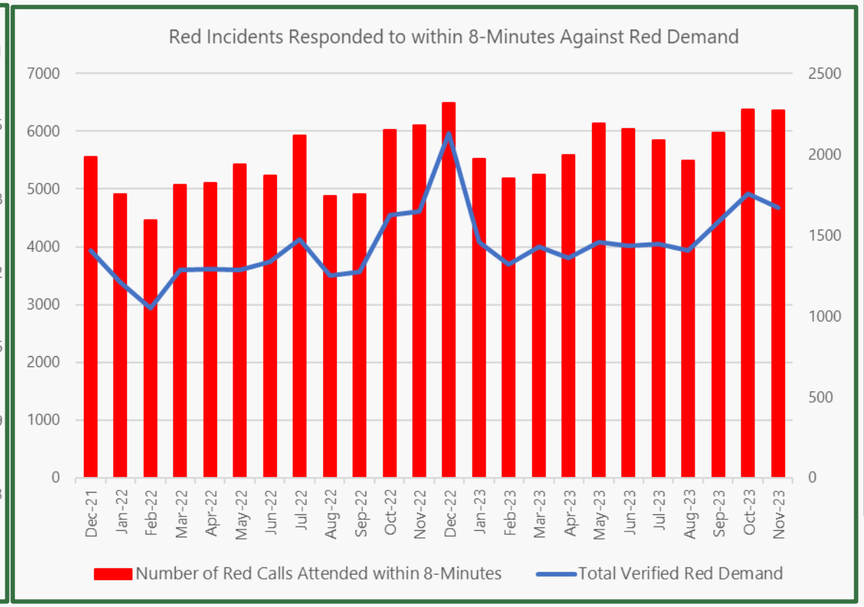
Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

65% R | 95% R | QUEST | FPC | CI







Analysis

Red performance increased slightly in November 2023 to 49.48%, but continues to remain below the 65% target. None of the seven health boards achieved this target. Red 10-minute performance was 62.5% for November 2023, up from 59.8% in October 2023 and the first time since June 2023 to see a month-on-month increase.

Three of the main determinants of Red performance are Red demand, unit hours produced, and handover lost hours.

The bottom right graph shows that even though Red 8-Minute performance, based on percentage is falling, as demand increases the number of Red incidents the service is responding to inside 8-minutes has increased. In September 2023, the Trust responded to 2,131 Red incidents inside 8-minutes. This increased to 2,278 incidents in October and only decreased very slightly to 2,274 in November 2023, which is a shorter month.

The lower left graph demonstrates the correlation between overall Red performance and hospital handover lost hours. November 2023 saw a decrease to 20,110 lost hours compared to 23,232 in October 2023. This decline in November mirrors the pattern seen in each of the previous 3-years, with handover lost hours expected to rise again in December. Although these levels are lower than the figures seen during 2022, they continue to remain significantly above where they need to be.

Remedial Plans and Actions

The main improvement actions are:

- To maintain commissioned establishment levels overall. WG have confirmed funding for the additional 100 will remain in place for this financial year
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (127 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas. Further actions to address;
- Changes to the response logic and clinical screening of red calls, which are now live (19 June 2023);
- Reduce hours lost through sickness absence via managing attendance programme – trajectory for improvement in place as part of the IMTP (6% Mar-24);
- Working closely with Health Boards to support reduction in lost hours and a reduction in conveyances to ED. This is undertaken within local Integrated Commissioning Action Plan meetings and will include work on improvements in referrals to Same Day Emergency Care Units (SDECs).

Expected Performance Trajectory

Winter modelling estimates Red 8 minute (most likely scenario) of 50% in October and November, declining to 45% in December, before recovering somewhat in Q4. The modelling has been shared with Welsh Government and EASC..

*NB: Data correct at time of abstraction

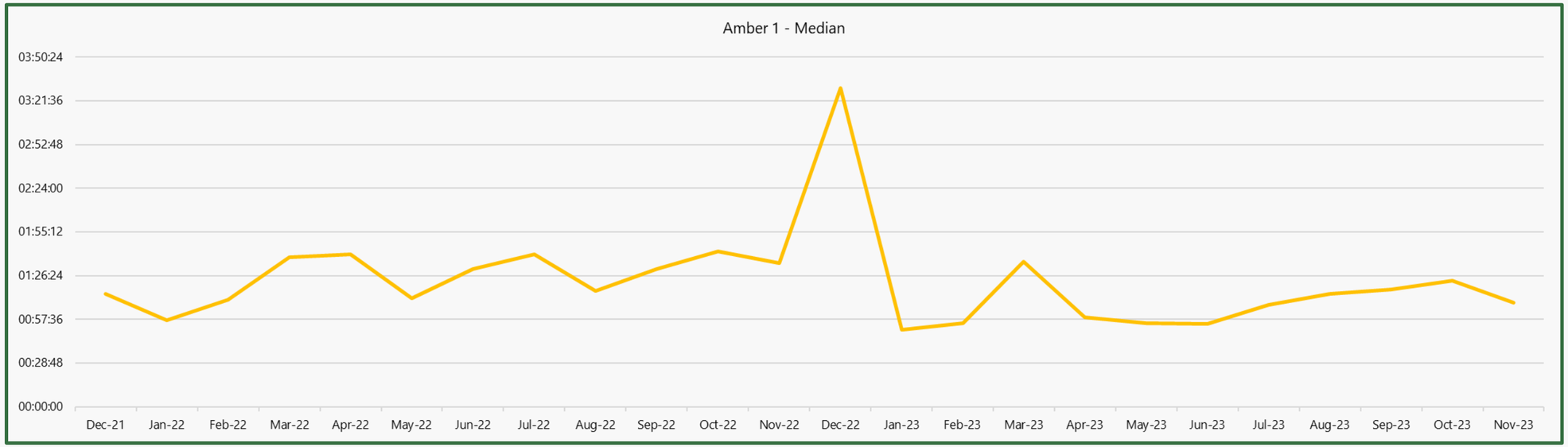
Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

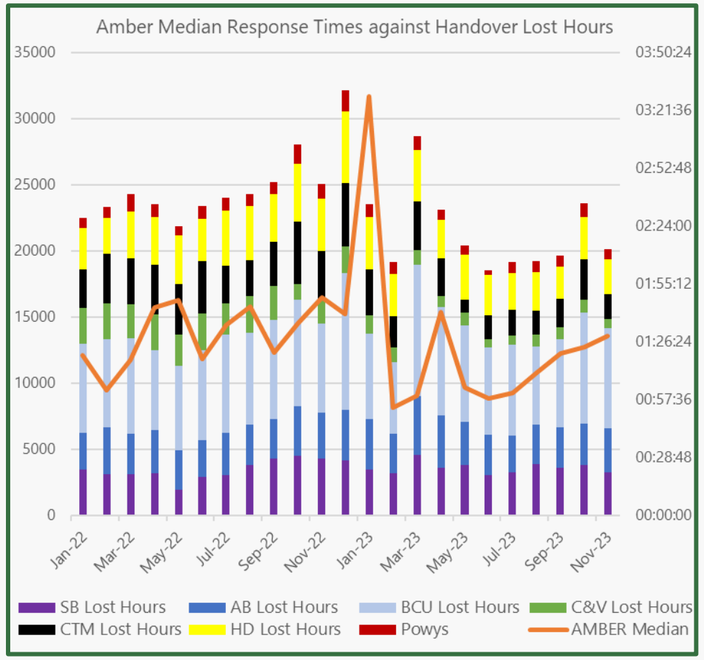
(Responsible Officer: Lee Brooks)

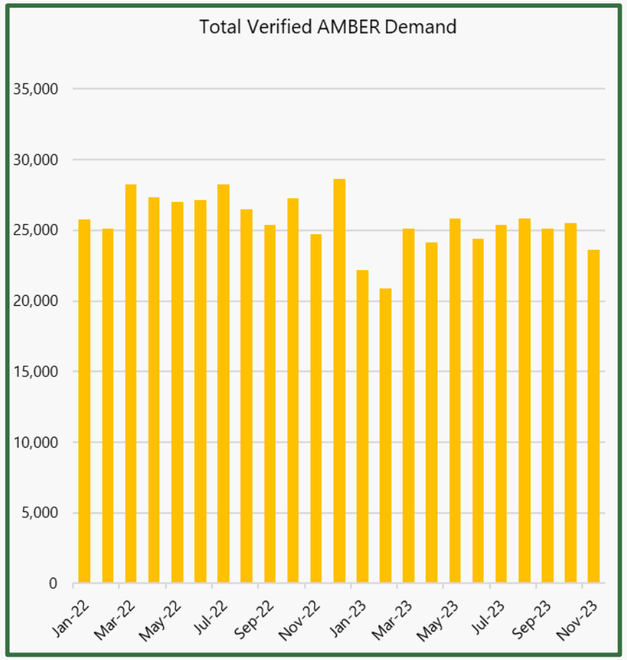
R

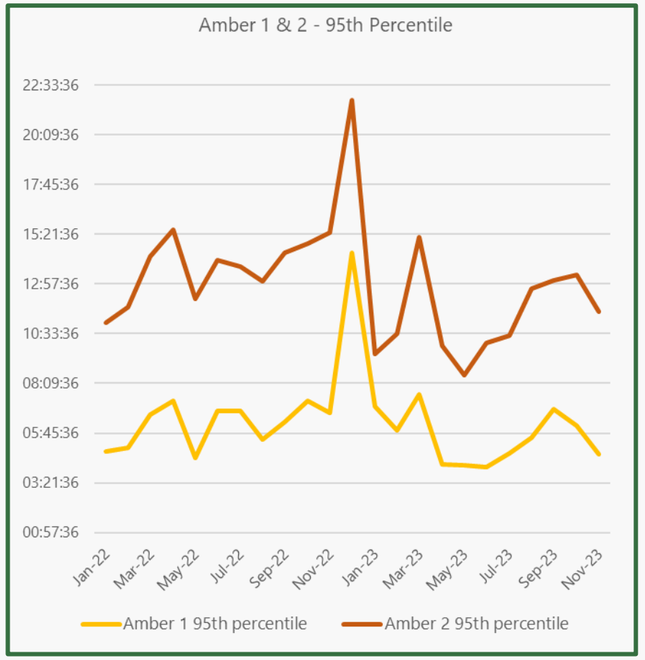
FPC CI QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Amber 1 median performance improved during November 2023 to 1 hour 8 minutes, from the 1 hour 23 minutes recorded in October 2023. The ideal Amber 1 median response time is 18 minutes. The 95th percentile also improved to 4 hours and 44 minutes from 6 hours 6 minutes in October 2023.

There were some long patient waits in November 2023, with 1,680 patients (all categories, not just Amber) waiting over 4 hours, although this was an improvement on the 1,888 waiting over four hours in October 2023.

Amber demand decreased slightly in November 2023 to 23,617 verified incidents, although this remains 4.6% lower than demand levels seen in November 2022.

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

Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide.

Expected Performance Trajectory

The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments and system efficiencies, not all of which are within the Trust's control. This programme is now coming to an end, but the Trust is now well advanced with the strategic EMS Demand & Capacity Review.

Our Patients: Quality, Safety & Patient Experience

Patient Experience – Influencing Ambulance Care Indicators

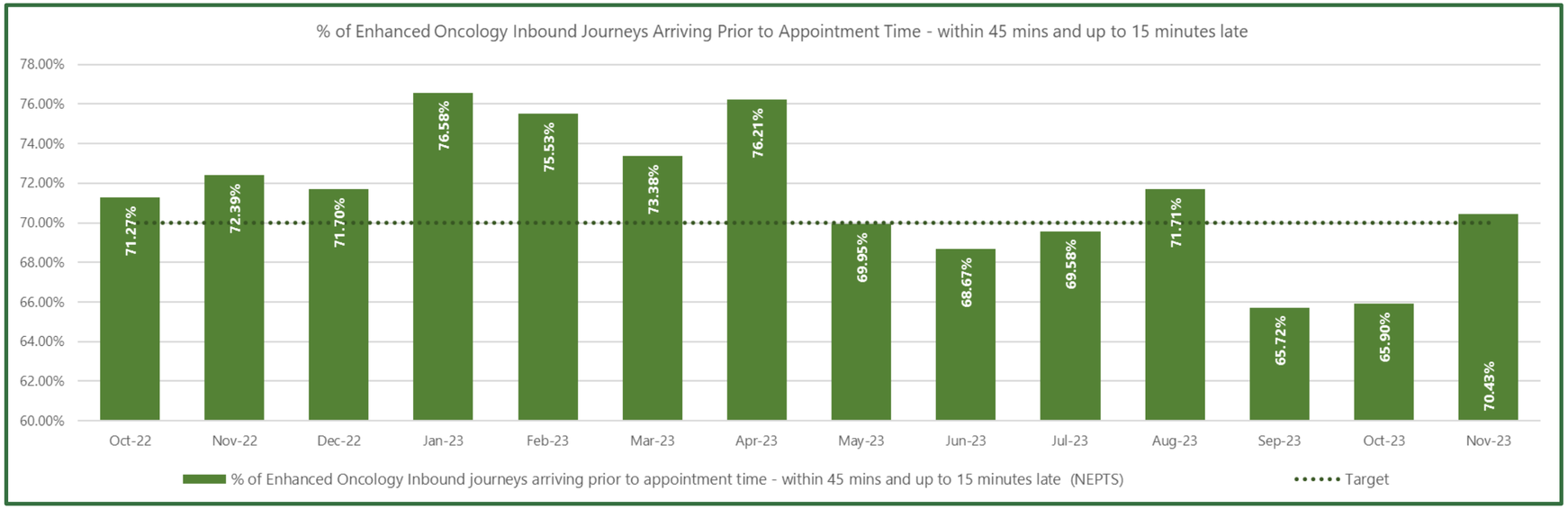
(Responsible Officer: Lee Brooks)

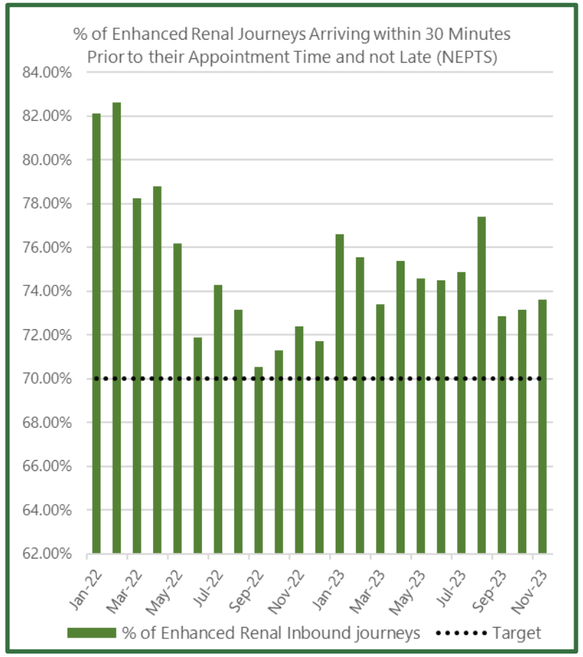
Oncology

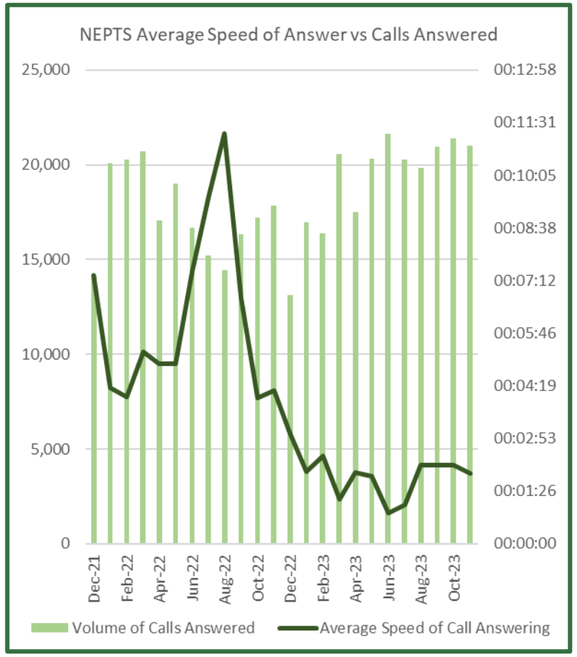
G

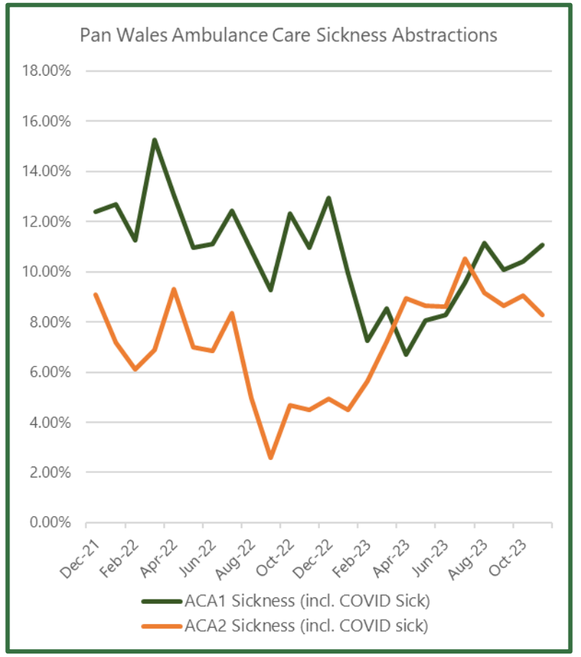
FPC

CI









Analysis

Ambulance Care (NEPTS element) performance increased slightly during November 2023. 70.4% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, an increase from 65.9% in October 2023, and achieving the 70% target. Enhanced Renal journeys also saw an improvement, from 73.1% in October 2023 to 73.6% in November 2023.

Overall demand has continued to increase as the planned care system continues to reset. In particular:-

- Completed journeys for Patients requiring Ambulance Transport – Non T1 & C3 mobility (exc. Discharge & Transfer) are at or in excess of levels seen prior to the pandemic.
- Oncology journeys in particular have increased significantly since April 2023 and in June 2023 were at levels not seen since 2019.
- There has been a notable increase in requests for discharges from the ED. This correlates with EMS no longer facilitating these requests.

Call volumes answered decreased slightly in November 2023 (21,023) compared to October 2023 (21,374). Average speed of call answering also increased in November 2023 (00:01:55) compared to October 2023 (00:02:09). However, the overall percentage of calls answered within 60 seconds declined in November 2023 to 59.7%, compared to October 2023 (60.9%).

ACA1 (NEPTS) sickness increased in November 2023 to 11.08% compared to October 2023 (10.41%). ACA2 (UCS) sickness decreased to 8.27% in November 2023 compared to October 2023 (9.03%).

Remedial Plans and Actions

- Local management teams are working closely with Health Board colleagues to develop local actions in response to the current level of Oncology performance. This should address the lack of cohesive planning that includes transport as we have in Renal services.
- The renal hub has begun the transformation from a renal only service into an enhanced service hub focused. The first piece of work they will focus on will be the creation of a group of oncology focused volunteers and a buddy system for those patients that have regular transport patterns. This will improve patient experience and performance.
- A separate workstream has also been created focused on data management on ready and pick up times. I tis believed that this will improve overall performance and ensure a more robust data set.
- All of the above actions will be contained within an improvement plan to be presented to SLT on the 9th November.

Expected Performance Trajectory

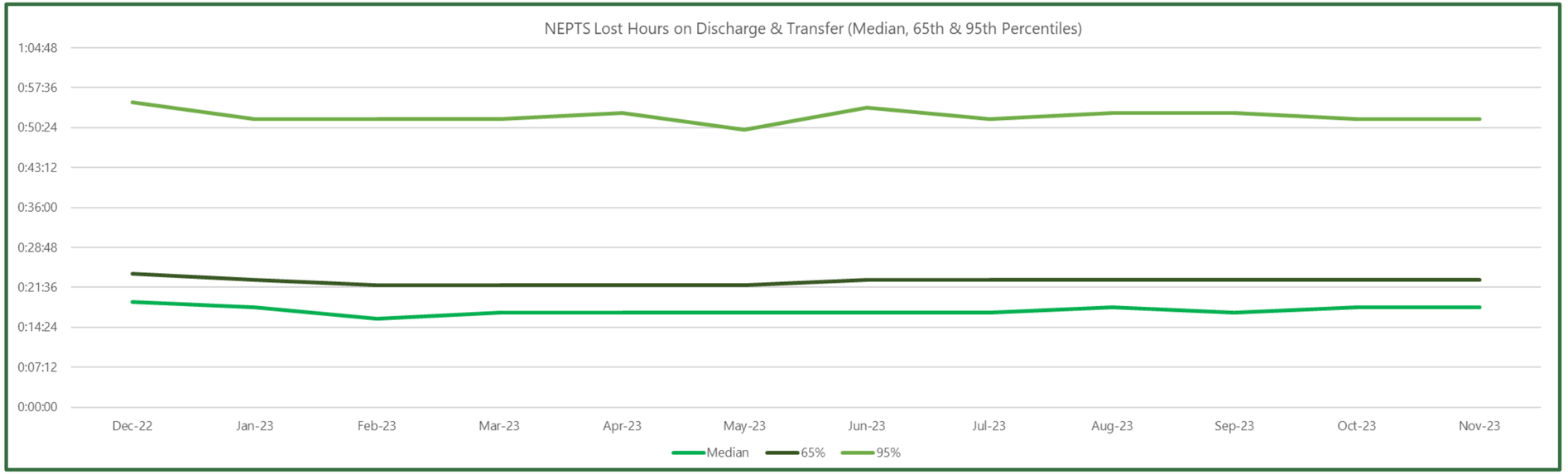
With the implementation of the above actions, it is anticipated that Oncology performance will improve over Q3. Initial improvement trends have already been seen after just a few of the actions have been partly implemented.

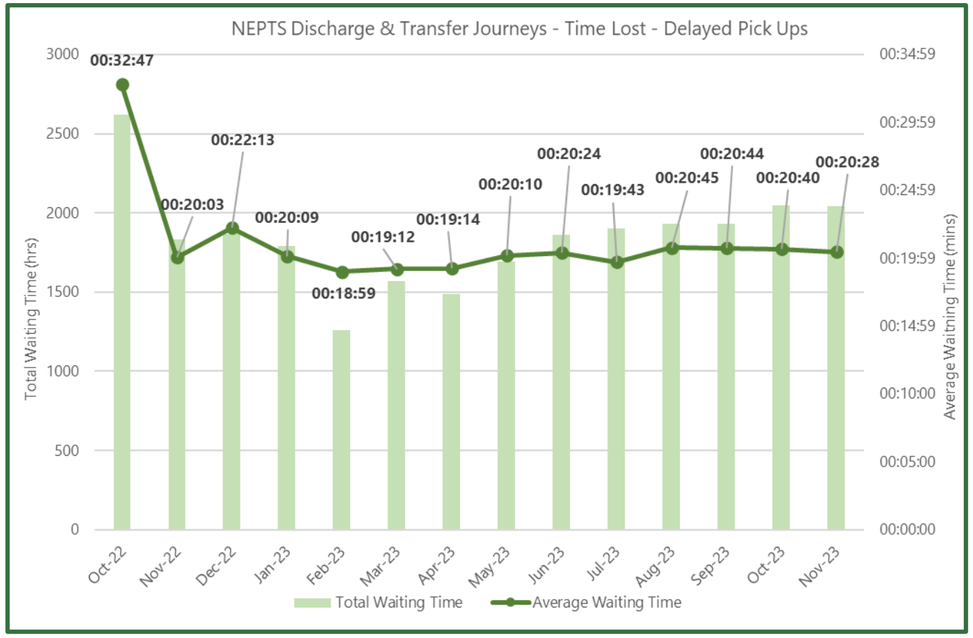
Our Patients: Quality, Safety & Patient Experience
Ambulance Care Indicators

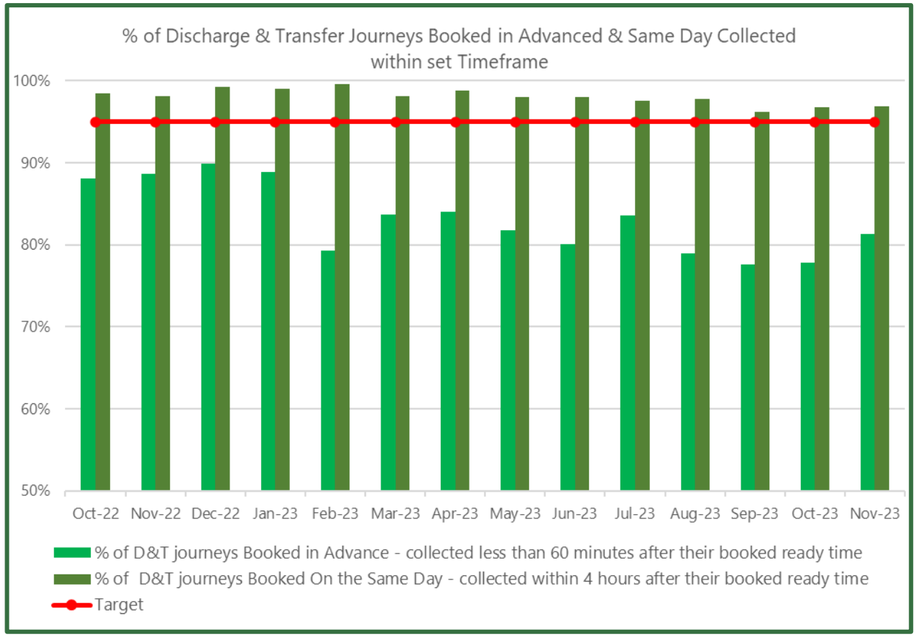
(Responsible Officer: Lee Brooks)

D&T
R

Patient Experience – Hospital>Hospital Transfer Waiting Times







Analysis

Time lost on discharge and transfer pickup has remained consistent for some time now with minimal variation experienced.

The data shows that the average time lost over the past 12 months is 17 minutes, which includes time from arrival at site to when the patient is loaded on the vehicle. The hope is that over time this can be reduced to 15 minutes.

Where sites have discharge lounges, it may be possible to reduce current performance and within some sites this occurs regularly.

The main area of concern are those sites where no discharge lounge exists or where the discharge lounge is poorly located in addition to sites that have no robust process to make sure that a patient and their accompanying requirements are ready when crews arrive.

81% of discharge & transfer journeys booked in advance were collected within 60 minutes of their booked ready time, an increase compared to October 2023 (78%), but below the 95% target. 97% of discharge & transfer journeys booked on the same day were collected within 4 hours of their booked ready time, consistent when compared to October 2023 (97%), and above the 95% target.

Remedial Plans and Actions

We have started work with BCU at YGC and CTM to develop an optimal discharge model to minimise this figure as close to the 15 minutes as is possible.
This model can then be rolled out across all areas of Wales.

In addition, our teams are refining our processes including making it clear to crews when to input to their MDT, the rollout of MDVS will assist with this.

Expected Performance Trajectory

Until the model is developed and rolled out, we do not anticipate any significant variation in this data. However, we continue to work with sites and the teams to identify opportunities to reduce.

Our Patients: Quality, Safety & Patient Experience
Clinical Outcomes Indicators

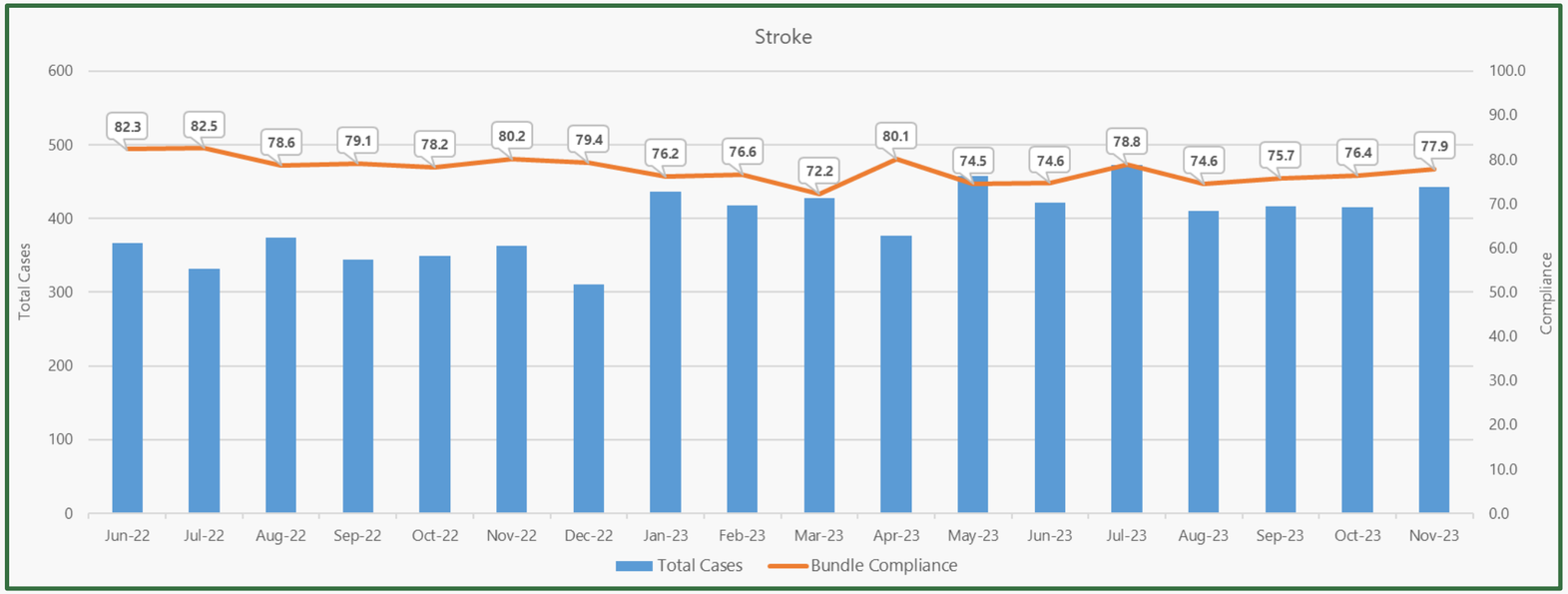
(Responsible Officer: Andy Swinburn)

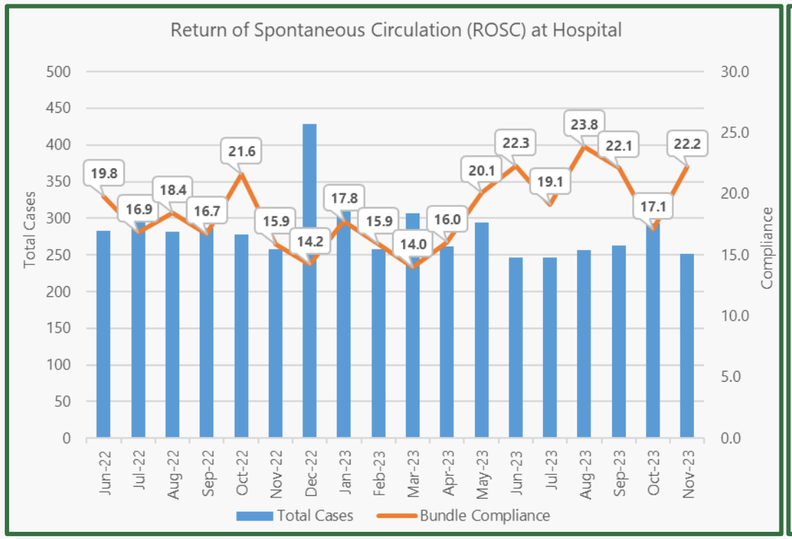
Stroke/Hip Fracture/Hypoglycaemic
A

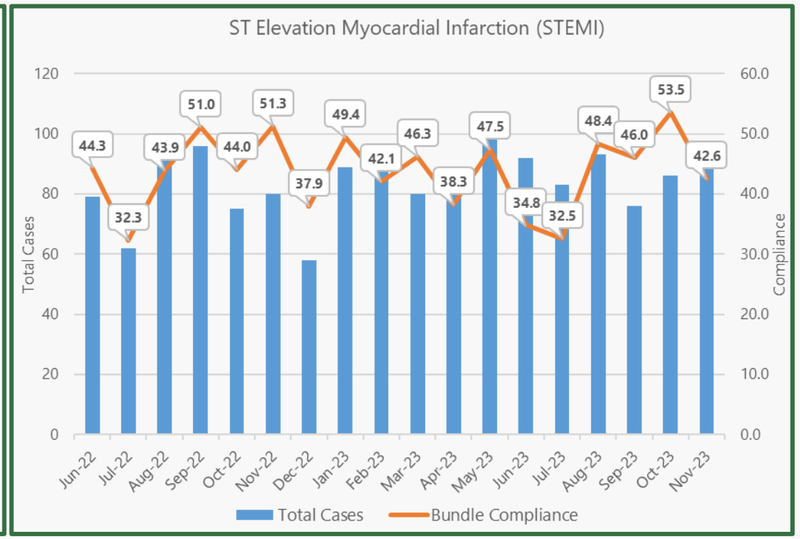
Self-Assessment: Strength of Internal Control: Moderate

QUEST

Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, Acute Coronary Syndrome Patients with Appropriate Care







Analysis

The percentage of suspected stroke patients receiving an appropriate care bundle in November 2023 was 77.88%. This was a slight improvement from the 76.39% recorded in October 2023. This was against a total case number of 443 during the month of November. There is a correlation between documenting FAST and the care bundle, this will inform the improvement plan.

The ROSC rate for November 2023 was 22.22% an increase from 17.06% in October 2023. This was against a total case number of 252 during the month of November. The rate for August 2023 was 23.83% which was the highest figure recorded since the implementation of ePCR. Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this may include:

- Response Times
- Bystander Resuscitation
- Response Type/Numbers

The percentage of suspected STEMI patients receiving an appropriate care bundle in November 2023 was 42.55%, a decrease from 53.49% in October 2023. This was against a total case number of 94 during the month of November. There is a correlation between documenting of Aspirin and the care bundle, this will inform the improvement plan.

All CIs remain within the normal bundle control limits.

The Trust was aware that changing from Digital Pen to ePCR necessitated a change in data collection and anticipated a reduction in compliance as Clinical Indicators are now compiled from data recorded by clinicians and is not subject to any validation process.

In addition, other UK ambulance services reported a reduction in clinical indicator compliance when using ePCR data only . The Trust generated risk 535 with three key mitigations to work on:

- User understanding and behaviour with the ePCR application
- Adapting the user interface
- Reviewing the coding used to draw data from the data warehouse

Our Patients: Quality, Safety & Patient Experience
Clinical Outcomes Indicators

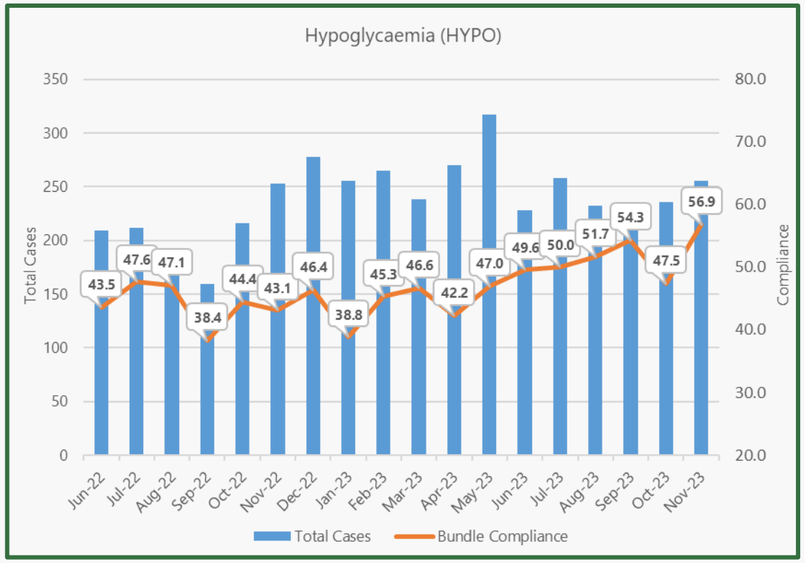
Hypoglycaemia, Neck of Femur (NOF) and Time-Based metrics (Stroke & STEMI)

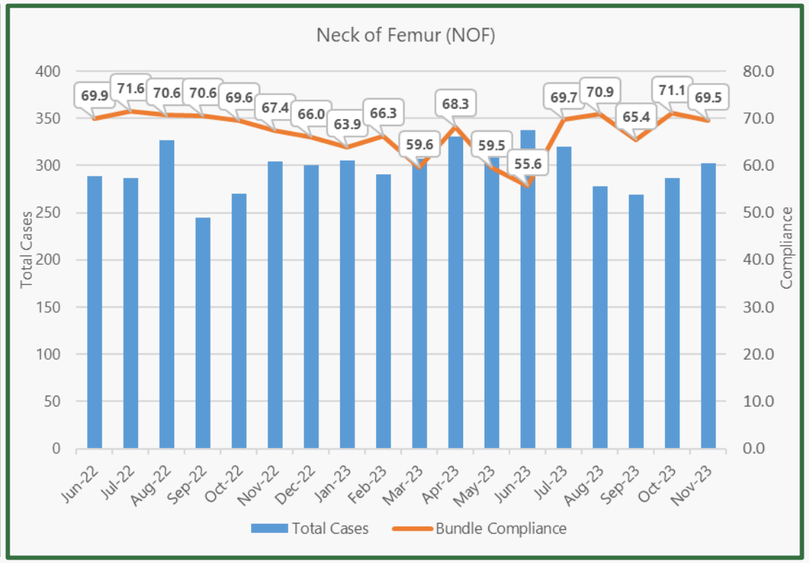
(Responsible Officer: Andy Swinburn)

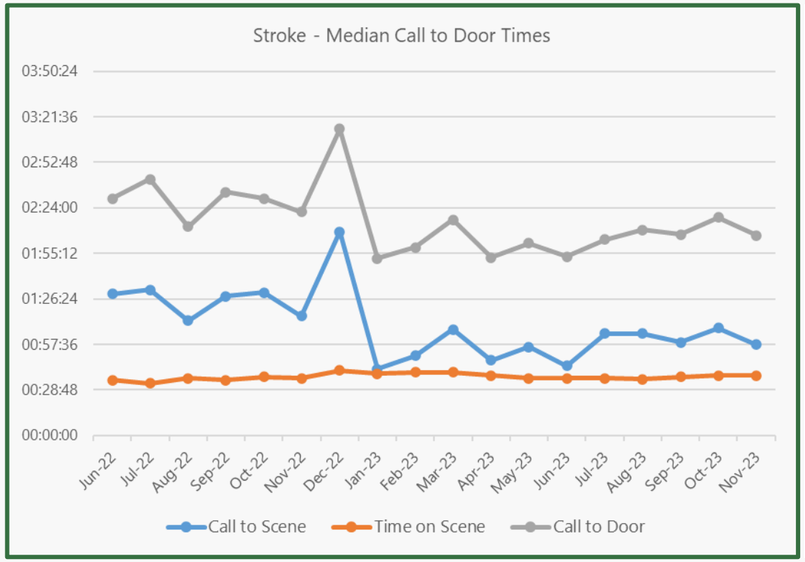
Stroke/Hip Fracture/Hypoglycaemic
A

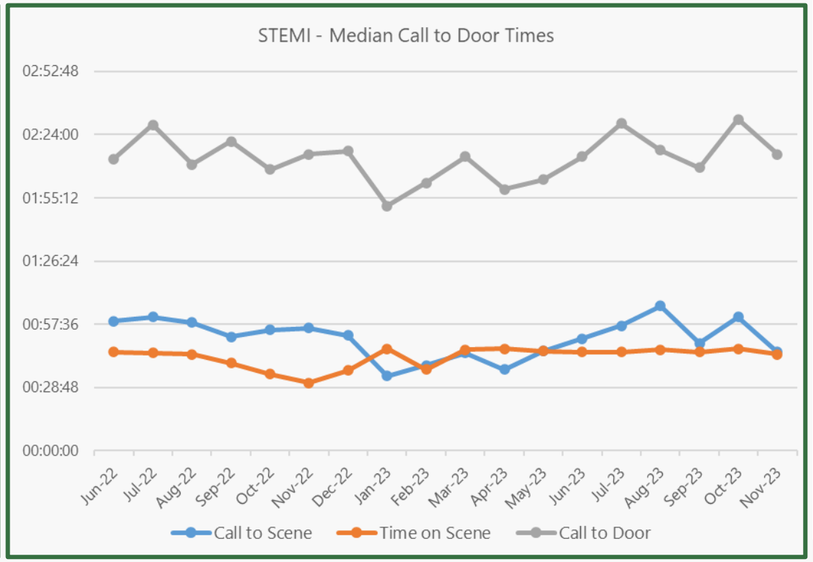
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

The percentage of hypoglycaemic patients receiving an appropriate care bundle in November 2023 was 56.86%, an increase from 47.46% in October. This was against a total case number of 255 in November. There is a correlation between documenting BM readings and the care bundle, this will inform the improvement plan.

The percentage of #NOF patients receiving an appropriate care bundle in November 2023 was 69.54%, a slight decrease from 71.08% in October. There is a correlation between documenting pain score and analgesia, and the care bundle which will inform the improvement plan.

The development to enable reporting new clinical indicators relating to call to door times for STEMI and Stroke has been completed and approved. These show the breakdown for:

- Time the call started to time of arrival at scene
- Time on scene of the conveying vehicle
- Time the call started to time of arrival at hospital

Remedial Plans and Actions

An improvement approach has been taken which includes Senior Paramedics support to discuss CIs with WAST clinicians as part of the ride-out process. A CI dashboard (v2) which includes separate diagnostic code pages for '000' & '1-183' was approved by CIAG and will be available during December 2023, this illustrates performance by HB area and informs discussions.

ePCR User Interface (UI) changes resulting from recommendations based on quality assurance audits conducted for each of the CIs are being implemented during December 2023. This includes a further change to allow prompts and messages when an ePCR is being closed and alert the clinician to incomplete fields which will improve compliance.

A pain management framework has been developed in response to an internal audit action to improve assurance on completeness of documented pain management for patients, and the ability to extract data, identifying and reporting themes and trends.

The Trust's introduction of the Cymru High Acuity Response Unit (CHARU) model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients and is our main response to the need to improve ROSC rates. This has been in place since October 2022 in some areas and since May 2023 there has been an increase in numbers and availability.

Expected Performance Trajectory

The UI change to allow prompts and messages when an ePCR is being closed and alert the clinician to incomplete fields will be monitored by the ePCR Compliance Approval Group. This, along with continuing improvements in clinical supervision and the support of SPs working with the Clinical Improvement and Clinical Intelligence and Assurance Teams should increase compliance rates.

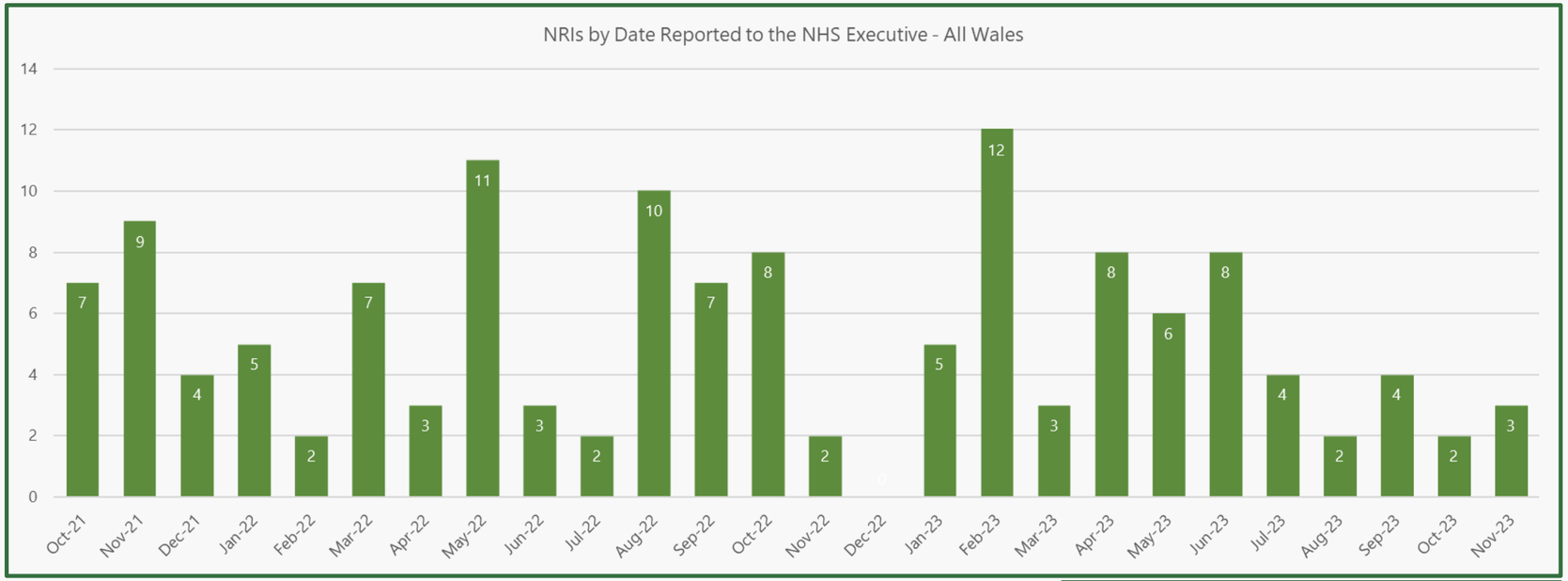
Our Patients: Quality, Safety & Patient Experience
Patient National Reportable Incidents & Patient Concerns

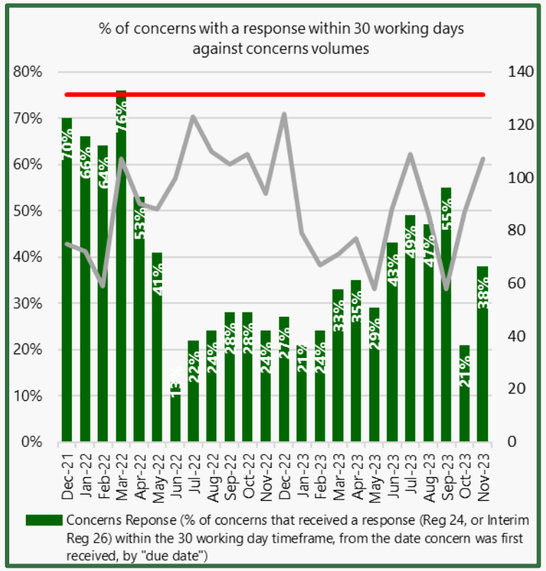
(Responsible Officer: Liam Williams)

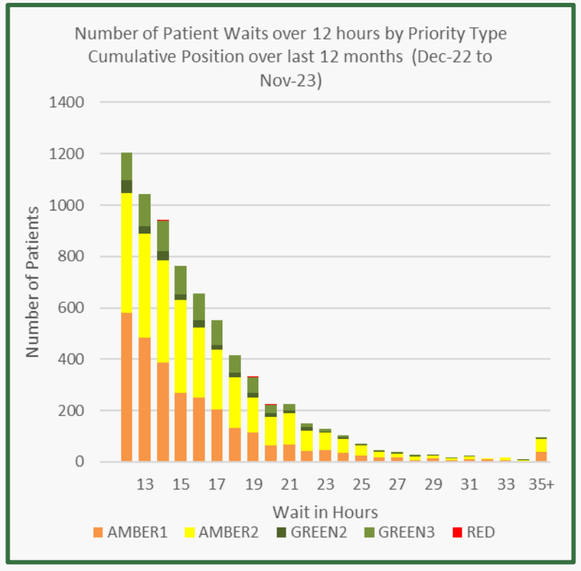
Concerns.	NRI.	Self-Assessment: Strength of Internal Control: Moderate	QUEST
A	A		

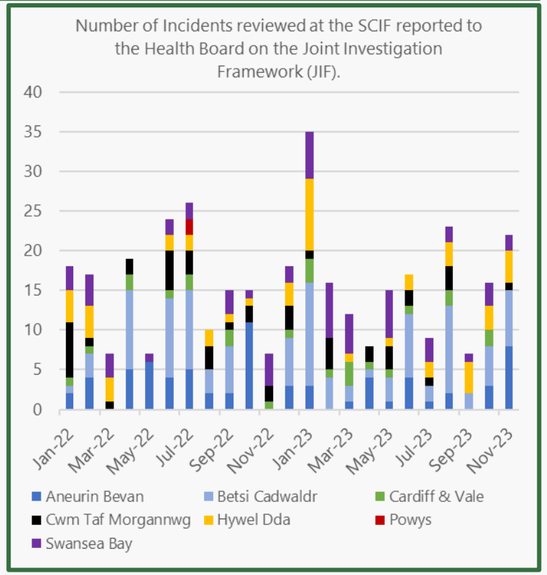
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis

The percentage of responses to concerns in November 2023 is 38% against a 75% target (30-day response) which is a slightly increased position. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of Nationally Reportable Incident's (NRIs) and timely response to requests for information from key parties. The number of total concerns has increased with 107 complaints being received and processed in November 2023. These complaints are frequently complex with our concerns administrators taking lengthy calls from distressed patients or family members for up to one hour per call.

Seven (7) Serious Case Incident Forums (SCIF) were held during the month and 33 cases were discussed. Following discussion 3 serious patient safety incidents were reported to the NHS Wales Executive and 22 cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received no referrals from Health Boards under the Joint Investigation Framework during the period. Learning from the Joint Investigation Framework process remains limited with Health Boards citing high levels of escalation as causal factors.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families as appropriate.

Themes relating to serious patient safety incidents reported to the NHS Wales Executive (Delivery Unit) as Nationally Reportable Incidents (NRIs) include delayed community response times and call categorisation, predominately ineffective breathing which is being discussed at national ambulance forums as a consistent theme.

In November 2023, 403 patients waited over 12 hours for an ambulance response and 52 compliments were received from patients and/or their families.

Remedial Plans and Actions

A range of actions are in place:-
Recruitment, redeployment and assessment of workload and where to best place resources continues corporately and within the Operations Quality Team. Following financial agreement at the Executive Leadership Team in September 2023 an organisational change process commenced in the Putting Things Right Team on 25.09.2023 and posts are currently being recruited to. It is envisaged that the structure will be fully recruited to by April 2024.

Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations and current actions, both are considered at Board sub-committee level and at Trust Board. The key strategic action is the EMS Operational Transformation Programme.

Expected Performance Trajectory

The Trust is expecting continuing challenges with performance especially as hospital delays remain a significant challenge impacting on the quality and safety of care to patients in the community and those delayed outside of hospitals awaiting transfer to definitive care which are detailed on the Corporate Risk Register.

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

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

***NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated*

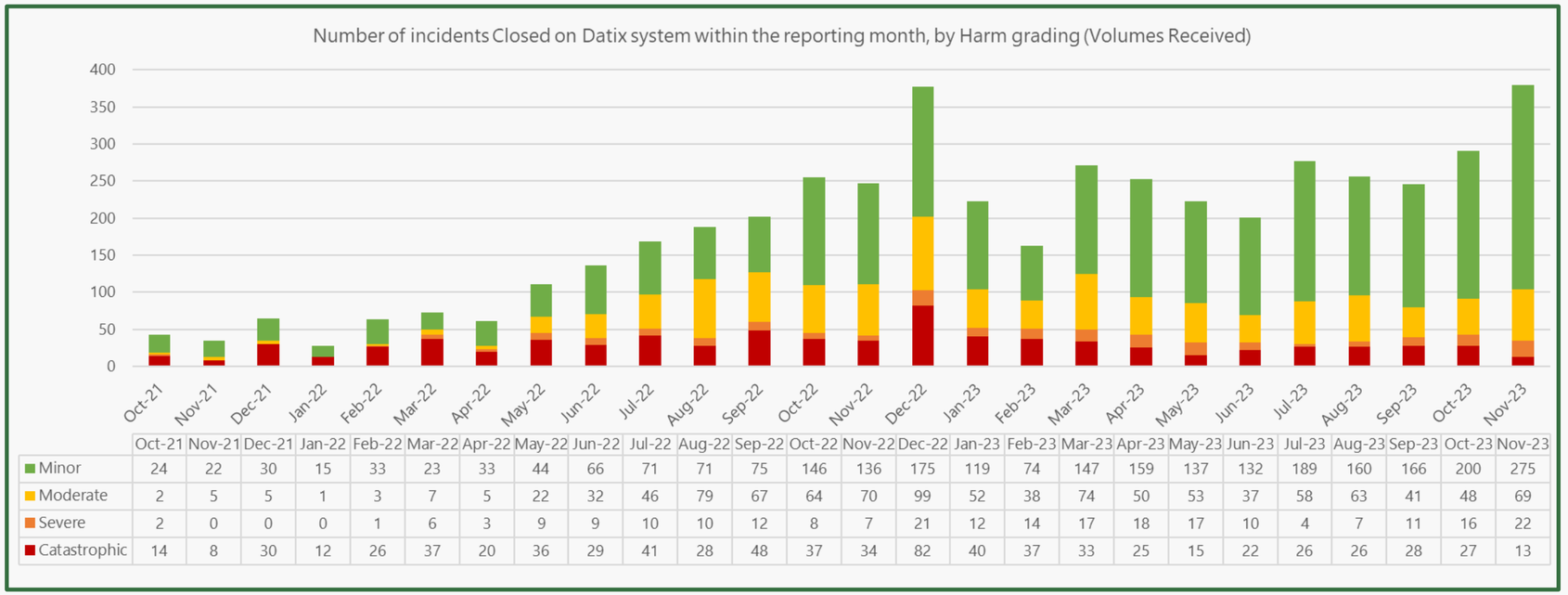
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

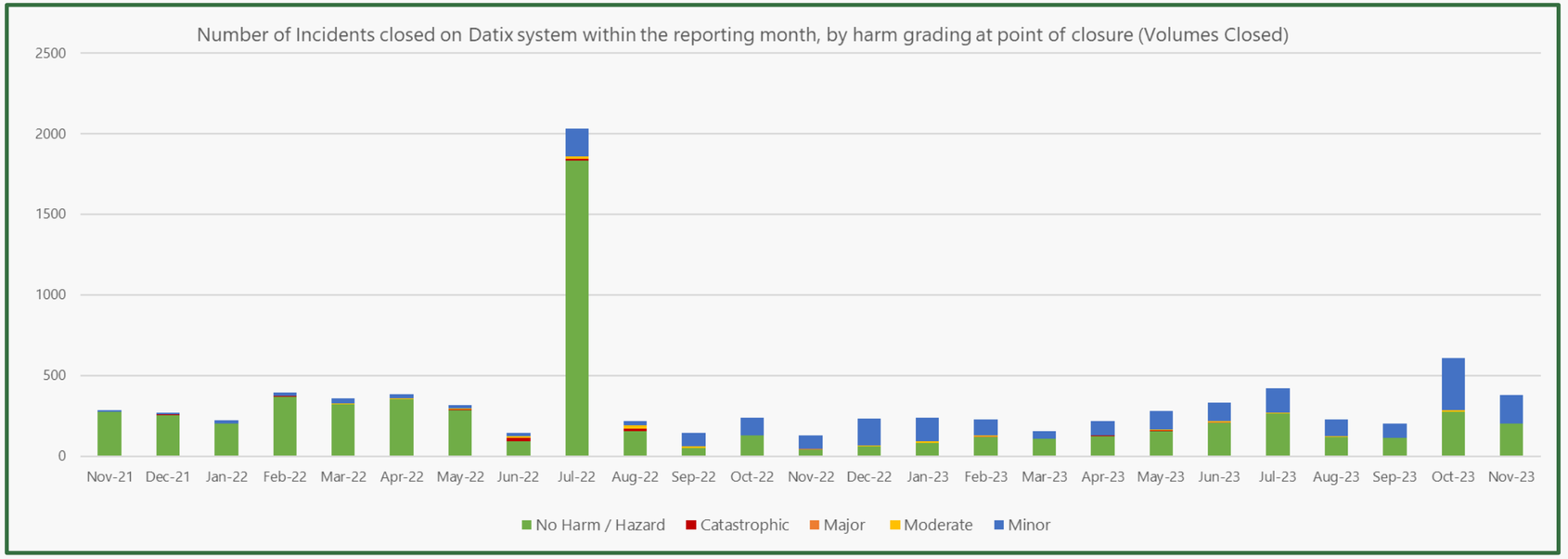
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Minor	24	22	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132	189	160	166	200	275
Moderate	2	5	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	74	50	53	37	58	63	41	48	69
Severe	2	0	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	17	18	17	10	4	7	11	16	22
Catastrophic	14	8	30	12	26	37	20	36	29	41	28	48	37	34	82	40	37	33	25	15	22	26	26	28	27	13



Analysis

Once cases are investigated and any improvement actions / learning is identified by the Patient Safety or Clinical Team, (or for instances where serious harm has occurred referred to the Serious Case Incident Forum (SCIF) for review) they are closed.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families. The Datix Cymru System has recently been updated nationally to allow Duty of Candour to be captured and reported and further work to develop a dashboard is in progress. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

- No harm or hazard – 72
- Minor harm – 275
- Moderate harm - 69
- Severe Outcomes - 22
- Catastrophic - 13

(*NB: Volumes received).

The bottom graph highlights the 379 Incidents that were closed on the Datix system in November 2023. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

Remedial Plans and Actions

Workload for all members of the team continues to be high due to continued system pressures resulting in a backlog of Putting Things Right concerns which are frequently complex. The combination of the implementation of the Duty of Candour, Duty of Quality and the Medical Examiner Service has meant additional activity for the Putting Things Right Team.

The Putting Things Right Team organisational change process consultation phase has completed, and the final structure is approved and is currently being progressed. This new structure has considered our local and national priorities and resources to meet the needs of our patients and families.
The Trust is represented at national networks including Duty of Candour, Complaints, Ombudsman, Learning, Mortality, Claims, Redress and Datix Cymru development groups as resources allow. Work is progressing in respect of the development of dashboards and the aggregation of data and information to inform patterns, trends and learning opportunities as part of the quality management system.

Expected Performance Trajectory

The Trust will continue to identify quality and safety improvements through the Putting Things Right processes.

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

Data source: Datix

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

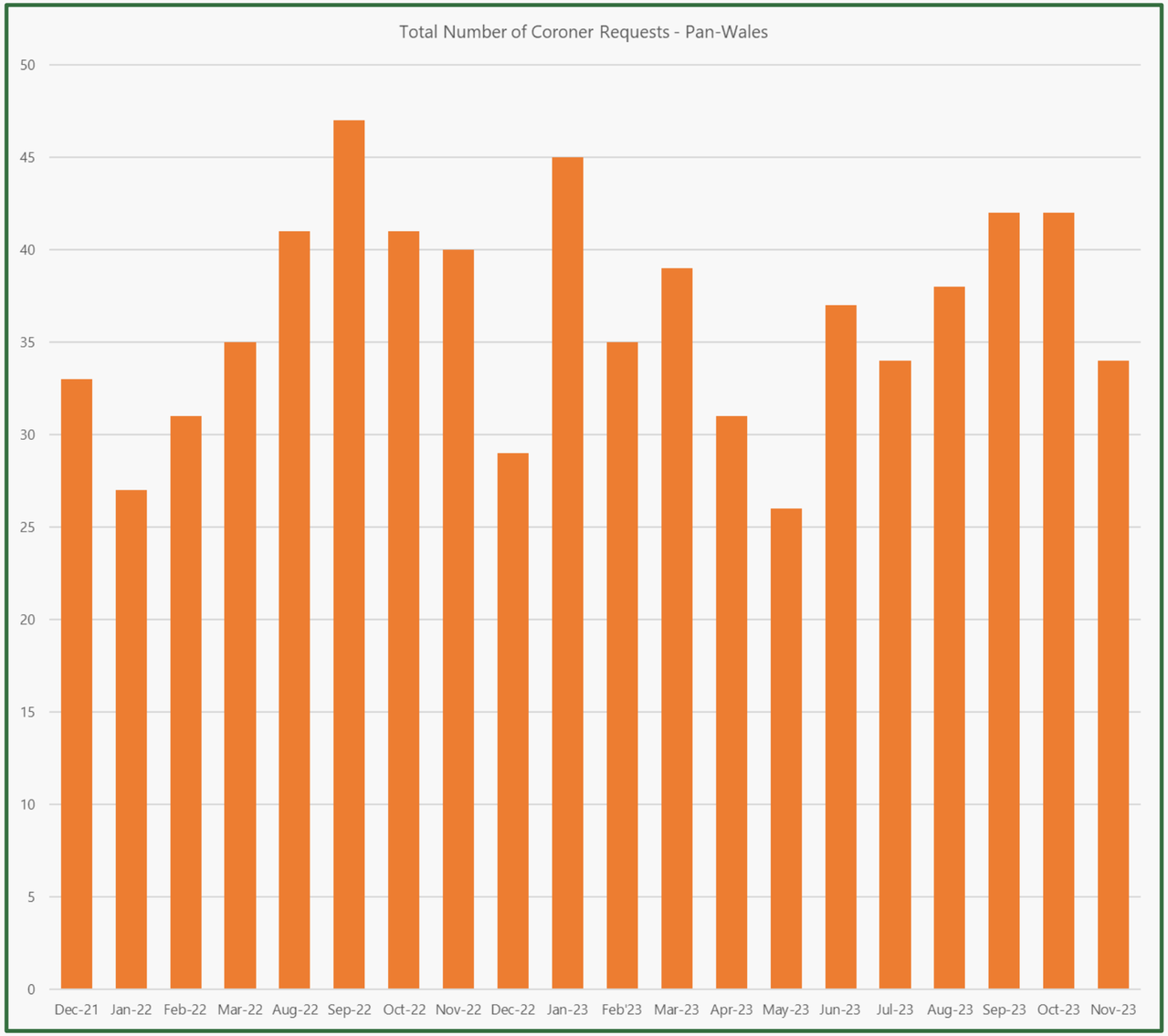
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



*NB: Temporary graph at All-Wales level: The Trust is currently unable to report Coroner requests at Health Board level due to the implementation of the new Datix system

Analysis

Coroners: The complexity of the cases remains high, with multiple statements and actions per approach. This is in addition to the work required to manage cases where the Trust has been given IP status. Cases continue to be registered and distributed and the Team has had to introduce a new process surrounding the notification of summons to inquest. At the national network , all Health Bodies reported an increase in both volume and complexity of the coronial work post pandemic. There continues t be additional work due to the illness of the Trust solicitor/claims manager.

Ombudsman: There has been a reduction in initial approaches to the Trust by the PSOW. All PSOW cases are now being managed via Datix Cymru.

Mortality Review: The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the patient safety team and clinical colleagues as available. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. Feedback from the Medical Examiner Service in respect of themes and trends include timeliness in response to patients in the community, handover of care delays and patients on the end-of-life care pathway being conveyed to acute care.

The All-Wales Mortality Review Group at which WAST has representation has recently commissioned 'A Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) All-Wales Thematic Review' selecting cases covering January 2022 to January 2023. This review encompasses all Health Boards, and the final report will be provided by the end of 2023 (delayed nationally was expected October 2023).
To date the Trust has not received any requests to undertake any Level 2 mortality reviews of patients in our care under the new processes in place across NHS Wales. Currently the focus of the Medical Examiner Service is undertaking mortality reviews in the acute care setting and the plan is for all non-coronial deaths, including community deaths to be reviewed by the Medical Examiner Service by April 2024 when the Service becomes a statutory body. An increase in activity for requests / reviews for the Trust is expected when this occurs.

Remedial Plans and Actions

Coroners: The Team continues to ensure that we are meeting the dates for the production of statements, and escalating should difficulties be experienced. There continues to be additional work due to the illness of the Trust solicitor/claims manager. This has resulted in the Trust being represented by external counsel (such as Legal and Risk Solicitors), all these cases require the instruction of counsel (preparation of bundles, instruction,). The contract in relation to the temporary member of staff has been extended to the end of the financial year to provide support for this additional work

Ombudsmen: *All cases are recorded and monitored on the Datix system.*

Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach and our internal framework has been approved at the Clinical Quality Governance Group. Representation and contribution by the Trust at the All-Wales Mortality Working Group continues, and a task and finish group has been established to review the process for contacting families following their meetings with the Medical Examiners. Additionally, the Patient Safety Team are engaged in the meetings lead by the Once for Wales Datix Cymru team who are developing the Datix Cymru Mortality Module currently.

Internally the Trusts Learning from Deaths Group is set to commence from November 2023 (07.11.2023) with the terms of reference drafted and going through approval processes. A detailed report was presented at the QUEST Committee in October 2023.

Expected Performance Trajectory

Coroners: This level of activity seems to be the new normal and will continue to be monitored.

Ombudsmen: Learning has been placed in a Patient Safety Newsletter, for sharing pan-Wales.

Mortality Review: Whilst the multiple benefits of the Medical Examiner Service are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales by April 2024 and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. It is recognised that some cases will have already been reviewed via Putting Things Right processes internally through the Serious Case Incident Forum.

Data source: Datix

Mortality Reviews Data source: Internal Web Application

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

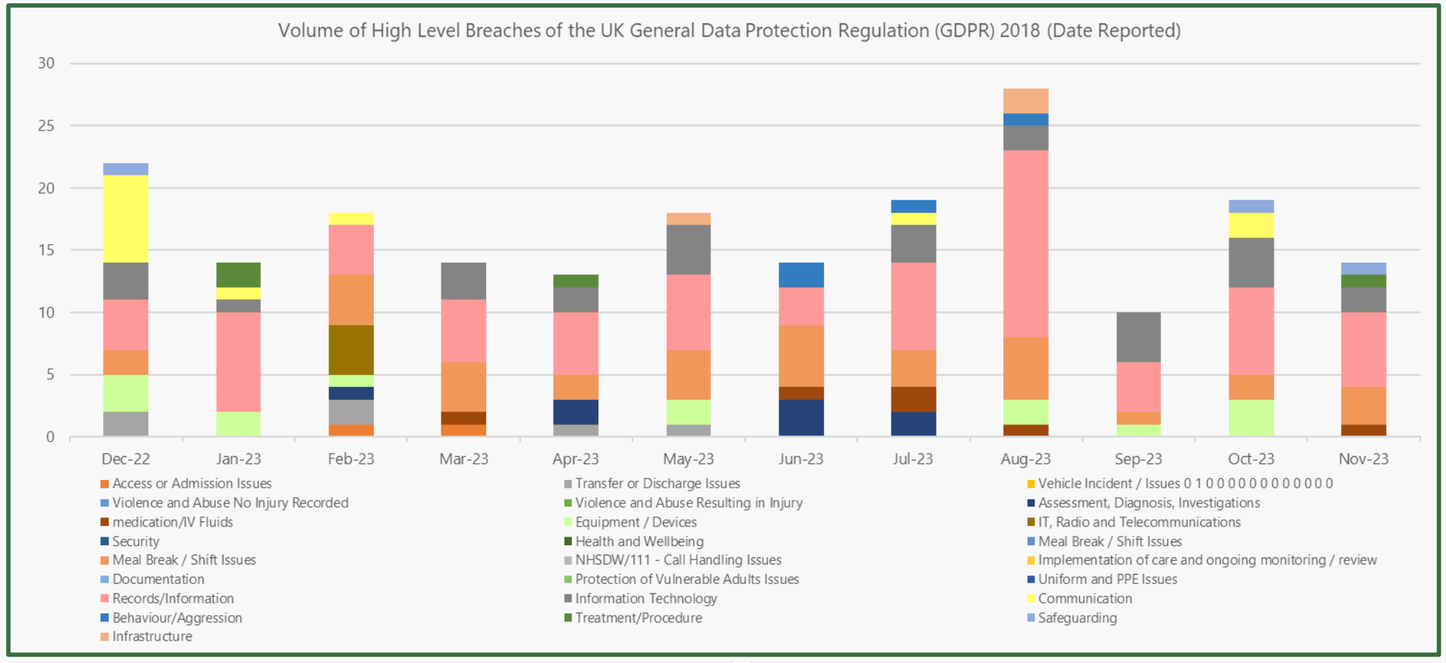
(Responsible Officer: Liam Williams)

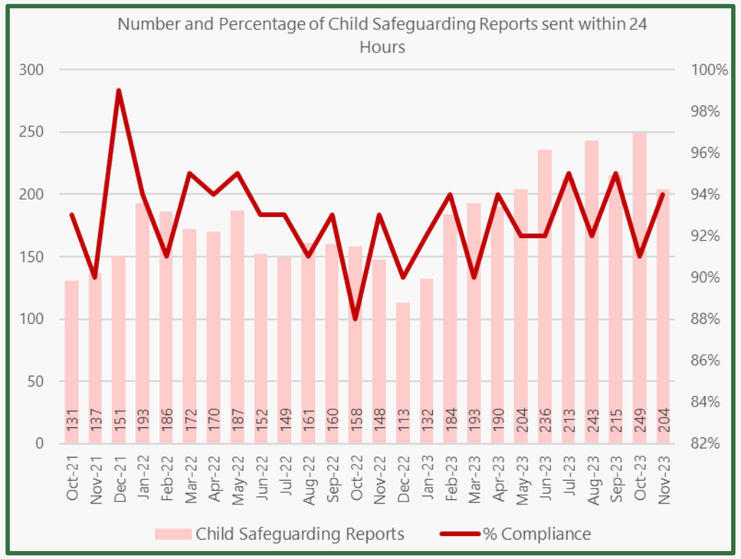
Self-Assessment: Strength of Internal Control: Strong

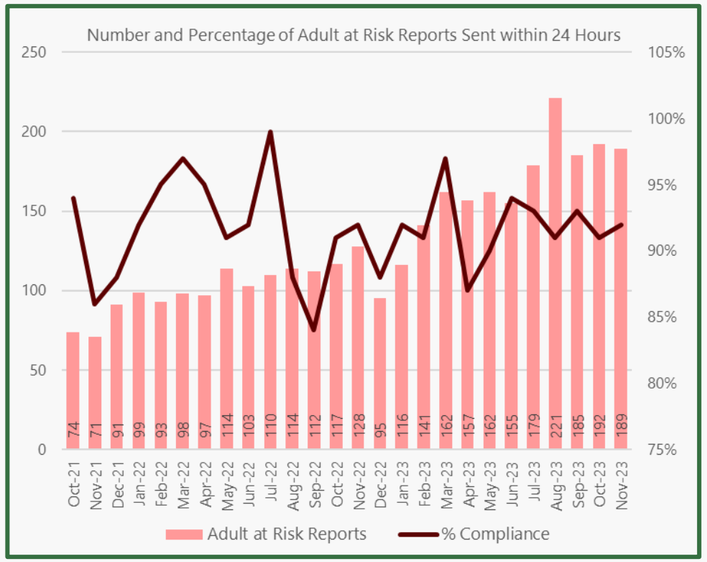
QUEST

Health & Care Standard
Health – Safe Care

Safeguarding Data source: Doc Works







Analysis

Safeguarding: In November 2023 staff completed a total of 189 Adult at Risk Reports, 92% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 478 referrals were received and processed to the local authority during this reporting period. There have been 204 Child Safeguarding Reports in November 2023, 94% of these were processed within 24 hours.

Data Governance: In November 2023 there were 14 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 14 breaches, 3 related to information governance/confidentiality, 6 records/information, 2 Information Technology, 1 safeguarding, 1 treatment/procedure, and 1 medication/IV/fluids.

Public Engagement: During November, the Patient Experience and Community Involvement Team attended 26 community engagement opportunities, engaging with approximately 664 people. This month engagement has included the launch of the WAST 'Welcome Pack', a dedicated resource explaining how to use our services appropriately and how to access the wider NHS, aimed at people seeking sanctuary in Wales and those whose first language isn't English or Welsh. This pack was coproduced with colleagues from the Ethnic Youth Support Team and was initially devised following feedback from people attending support services for asylum seekers and refugees. This month we have also engaged with a number of mental health support services and provided feedback directly to the Mental Health Team, we have also attended a number of general community visits with older people's groups, cancer support services and youth groups to name just a few. We also continue to meet regularly with colleagues from Llais as the national Citizen Voice body for Wales, maintaining an open dialog and sharing relevant information and opportunities to collaborate. During November we continued to make a range of Patient Experience Surveys (PREMs) available, asking people to provide feedback about their interactions with our services. Engagement and survey outcomes remain largely consistent and tell us that people continue to be concerned that help will not be available when they need it and that people have experienced delays after calling 999, but that people are generally happy with the care they eventually receive. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience longer than wanted delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support staff with the use of the Docworks Scribe App and liaise with local authorities when or where required. Numbers of paper safeguarding reports have significantly reduced with the embedding of Docworks; however, they are used as a back-up and are sent directly to the Safeguarding Team for further action. Continued monitoring supports practice in this area which is seeing a steady improvement.

Data Governance: During the reporting period, of the 14-information governance related incidents reported on Datix, 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO). The IG Team will continue to review and provide advice on reported incidents.

Public Engagement: Community involvement and engagement with patients/public forms an integral part of the Trust's ambition to 'invert the triangle' and deliver value-based healthcare evaluated against service users' experiences and health outcomes. The work delivered by the PECI Team is supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change and delivering services which meet the differing needs of communities we serve without prejudice or discrimination. The PECI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. Response rates to some of our PREM's surveys is disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences with us. We have escalated our concerns to barriers which are preventing us from directly contacting patients to colleagues at the Welsh Risk Pool who oversee implementation of the Once for Wales Civica & Datix systems. We are seeking their advice on a way forward following a letter to WAST from the Welsh Risk Pool which highlighted WAST as an outlier in not fully utilising all of the available features in Civica to record and report on patient experience.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission for FY22/23 continues to be worked on. A weekly meeting has been established to monitor the population of the IG toolkit and outstanding actions. The action plan for the Minimum Expectations criteria currently stands at 47% completed.

Public Engagement: All feedback received is shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement.

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

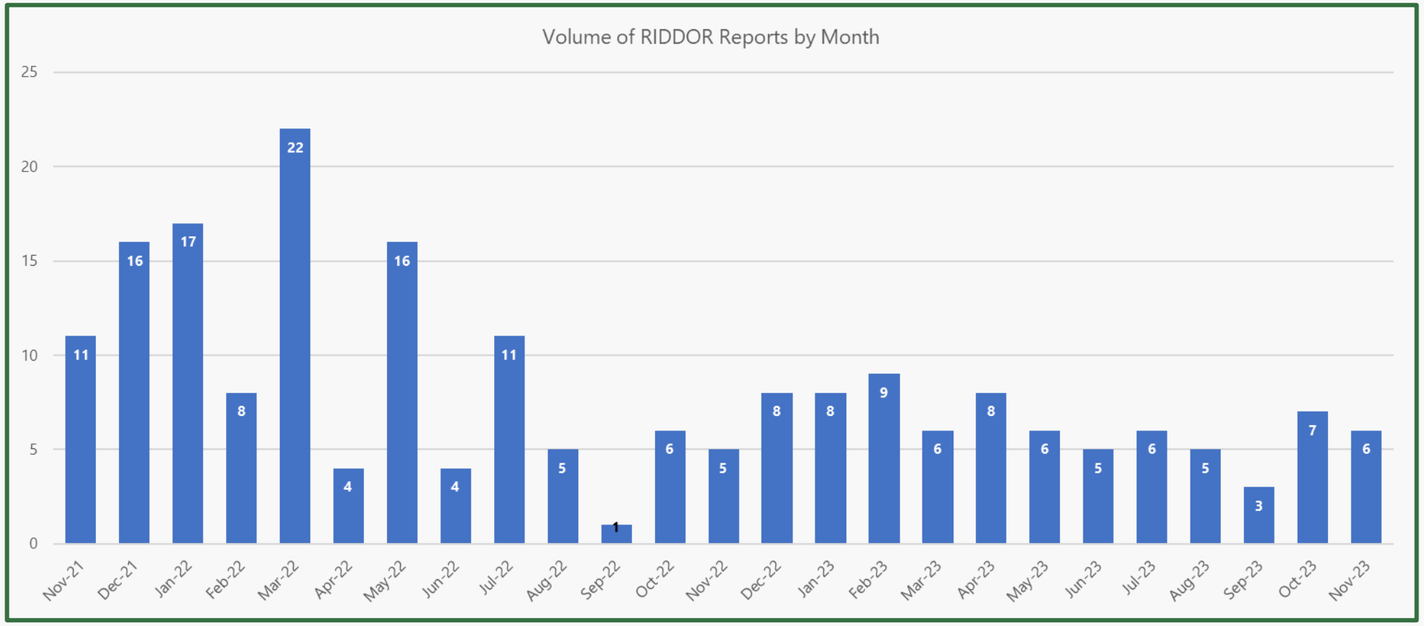
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

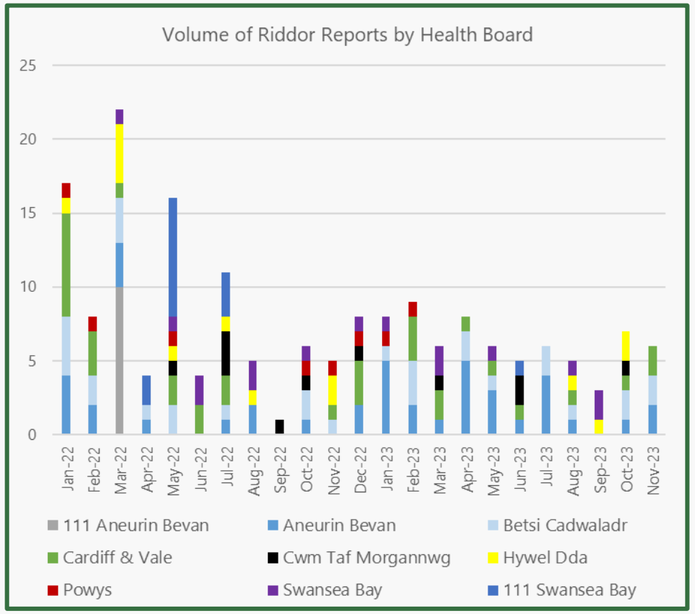
(Responsible Officer: Liam Williams)

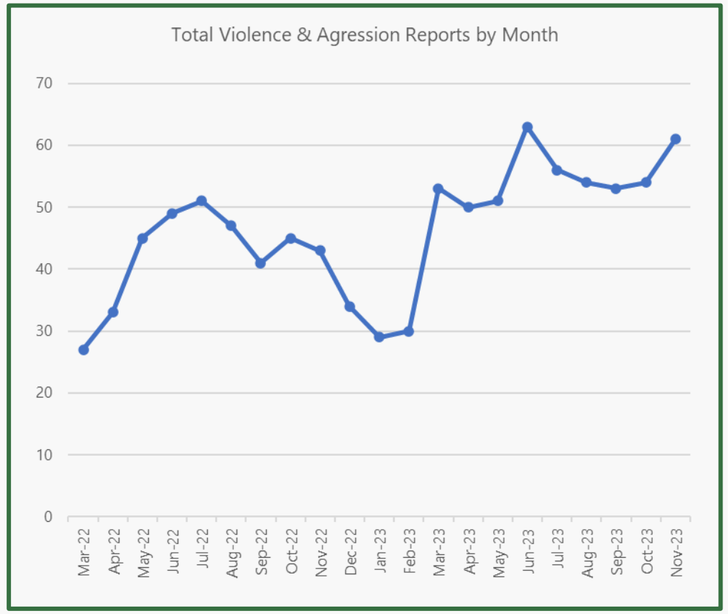
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: There were six incidents requiring reporting under RIDDOR during November. Five required staff being absent from work for over 7 days as a result of their injury. One was a wrist fracture and reported as a specified injury. Three were as a result of manual handling with handling equipment accounts for 2 of the incidents. Manual handling remains one of the highest incident types recorded on Datix.

There were 3 incidents reported of slips, trips and falls with 1 resulting in a broken wrist and reported as a specified injury.

100% of the reports were completed within the reporting required time frames.

The Health and Safety team will continue to work with Incident Handlers to ensure reports are submitted within the required timescales.

Violence and Aggression: A total of 61 incidents have been reported of V&A in November.
3 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 4 for the month. Aneurin Bevan and Betsi Cadwaladr Health Boards remain the highest reporting area with a total of 18 incidents in Aneurin Bevan and 13 in Betsi Cadwaladr.

17 incidents were reported as Moderate in harm and 29 noted as low harm which continues to trend upwards since August 2023.

Remedial Plans and Actions

RIDDOR: The risks associated with winter weather have been addressed in the quarterly Health and Safety newsletter. With advice given on how to keep oneself safe during periods of bad weather.

RIDDOR performance continues to be presented in monthly reports and service units business meetings and training is being developed to improve the quality of incident investigations on Datix.

Violence and Aggression: A V&A Gap Analysis has been undertaken of incidents across the Trusts along with the mechanisms in place to lower incident rates and support staff. This has identified a number of work streams to further protect our work force from potential V&A incidents.

The Case Manager continues to actively support staff who are involved cases being heard at Court to ensure they are given any help they require.

Expected Performance Trajectory

RIDDOR: During the winter period we can expect an increase in manual handling injuries and slip, trip and fall events due to a combination of colder weather and darker working periods.
Advice contained in the quarterly newsletter has been designed to help limit the number of incidents during this period.

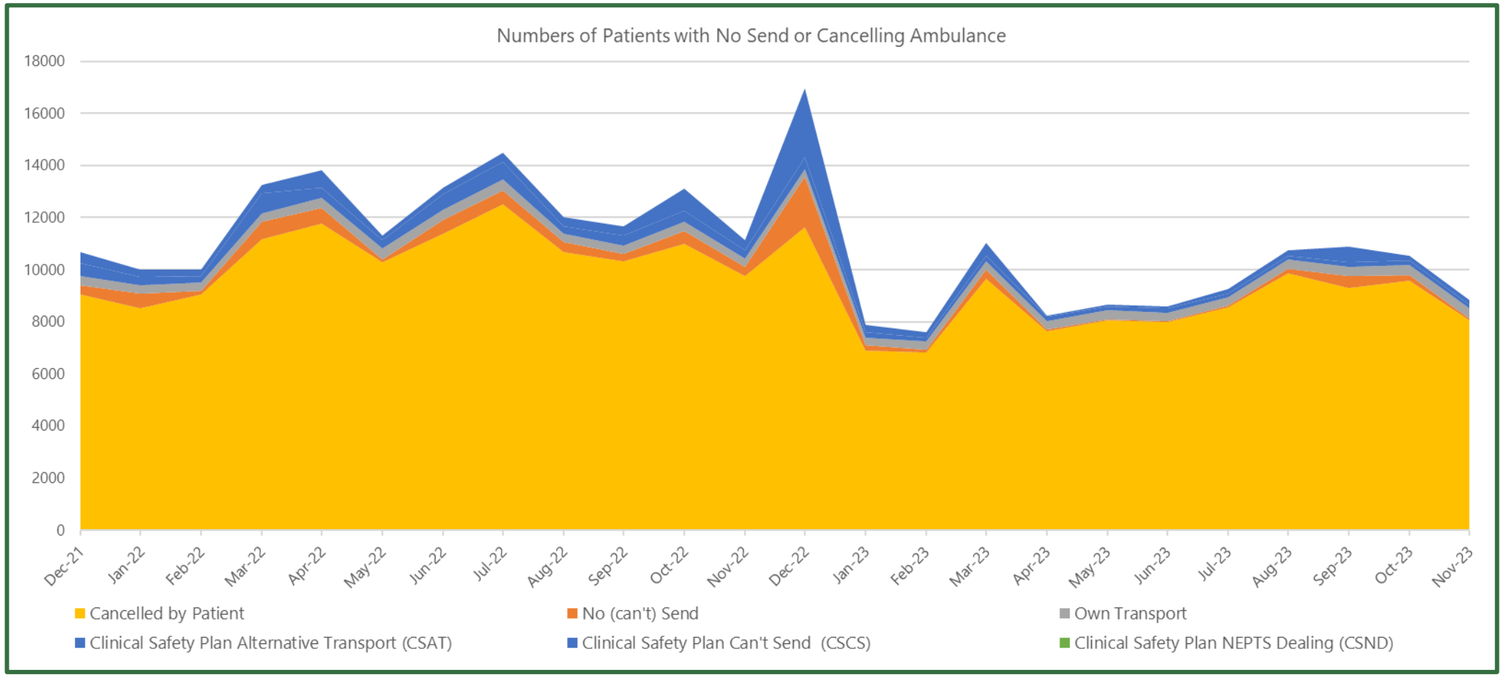
Violence and Aggression: Toolbox talks, raising awareness of case management continue to take place across the Territories by the Case Manager & V&A Manager to support staff and raise awareness. It is planned to establish regular interaction with staff directly affected by incidents of V&A with the aim of improving the help and support available to staff.

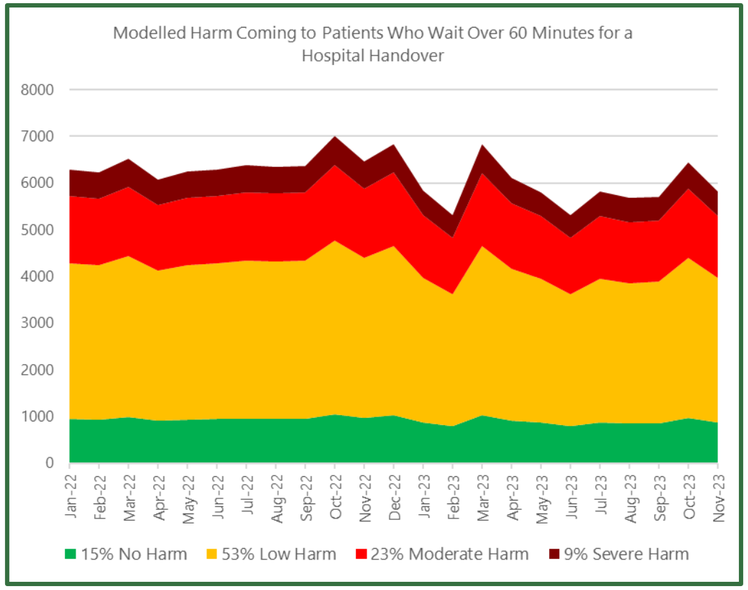
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

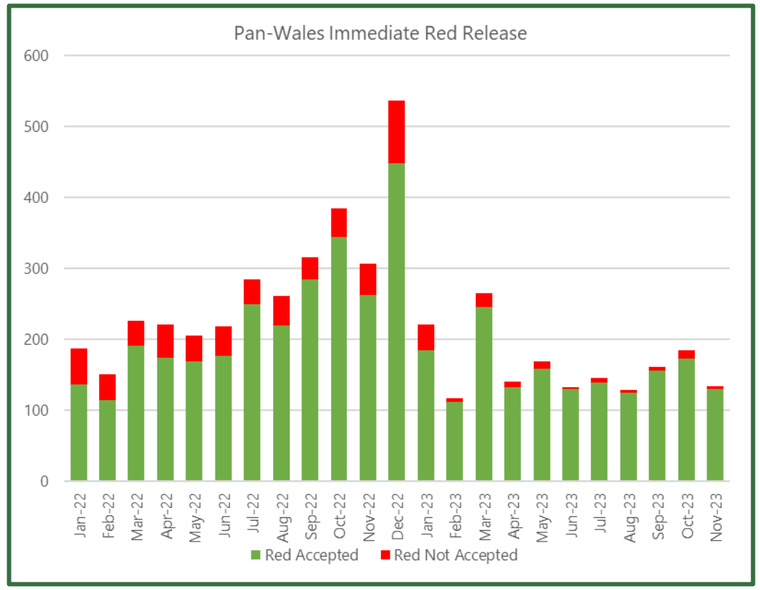
Data source: Datix

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

(Responsible Officer: Andy Swinburn) A FPC







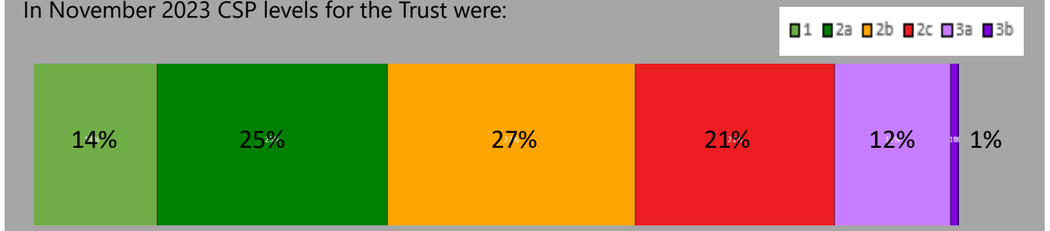
Analysis

In November 2023, 156 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 164 were stopped as a result of CSP 'Can't Send' options. In addition, 8,041 ambulances were cancelled by patients (including patients refusing treatment at scene) a decrease from 9,589 in October 2023 and 385 patients made their way to hospital using their own transport.

There were 598 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in November 2023. Of these 130 were accepted and released in the Red category, with 4 not being accepted. Further to this, 162 ambulances were released to respond to Amber 1 calls, but 302 were not.

The graph in the bottom left shows that in November 2023 of the 5,823 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (873 patients) would experience no harm, 53% (3086 patients) would experience low harm, 23% (1339 patients) would experience moderate harm and 9% (524 patients) would experience severe harm.

In November 2023 CSP levels for the Trust were:



Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings have commenced with Health Boards, the Commissioner and the Trust and performance is reviewed monthly with questions posed to Health Boards regarding immediate release and handover reduction plans and actions.

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Seasonal pressures impact the Trust and planning is being used to prepare for this through a range of measures including the use of forecasting and modelling.

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

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

November 2023		
NEPTS (117 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	68
Were you happy with the transport you received?	85	90
999 (2 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	100
The 999-call taker who answered your call explained what was going to happen next.	85	100
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	100
The length of time I waited for an ambulance to arrive was acceptable.	85	25
111 (10 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	50
Did you follow the advice given to you by NHS Direct Wales?	85	71
Would you consider using NHS 111 Wales again?	85	60
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
○ Ambulance care	85.58% Good	11.54% Poor
○ Integrated Care (NHS 111 Wales Telephone line only)	66.67% Good	33.33% Poor
○ EMS (including CSD)	100% Good	0% Poor
○ NHS 111 Wales Online	50% Good	23.08% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis
Within the NEPTs survey the responses provided did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment, therefore not providing the level of service the patient expected. However, 90% were happy with the transport they did receive.

It is acknowledged that the small number of respondents for the 999 and 111 surveys does not provide a great enough response to reflect a true patient experience picture, but work is currently underway to develop a process that will increase response rates and make them more meaningful.

Remedial Plans and Actions
We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:

- 999 EMS Response (incorporating CSD)
- Ambulance Care (NEPTS)
- NHS 111 Wales Telephony
- NHS 111 Wales Online

The Civica Experience platform provides some enhanced reporting facilities, including the ability to weight questions and produce 'Heat Maps' based on responses. A benchmark is set of 85, with aggregated scores of 85 and above representing a positive response. WAST is currently working through the requirements to add the SMS functionality within the Civica experience platform and other systems as well as strengthening information governance arrangements to increase the data experience returns.

The aim is to increase the number of patient experience feedback returns and to further integrate systems with Civica to push email/text surveys to patients. However, this requires input from the ePCR team to look at opportunities to capture patient permissions to participate in experience surveys.

These surveys are mandatory requirements; Under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. WAST has a duty to secure quality in its services and must exercise its functions with a view to securing improvement in the quality of its services. The Duty of Quality includes the experiences of individuals to whom health services are provided.

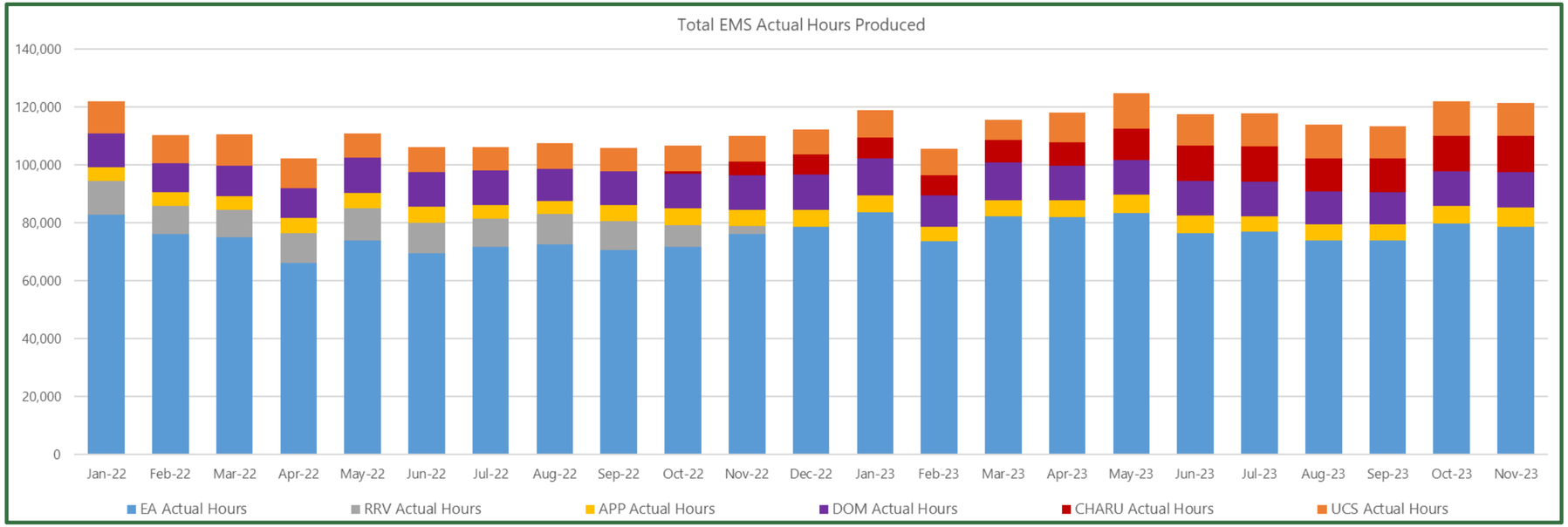
Expected Performance Trajectory
It is hoped the ongoing work will increase the number of surveys completed over the next few months to improve the overall significance of the surveys.

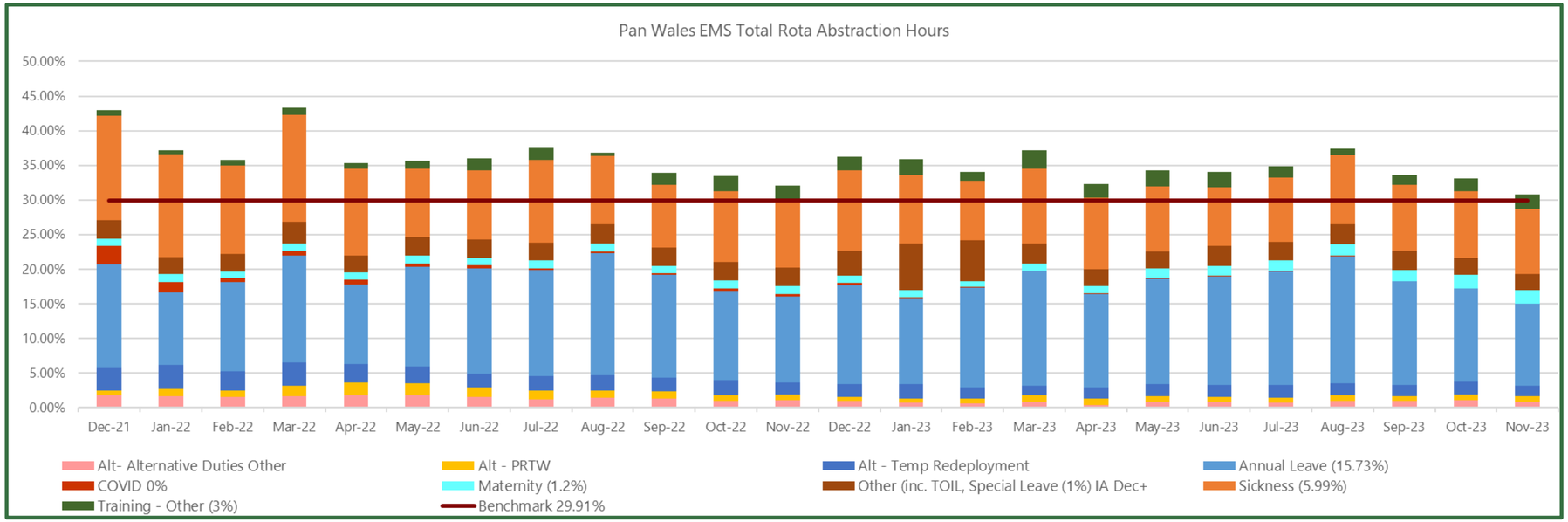
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
G	R

CI PCC FPC





Analysis

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In November 2023, total EMS abstractions (excluding Induction Training) stood at 30.74%. This was a decrease from the 33.09% recorded in October 2023. This percentage continues to marginally remain above the 30% benchmark figure set in the Demand & Capacity Review. The highest proportion of abstractions was due to annual leave at 11.82% followed by sickness at 9.40%. This figure for sickness abstractions for November 2023 was a decrease when compared to the same month last year (9.44%).

Emergency Ambulance Unit Hours Production (UHP) was 96% in November 2023 (78,547) Actual Hours). CHARU UHP achieved 142% (12,290 Actual Hours) compared to 136% in October 2023 (this is the commissioned level not the modelled level). The total hours produced is a key metric for patient safety. The Trust produced 121,349 hours in November 2023, which is a slight decrease on the 122,050 hours produced in October 2023.

Remedial Plans and Actions

The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A formal programme of work has commenced to review and take action to reduce sickness absence / alternative duties, which is reported into EMT every two weeks.

The Trust is currently widening out its focus on sickness absence to look at all abstractions recognising that abstractions are already regularly reviewed in Operations performance meetings.

Expected Performance Trajectory

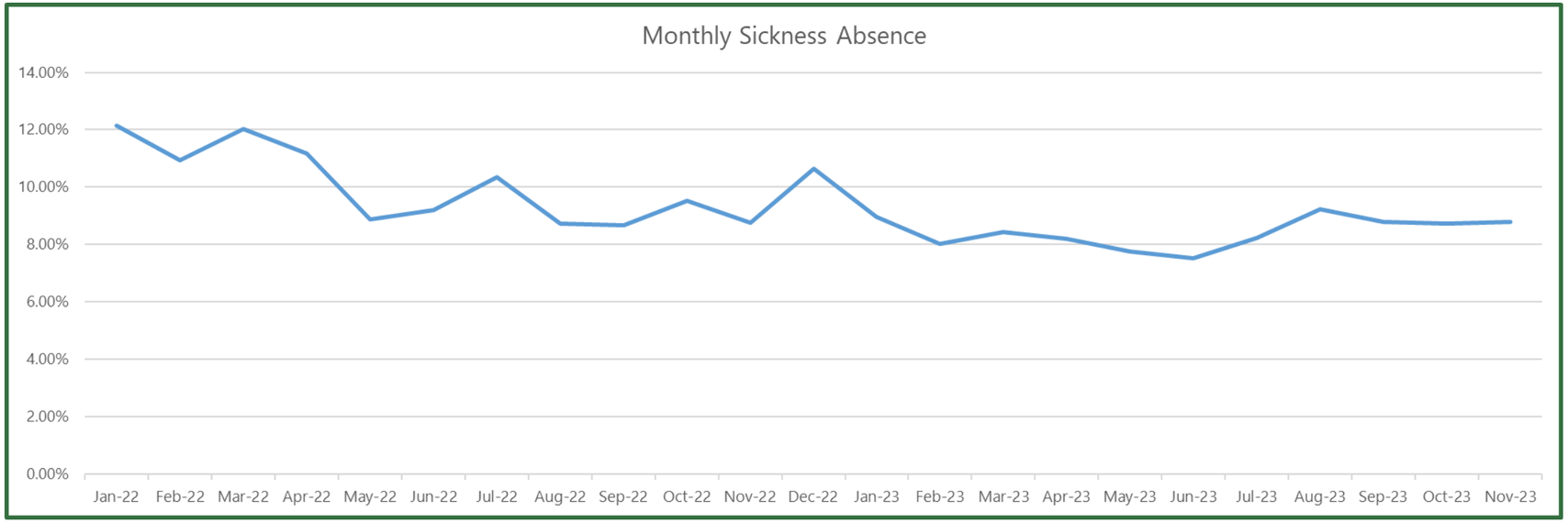
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good. The Trust has an ambition to reduce sickness to 6% and abstractions to 30% by March 2024, which would further boost production; however, the handover levels are extreme, and the rosters are simply not designed to cope with over 23,000 lost hours; they were predicated on 6,000 hours.

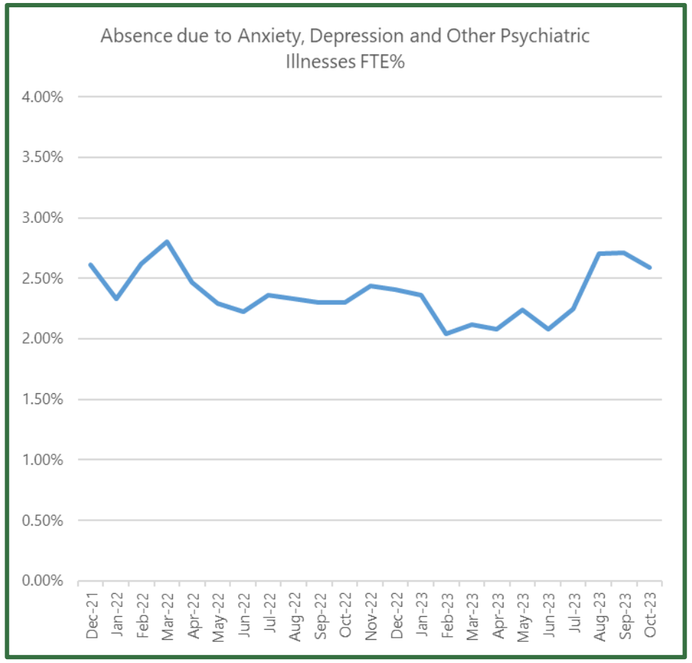
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

A

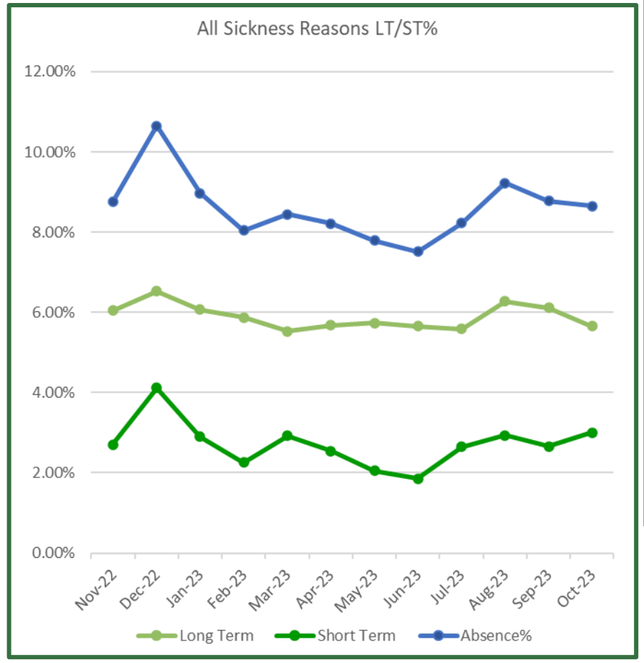
CI





Average working days lost per FTE (Annual)	
19.63	days
Single month Absence %	
9.46%	
Long Term	**Short Term**
6.23%	3.24%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.59%	1.04%

October 2023



Analysis

There was a slight increase in overall sickness absence rates between October and November 2023, rising from 8.73% to 8.79%.

Short-term absence increased from 2.66% in September 2023 to 3% in October 2023, while long-term absence dropped from 6.12% to 5.65%.

Indicative figures for November 2023 show a further decline in long term absence to 5.47% as well as a decrease in short term absence to 3.13%.

The highest reason for short term absence in October was Anxiety/ Stress/ Depression, other musculoskeletal problems and injury/fracture.

Absence due to Mental Health has risen slightly since June 23 and is now at 2,59%, which is back in line with figures seen during the early part of 2022.

Physiotherapy: 22 referrals were received in October 2023- 2 less than in September 2023.

Remedial Plans and Actions

- MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions).
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
- The findings of the audit displayed common themes across all areas within the Operational Directorate, including missing paperwork, no return-to-work meeting and inappropriate discretion applied.
- Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.

Expected Performance Trajectory

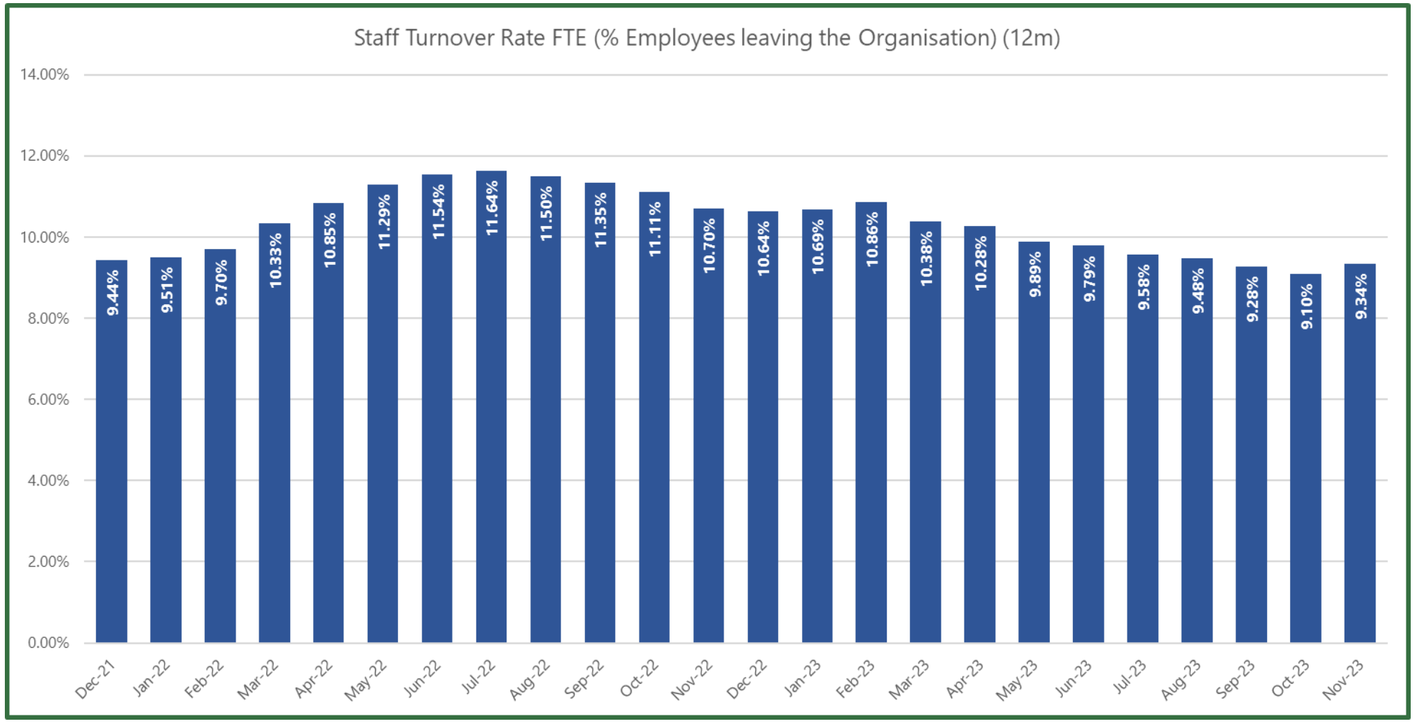
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

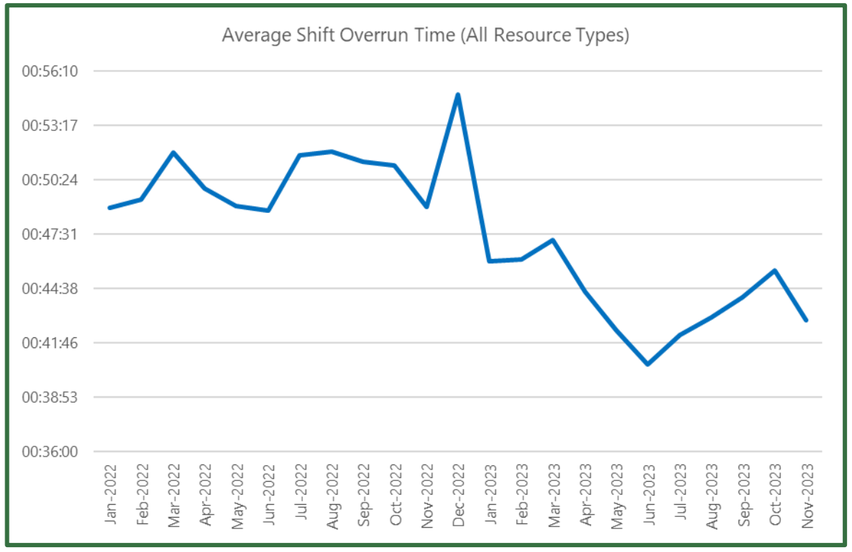
NB: Sickness data will always be reported one month in arrears.

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

A





Nov-23 Org L4	FTE by Post
020 Ambulance Care L4 (NX10)	893.53
020 Emergency Medical Services L4 (DX04)	1,781.46
020 Integrated Care L4 (DX03)	447.11
020 National Operations & Support L4 (DX02)	140.95
020 Resourcing & EMS Coordination L4 (DX05)	354.31
Grand Total	**3,617.36**
Ambulance Response	**1508.21**
020 Ambulance Care L4 (NX10) ACA2/Team Leaders	**261.03**

Analysis

Staff turnover rates in November 2023 were 9.34%, which is an increase from the 9.1% recorded in October 2023, although rates have generally been declining since they peaked in July 2022. Staff leave the Trust for a variety of reasons including promotions, relocations, culture and due to the pressures of NHS working.

Shift overrun average times have been steadily increasing again following a two year low recorded in June 2023. However, the average figure for November 2023 was 42 minutes and 57 seconds compared to 45 minutes and 36 seconds in October 2023. 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.

The wellbeing of staff is a priority for WAST, all activities for the team reflect this where each action in our annual plan is aligned to the objectives of the Health and Wellbeing strategy. Through gathering feedback from staff, the team ensure that provision in place for colleagues is appropriate, up to date and fit-for-purpose and that it is tailored to individuals' needs and can be easily accessed by all staff.

As part of the continuing service review, we will be conducting a tender process in the new year for our employee Assistance Programme (EAP). A timeline has been agreed and a panel will be set up (led by Adam Cann, newly appointed Head of Workplace Wellbeing) to evaluate and score all tender submissions. The successful provider will be appointed in March 2024.

Team members from OH/Wellbeing/TRiM continue to promote the service using our Occupational Health & Wellbeing vehicles. The team will continue to run flu clinics throughout the next couple of months and promote our Flu campaign to WAST staff.

The REACT (Recognise, Engage, Actively Listen, Check Risk, Talk) training is still proving very popular, upcoming dates have been advertised on Siren.

Our Health and Wellbeing calendar; December's focus is on, 'Decembeard' and National Grief Awareness Week.

The team continue to deliver Drop-in sessions across all of our Clinical Contact Centres, dates have been shared with the relevant teams and managers. Our 'Living Life to the Full' sessions are being delivered online and f2f. A (seasonal) newsletter was recently published on Siren, WAST Wellbeing Team Winter Newsletter - Winter Antidotes Seasonal Tips, December 2023- offering advice and guidance for staying well during the holiday season and beyond.

We continue to promote our EAP (Health Assured) throughout WAST which offers a 24/7 helpline, counselling services and information services for financial and legal support. A new App has been developed by Health Assured 'Wisdom' which is now available on mobile, tablet, and desktop to ensure continuity throughout.

The service is promoted across the organisation via our networks, E.g. Peer Support Network, Menopause Champions etc. Our chaplaincy service continues to grow and the TRiM coordinator (who also manages the Chaplaincy service) will be recruiting several more chaplains in the new year.

TRiM Refresher Training is scheduled throughout the year to ensure practitioners and managers are up to date regarding their role.

Good news - The team has just welcomed a newly appointed Occupational Health Manager, Kim Crichton, who will be heading up the service.

Remedial Plans and Actions

Accessible financial wellbeing support is available to colleagues through a dedicated page on Siren. The page links to a short video presentation outlining available support, ideas shared through the digital suggestion box which remains open to all colleagues (including our volunteers) and broader employee benefits information. We have recorded a podcast with Money & Pensions Service which will be shared through communications platforms in April.

The WAST Voices Network had their first Advocate meeting in March and activity continues relating to themes of misogyny and sexual safety within the organisation. Reverse mentoring relationships have been established and we will measure the impact of this after 2 sessions of Senior Leaders hearing from lived experience of these issues. The network have a collaborative event with North-West Ambulance Services taking place in April.

Work around improving the preparedness of new colleagues has begun and we now facilitate group discussions around anti racism and sexual safety at all welcome sessions. We are also capturing organisational culture experiences through the 3 months check in carried out with all new colleagues. The allyship programme continues to be rolled out for current colleagues and where required, team interventions taking place.

A volunteer wellbeing package has been put together and the OD Team are running monthly evening Warm WAST Welcome sessions for new volunteers.

2nd Carers passport training arranged for 17th May - Carers week workshop being arranged for 8th June. Theme suggested by the unofficial carers network.

WAST Outdoors initiatives being trialled.

Expected Performance Trajectory

The People and Culture Strategy will continue with its wellbeing focus. A robust wellbeing provision is in place to support staff and managers- this is regularly reviewed through feedback from staff members and from the OH/Wellbeing team. We receive MI reports from external providers where we can identify patterns and/or decide on a more targeted approach in specific areas of need. Through visits to stations and A+E departments, also to CCCs (where the Wellbeing Practitioners facilitate drop-in sessions) staff are more aware of the wide range of services that they can access. This includes emotional support through counselling or financial and legal advice. Our Health and Wellbeing calendar of events helps raise awareness of the service whilst focusing on different themes each month- this month the team published a seasonal newsletter, enhancing our promotion of the service whilst offering appropriate advice and guidance (including money saving ideas) for the holiday season and beyond.

Our People
Culture - Staff Vaccination Indicators

(Responsible Officer: Angela Lewis)

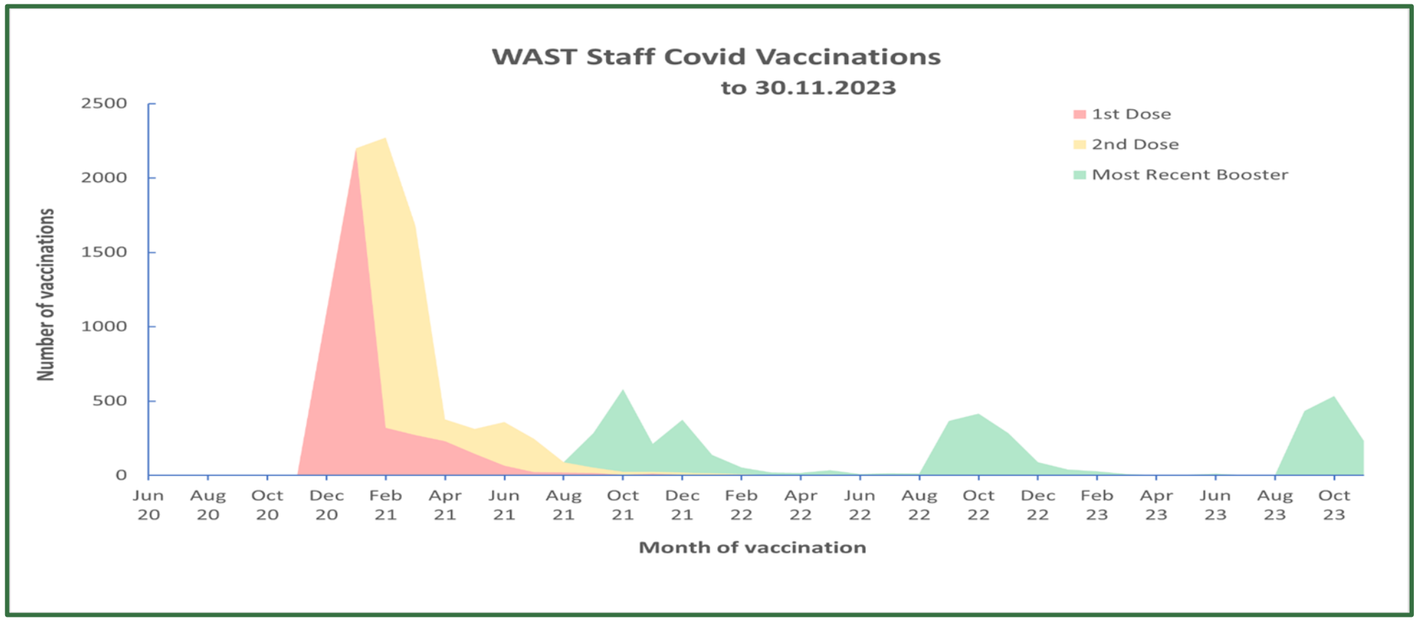
Self-Assessment: Strength of Internal Control: Moderate

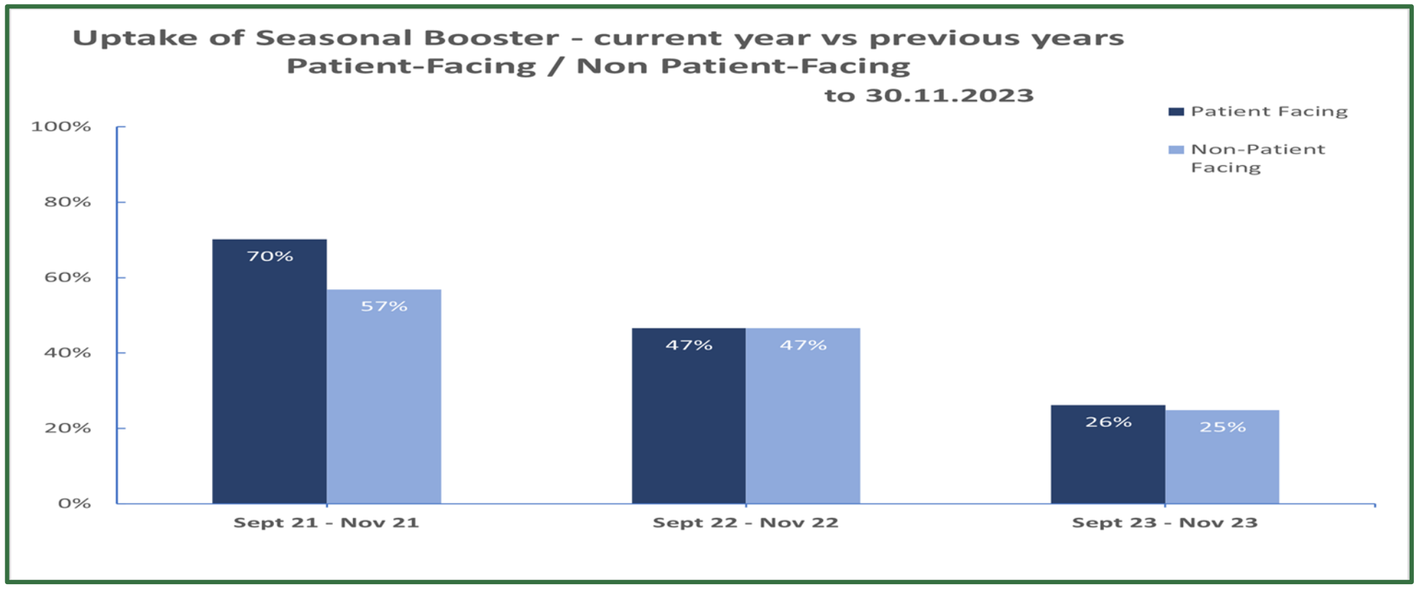
Flu A

PCC

CI

Health & Care Standard - Health (PPI)





Analysis

Flu: 1,268 flu vaccines have been administered by our Occupational Health and Peer Vaccinators (including to staff from the follow groups:- CFRs, EMRTS, HCS, PHW, St John Cymru and Students). Of these vaccines administered within the Trust, 1,056 have been received by WAST staff* (*staff who hold an ESR payroll number) and a further 273 have been given to WAST staff elsewhere (i.e. GP surgery / COVID Booster setting) therefore, a total of 1,329 WAST staff have received the vaccination against flu, equating to 30.6% of the overall workforce.

Additional engagement has been received from 198 WAST staff completing the Microsoft Form indicating that they have chosen to opt-out of having the flu vaccine, meaning the campaign has reached a 35.2% engagement rate so far.

COVID-19: As of the end of November 2023, 94% of all WAST staff have received both the first and second COVID-19 vaccination dose.
These percentages are the same for both Patient-Facing and Non-Patient-Facing Staff.
86% of Patient-Facing, and 87% of Non-Patient-Facing, WAST staff have received at least one of the Covid-19 boosters offered in the last 3 years.
Since September 2023, 26% of Patient-Facing staff and 25% of Non-Patient-Facing staff have received this season's Covid-19 Booster
This is compared to 70%/57%, respectively, for the equivalent time period in 2022 and 47%/47%, respectively, for the equivalent time period in 2021

Remedial Plans and Actions

Flu: Though many staff have received their flu vaccine in the workplace so far, there is still a vast majority of the workforce to engage with. Therefore, in line with this campaign's Communications Plan, additional notices and posters will be circulated to staff, including ones that will again promote this campaign's incentives; the prizes will comprise of 6x tier one vouchers of £250 each and 60x tier two vouchers of £20 each.

COVID-19: The four UK CMOs agreed it was appropriate to pause the alert level system, which was suspended on 30th March 2023.

Routine testing was also paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools during the spring of 2023.

Expected Performance Trajectory

Over 30% of the WAST staff workforce have now either had the flu vaccine in a WAST setting or elsewhere. The aim going forward is to offer out the flu vaccine to the remaining staff who are yet to have the flu vaccine.

***NB: COVID Vaccinations are reported using the WAST definition of Frontline Patient Facing employees and therefore includes those employed within Clinical Contact Centres.*
****NB: Flu data accurate at time of publication and subject to change / Spikevax vaccination data correct at time of publication and subject to change.*

Date source: Cohort Electronic System / Welsh Immunisation System (WIS)

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

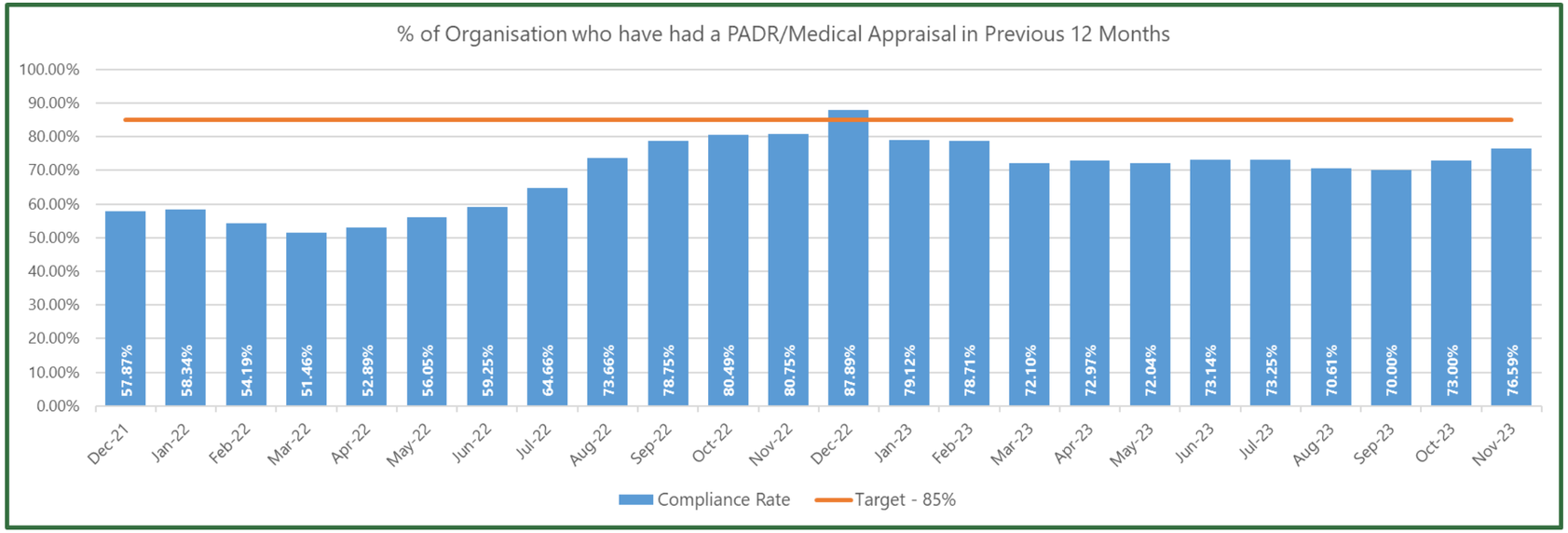
A

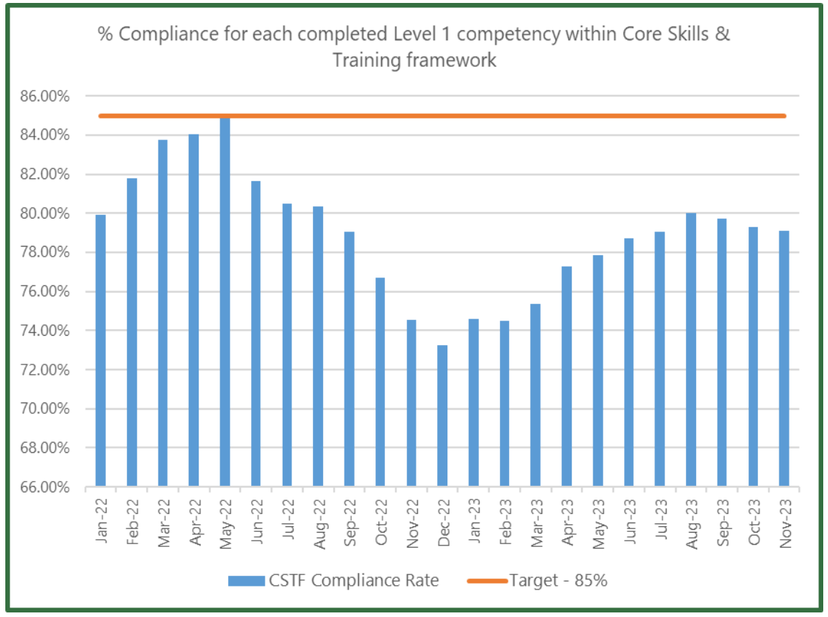
Self-Assessment: Strength of Internal Control: Strong

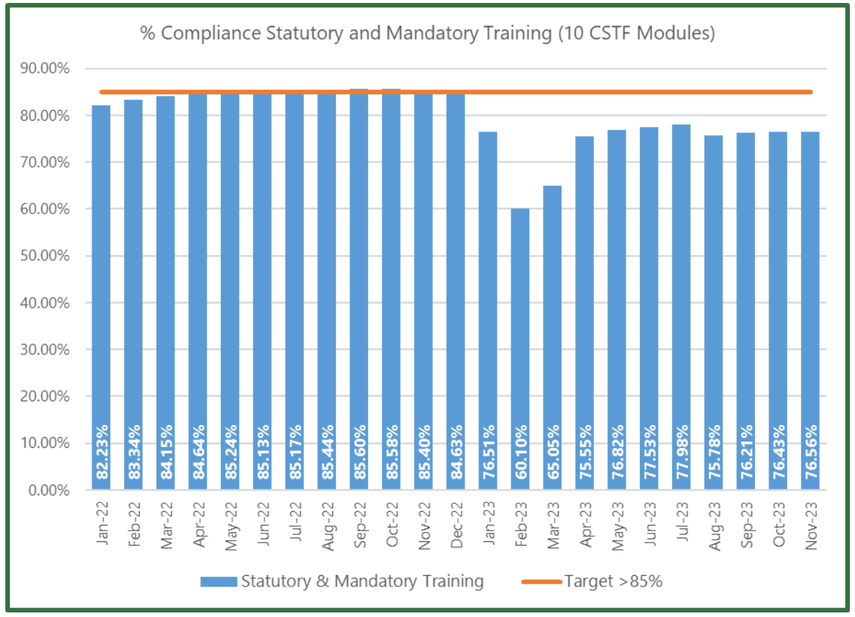
CI

PCC

Health & Care Standard
Health – Staff & Resources







Analysis

PADR rates for November 2023 increased when compared to the previous month to 76.59%, but remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, although current rates remain higher than during the same period last year.

In November 2023 Statutory & Mandatory Training rates reported a combined compliance of 76.56%; with Dementia Awareness (91.75%) and Safeguarding Adults (89.40%) achieving the 85% target. Moving & Handling (76.03%), Fire Safety (76.49%), Equality & Diversity (79.07%), Information Governance (71.14%), Welsh Language Awareness (52.68%), Fraud Awareness (43.02%), Violence Against Women, Domestic Abuse & Sexual Violence (84.03%) and Paul Ridd (60.82%) all remain below this target.

There are currently 15 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table below:

Remedial Plans and Actions

Throughout August the Workforce Education and Development team opened and have been assisting colleagues in using the self-service booking system for the 2023/24 Mandatory In-Service Training (MIST) annual refresher programme. As of the end of August, 685 members of staff from ACA1, ACA2, EMT and Paramedic roles have booked their face-to-face day. MIST 2023/24 commenced on the 4th of September; sufficient MIST sessions will be provided to enable all those requiring a place to secure one. MIST provision is planned to be closed mid Q3, subject to Operational pressures and demand. Communications via Yammer and Siren are in place to make people aware of dates/how to book on. Progress toward 100% compliance is tracked and communicated throughout the MIST 'window' via a combination of update reports and presentations detailing performance and gain assurance that under-performance will be addressed locally. For road-based colleagues who attend MIST sessions, the opportunity will be taken to encourage individuals to complete any E-learning statutory or mandatory areas they are not compliant with.

Skills and Training Framework	NHS Wales Minimum Renewal Standard
Equality, Diversity & Human Rights (Treat me Fairly)	3 years
Fire Safety	2 years
Health, Safety & Welfare	3 years
Infection Prevention & Control - Level 1	3 years
Information Governance (Wales)	2 years
Moving and Handling - Level 1	2 years
Resuscitation - Level 1	3 years
Safeguarding Adults - Level 1	3 years
Safeguarding Children - Level 1	3 years
Violence & Aggression (Wales) - Module A	No renewal
Mandatory Courses	
Violence Against Women, Domestic Abuse and Sexual Violence	3 years
Dementia Awareness	No renewal
Welsh Language Awareness	3 Years
Paul Ridd Learning Disability Awareness	No renewal
Environment, Waste and Energy **(Admin & Clerical staff Only)**	Yearly

The ESR statistics at the end of July are as follows, 67.4% of operational colleagues had completed their Tail Lift Refresher Training, 55.4% if all colleagues had completed their Paul Ridd Learning Disability Awareness Training, and 43.7% of all colleagues have completed their Welsh Language Awareness.

Expected Performance Trajectory

Performance is improving as compliance has risen in relation to Paul Ridd.

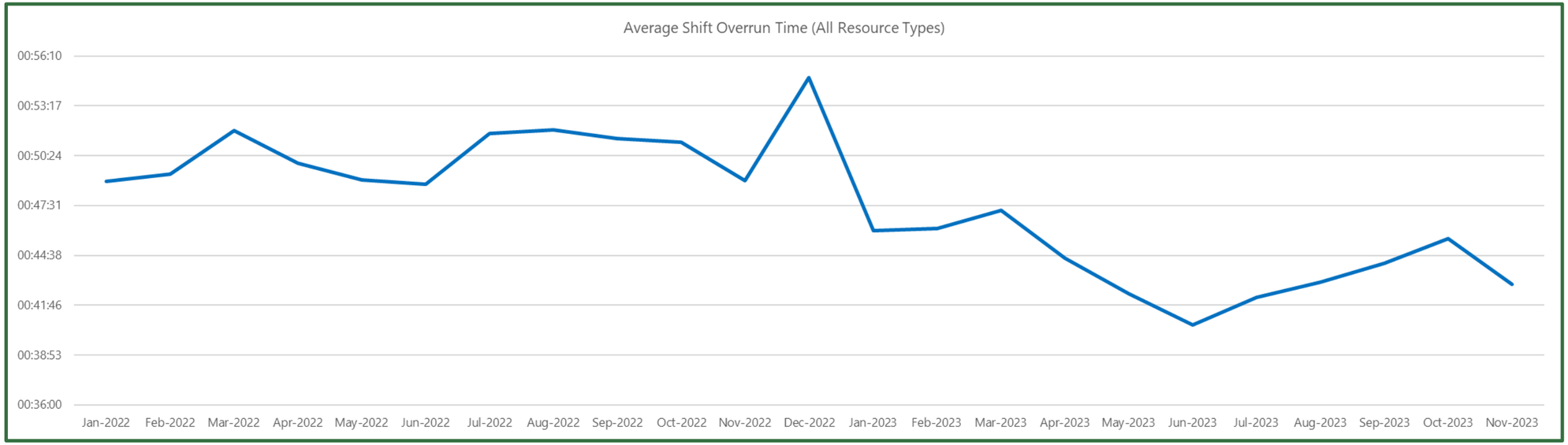
Data source: ESR

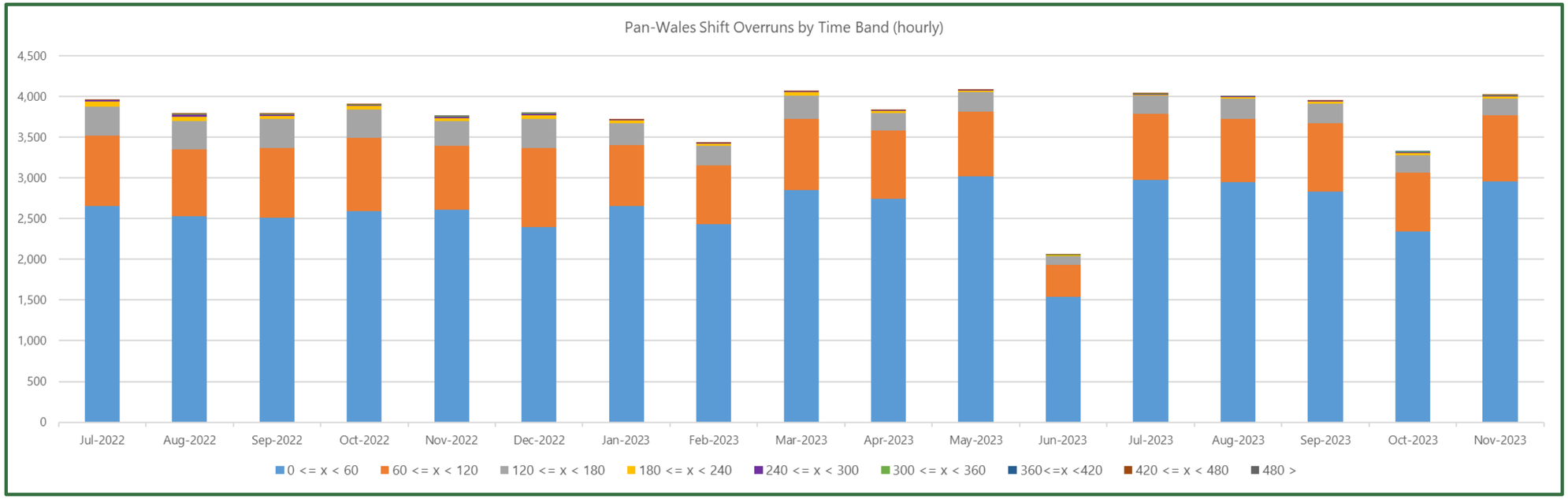
Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

R

CI





Analysis

Shift overrun average times have been steadily increasing again following a two year low recorded in June 2023; however, the average figure for November 2023 was 42 minutes and 57 seconds compared to 45 minutes and 36 seconds in October 2023.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 71.5% of the total. 21% fall within the 61 to 120-minute category, 6.5% in the 121 to 180-minute category, 0.7% in the 181 to 240-minute category and 0.4% 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.

As part of the Trust's winter resilience planning, it is introducing "pods" at some hospital locations to aid staff finishing on time.

Expected Performance Trajectory

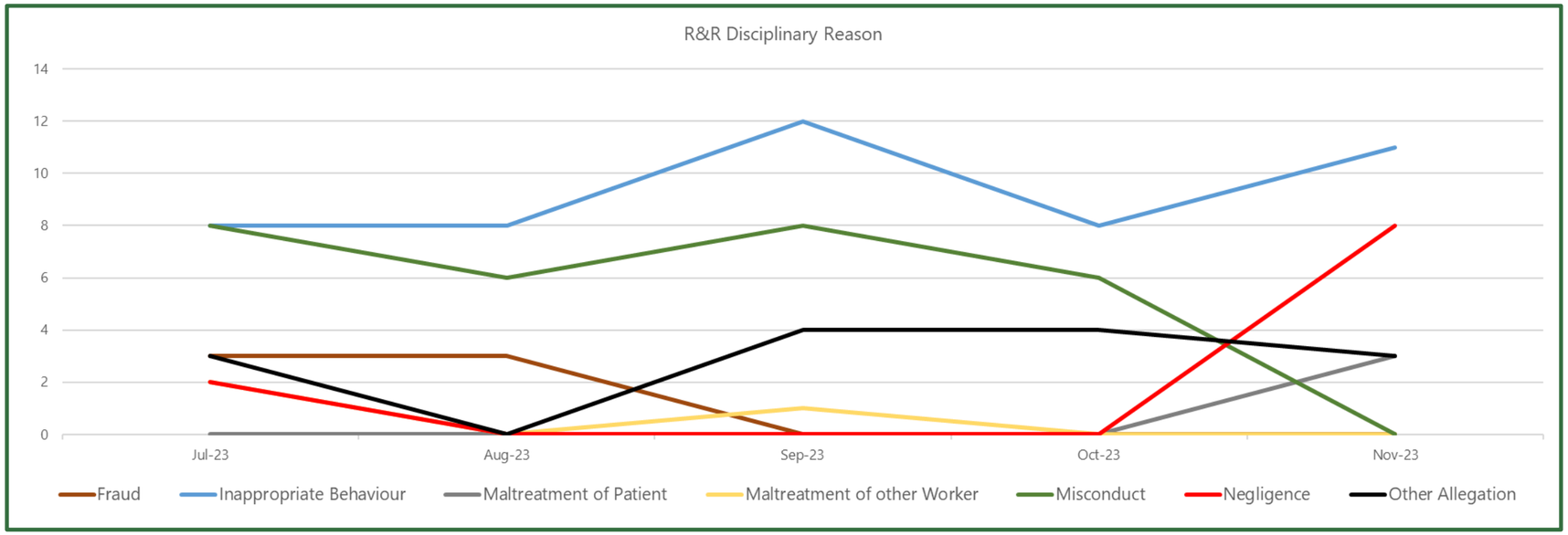
There is clearly an upward trajectory from Jun-23 as handover has started to increase. Whilst the Trust had amended its end of shift policies and introduced "pods" at key sites, as above, as handover increases further into the winter, we may expect overruns to increase.

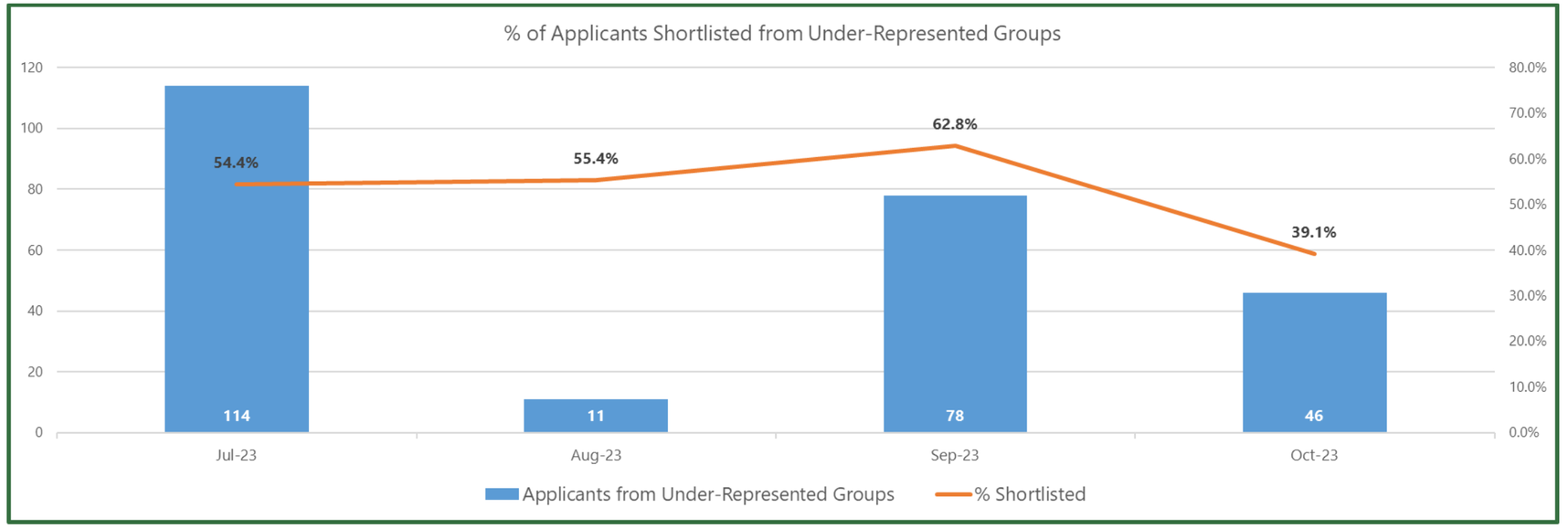
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 25 open formal disciplinary cases recorded at the end of November 2023, an increase compared to the month of October 2023 where 18 open cases were recorded. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by negligence.

There were 5 open formal Respect and Resolution cases submitted by employees, which was again a decrease on the 8 cases that were recorded during September.

In October 2023, 39.1% of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 62.8% in September 2023, while the volume of applications also declined, from 78 to 46.

Of the 46 total applications from under-represented groups in October 2023, 24 were in the category of Ethnicity, 13 within Disability and 9 within Sexual Orientation.

Remedial Plans and Actions

Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

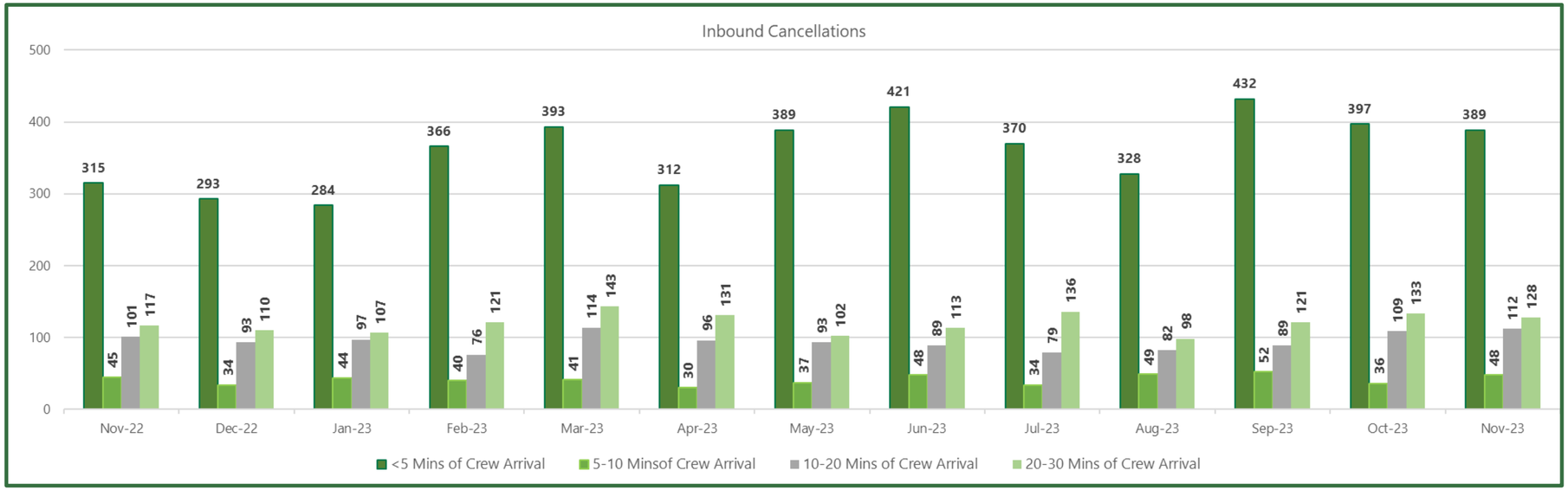
Expected Performance Trajectory

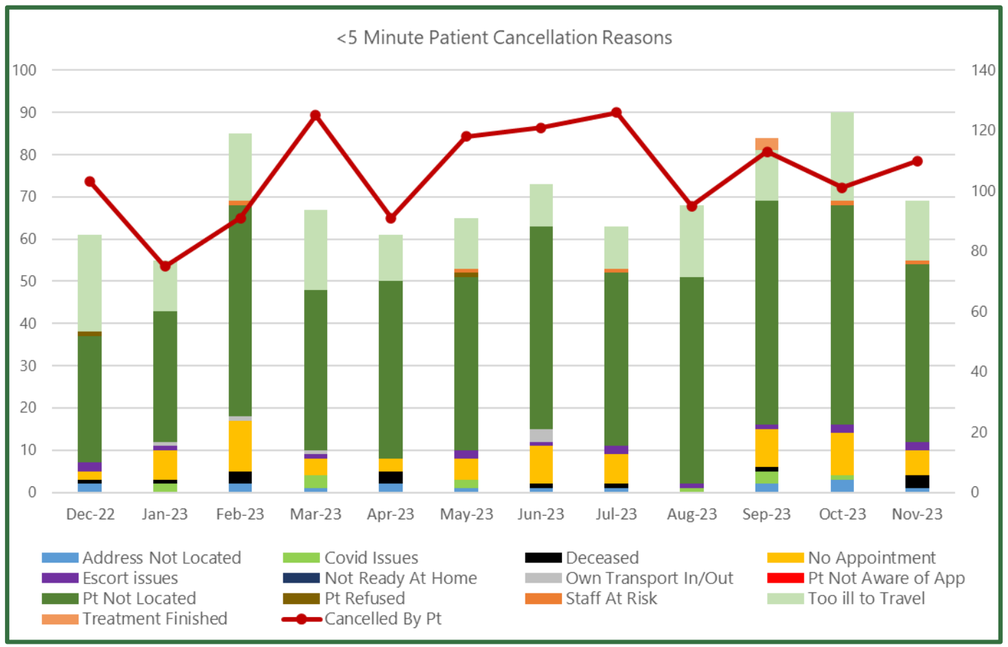
Continue to monitor levels, no trajectory for this measure.

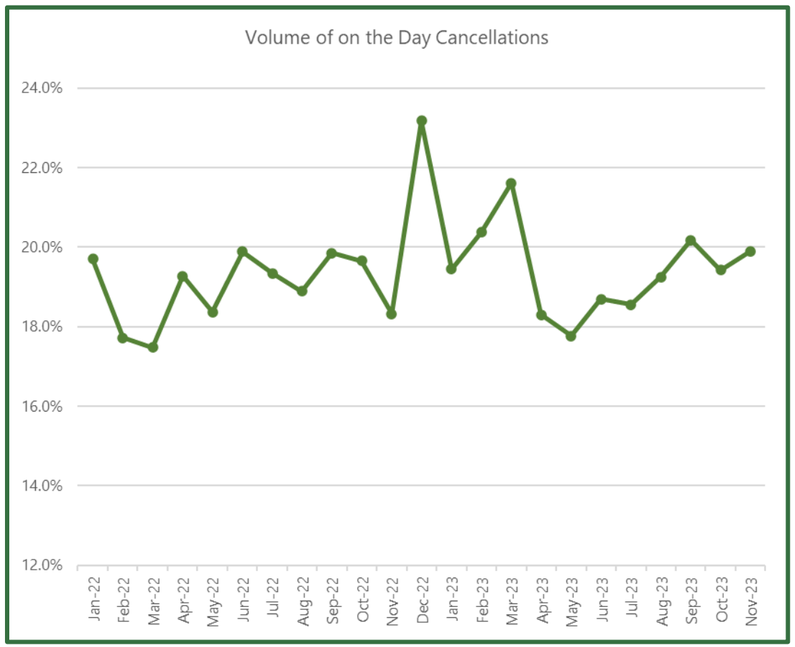
NB: No update recieved

Finance, Resources and Value
Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a decrease in November 2023 to 389, compared to 397 in October 2023. The total number of cancellations within 30 minutes also slightly increased from 675 in October 2023 to 677 in November 2023.

Cancellations within 5-minutes of arrival appears to have seen an overall increase during the past 12 months. In November 2023 there were 110 cancelled by patient* entries made within 5-minutes of crew arrival an increase compared to the previous month of 101. The top reasons for less than 5-minute cancellations included: 42 patient not located, 14 too ill to travel and 6 no appointment.
During the past 12 months there has been a minimum of 30 patients not located in the 5-minutes or less each month.

Same day cancellations increased slightly from 19.4% in October 2023 to 19.9% in November 2023.

Remedial Plans and Actions

The loss of hours through late notice cancellations is disruptive to the service and a number of actions have already been implemented including text reminders, call ahead by crew and pre-travel calls by admin staff as resource allows.

In addition, the enhanced service hub undertakes focused actions to identify and address incidences of enhanced patients late notice cancellations.

However, what is needed to really improve this position is alignment between WAST and HB systems so that cancellations flow and HB staff not booking discharges where transport is not assured, or cancellation occurs due to a change in patient circumstances. A trial is being worked on with BCU & CTM to try and improve this locally and develop a national model.

Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory.

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

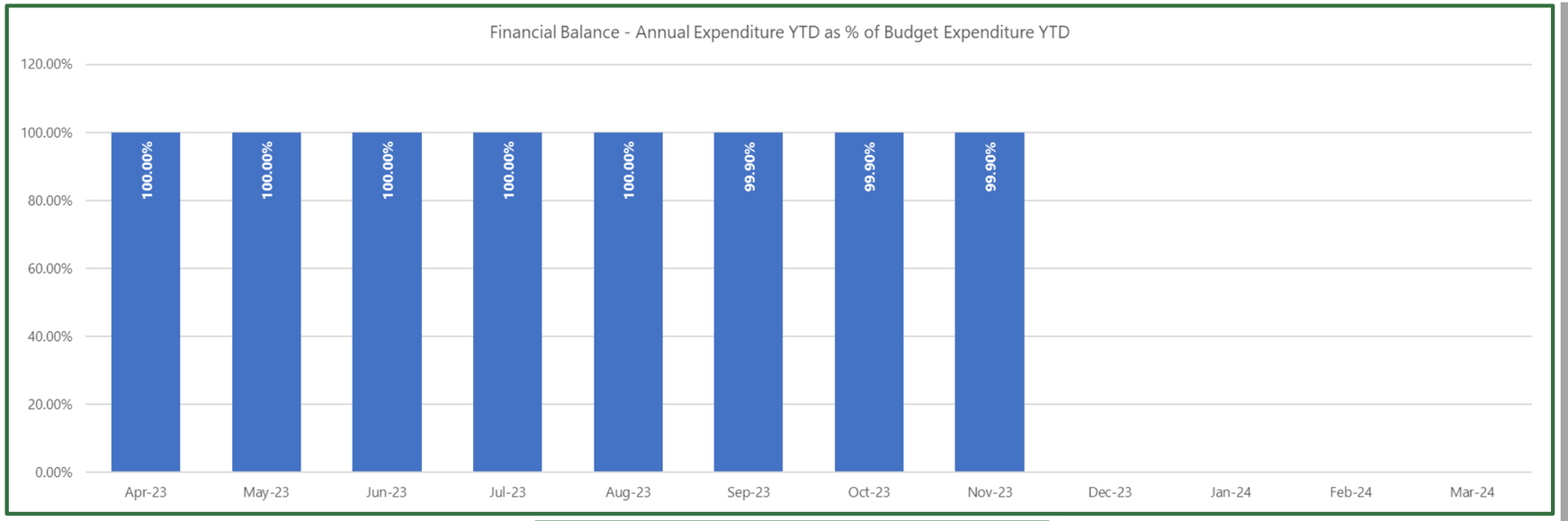
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

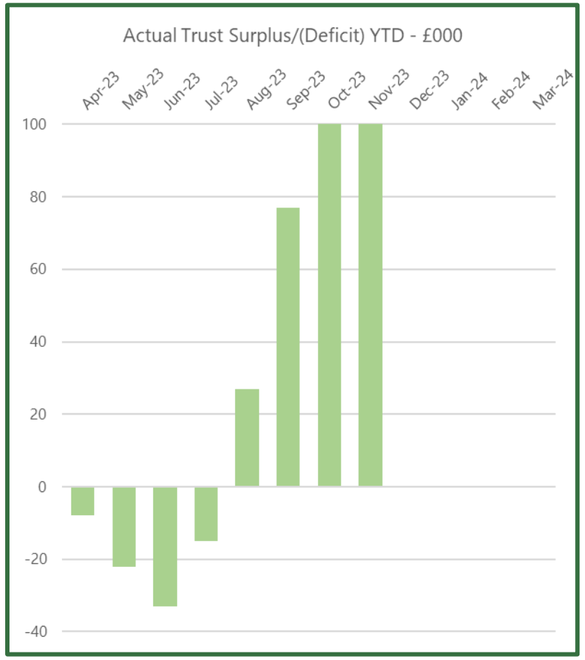
Finance, Resources and Value
Value - Finance Indicators

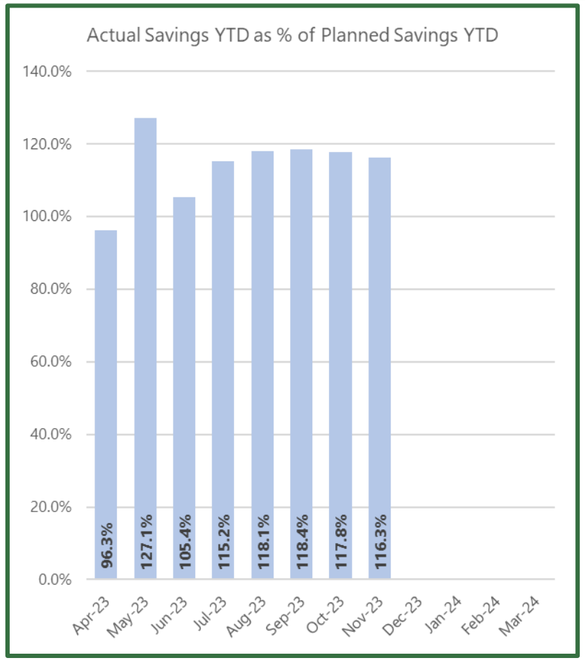
(Responsible Officer: Chris Turley)

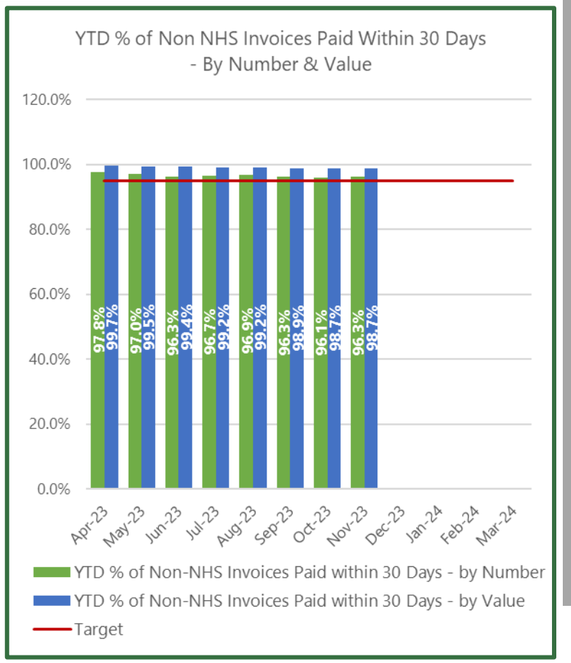
G

FPC









Analysis

The reported outturn performance at Month 8 is a surplus of £108k, with a forecast to the yearend of breakeven.

For Month 8 the Trust is reporting planned savings of £3.380m and actual savings of £3.931m (an achievement rate of 116.3%).

The Trust's cumulative performance against PSPP as at Month 8 is 96.3% against a target of 95%.

At Month 8 the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

The Trust's financial plan for 2023-26 has been built on the plans and financial performance of the last few financial years, in which the Trust has, year on year, achieved financial balance; the 2023-26 financial plan was submitted to WG following Board sign off on 31st March 2023.

No financial plan is risk free. Financial risk management forms a key element of the project plans which underpin both the Trust's ambitions and savings targets. The Trust continues to seek to strengthen where it can its financial capacity and corporate focus on finance, and as an organisation have structures in place to drive through the delivery of our financial plan.

Key specific risks to the delivery of the 2022/23 financial plan and beyond include:

- Continuing financial support from Welsh Government in relation to Covid costs;
- Availability of capital funding to support the infrastructure investment required to implement service change, and the ability of the Trust to deliver the revenue consequences of capital schemes within stated resource envelope;
- Financial impact of EASC Commissioning Intentions, and confirmation of the EMS financial resource envelope as assumed within our financial plan;
- Ensuring additional avoidable costs that impact on the Trust as a result of service changes elsewhere in the NHS Wales system are fully recognised and funded;
- Ensuring any further developments are only implemented once additional funding to support these is confirmed;
- Delivery of cash releasing savings and efficiencies via the Financial Sustainability Program (FSP);

Expected Performance Trajectory

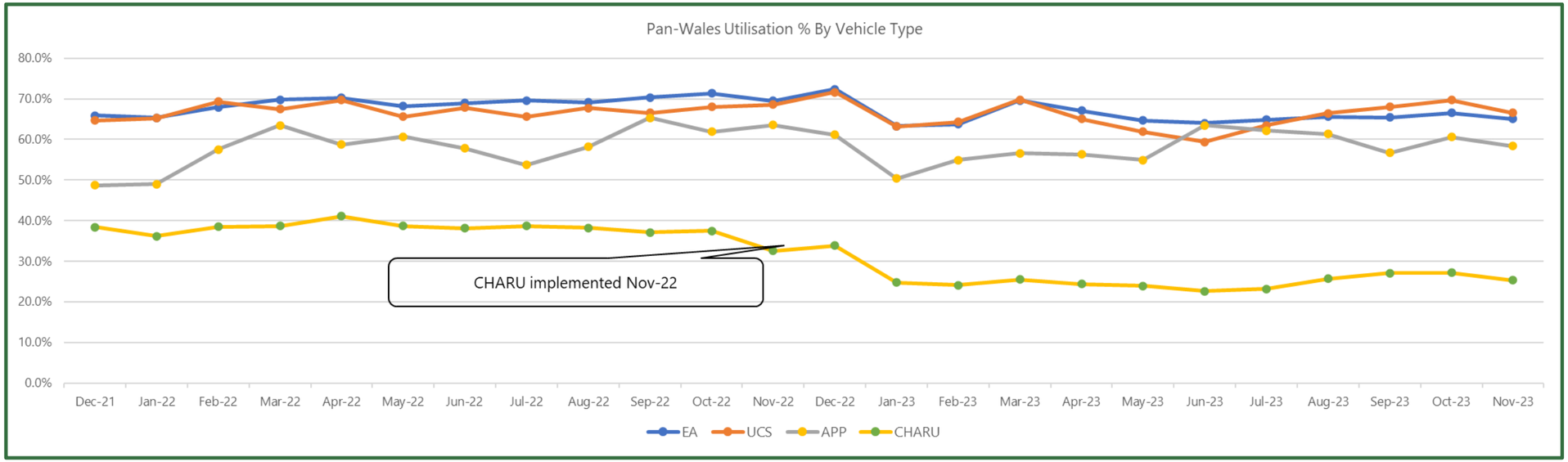
The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2023/24 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver further significant level of savings into the 2024/25 financial year.

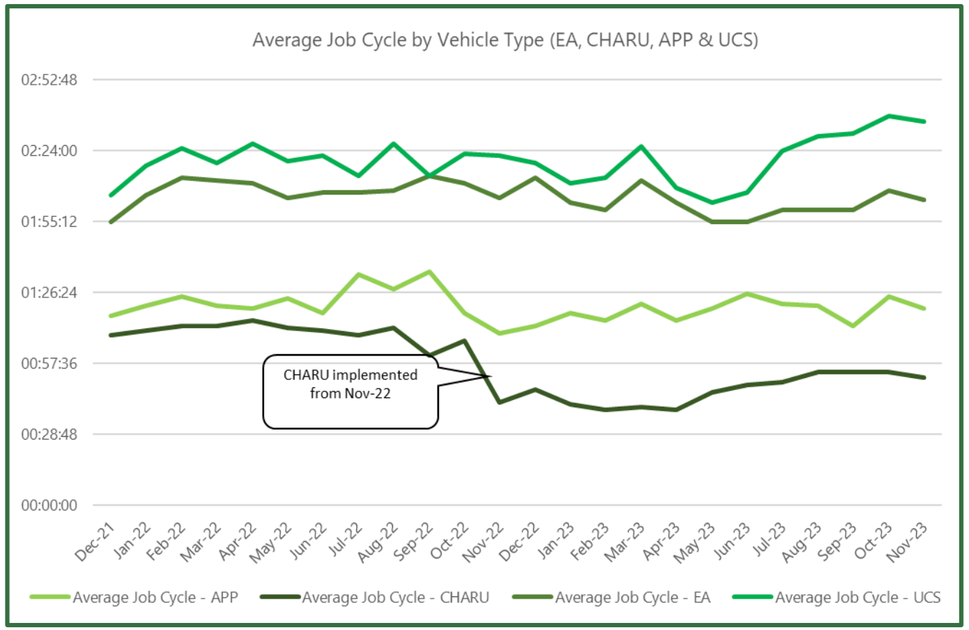
Finance, Resources and Value
EMS Utisation & Average Job/Shift Times

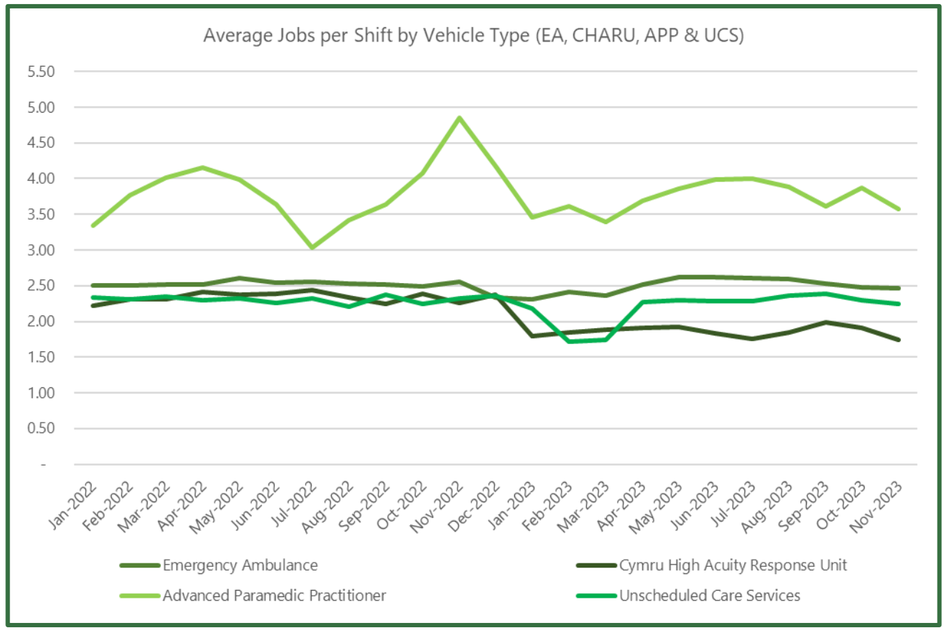
(Responsible Officer: Lee Brooks)

CHARU Utilisation
R

FPC







Analysis

Pan Wales Utilisation metrics in November 2023 were 56.4% for all vehicles types, a slight decrease from 58.5% in October 2023. UCS achieved the highest rate during the month at 66.5% while EA was at 65%. Both have seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle in November 2023 decreased to 2 hours 04 minutes for EAs, and to 2 hours 36 minutes for UCS crews. CHARUs also reduced to 52 minutes and APPs decreased from 1 hour 25 minutes to 1 hour 20 minutes.

Overall average jobs per shift was 2.29 in November 2023, a decrease from the 2.36 recorded in October 2023. APPs attended on average 3.58 jobs per shift, EAs 2.47 jobs per shift, UCS crews 2.25 jobs per shift and CHARU's 1.75 jobs per shift.

Overall average jobs per shift has remained relatively static with APP & CHARU resources having a job cycle that is half that of a conveying resource.

Remedial Plans and Actions

The increase in average job cycle time since 2021 can be attributed to numerous factors including the introduction of ePCR and increasing hospital delays (staff pre-empting and packaging patients in readiness for long waits and patients waiting longer for an ambulance response therefore requiring more treatment/assessment). These times are monitored at Weekly Performance Meeting and local work to establish appropriate efficiency initiatives is ongoing

Expected Performance Trajectory

The increase in job cycle time since 2021 is caused by numerous complex factors. As ePCR embeds, a decrease may be seen, but with the factors outside of WAST's control a reduction to pre pandemic levels may not been seen. The EA and UCS utilisation is too high. The APP utilisation is being considered via the inverting the triangle transformation work. The CHARU rate is being reviewed linked to modelling.

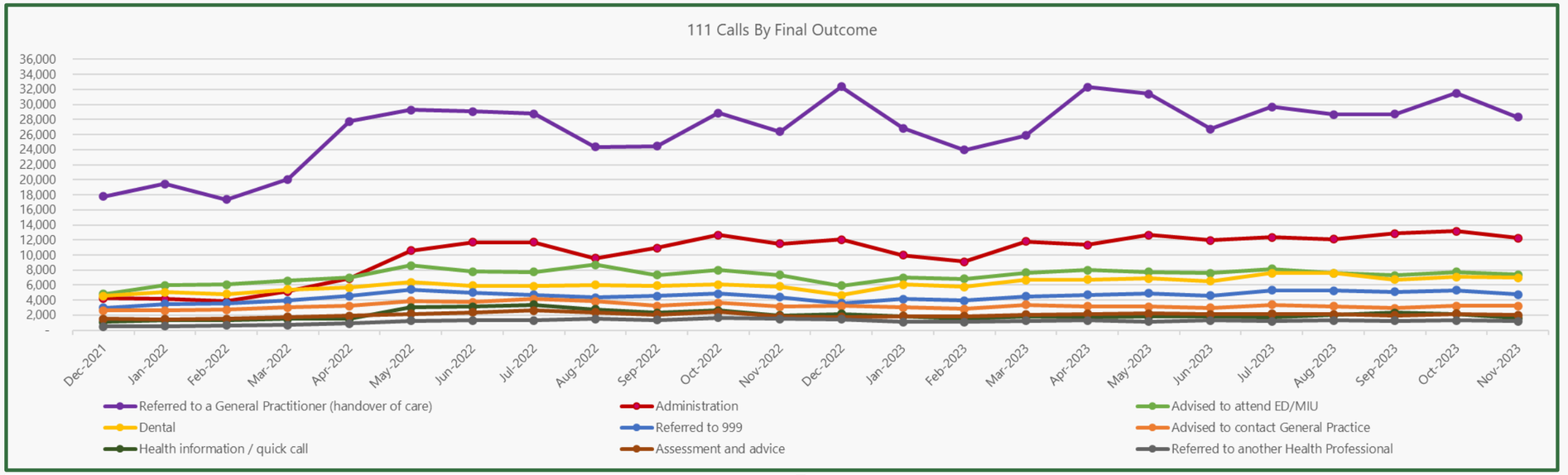
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

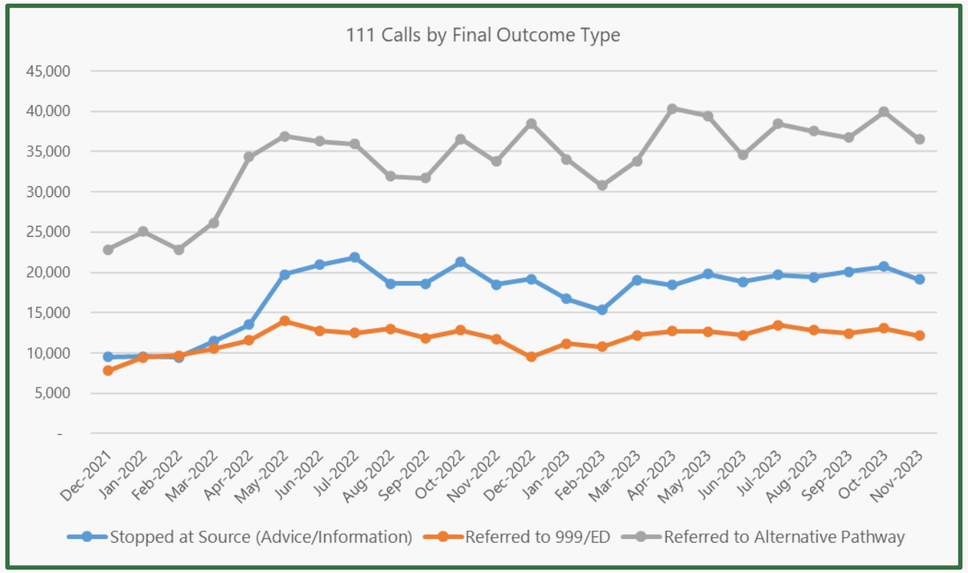
(Responsible Officer: Lee Brooks)

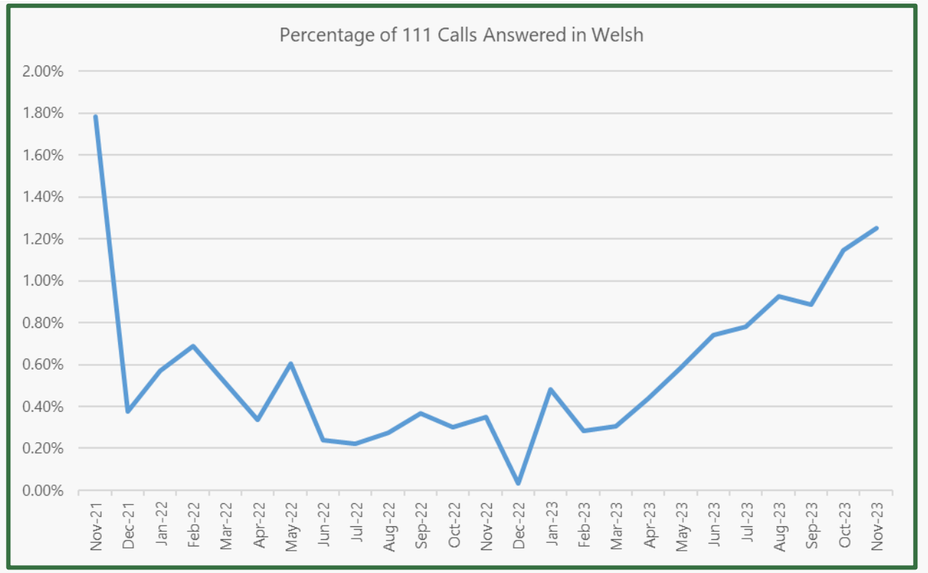
A

FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

67,797 calls were received into the 9 categories displayed in the graph opposite during November 2023, a decrease compared to the 73,694 received during October 2023.

In November 2023, calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 42% of all calls.

As the bottom left graph highlights, in November 2023, 19,135 calls into 111 were provided with information or advice, with no onward referral, a decrease from 20,713 in October 2023.

111 calls answered in Welsh increased in November 2023 to 1.25% of all 111 calls received compared to October 1.15%. For November this would equate to 67.9% of 111 calls offered and answered in Welsh compared to October 72.2%.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST its commissioners and DCHW. The focus is the development of a Nationally reportable 111 data set. Similar to what is currently in place for ASIs. Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

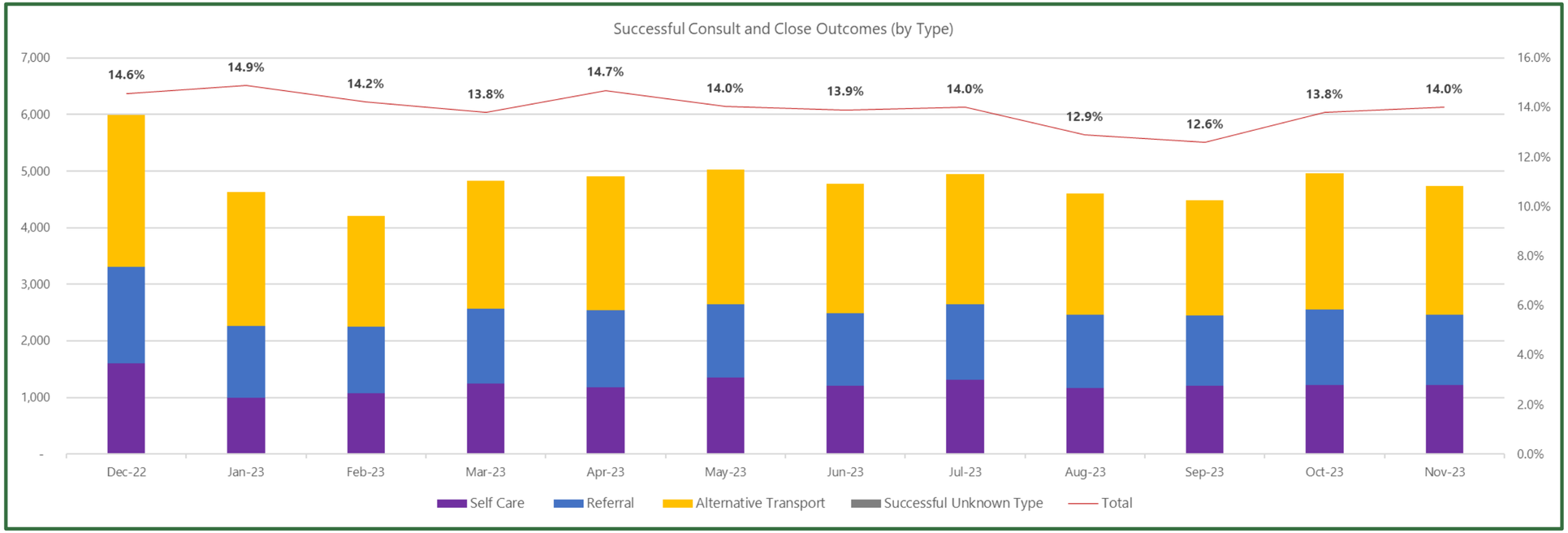
No performance trajectory is set at this time, as the Trust develops is measures and systems around these metrics. Once these have been developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

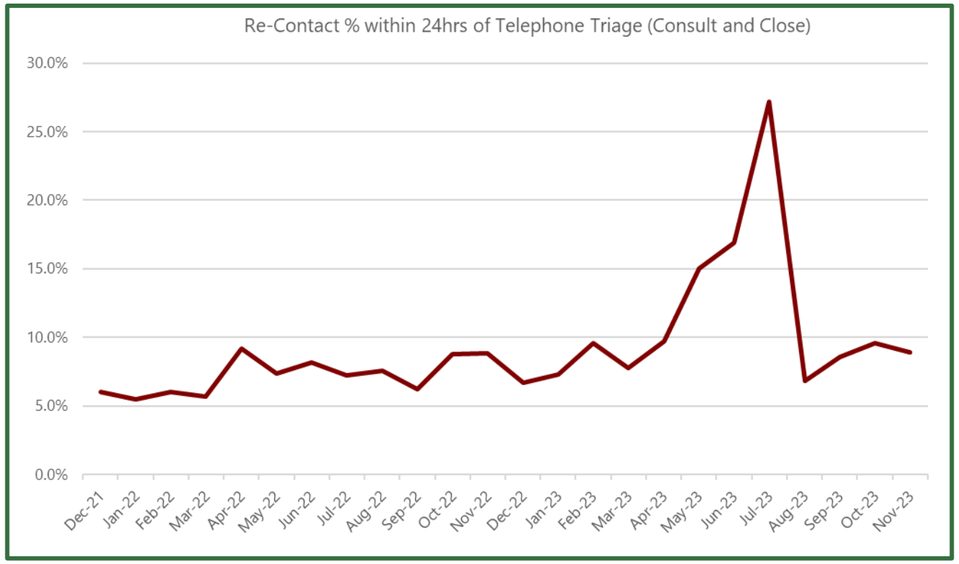
Partnerships / System Contribution
Consult & Close Indicators

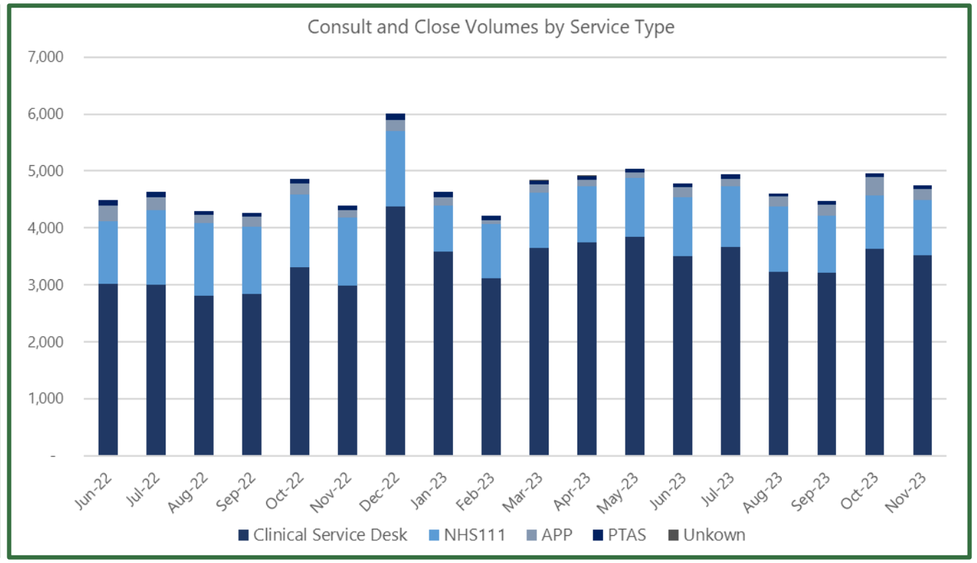
(Responsible Officer: Lee Brooks)

C&C R

FPC







Analysis

Consult and Close, with contributions from Clinical Service Desk (CSD) (10.4%), NHS111 (2.9%), WAST APP (0.5%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.2%) achieved 14% in November 2023. This was an increase on the 13.8% seen during October 2023, but remained short of the new 17% IMTP ambition. In November 2023, the number of 999 calls resulting in a Consult and Close outcome was 4,745, up from 4,960 in October 2023.

Of the calls successfully closed in November 2023, 1,215 patients received an outcome of self-care; 1,244 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,282 were advised to seek alternative transport services in order to acquire treatment.

Re-contact rates in November 2023 were 8.9%, a decrease on the 9.6% seen in October 2023.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support which is recognised by those calling
- Reporting still challenging without telephony data
- Failed contact activity from EMSC has reduced
- Progressing process with 111 to pass calls electronically from CSD, saving time
- More staff are at work in CSD
- Additional staff start live this month
- Work commenced on PDSA for CSD First

Expected Performance Trajectory

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

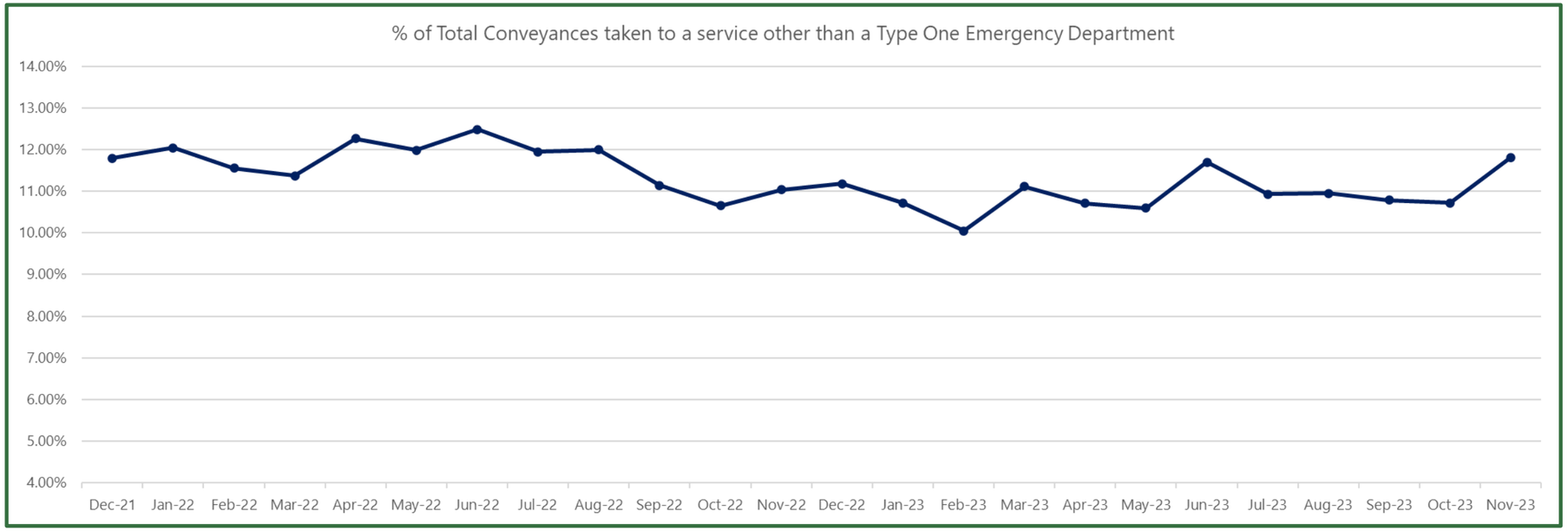
Partnerships / System Contribution
Conveyance to ED Indicators

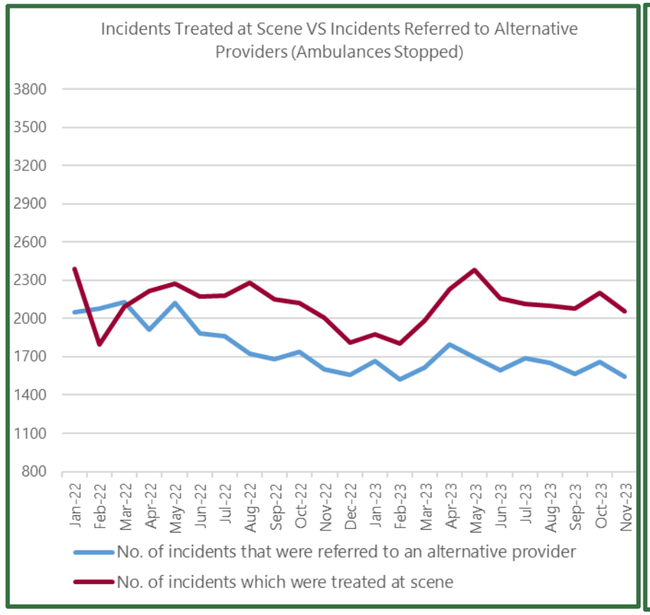
(Responsible Officer: Andy Swinburn)

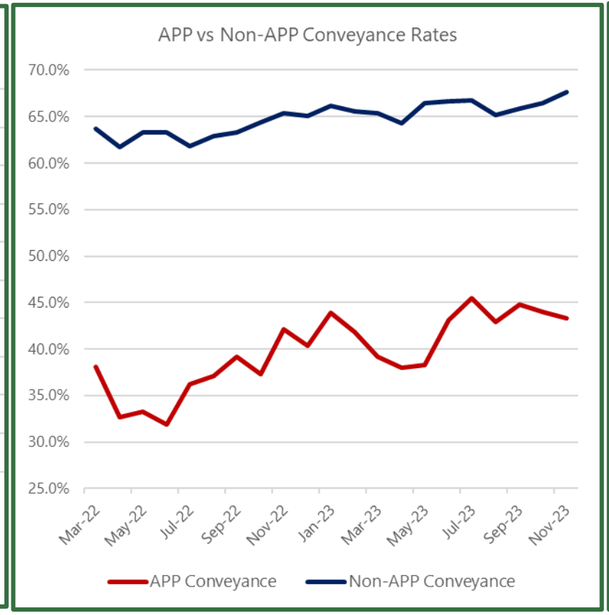
A

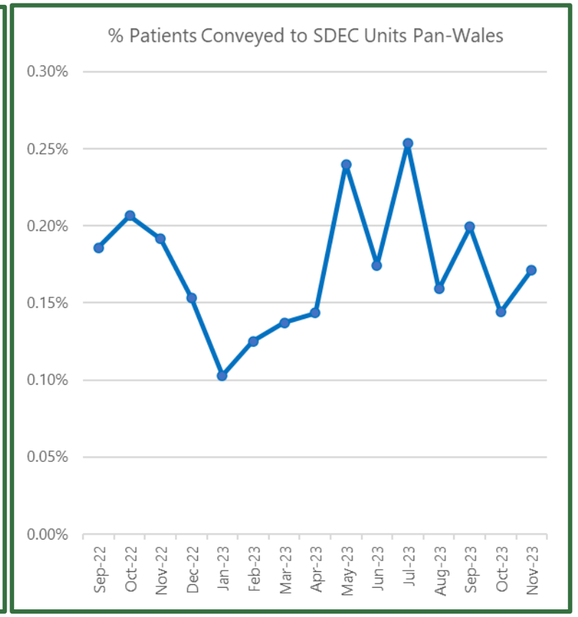
FPC

Ministerial Measure









Analysis

In November 2023 11.81% of patients (1,795) were conveyed to a service other than a Type One ED, while 39.63% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers decreased slightly, from 3,862 in October 2023 to 3,594 in November 2023.

APP conveyance rates decreased slightly to 43.3% in November 2023, although there has been a general increase seen in recent months due to increased levels of CSP, which results in patients choosing to transport themselves to the ED, with only patients who do not have this ability (usually sicker) receiving a response.

Patients conveyed to SDEC's rose from 0.14% in October to 0.17% in November 2023.

Remedial Plans and Actions

The Trust has modelled the use of same day emergency care (SDEC) services and identified that they could take an estimated 4% of EMS demand; it is currently less than 0.5%. The percentage increase in conveyance to services other than EDs is a Ministerial Priority. The Trust's ability to improve this figure is dependent on pathways that are open to the Trust such as SDECs.

Utilisation of APP resources will continue to be monitored as part of weekly performance reviews and evaluation of the appropriate APP code-set will be undertaken through the Clinical Prioritisation and Assessment Software (CPAS) group.

Expected Performance Trajectory

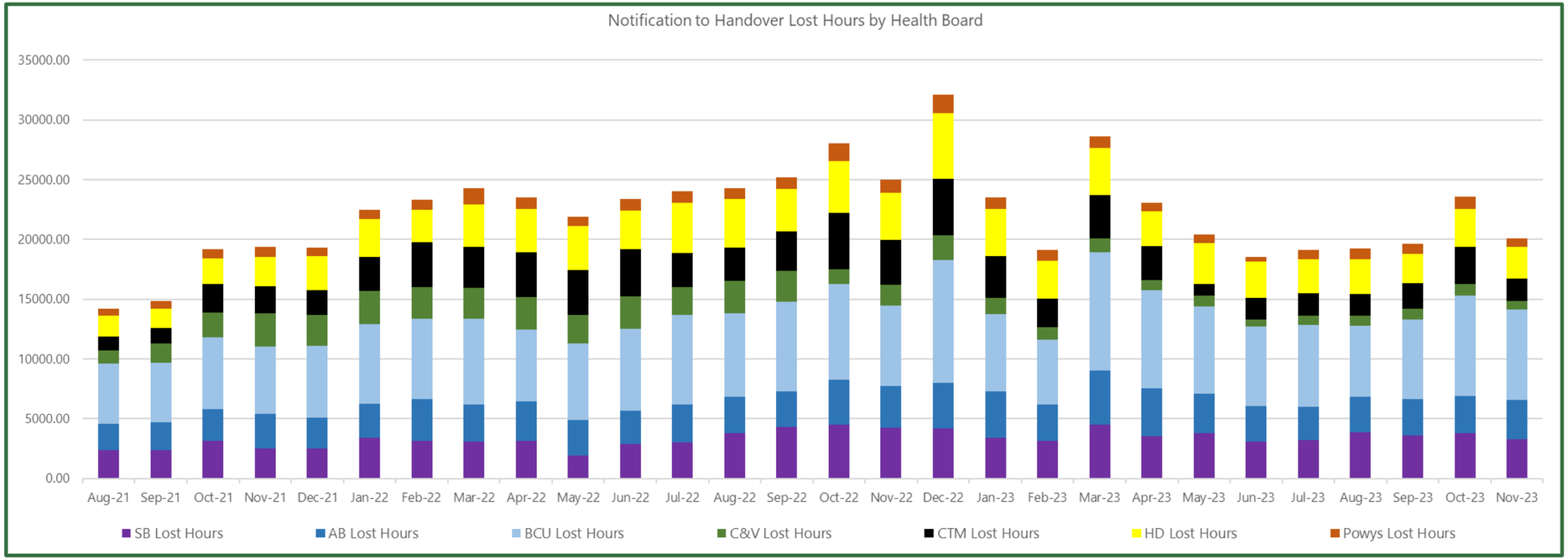
The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes are required as well. This modelling indicates a reduction in patients conveyed of 1,165 per week but is predicated on large scale investment in APPs (470 v starting position of 67).

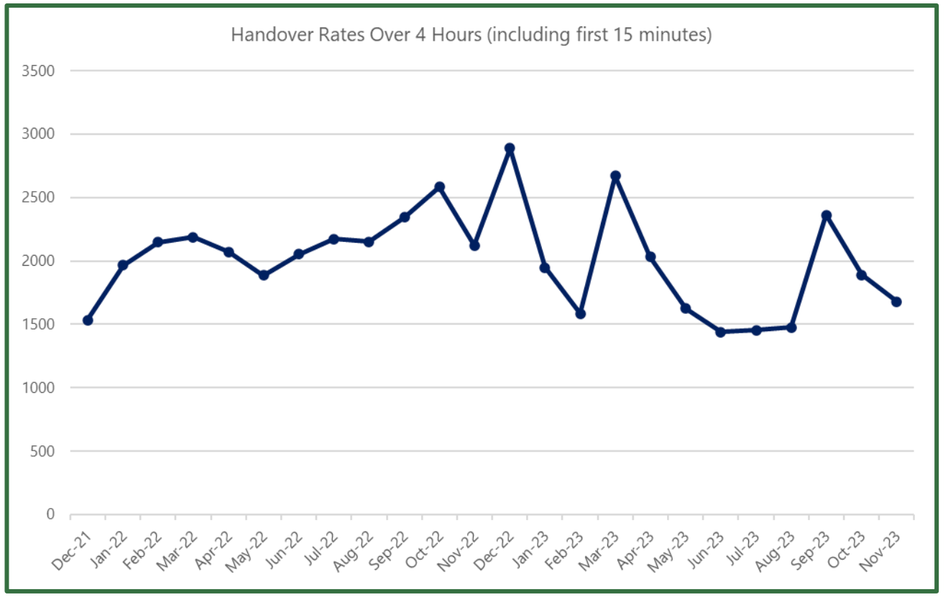
Partnerships / System Contribution Handover Indicators

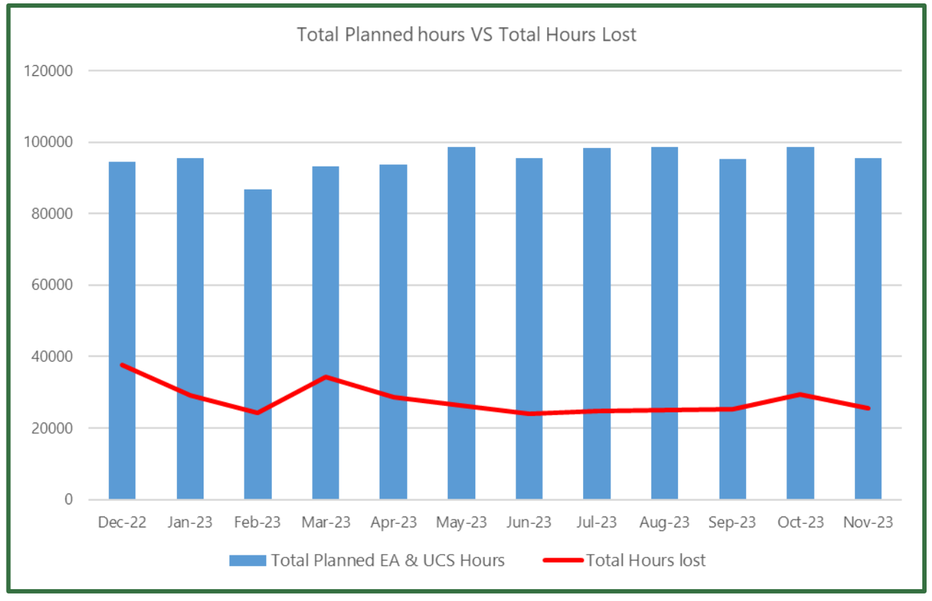
(Responsible Officer: Health Boards)

R

CI QUEST







Analysis

267,017 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Dec-22 to Nov-23), compared to 285,329 over the same timeframe the previous year. There were 20,110 hours lost in November 2023, a decrease from the 23,571 lost in October 2023. This is the first time in four months that the figure has decreased, and levels remain below where they were during the same period last year.

The hospitals with the highest levels of handover delays during November 2023 were:

- The Grange University Hospital (ABUHB) at 3,194 lost hours
- Morriston Hospital (SBUHB) at 3,163 lost hours
- Wrexham Maelor Hospital (BCUHB) at 3,123 lost hours
- Glan Clwyd Hospital (BCUHB) at 2,593 lost hours

Notification to handover lost hours averaged 670 hours per day during November 2023 compared to 760 hours a day in October 2023.

In November 2023, the Trust could have responded to approximately 6,344 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

Remedial Plans and Actions

Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to EASC, Health Boards and to Welsh Government / Minister, and this will continue through the year as we seek to influence and put pressure on the system to improve. Healthcare Inspectorate Wales (HIW) has undertaken a local review of WAST to consider the impact of ambulance waits outside Emergency Departments, on patient dignity and overall experience during the COVID-19 pandemic.

The WIIN platform continues to focus on patient handover delays at hospital and Electronic Patient Care Record (ePCR).

Expected Performance Trajectory

The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The ambition that there should be no waits over 4 hours during 2023/24. Non-release for Immediate Release Requests should become a Never Event.

**NB: Data correct at time of abstraction.*

Partnerships / System Contribution

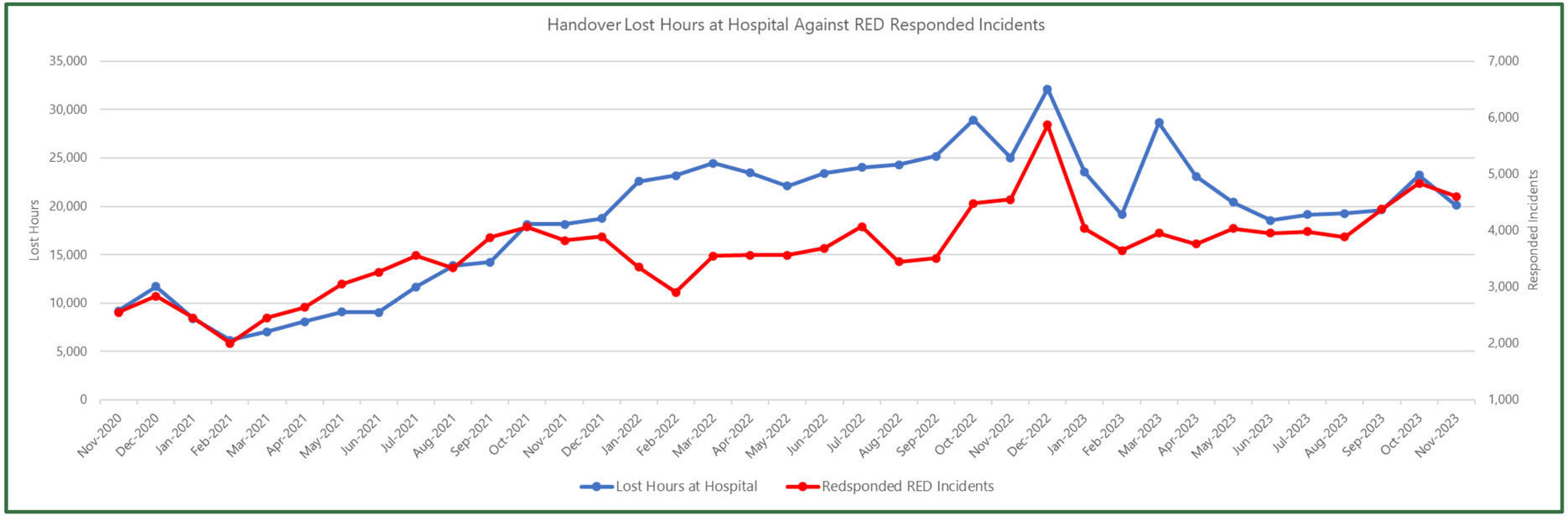
Handover Lost Hours Against Red & Amber 1 Responded Incidents

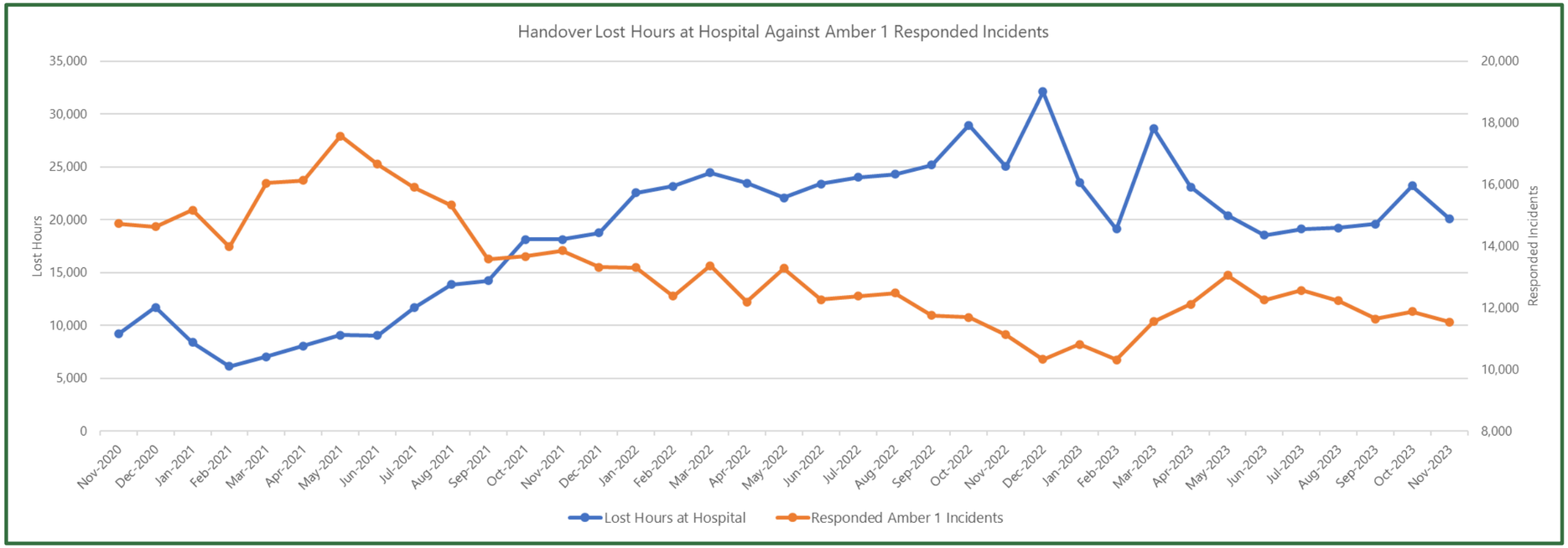
(Responsible Officer: Health Boards)

R

CI

QUEST





Analysis

The top graph highlights that as handover lost hours have increased since March 2021, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system. However, as the bottom graph illustrates, as the response to Red increases, there is an impact on Amber 1 responses, particularly at times of high demand, such as during December 2022. During these periods, the number of Amber 1 incidents attended decreases, notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.

The bottom graph also highlights that as lost hours have increased since mid-2021, so Amber 1 responses have declined, due to the increased system pressures. However, as lost hours reduced during the first half of 2023, so Amber 1 responses increased, from 10,326 in December 2022 to 13,055 in May 2023. Therefore, it was possible to see the reduction of pressure within the system and subsequent performance improvement through the Amber 1 metric.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The ambition that there should be no waits over 4 hours during 2023/24. Non-release for Immediate Release Requests should become a Never Event.

**NB: Data correct at time of abstraction.*

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

Definition of Indicators

Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self-serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up, they are counted as "abandoned" as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	**PADR/Medical Appraisal**	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.		
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

Welsh Ambulance Services NHS Trust

Interim Monthly Integrated Quality & Performance Report

December 2023

GIG CYMRU NHS WALES

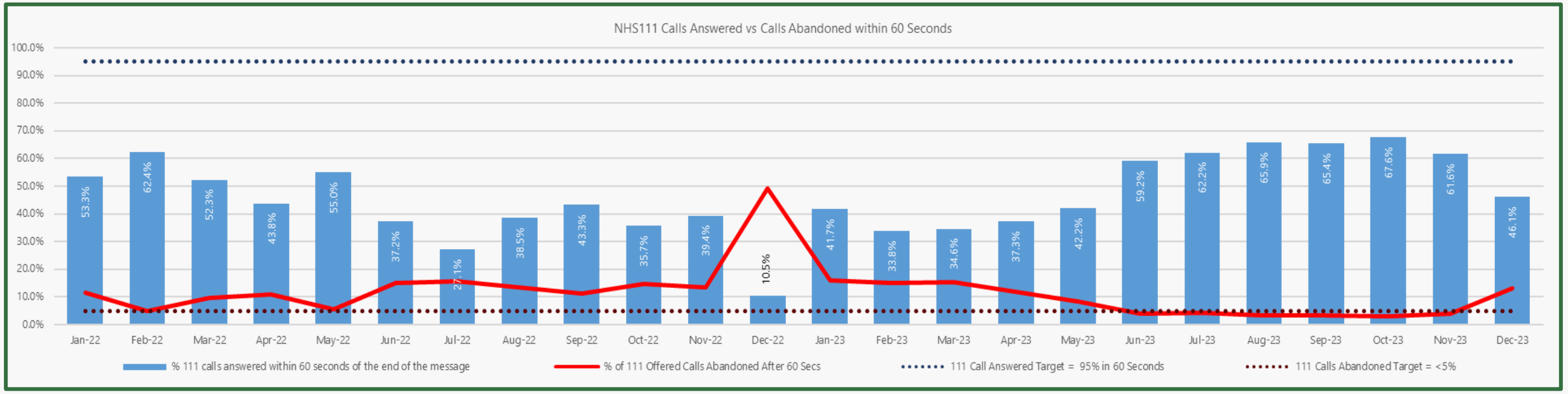
Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

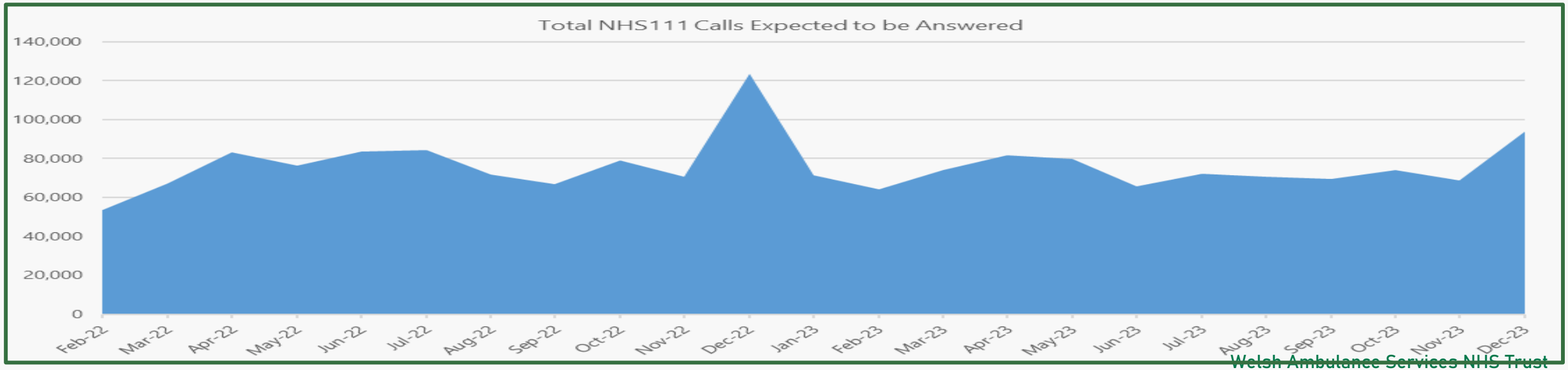
Welsh Ambulance Services
NHS Trust

Version 1.0
Released: January 2024

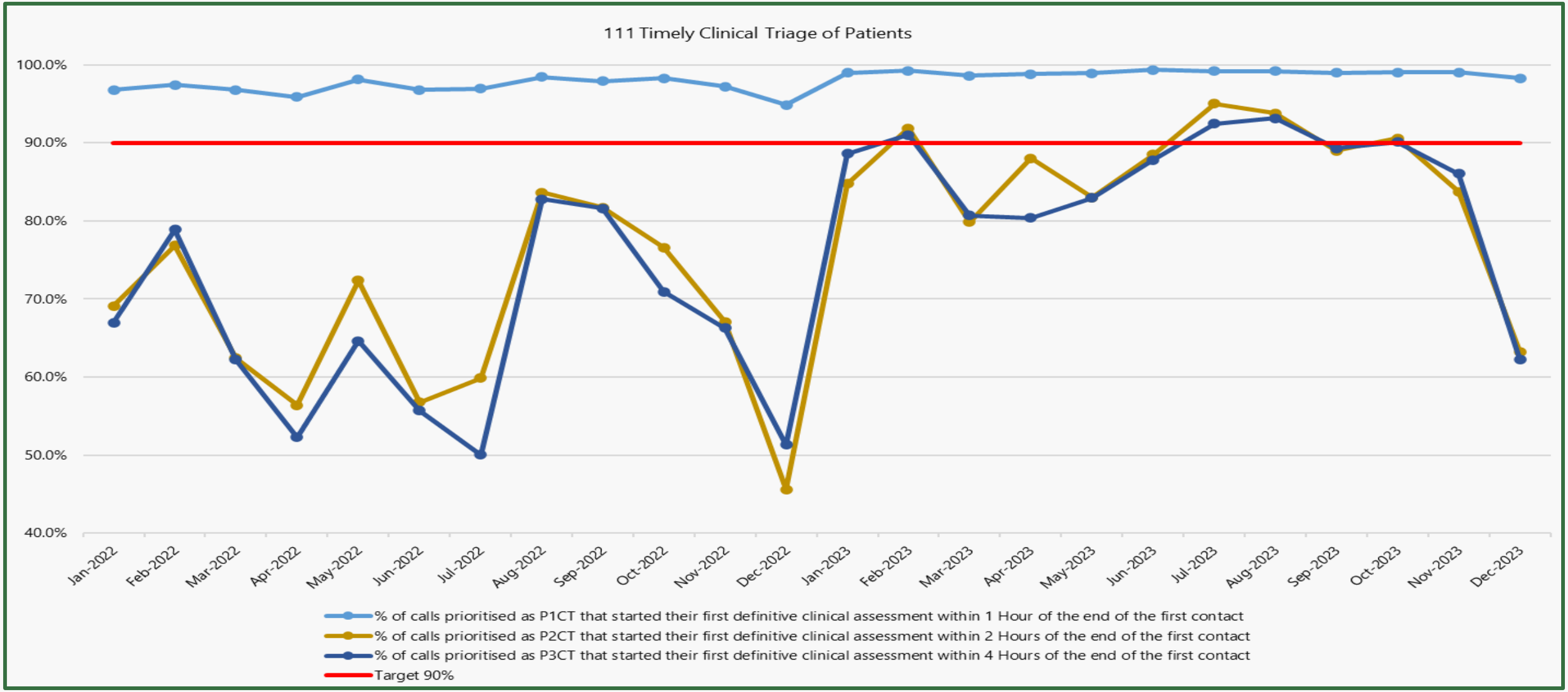
by Commissioning & Performance Team

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



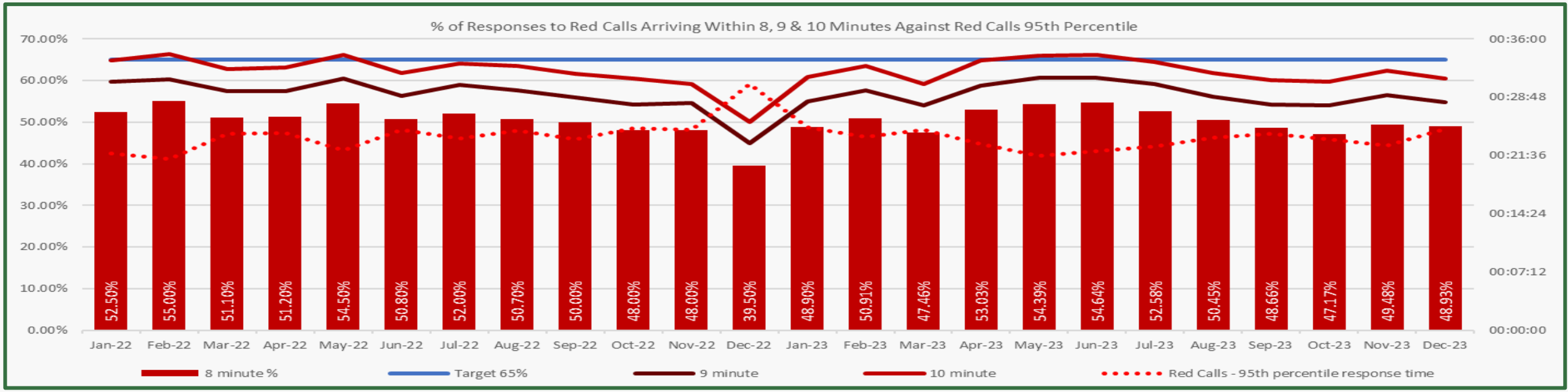


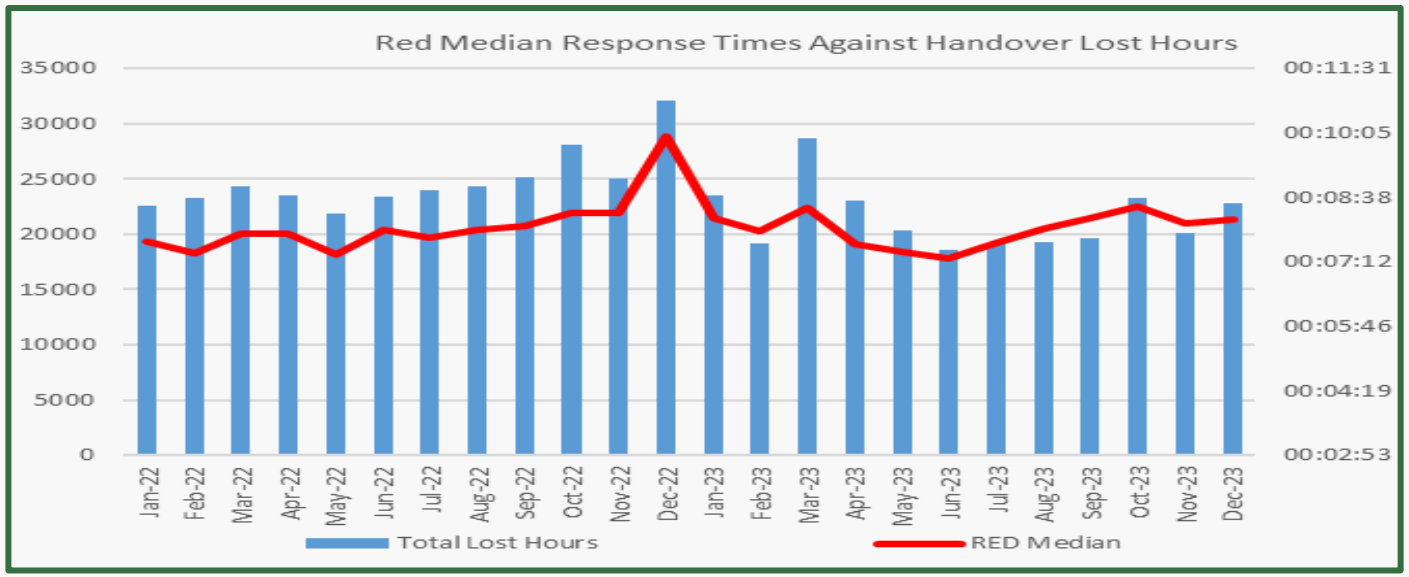
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

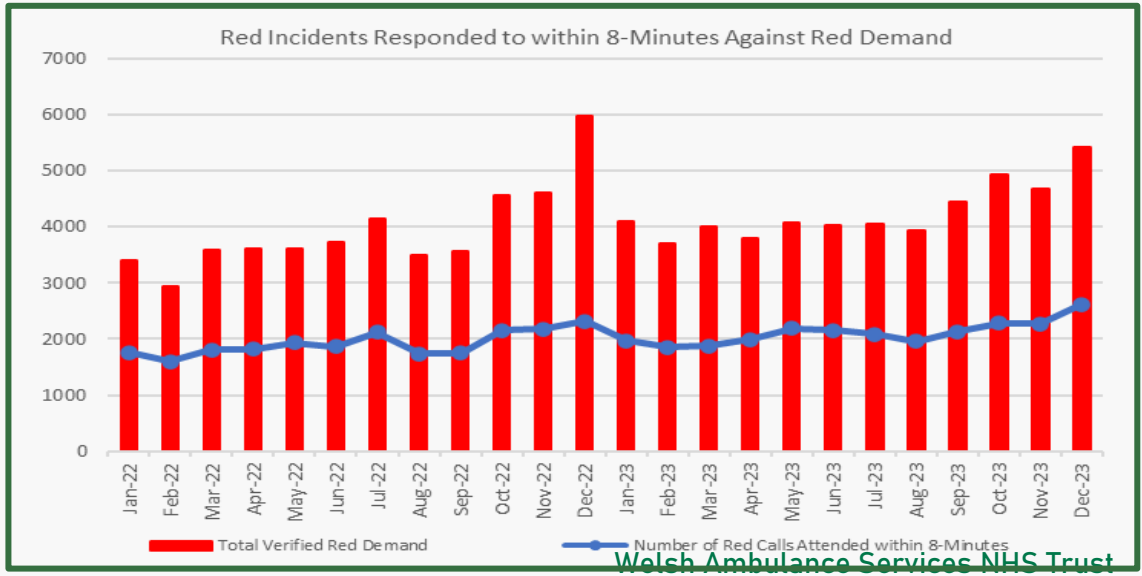


Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

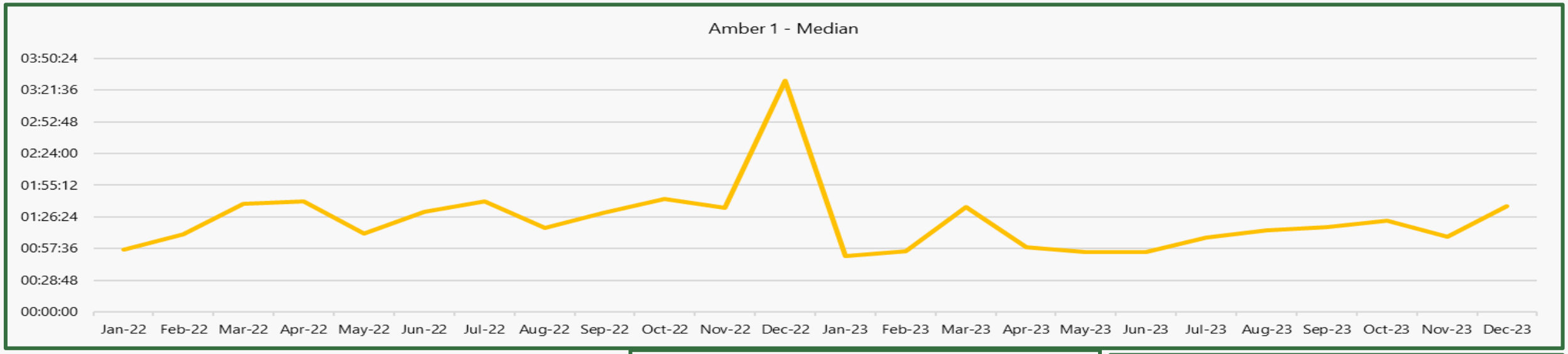


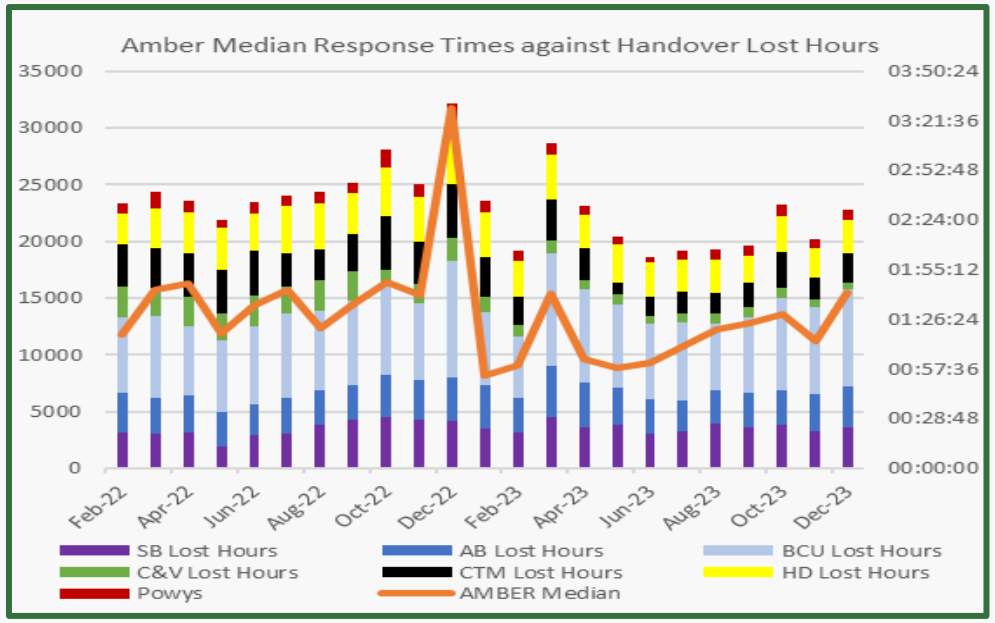


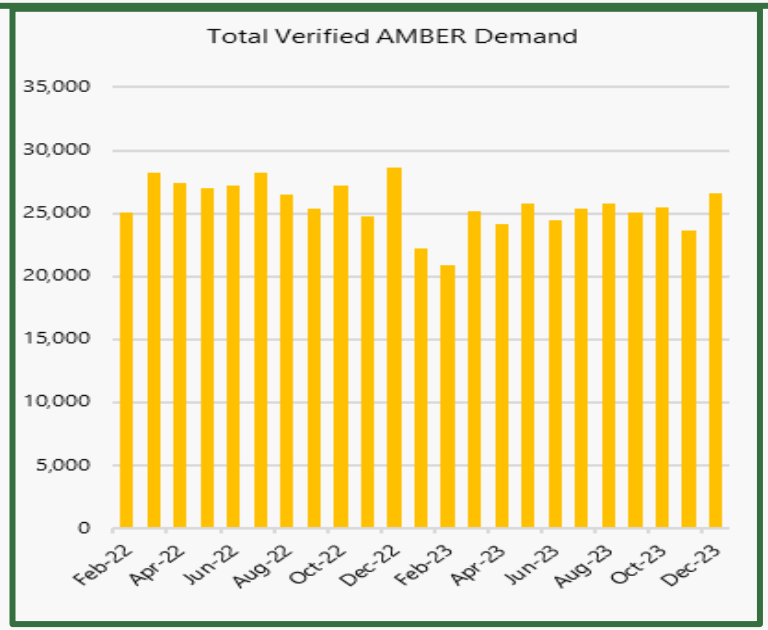


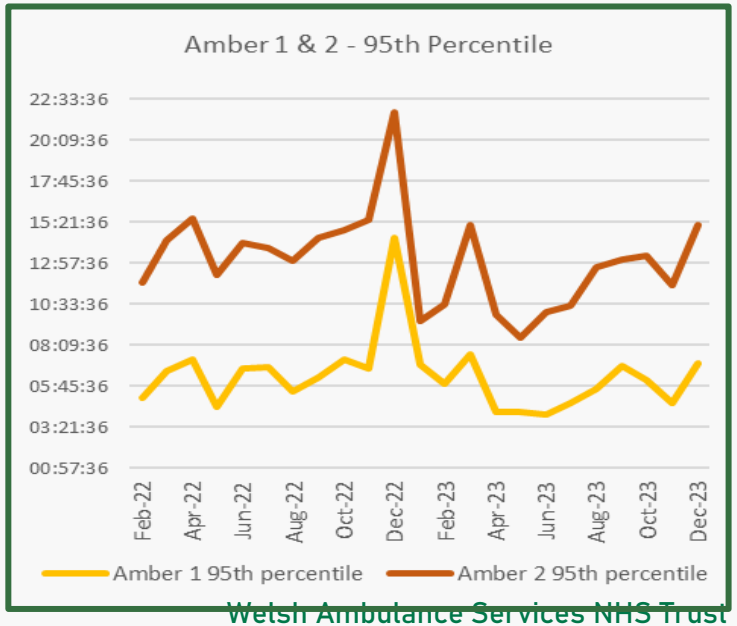
*NB: Data correct at time of abstraction

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



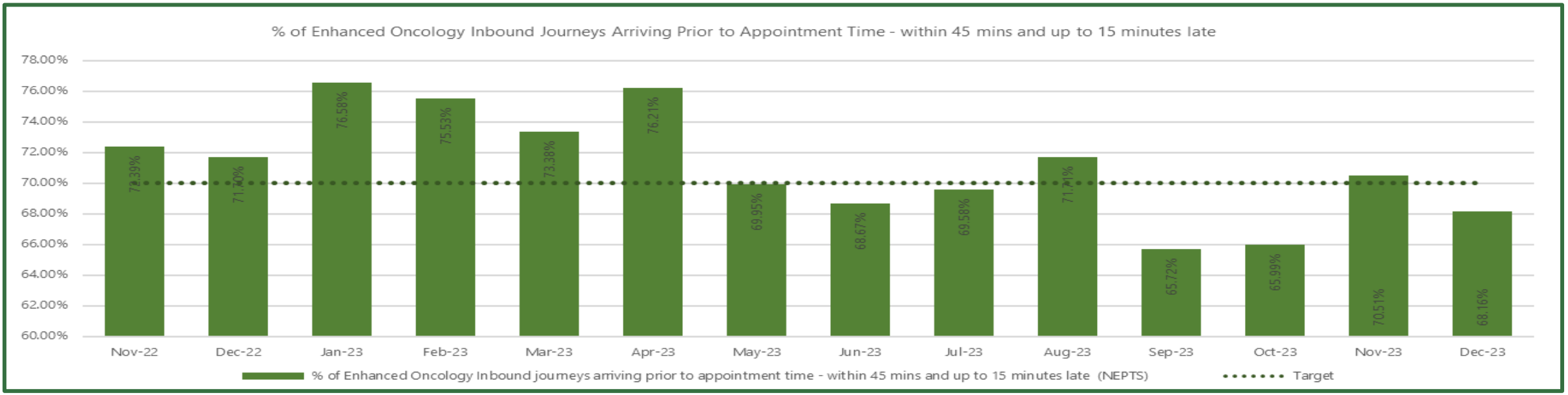


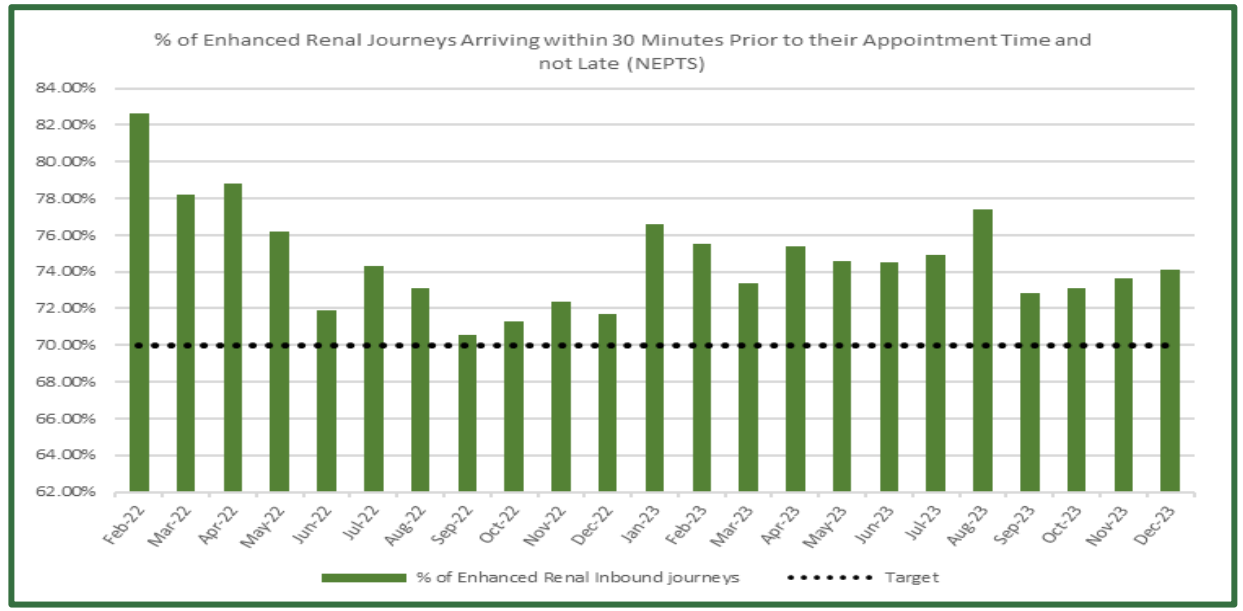


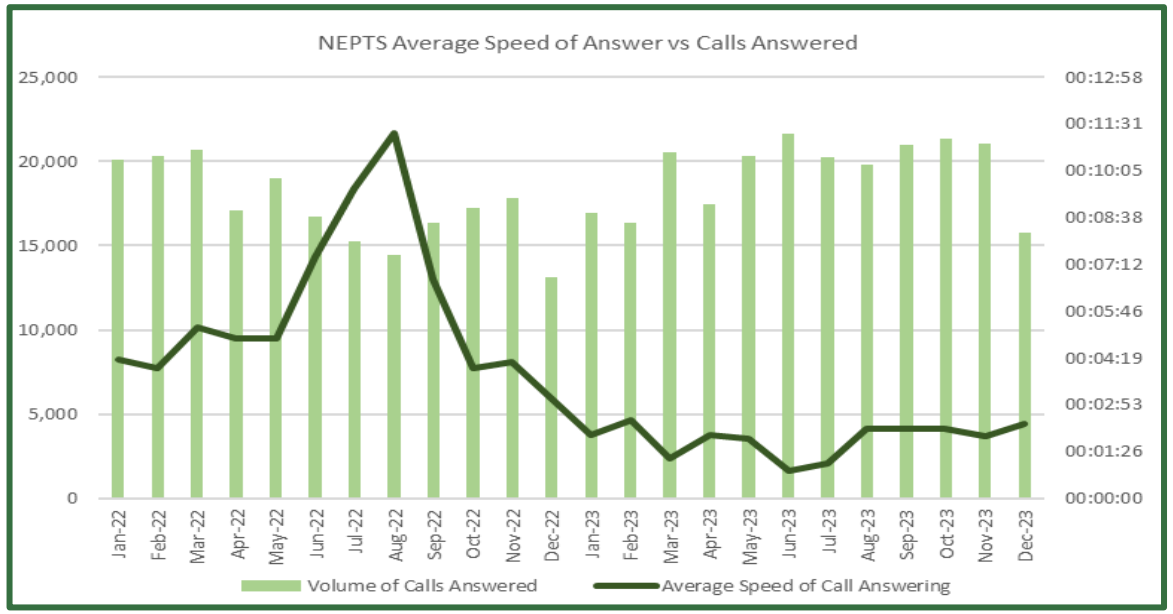


Our Patients: Quality, Safety & Patient Experience

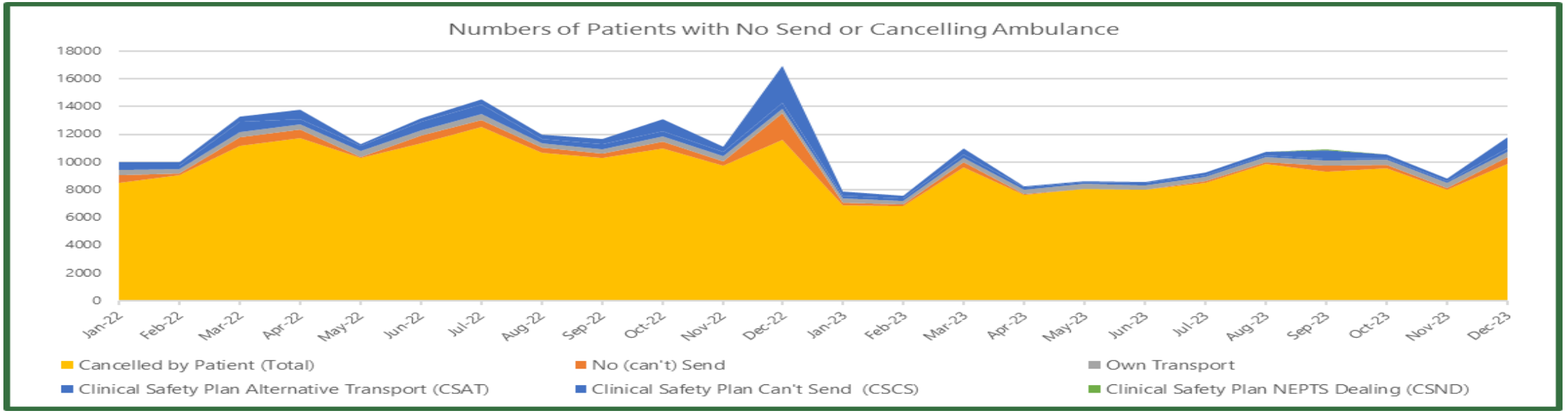
Patient Experience – Influencing Ambulance Care Indicators

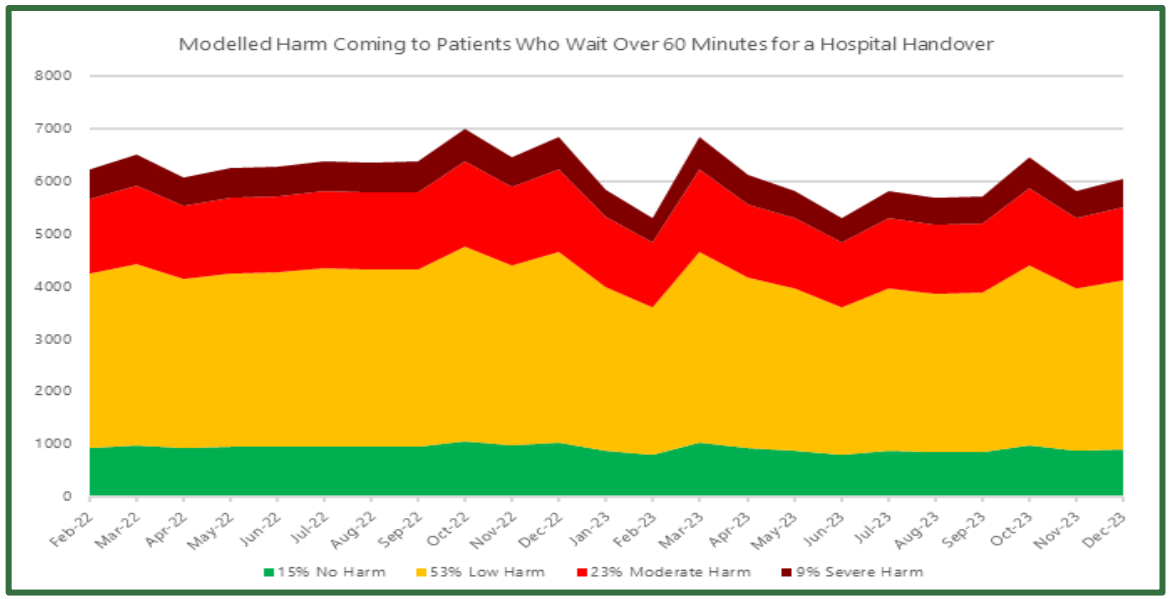


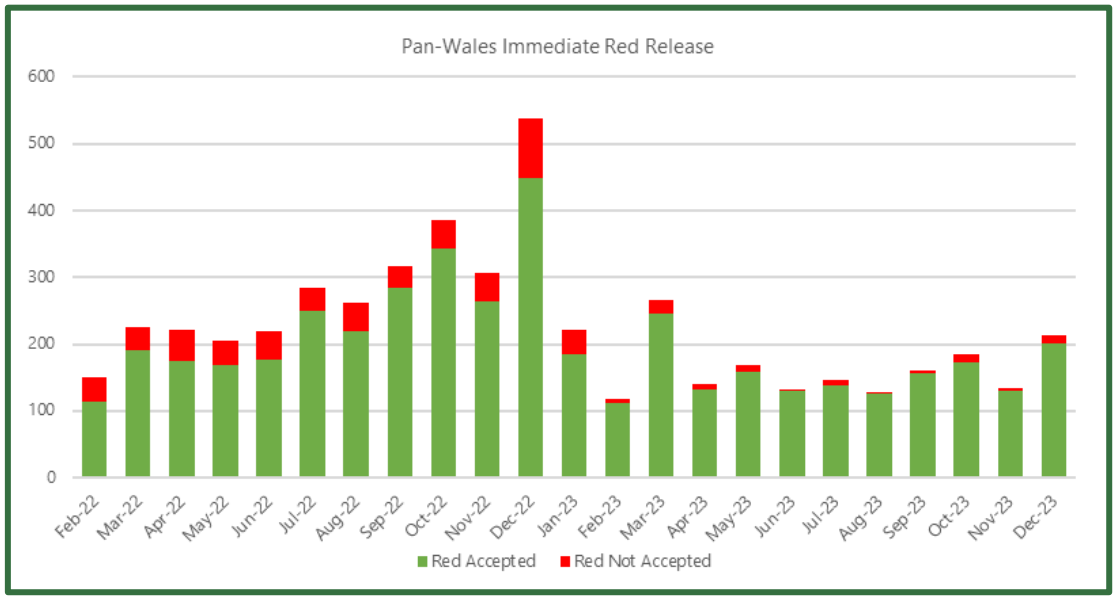




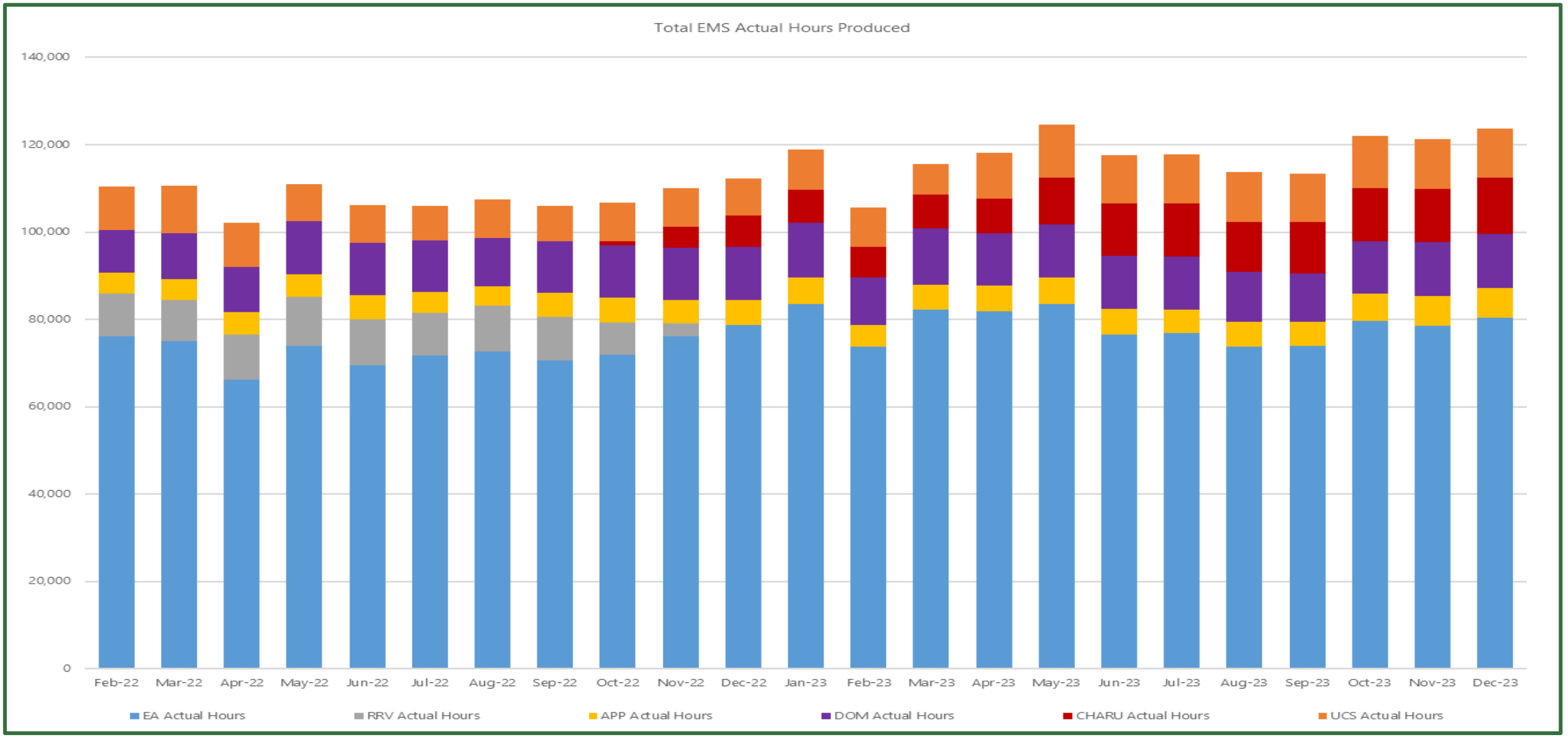
Our Patients: Quality, Safety & Patient Experience
Potential Patient Harm Indicators



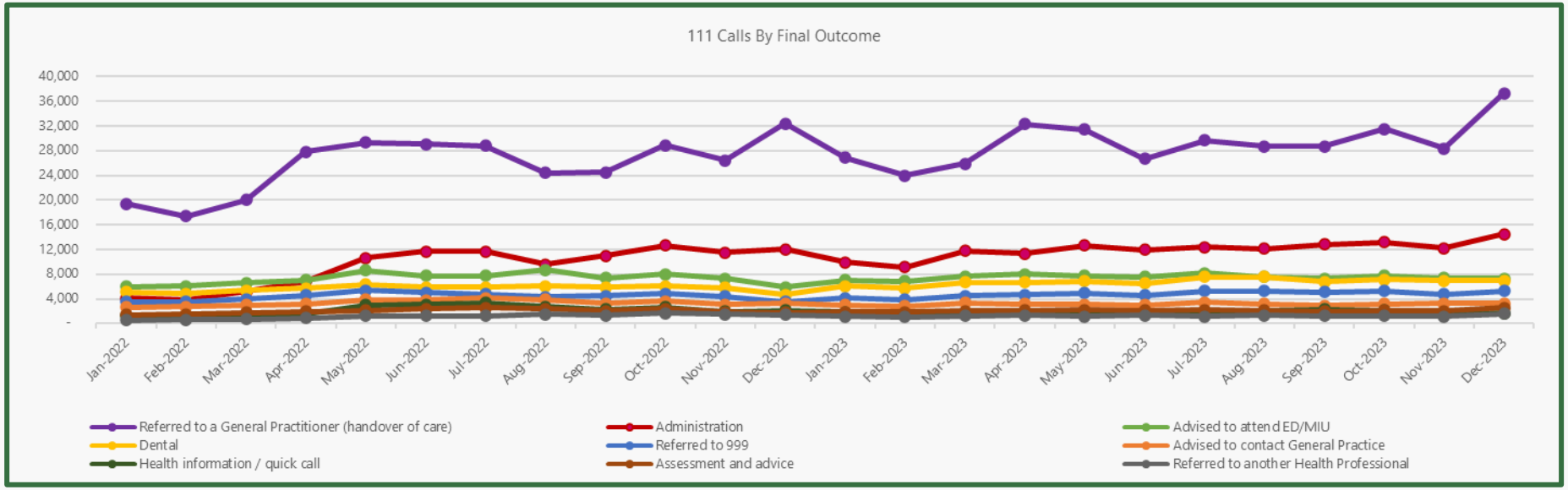


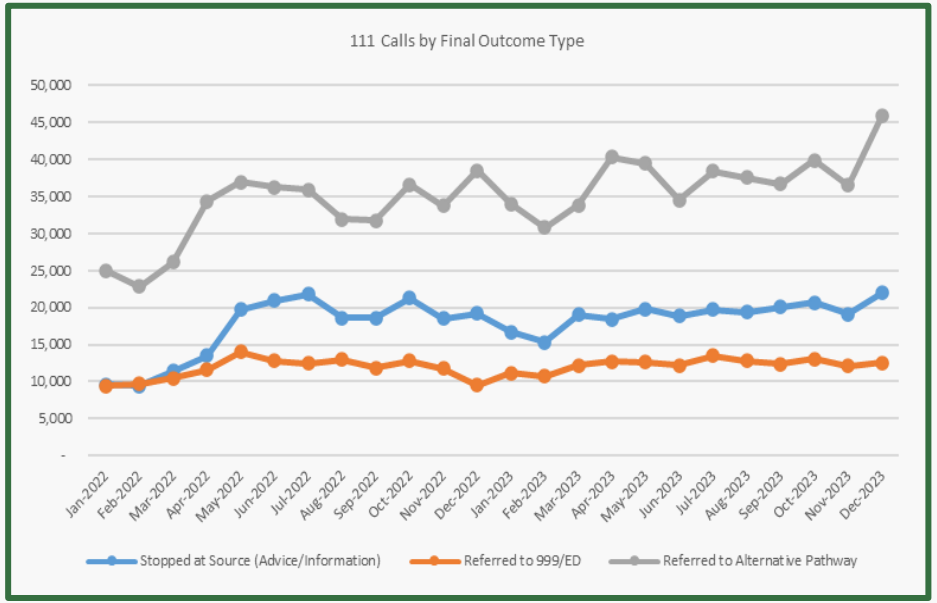


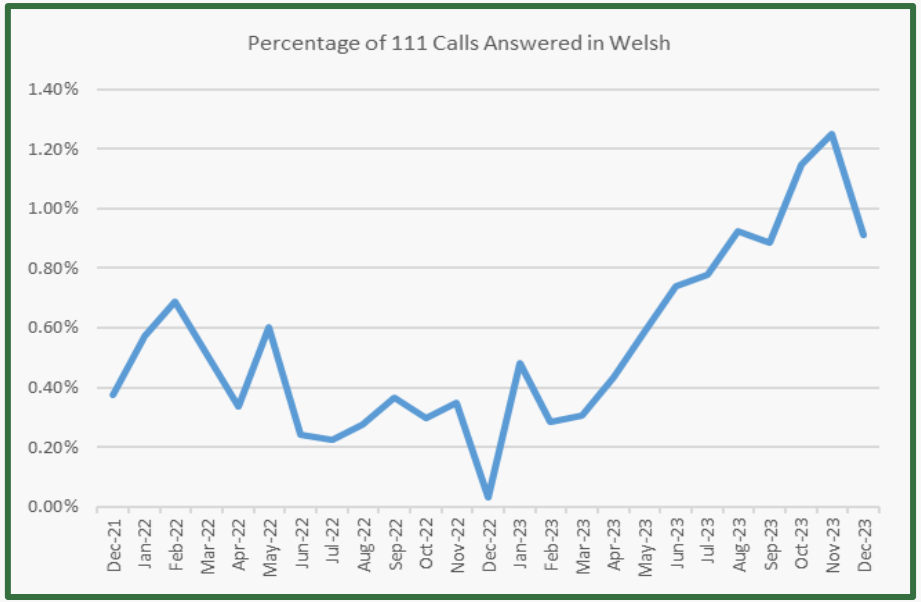
Our People
Capacity - Ambulance Abstractions and Production Indicators



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







Analysis

During December 2023, 80,7449 calls were received into the 9 categories displayed in the graph opposite, an increase compared to the 67,797 received during November 2023.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 46% of all calls during December 2023.

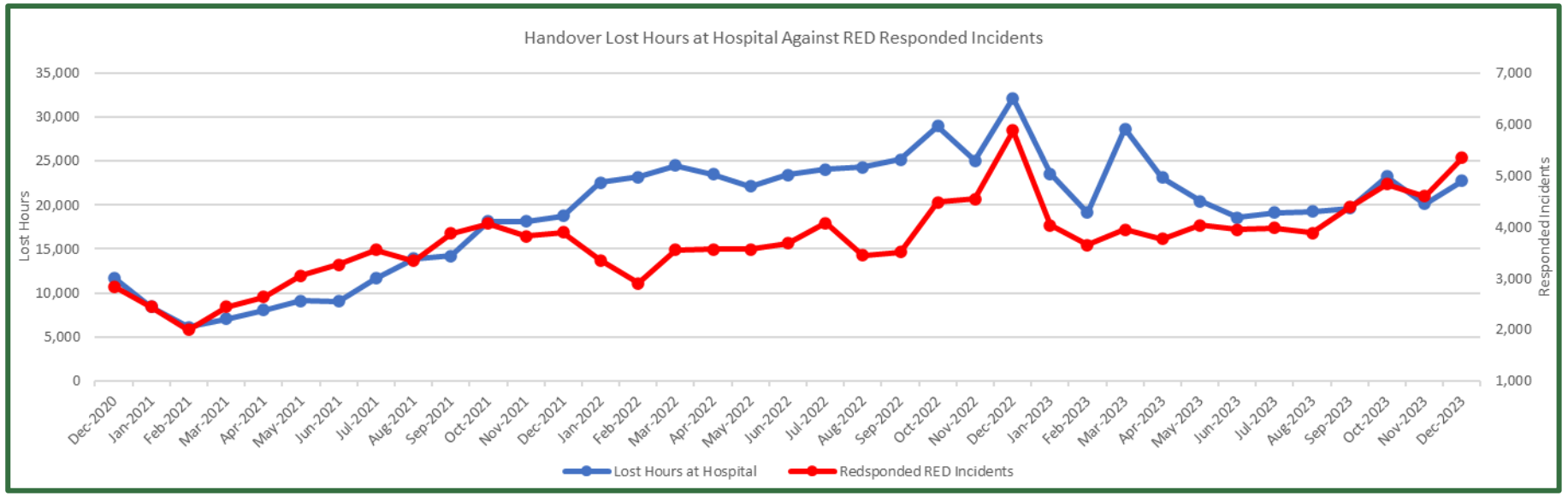
As the bottom left graph highlights, in December 2023, 22,018 calls into 111 were provided with information or advice, with no onward referral, an increase from the 19,135 in November 2023 and from the 19,199 during December 2022.

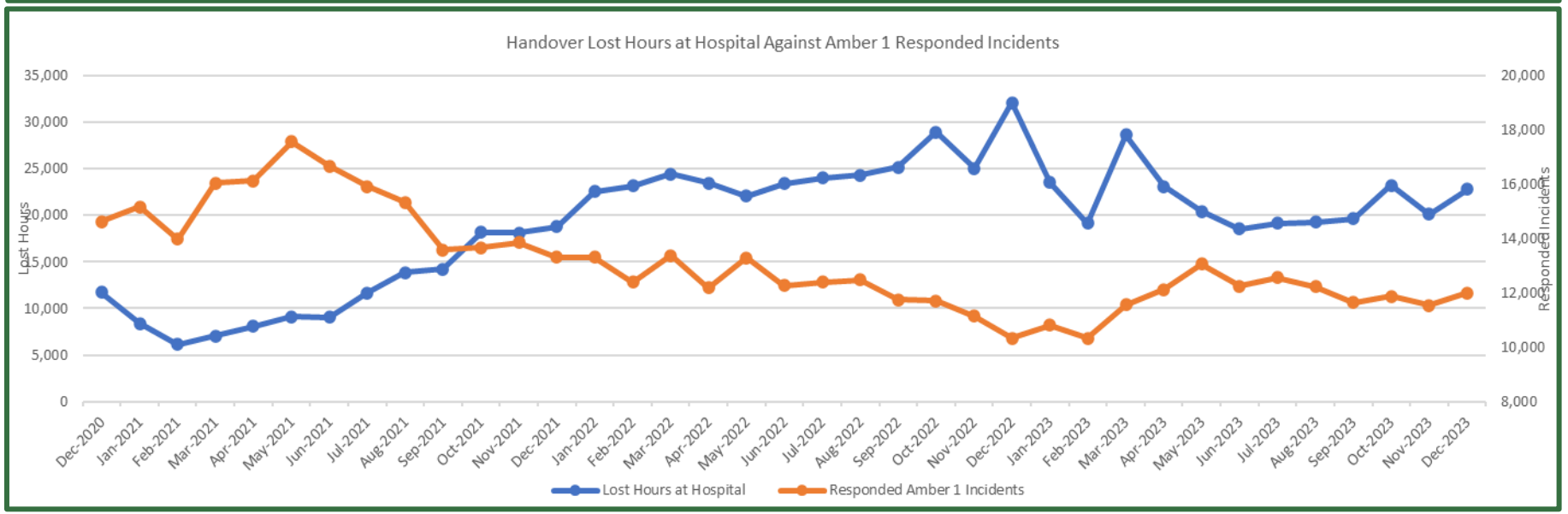
The percentage of total 111 calls being answered in Welsh decreased in December 2023 to 0.91% compared to 1.25% in November 2023.

This equated to 50.9% of all 111 calls being offered in Welsh being answered, a drop from the 67.9% answered in November 2023.

Partnerships / System Contribution

Handover Lost Hours Against Red & Amber 1 Responded Incidents





AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

DIGITAL REPORTING

MEETING	Finance & Performance Committee
DATE	15th January 2024
EXECUTIVE	Jonny Sammut, Director of Digital
AUTHOR	Leanne Smith, Assistant Director of Digital
CONTACT	leanne.smith4@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report brings to the committee Digital Key Performance Indicators (KPIs) relating to Data & Analytics, ICT Systems, Service Provision and the IMTP.

2. The data in this report refers to the period of 1st April-23 to 30th November 2023 unless otherwise indicated. Note that some metrics are still in development, and will continue to evolve as new systems come online, risks are identified, and internal audits make recommendations for areas of focus.

3. ICT Service desk and robotics metrics for November 2023 are not updated in this report due to current pressures on the team and limited capacity to extract the data. For these metrics, trends since September 2023 will be commented on in the next report (March 2024).

4. Key points of note from this report include:
   a. **Mobile Data Vehicle Solution** (MDVS) rollout for EMS is on track and approximately 25% complete, with the NEPTS pilot commencing in January (slightly later than planned).
   b. **Automation** wasn't separately funded in 2023/24, and as such, progress has been limited to smaller requests. However, it is likely that a more detailed plan along with dedicated resources, will feature in the 2024/25 WAST plan, allowing for faster paced progress.
   c. The **Data Linkage** project has progressed following receipt of a letter from Welsh Government stating support for the sharing of information between Health Boards and Trusts and DHCW. The first WAST use case for the National Data Resource (NDR) is the Out-of-Hospital Cardiac Arrest dataset

which will be consumed via the NDR analytics platform by the NHS Wales Executive on behalf of the Cardiac Network.

d. The **999 Upgrade**, as agreed, is now scheduled for late February 2023 and on track for this revised plan.

e. The **Digital Experience** initiative has made small improvements this year (slower pace is largely linked to the lack of resourcing support for automation), however, will be considered as part of the Digital Plan Refresh and likely feature more heavily and realistically in the 2024/25 IMTP. The **Digital Plan refresh** is expected by end of Q4 2023/24.

5. **The COMMITTEE are asked to NOTE the contents of the accompanying report and the trends in metrics presented.**

KEY ISSUES/IMPLICATIONS
6. Staffing / resourcing continues to be under pressure, particularly in the areas of IG, Records Services, analytics, web development and ICT engineering. This results in risk to existing / planned projects as new in-year tasks materialise (e.g. from 6 Goals or in support of Winter pressures). 7. Additionally, the closure of 111 Integrated Information Solution (IIS) programme (aka SALUS) and initiation of the CAS replacement project has adjusted Q4 Digital priorities and capacity from the original 2023/24 plan.

REPORT APPROVAL ROUTE
Digital Leadership Group – 3rd January 2024

REPORT APPENDICES
Main report – 'Digital Reporting Jan24_Open FPC'

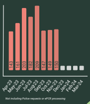
REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding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

Digital: Data & Analytics

Data Lifecycle

The 6 stages of the data and analytics lifecycle and related metrics.

Records Requests



Data Warehouse completion (reduction of manual data sets e.g. for MIQPR)

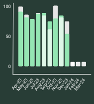
tbc

Metric in development

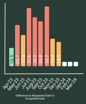
Warehouse availability

Metric in development

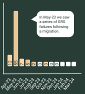
Information Requests Received vs Completed



Turnaround for non-trivial tasks (avg days)



Total Data Load Failures



Data Protection & Data Quality metrics found in Information Governance and Security Report

Digital: ICT Systems

System availability metrics

N.B. these are not reflective of SLAs, and do not yet differentiate supplier issues & resolutions

Definitions based on industry standards
<4.32 mins downtime >99.99%
>4.32 and <43.8 mins >99.9%
>43.8 mins downtime <99.9%

System	System Availability %	Notes
EMSC CAD C3	A M J J A S O N D J F M	PSBA issues in April & June caused short network outages. Network outage following planned maintenance in July. Users experienced CAD impact.
999 EMS Telephony	A M J J A S O N D J F M	Shared issue as for CAD C3 in July.
NEPTS CAD Cleric	A M J J A S O N D J F M	
CSD ECNS Lowcode	A M J J A S O N D J F M	
ePCR Terrapace	A M J J A S O N D J F M	Users unable to login to Terrapace app due to database issue (supplier fix)
111 CAS	A M J J A S O N D J F M	
111 Telephony	A M J J A S O N D J F M	

Digital: Service Provision

Quality, efficiency, and stakeholder feedback: NOV 23

IT Service Desk

28 Service Desk hours saved in Sept through use of RPA

This is double the saved hours from July and August (which was 14)

With overall demand up >34% since July & August

Top 5 September Service Desk Requests
- RPA Service Requests 147
- Password Resets 104
- iPad functionality issue 54
- Laptop issue 48
- iPad mobile data issue 47

1670 total requests

Metrics not updated for Nov-23 due to current pressures

94% Incidents resolved within target
97% Requests resolved within target
Note: not all incidents or requests can be resolved by WAST

Records

RPA for PCR requests saved 12 people hours in Sept 2023

Assumes 10 minutes per request

Metrics in development following Internal Audit recommendations

HI Help Desk

Nov + Dec Informatics Requests
88 + 75
total requests

Same day turnaround of 'quick' tasks **65%**

N.B. Aug=83%; Oct=68%; Dec=50%

If non-quick tasks = 3 days on average to complete, then 90 requests = 2000 people hours, which would require >13 FTE analysts to complete each month.

111 Website

52% average engagement rate

Down from 59% in previous months despite stable visitor numbers

Engagement = users with a session >10 seconds, a conversion event, or 2 or more page views.

Average engagement time via mobile and desktop **~1 MINUTE**

Digital Contribution 23/24

Digital Patient
- Digital Medicines
- 111 Website
- CSC

Digital Workplace
- MDVS EMS
- MDVS NEPTS
- 111 IIS — Closed
- CAS replacement
- Automation

Intelligence through Data
- Data Linkage
- Q&PMF reporting
- MSc Projects

Digital Foundations
- CRS
- 999 Upgrade
- ECNS Upgrade
- Estates / Fleet

Our People
- Dig Experience
- Dig Champions

See IMTP trackers (STB) for action & milestone based progress.

RAG and progress based on LDP
Last updated 3rd January 2024 by DLG

AGENDA ITEM No	**16**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**0**

Fire Safety Compliance – January 2024

MEETING	Finance and Performance Committee
DATE	15th January 2024
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Richard Davies – Assistant Director of Capital Development & Estates Susan Woodham – Head of Estates and Facilities Kataya Miura – Facilities Manager
CONTACT	richard.davies16@wales.nhs.uk

EXECUTIVE SUMMARY

- To update the Committee in relation to fire safety compliance across the estate of WAST, including emergency lighting and fire alarm systems;
- To provide an update on the progress of undertaking Fire Risk Assessments (FRAs) across the whole estate;
- To update on other areas of improvement since the last internal audit on fire safety, and highlight next steps in the continuing progress against some areas, including since the appointment of a small, dedicated facilities team focussing on these issues.

RECOMMENDATIONS:

The Finance and Performance Committee is asked to:

1) **NOTE contents of the report;**
2) **NOTE the update and progress made since the appointment of a more dedicated facilities team to progress with the improvement of fire safety compliance across all WAST sites;**
3) **NOTE the appointment of new Fire safety advisor, namely Anolex Fire, and**
4) **NOTE the changes made to the training of fire marshals through Thomas Carroll Management Services.**

KEY ISSUES / IMPLICATIONS

REPORT APPROVAL ROUTE
Fire Safety Group - 15th November 2023 **ELT – 10th January 2024** **F&PC – 15th January 2024**
REPORT APPENDICES
None

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

Welsh Ambulances Services NHS Trust

Fire Safety Compliance Update – January 2024

SITUATION

1. This paper presents the Finance and Performance Committee (F&PC) with an update on the work being undertaken in support of ensuring and significantly improving fire safety compliance across the WAST estate, including since the appointment of a more dedicated facilities team, focussing specifically on this. It is the first of what will now be planned to be annual reports on such matters to F&PC.

BACKGROUND

2. This paper has been developed in part as a result of previous internal audit reviews and recommendations to provide a minimum of an annual update of compliance to the appropriate fire group and onward to the Finance and Performance Committee, for which such issues are devolved from the Trust Board.

ASSESSMENT

Emergency Lighting Systems (British Standard 5266)

3. Emergency lighting is provided to illuminate evacuation routes should the main building lighting fail. Chubb Fire are our appointed contractor to maintain the Emergency Lighting systems throughout Wales at all premises, where it falls within our statutory obligation to maintain. It is noted that in the past remedial works for some of our premises had not previously been fully completed, leaving, at some times in the past, up to 2/3rds of sites without fully adequate provision of emergency lighting. However, as of November 2023, it is pleasing to report that **all the remedial works have been completed across all sites**.

4. However, as per the above standard, all emergency lighting systems should be also subject to a monthly 'flick' testing and suitable records maintained. This will also allow for the above significant improvement in compliance to be maintained going forward.

5. Whilst this is being completed at our larger, higher risk sites, we are not currently able to do this at all ambulance stations. Whilst, given the recent completion of all outstanding remedial work highlighted above, results in this being a low risk, it is recommended that a site lead (site responsible person) or equivalent be nominated to undertake these weekly tests and ensure adequate records are kept for auditing purposes at all sites. This will be further progressed now at pace in conjunction with colleagues from Health & Safety, with any alternative potential solutions also sought if this is not fully feasible across all sites.

Fire Alarm Systems - British Standard 5839

6. Fire Systems are currently serviced and maintained by our appointed specialist contractor - Chubb Fire. **Servicing and maintenance are completed bi-annually across all WAST owned sites in line with our statutory obligations**. Bi-annual servicing is included in our Annual PPM (Preplanned Preventative Maintenance) Planner for each site and managed by the Facilities Team.

7. Weekly fire alarm testing is being completed at our larger corporate and contact centre sites and some ambulance stations. It is planned that the above nominated site lead (site responsible person) or equivalent, once identified for the remaining Trust sites, also undertakes these weekly tests and ensures adequate records are kept for auditing purposes.

EICR - Electricity at Work Regulations 1989

8. 26% of WAST sites were completed in 2023**. The Trust is now fully compliant as all sites have up to date EICR Electrical testing certificates**. EICR testing needs to be completed every 5 years and this is reflected in our site-specific PPM Planners.

Fire Risk Assessments (FRAs)

9. In order to comply with the relevant statutory provisions of the Regulatory Reform (Fire Safety) Order 2005, fire risk assessments have been carried out to assist the site 'Responsible Person' of our statutory obligations. It also seeks to address relevant issues relating to business, property and environmental protection. It is a non-invasive survey, carried out in accordance with PAS 79:2020. We have recently appointed a new Fire Risk Assessment Consultant (Terry Lawes – Anolex Fire).

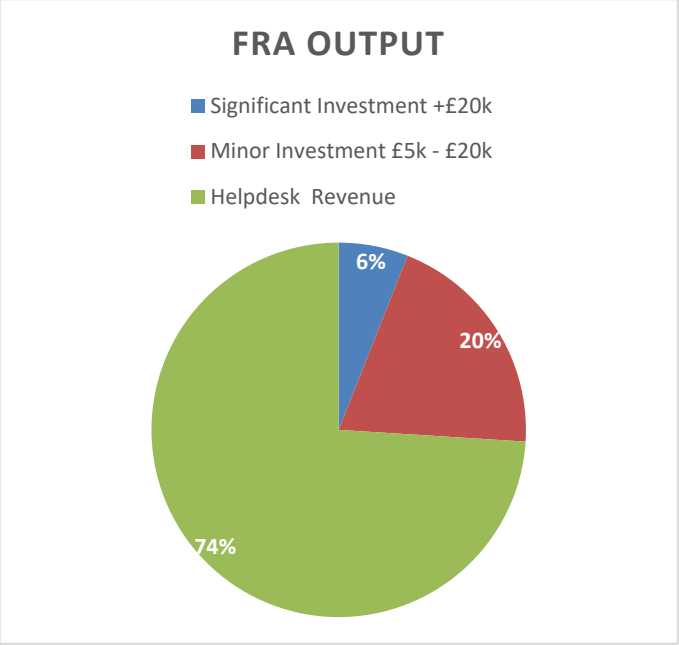
10. The proposal to change consultants was approved by the Fire Safety Group at the beginning of 2023. Following the appointment, Anolex Fire have been conducting Fire Risk Assessments throughout the Trust following the development of a Site Risk Matrix prepared by the Estates team and signed off by Health and Safety with the aim to prioritise high risk sites based on the following complexity rating criteria:

    - Size;
    - Number of floors;
    - Significant changes to a building; and
    - Significant changes of occupancy.

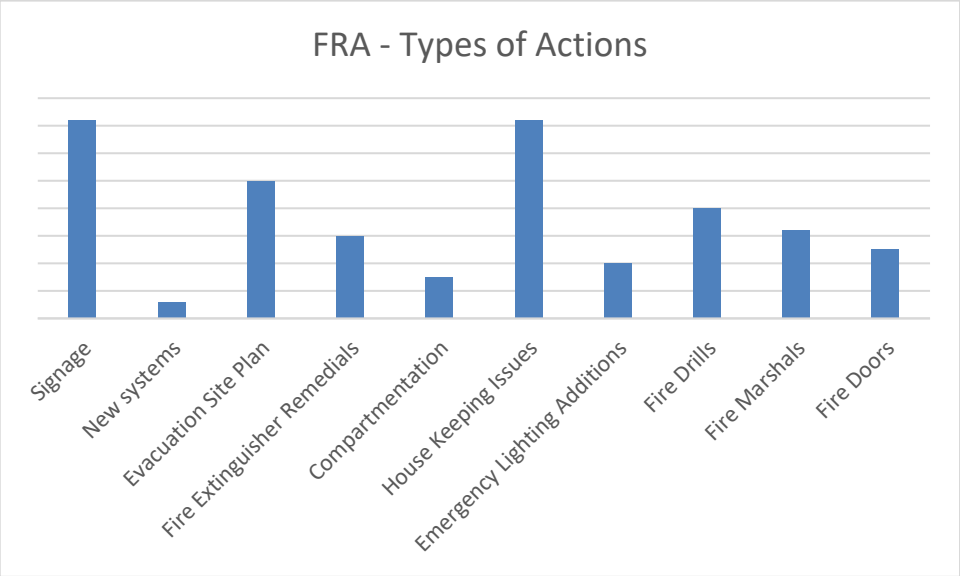
11. Since January 2023, **a total of 72 FRAs have been undertaken** with all sites of a risk rating 11-7 (high to medium risk) being completed leaving lower risk sites with a score rating of <7 to complete by the end of the financial year.

12. The fire risk assessments provide an overview of the current performance of each premises against our statutory obligations and documents recommendations in the format of a remedial action plan for each site. We have collated all remedial actions from the completed FRAs and categorised the actions based on the following criteria:

    - Reactive works via the estate's helpdesk – ongoing;
    - Minor investment needed; and
    - More significant investment needed.



13. The strategy is to target our high and significant risks and complete what budget allows by end of the financial year and to address the lower risk actions through the helpdesk. **It is pleasing to report however that the majority of the more significant / high risk items have been able to be remedied through funding available in this financial year.**



Fire Drills

14. In accordance with the Regulatory Reform (Fire Safety) Order 2005, it is recommended that fire drills should be undertaken as a minimum, annually. This is being completed at larger sites but not historically at Ambulance Stations. **Annual fire drills have now been added to the Estates & Facilities CAFM system and a planned preventative maintenance (PPM) task will be raised to prompt all site responsible persons that they need to complete their annual drill**.

15. Estates (via the help desk) will be notified once the fire drill has been undertaken and the correct forms completed providing an overview of the drill and any recommendations that are highlighted are recorded, the forms will be stored for compliance evidence and for Health and Safety audit purposes and recorded in the Estates CAFM system.

Fire Marshals

16. A suitable number of persons should be trained in order to ensure that adequate cover is provided in the event of an evacuation for "every operational hour" and available 24 hours a day. A full list of trained site-specific Fire Marshal's should be prominently displayed on site. As has been noted previously however given the spread, size, occupancy and type of some of the Trust's buildings this is always going to be challenge to evidence 100% coverage at all times (and in some instances there is little or no need for such coverage in this way). Again, the continuing focus is to ensure that the higher risks sites have more than adequate coverage and is risk assessed based on the FRAs.

17. WASTs Fire Policy states:
    "The Estates department will liaise with Operations to nominate Fire Marshals at each building. The Estates Department will manage an annual programme for fire marshal training and arrange courses as necessary to maintain the overall numbers of trained fire marshals."

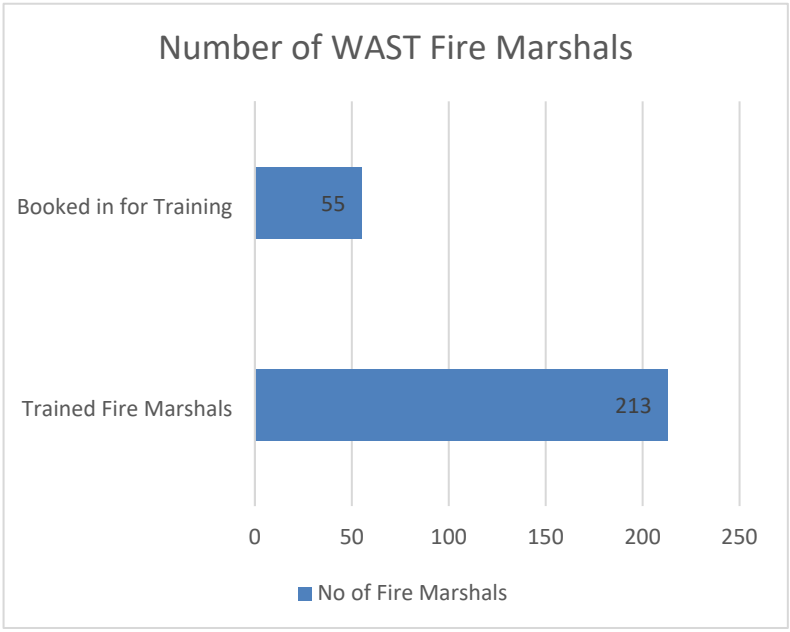
18. Previous internal audits have recommended 'numbers' of staff that should be trained, however due to WAST supporting agile working, increased numbers of trained fire marshals will be required to provide sufficient cover across all WAST sites. Also, as above, pure numbers themselves, in terms of those trained and where located, do not necessary provide a full picture of how the Trust continues to manage the risk of this.

19. Since April 2023 we have implemented a change in the way Fire Marshal training is provided. Following feedback from staff and noting some decreasing attendance numbers on fire training courses on Teams, we have invested in an e-Learning alternative provided by Thomas Carroll Management Services, an external

provider with substantial experience in developing and delivering business critical Fire and Health and Safety training.

20. The significant benefit of the e-Learning training is staff can complete the course independently and at their own convenience. It requires log on and user password details which are provided by the Compliance Officer. The interactive course can be completed in 2-3 hours and provides a Certificate once the course is completed.

21. WAST's Compliance Officer is responsible for sending out requests on a quarterly basis to the site responsible person requesting them to provide details of nominated staff members to undertake Fire Marshal training. Whilst noting that pure numbers themselves are not the only measure of coverage for this, the graph below provides an overview of the current number of trained fire marshals, and those about to undertake their training ahead of the financial year end. This shows a significant increase from that at the time of the last internal audit.



22. The team are also now mapping the coverage of trained fire marshals to the Site Risk Matrix used for the above FRAs, to further evidence that there is at the very least more than sufficient coverage at what is defined as our higher risk sites. Whilst we know this to be the case through other measures and risk assessments undertaken, this will provide even further evidence of this and highlight where we may need for further focus efforts to improve coverage. As noted above however, we are highly unlikely to ever get to 100% coverage across all of our sites 24/7, nor do we necessarily need to for a number of sites noting how these are occupied and which, by definition, fall into our lower risk estate.

ESR Fire Safety Compliance

23. In conjunction with the above the table below provides the latest available compliance against the Statutory and Mandatory Fire Safety Training. Whilst there are undoubtably areas of further improvement required, this does provide for a much better level of compliance than in recent years.

Assignment Count		Required	Achieved	Compliance %
4360	WAST	4360	3330	76.38%
Org L3	**Assignment Count**	**Required**	**Achieved**	**Compliance %**
020 CHIEF EXECUTIVE DIRECTORATE (BX01)	19	19	13	68.42%
020 CORPORATE GOVERNANCE (BX02)	9	9	9	100.00%
020 DIGITAL DIRECTORATE (KX01)	57	57	45	78.95%
020 FINANCE & CORPORATE RESOURCES DIRECTORATE (FX01)	106	106	96	90.57%
020 MEDICAL & CLINICAL DIRECTORATE (UX01)	56	56	45	80.36%
020 OPERATIONS DIRECTORATE (DX01)	3872	3872	2901	74.92%
020 PARTNERSHIPS & ENGAGEMENT DIRECTORATE (CX01)	12	12	7	58.33%
020 PEOPLE & CULTURE DIRECTORATE (PX01)	92	92	83	90.22%
020 QUALITY, SAFETY & PATIENT EXPERIENCE DIRECTORATE (JX01)	119	119	117	98.32%
020 STRATEGY, PLANNING & PERFORMANCE DIRECTORATE (HX01)	18	18	14	77.78%

Reporting Structure

24. The Fire Safety Group (FSG) will ensure that the reporting of Fire Safety issues is communicated through a formal assurance reporting framework to Board level, including through future annual reports such as this and any issues that arise in between times by exception. Any high-risk items recommended at the group will initially be formally reported at the following ELT. The FSG and Estates Department will produce a detailed action plan to successfully conclude all high-risk recommendations.

Conclusion

25. Whilst there are always areas of potential future improvement, it is hoped that the Committee will receive assurance from this first annual fire safety report in this way, the significant further improvements that have been delivered since the last (reasonable assurance) follow up audit and one which provides a baseline to track future improvement trends.

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

Committee Priorities and Cycle Monitoring Report

MEETING	Finance and Performance Committee
DATE	15 January 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed cycle of business for the Committee. There is nothing to escalate on the cycle of business monitoring report.

RECOMMENDATION

2. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – FPC Cycle of Business Monitoring Report

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

COMMITTEE PRIORITIES AND
CYCLE OF BUSINESS MONITORING FOR 2023/24

SITUATION

3. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed cycles of business.

BACKGROUND

4. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2023 and will be tracked quarterly.

5. The Committee's cycle of business was approved by the Committee in May 2023. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

6. The monitoring report is at Annex 1. Items in green show they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports. The blue indicates that the item is either on the agenda as scheduled, or is an ad hoc item which was discussed in agenda setting.

ASSESSMENT

7. The Committee priorities, and progress against them is as follows:

Priority	Progress
Focused oversight on the implementation of the digital strategy	• A Digital Strategy Plan update was given to the Committee at its meeting on the 18 September 2023 by the Interim Director of Digital Services. This report gave a snapshot of the current position and relevant data from the period 01 April 2023 – 31 July 2023. • At the September meeting the Committee also endorsed the related metrics as presented by the Interim Director of Digital Services. The metrics for digital systems infrastructure will be received (in line with the agreed reporting) on 13 November 2023.

	• In September the Committee noted that the recent appointment of the new Director of Digital Services may affect the strategy implementation timeline. • In November the Committee noted that an update on the progress against the Digital Strategy would likely be programmed for either the January or March 2024 meeting of the Committee. • Receipt of an update on the implementation of the Digital Strategy will be programmed for the March 2024 meeting of the Committee (a position confirmed with the Director of Digital Services).
PRIOR 2023/24 Committee Priority	
Focused oversight on the implementation of the Quality and Performance Management Framework (QPMF)	• As of September 2023, oversight of this has moved to the Audit Committee. The Committee's ToR require that it "*review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework*". • The Committee will remain responsible for reviewing of the effectiveness of the QPMF once the Framework has been implemented. The Committee Cycle of Business will be updated to reflect the change in oversight of implementation of the Framework to Audit Committee.

RECOMMENDATION

8. The Committee is asked to note the update.

PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENTS
FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2023/24											
See full cycle of business for reference to the duties in the terms of reference as they relate to Committee reports below											
MAIN ELEMENTS											
FINANCE											
Annual revenue budget	EMT	Annually							EDOF	Endorsement	
Annual capital budget	Capital M'ment Board	Annually							EDOF	Endorsement	Presented at May meeting (private session)
Financial report	EMT	Each meeting							EDOF	Assurance	
Financial Sustainability Programme	EMT	Each meeting							DPC	Assurance	Keep on each meeting for 23/24 and re-evaluate
Business cases over £500K	TBC	As required							EDOF	Endorsement	No business cases for May, July, Sept, Jan 24 meetings
IMTP financial plan	STB/EMT	Annually							EDOF	Endorsement	Programmed for Jan 24 (update inc in the IMTP 24-27 item)
Value Based Healthcare Report	TBC	Every other meeting							DOF	Assurance	Papers for May, November and March
Assurance paper on PIR process	TBC	One off and then cyclical							EDSPP	Assurance	PIR process in July IMTP paper
Post Implementation Reviews	TBC	As required							Relevant Director	Assurance	No PIRs for May, July meetings; MDVS Gateway Review Sept meeting, no PIR for Jan 24
Monitoring of key projects as requested from time to time	TBC	As required							Relevant Director	Assurance	Salus monitoring in closed; Q4 CAS update in open.
PLANNING											
Refreshes of 2030 Delivering Excellence	EMT	Ad Hoc							EDSPP	Endorsement	No refreshes due
Service or Directorate Specific Plan New & Refreshes	EMT	Ad Hoc							EDSPP	Endorsement	No plans for revew May, July, Sept, Nov or Jan meetings
IMTP for following year	STB/EMT/Board	Annually							EDSPP	Endorsement	Programmed for Jan 24
Report on commissioning	TBC	TBC							EDSPP	Assurance	National Commissioning Review in September. Further update due in January
Demand and capacity reviews	EMT	Ad Hoc							EDSPP	Endorsement	Paper in May meeting; Winter 2023/24 Modelling paper inc for Nov '23 (added on 26.10.23); Strategic D&C Review outcomes for March 24
PERFORMANCE											
Monthly Integrated Quality Performance report	EMT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	EMT/Board Committees	Annually	→						EDSPP	Endorsement	Delayed from May meeting to July
Annual HART KPI report	TBC	Annually							DO	Assurance	Reported in July meeting
IMTP progress updates	STB/EMT/Board	Each Meeting							EDSPP	Assurance	
ESTATES AND FLEET											
Estates and fleet strategy refreshes	TBC	Periodically as required							EDOF	Approval	No refreshes May, July, Sept, Nov, Jan meetings. To pick up in 24/25 re Estates refresh
Fleet replacement programme	Capital M'ment Board	Annual BJC see notes							EDOF	Approval/Endorsement	On closed November meeting
Fire safety update	EMT	Periodically as required				→			EDOF	Assurance	No update May, July, Sept, Nov meetings. Fire Safety Annual Report 22/23 (inc updates for all of 2023) programmed for Jan 24.
ENVIRONMENTAL AND SUSTAINABILITY											
Decarbonisation Update	Decarb Programme Board	Every other meeting									Reported in May and Sept meetings
Waste Management Update	Decarb Programme Board	Annually							EDOF	Assurance	Reported in Sept meeting; Waste Management Annual Report 22/23 was received in September 2023 (not required for Q4).
DIGITAL SYSTEMS AND STRATEGY											
Digital strategy	STB	Periodically as required							DD	Review and Endorse	No refreshes May, July, Sept meetings. Update on strategy direction in September meeting. Update to be received at March 2024 mtg.
Metrics for digital systems infrastructure	TBC	Each meeting							DD	Assurance	Reporting began from Sept meeting and will be bi-monthly from there
Review/Monitor of digital major projects	TBC	Ad Hoc							Relevant Director	Assurance	Salus (closed); MDVS Sept meeting
BUSINESS CONTINUITY											
WG Annual Emergency Planning Report	EMT/Board	Annually							EDO	Assurance	Reported in July meeting
Incident Response Plan Report	EMT	Annually		→	→				EDO	Assurance	Due to report in November 2023
Business Continuity Annual Report	EMT	Annually		→	→				EDO	Assurance	Not reported in July; The BC Annual Report was received in November 2023.
Cyber Resilience and Cyber Security Reporting	TBC	TBC							DD	Assurance	Reporting commenced in closed in September
POLICIES AND RISK											
Report from policy group	Policy Grop	Annually							BS	Assurance	Policy Report presented July 2023 meeting
Policies for review and approval	Policy Grop	Ad Hoc							BS	Approval	Q4: TBC re Waste Management Policy
Board Assurance Framework	Board	Each meeting							BS	Assurance	
Corporate Risk Register	Board	Each meeting							BS	Assurance	
Audit Recommendation Tracker	ADLT	Each meeting							BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc							Relevant Director	Assurance	
STANDARD ITEMS											
Quarterly operations update	TBC	Each meeting							EDQN	Information/Discussion	Only received in quarter, not at every FPC meeting (ADD IN THE MEETINGS TO BE RECEIVED)
GOVERNANCE											
Committee effectiveness review and annual report	Audit/Board	Annually							Board Sec.	Approval	
Review of Terms of Reference	Audit/Board	Annually							Board Sec.	Approval	
Committee cycle of business refresh	N/A	Annually							Board Sec.	Approval	
Committee Cycle of Business review	Audit/Board	Each meeting							Board Sec.	Approval	
Committee Review of Annual Priorities	None	Every other meeting							Chair	Review	
SUB-GROUPS											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-groups established
PROMPTS											
External Reports	N/A	Ad Hoc							TBC	TBC	No external reports for review

EDOF - Exec Director of Finance and Corporate Resources
EDO - Exec Director of Operations
EDSPP - Exec Director of Strategy, Planning and Performance
DD - Digital Director
BS - Board Secretary

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Presented as cycled/ad hoc item considered at agenda setting
Deferred