Bundle Finance and Performance OPEN 16 January 2023

Agenda attachments

ITEM 0 Open F and P Agenda - 16 January 2023.docx

0	09:30 - OPENING ITEMS
1	Chair's welcome, apologies, and confirmation of quorum
2	Minutes of last meeting DRAFT ITEM 2 OPEN F and P Minutes - 14 November 2022.doc
3	Action log and matters arising ITEM 3 F and P Action Log.docx
4	09:35 - Operations Quarterly Report ITEM 4 Operations Quarterly Report for Committees 22-23 Q3.docx
4.1	ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
5	09:45 - Financial Position for Month 9 - PRESENTATION
6	10:05 - Risk Management and Board Assurance Framework ITEM 6 Executive Summary Risk Management Report FPC 160123.docx
7	10:15 - Monthly Integrated Quality and Performance Report ITEM 7 MIQPR SBAR FPC NovemberDecember 2022.docx ITEM 7.1 Annex 1 MIQPR November December 2022.pdf
8	10:35 - Non-Emergency Patient Transfer Service - Deep Dive ITEM 8 Ambulance Care Deep Dive FP20230209.pptx FINAL.pdf
9	10:50 - Integrated Medium Term Plan (IMTP) 2022-2025 Quarter 3 Progress Report ITEM 9 Executive Summary - Q3 - IMTP Assurance Report - IMTP & Programme Delivery_v1.1.docx ITEM 9 Q3 - IMTP Assurance Report - IMTP & Programme Delivery.pdf
10	11:00 - IMTP 2023-26 Update - PRESENTATION
11	11:45 - Internal Audit Tracker Report *11.1 Hazardous Area Response Team (HART)* *11.2 Electronic Patient Care Record (ePCR)* *NB Audit Tracker circulated separately by e mail (Fri 06/01/2023 14:04)* ITEM 11 Executive Summary F&P - Internal Audit Report 160123.docx ITEM 11.1 WAST_2223_07_HART_Final Internal Audit Report_for Trust issue.pdf ITEM 11.2 WAST ePCR Final Audit Report 2122.pdf
12	12:00 - Environment, Decarbonisation and Sustainability Update – December 2022 ITEM 12 FPC Decarb update Jan 19.12.22 vFINAL.docx
12.1	12:10 - CONSENT ITEMS *The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.*
13	Committee Priorities Update ITEM 13 F&P Committee Priorities January 23.docx
13.1	CLOSING ITEMS
14	Any other business
15	Key messages for Board
16	Date and time of next meeting; 20 March 2023, 09:30

MEETING OF THE OPEN FINANCE AND PERFORMANCE COMMITTEE

Held on 16 January 2023 from 09:30 to 12:15
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.	Minutes of last meeting	Approval	Joga Singh	Paper	
3.	Action log and matters arising	Review	Joga Singh	Paper	
4.	Operations Quarterly Report	Information	Lee Brooks	Paper	10 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Financial Position for Month 9	Assurance	Chris Turley	Verbal/Presentation	20 Mins
6.	Risk Management and Board Assurance Framework	Assurance	Julie Boalch	Paper	10 Mins
7.	Monthly Integrated Quality and Performance Report	Assurance	Rachel Marsh	Paper	20 Mins
8.	Non-Emergency Patient Transfer Service - Deep Dive	Assurance	Rachel Marsh	Paper	15 Mins
9.	Integrated Medium Term Plan (IMTP) 2022-2025 Quarter 3 Progress Report	Assurance	Rachel Marsh	Paper	10 Mins
10.	IMTP 2023-26 Update	Discussion	Rachel Marsh	Presentation	45 Mins
11.	Internal Audit Tracker Report 11.1 Hazardous Area Response Team (HART) 11.2 Electronic Patient Care Record (ePCR)	Assurance	Julie Boalch	Paper	15 Mins
12.	Environment, Decarbonisation and Sustainability Update – December 2022	Assurance	Chris Turley	Paper	10 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.**					
13.	Committee Priorities Update	Information	Trish Mills	Paper	5 Mins
CLOSING ITEMS					
14.	Any other business	Discussion	Joga Singh	Verbal	
15.	Key messages for Board	Discussion	Joga Singh	Verbal	
16.	Date and time of next meeting; 20 March 2023, 09:30	Information	Joga Singh	Verbal	

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Joga Singh	Chair and Non Executive Director
Chris Turley	Executive Director of Finance and Corporate Resources

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

UNCONFIRMED MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 14 November 2022 VIA TEAMS

PRESENT:

Professor Kevin Davies	Non-Executive Director and Chair of Committee
Joga Singh	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk and Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Wendy Herbert	Assistant Director of Quality and Nursing
Navin Kalia	Deputy Director of Finance and Corporate Resources
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Liz Rogers	Deputy Director of Workforce and Organisational Development
Chris Scott	Audit Manager NWSSP
Leanne Smith	Interim Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources

APOLOGIES:

Bethan Evans	Non -Executive Director
Damon Turner	Trade Union Representative
Liam Williams	Executive Director of Quality and Nursing

56/22 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 declarations of interest register. Apologies were received from Bethan Evans, Damon Turner and Liam Williams.

Minutes

The minutes of the open session held on 20 September 2022 were considered by the Committee and agreed as a correct record.

Action Log

The action log was considered:

Action Number: F and P 1/21-22: Focused review of performance related metrics. Trish Mills explained this action had been reviewed at the Quality, Patient Experience and Safety Committee (Quest) on 10 November 2022 and Quest will undertake a deep dive in February 2023; an update will be provided to the Finance and Performance Committee in March 2023.

Action Number: 34/22b: Post-production Lost Hours – Benchmarking. Rachel Marsh updated the Committee, and it was agreed to close the action.

RESOLVED: That the minutes of the meeting held on 20 September 2022 were confirmed as a correct record; and the action log was reviewed with the following action closed; 34/22b, Post-production Lost Hours benchmarking.

57/22 OPERATIONS QUARTERLY REPORT

Lee Brooks updated the Committee on the following points:

1. 111 call handling continued to meet the required standards of the quality of service notwithstanding the particular challenges in meeting performance targets.

2. Handover delays at Emergency Departments continued to be wholly unacceptable with the continued loss of the Trust's resource capacity.

Comments:

1. Members welcomed the revised format of reporting which summarised the main points in more clarity.

2. It was asked what the position was regarding volunteer numbers. Lee Brooks commented there had been an uplift in the number of volunteers, which will be realised in January 2023. He added that the number of volunteer car service drivers had declined; this was due to the pandemic.

RESOLVED: That the Committee noted the report.

58/22 FINANCIAL POSITION MONTH 7

Chris Turley gave the Committee a presentation for the financial position for month 7 2022/23 and brought the following highlights to their attention; noting that the Board will have a detailed paper on the financial position on 24 November 2022.

1. There was a small underspend as at month 7 of £1K.

2. There had been gross savings of £2.590m having been achieved against a current year to date target of £2.514m.

3. A continued break-even position was forecast for 2022/23, however the outlook for 2023/24 onwards was looking extremely challenging.

4. The Public Sector Payment Policy target for quarter 2 was met with the payment of non-NHS invoices paid within 30 days, which exceeds the target of 95%.

5. An overview of the financial performance by Directorate was provided, noting the variances, and in particular, the known and planned underspend in the Operations

Directorate to offset the overspend (underachievement) in income.

6. In terms of the financial risks the Committee were updated, and these included the exceptional cost pressures, winter pressures and the funding for the additional Bank Holiday. These costs remained volatile, and the total current value was £6.614m.

7. Capital expenditure was planned to be spent; to date the Trust had expended £6.300m against the All Wales Capital Scheme budget of £22.306m. The Committee received an update on changes agreed with Welsh Government on the timing of some capital funding and additional monies being made available in-year.

8. The Committee were advised that Welsh Government guidance on financial planning for the next financial year would become much clearer following the UK Government's Autumn Statement, which was due very soon.

Comments:

The Committee discussed the work underway to ensure that the capital available for the remainder of 2022/23 was spent by March 2023 and were assured by Chris Turley that would be achieved.

RESOLVED: The Committee noted the update.

59/22 MONTHLY INTEGRATED QUALITY AND PERFORMANCE DASHBOARD – SEPTEMBER 2022

Rachel Marsh presented the Monthly Integrated Quality and Performance Report (MIQPR) for September, and drew the Committee's attention to the following highlights:

1. The indicators continued to show a poor picture in many areas with performance not achieving the ideal outcomes.

2. Lost hours to handover delays at Emergency Departments in October were the highest recorded at 28,940, equating to 36% of the Trust's conveying capacity being unavailable to respond.

3. 999 answering times have been challenging through significant increases in demand. The median and 65th percentile performance remained good; the call answering tail decreased in August 2022 to 52 seconds, however, this remained higher than the Trust would want. In terms of 111 call answering performance, this had improved over recent months and has continued to improve.

4. In respect of the clinical response time, this had significantly improved; the Trust continued to focus on recruitment and retention of clinicians to further improve these times.

5. Red and amber response times remained far longer than expected, with red response below 50% for the first time in October, at 48%. Whilst an improving picture was seen at the start of November, this continued to be a significant area of concern for the safety and wellbeing of patients and staff. The Committee was assured that the Trust had identified and was progressing all strategies and actions to mitigate this position. Lee Brooks added that red performance at the start of November was at 52%.

6. The Committee were asked to note that the performance metrics in relation to Welsh

language would be included in the next report to the Committee.

7. Ambulance Care (formally known as Non Emergency Patient Transfer Service) Performance was above target for enhanced renal patient arrivals prior to appointment in September 2022, and has improved for patients requiring discharge; however, overall demand for the service continued to increase.

8. There were several other metrics which the team have been working on which include inclusion and engagement, emissions data, symptom checkers, and consideration of the numbers of staff in post versus the number of staff commissioned to be in post.

9. In terms of staff sickness, staff training and PADRs, the improvements in these area since August 2022 were noted. A specific managing attendance programme had been set up to identify and implement actions to improve sickness absence.

10. The Committee noted that the Trust Board would review progress against the totality of Trust and system actions at its November meeting, and gain assurance on the impact of this activity.

Comments:

1. The Committee asked whether management were satisfied that all mitigating actions within the control of the Trust with regard to handover delays had been considered. Lee Brooks explained that the Trust had taken all the actions possible; further information was contained in the Mitigating Patient Harm Report and Action Plan regularly reviewed by the Board. He added that this winter had all the hallmarks of being the most challenging on record.

2. The Committee commented on the improvements with regard to staff sickness figures and PADRs. In relation to sickness absences, Lee Brooks advised that Covid related absences were beginning to decline. He added there had been a focus on completing PADRs. Liz Rogers gave an overview of the work being conducted by her team to improve sickness levels; this included the effective use of occupational health.

3. In respect of the impact of the impending industrial action on the services provided by the Trust, the Committee recognised this would be varied in terms of the several professions across the Trust.

4. Members also recognised that the All Wales Covid-19 sickness policy was still in place and this could represent challenges for the Trust.

5. The Committee asked of the reasons for challenges in recruiting clinicians. Rachel Marsh advised it was specifically related to the 111 clinicians and in the main regarded nurses; the recruitment of nurses is a UK wide issue. The Trust has been considering ways to improve this situation, which included supporting remote working. Liz Rogers added that the job description was being reviewed and modified. Significant work was also being conducted to enable training to be carried out virtually.

6. The Committee discussed which indicators they would like to see further analysis on, and it was agreed that indicators regarding Ambulance Care would be desirable. Rachel Marsh and Lee Brooks will take this forward and scope out the required detail, and will consider eligibility, inequities, new indicators, and transformation of this service.

RESOLVED: That the report was considered and provided sufficient assurance of progress against the 24 key performance indicators detailed, which demonstrate

how the Trust is performing against the following areas of focus: - Our Patients Our People; Finance and Value; and Partnerships and System Contribution.

60/22 QUALITY & PERFORMANCE MANAGEMENT FRAMEWORK 2022-2025 - Update

The report was presented by Rachel Marsh who reminded the Committee that the framework had been approved by the Board in March 2022.

1. The main issue in the first six months of 2022/23 had been the capacity to work on the Framework, as a result of having to recruit to every post in the Commissioning & Performance Team. This recruitment was expected to conclude on the 30 January 2023.

2. The two areas chosen for piloting were EMS Co-ordination and Resource. The initial findings indicated that EMS Co-ordination has developed quality and performance arrangements and there may be opportunities for making these arrangements leaner, but there needs to be a greater connection between Trust-wide strategy, as set out in the IMTP and local deliverables.

Comments:

The Committee recognised this was still a work in progress.

RESOLVED: That the Committee;

(1) NOTED that a Quality & Performance Management Steering Group has been established;

(2) NOTED two pilot assessments for the development of "local frameworks" have been conducted;

(3) NOTED that a self-assessment against the "organisational requirements" at a corporate level has been undertaken with the expectation that this will be concluded in December 2022; and

(4) NOTED that the recruitment into the new structure of the Commissioning & Performance Team will be concluded by 30 January 2023.

61/22 INTEGRATED MEDIUM TERM PLAN (IMTP) 2022-2025 INTERIM QUARTER 3 PROGRESS REPORT

1. Rachel Marsh presented the item which provided progress on the IMTP 2022-2025 Quarter 3 position against the conditions set by Welsh Government (WG) in relation to the Six Goals for Urgent and Emergency Care, value-based healthcare, minimum data set, improvement of sickness and absence rates, and delivery of workforce efficiencies.

2. An IMTP delivery tracker was in place which maps back all 2022-23 priorities into the agreed transformation and enabling programmes established within the IMTP delivery structure.

3. Planning for the 2023/26 IMTP was progressing well with extensive engagement taking place through internal structures which include the recent CEO roadshows, and development sessions with the Board in October and November. The deadline for

submission was now March 2023 rather than January, due to the national requirement for further work regarding the financial outlook for NHS Wales in 2023/24 and beyond, to be undertaken.

Comments:

1. With respect to the six goals as set by WG being achieved the Committee asked how confident the Trust was this was being reported going forward. Rachel Marsh advised that the Trust's Strategic Transformation Board has been given more detail in terms of how the 6 goals linked to the reporting process. She gave an outline of how the reporting process was structured.

2. The Committee discussed mental health and mental well-being, recognising that due to funding issues implementation of a mental health faculty was now unlikely. However, the possibility of being able to provide a mental health response in the Betsi Cadwaladr University Health Board area was progressing well.

3. In terms of the 6 goals, members commented on how engaged all the stakeholders were, and recognised the complex nature involved.

4. The red and amber rated priorities were reviewed by members as were the remedial plans in place. The Committee noted the good progress despite the ongoing operational challenges.

62/22 RISK MANAGEMENT AND CORPORATE RISK REGISTER

Julie Boalch presented the report and updated the Committee on the following:

1. There were currently 17 Corporate Risks on the register, 10 of which were assigned to Committee for oversight; and were described in further detail within the report.

2. Since this report was written, Risk 311, 'sufficient Estate to cope with staff associated with the Emergency Medical Services and Ambulance Care demand and capacity reviews', had been approved by the Executive Management Team for closure, and this will be reflected in the report presented to the Board later in the month.

3. It was noted that risk 244, 'Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service', and risk 245 ,'Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations', were both currently overdue in terms of their controls and mitigating actions, and were due for review by the Operations Senior Leadership Team.

Comments:

Risk 139, 'Failure to Deliver our Statutory Financial Duties in accordance with legislation', The Committee asked whether the Trust was still comfortable with the risk rating of 16? Chris Turley explained the risk had recently been further reviewed and was comfortable with the current rating, noting that this didn't specifically relate to the current financial year and in light of the financial outlook for 2023/24 and beyond.

RESOLVED: Members considered the contents of the report and reviewed the Board Assurance Framework, noting the 10 risks assigned to the Committee.

63/22 INTERNAL AUDIT TRACKER REPORT AND RELATED AUDITS

1. The report was presented by Julie Boalch who explained that its purpose was to provide the Committee with an update in respect of recommendations resulting from internal audit reviews presented to the Committee for oversight.

2. There were currently 2 internal audit reports relevant to the Committee, with a further 14 internal audit reviews which were included in the 2022/23 Internal Audit Plan.

3. The 2023/24 Audit plan was in development and was expected to be presented to the Audit Committee in March 2023 for approval.

4. The Committee's attention was drawn to the 7 high priority recommendations which were reported as being overdue; the report contained details with the expected completion dates.

5. There were 2 recommendations from 2019/20 which were outstanding, and were both due to be completed by March 2023.

Comments:

Members queried why the Clinical Contact Centres Performance Management high priority recommendation had been extended to January 2024. Julie Boalch explained it related to the Salus system.

RESOLVED: The Committee noted the contents of the report and considered the Internal Audit plan activity.

64/22 LEASE CAR POLICY

Chris Turley explained that the purpose of the report was to approve of the All Wales Lease and Pool Car Policy for Trust adoption. He added it had been through all the necessary due diligence prior to being presented at Committee. The main changes to the previous policy were contained within the covering report.

RESOLVED: The policy was approved for adoption by the Trust.

65/22 COMMITTEE PRIORITIES UPDATE

The report was presented for information purposes.

RESOLVED: The Committee noted the report.

66/22 KEY MESSAGES

The Chair advised that the Board Secretary would prepare the update report for the Trust Board, and would include reference to the expected challenges of the winter period and the effect on performance, and that the unavoidable harm as a consequence of hospital handover delays would be the main focus for the Trust.

67/22 ANY OTHER BUSINESS

The Members of the Committee thanked Kevin Davies for his support over the past few

years and wished him well on his departure from the Trust as a Non-Executive Director at the end of the year.

Date of Next Meeting: 16 January 2023

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
59/22	14 November 2022	MIQPR	'A deep dive to be conducted into NEPTS. Scope to be determined by RM and LB and take into account eligibility, inequities, new indicators and transformation of the service.'	Rachel Marsh and Lee Brooks	16 January 2023	Update for 16 January On Agenda - Item 8	Open

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2022-23 Q3 (Oct – Dec 22)

National Operations & Support

Challenges

Civil Contingency Act Obligations

A new corporate risk has been raised to highlight the Trust's inability to provide a civil contingencies response in the event of a major incident or mass casualty incident, and maintain business continuity, with potentially catastrophic consequences. This risk is articulated in the climate of ongoing external pressures across NHS Wales which precludes our ability to fulfil the pre-determined attendance requirements for major incidents as detailed within the Incident Response Plan. This could impede the Trust's legal obligations as a Category 1 responder under the Civil Contingencies Act 2004.

Industrial Action

December 2022 saw three dates of industrial action; 2 by RCN, predominantly affecting the Integrated Care portfolio, and 1 by GMB, which had more widespread impact across the Operations Directorate. An Industrial Action Planning Team was established in late November led by the Emergency Preparedness, Resilience & Response (EPRR) team and consisting of senior reps from across the Trust, and the team will continue to make arrangements for future strike dates. It is anticipated that industrial action will continue into Q4 with significant disruption as a result. The IA Planning Team will provide assurance to The Industrial Action Cell and Senior Business Continuity Planning Team (SBCPT) on planning arrangements for anticipated and confirmed industrial action.

IMTP

Manchester Arena

Following the Manchester Arena Inquiry, 149 recommendations have been identified within volumes 2 and 3 of the report. WAST's EPRR team will now need to consider and plan a response to these recommendations. Asks will need to be made to NHS commissioners for the additional resources required to ensure an effective response following the assessment against the recommendations.

A report is being considered at Emergency Ambulance Services Committee (EASC) on 17th January 2023 to note that for WAST to receive, review, consider and plan the response to all recommendations relating to the Manchester Arena Inquiry, additional resource to support the EPPR team to achieve this will need to be established. A plan is being prepared to protect resource to achieve this.

Volunteering

The Trust has commenced a rollout of analgesia (pain relief) provision for Community First Responders (CFRs). Initially this will consist of 500mg oral paracetamol as part of a stepped approach to further analgesia roll out at a later date. This is a significant development for volunteering and for patient experience, consistent with our Volunteer Action plan, given that because of protracted hospital handover, CFRs are experiencing extended on scene times with patients who are in pain.

General Update

Christmas

Christmas hampers were provided to all ambulance stations and were received well. Christmas dinners were also provided by hospitality establishments from across Wales for all staff working Christmas Day on a shift commencing before 14:00 hrs. Many establishments provided the dinners free of charge, and others were purchased through Charitable Funds. A further bid to Charitable Funds has been supported for additional winter welfare refreshments for all staff via the Senior Business Continuity Planning Team.

Resourcing & EMS Coordination

Challenges

EMD Recruitment and Retention

Recruitment and Retention has been an issue for some time but has been acute over the last 6-12 months. The current rate of external attrition for the 2022 calendar year pan-Wales is 24%, up from 14% for the 2021 calendar year, with more staff leaving to take up internal vacancies across the Organisation. Recruitment to other roles within EMS Coordination is generally achieved through recruitment internal to the department, and this has left the Emergency Medical Dispatcher (EMD) establishment under significant pressure. Of the current funded establishment of 111.76 WTE in the EMD function, 61 new EMDs (55%) have taken up post since August. This has a profound impact on the performance across the unit as new EMDs try to acclimatise to the operational environment after training, and also seriously diminishes the availability of experienced colleagues to support the new recruits. A further 20 EMDs have been recruited to start with EMS Coordination in January 2023 mitigating the 14 team members who are due to move to alternative positions within WAST, primarily ACA in Q4.

Concerns

The number of Concerns flowing through from the ‘Putting Things Right’ Team continues to challenge staff across Operations Quality. The number of investigations, audits and statements required as part of the investigation process remains high at circa 170. This activity is not solely related to the concerns of service users but also includes coronial work, medical examiner requests and briefings for Serious Case Incident Forums (SCIF). The Operations Quality team continues to work collaboratively with the ‘Putting Things Right’ team cross directorate to deliver a joint solution that meets the legislative requirements and patient safety needs with a proportionate investigative process.

Intelligent Routing Platform
Over the last 2 years the demand for 999 call answering services has increased dramatically and the ability of UK ambulance services to meet this demand has been challenged. This can impact BT's ability to answer incoming 999 calls. UK ambulance services are required to have pre-determined arrangements in place for BT to be able to direct 999 calls to an alternative site should the home Trust be unable to answer the call within an agreed timeframe. The current agreed timeframe is 5 minutes.

In November 2022, the 999 Intelligent Routing Platform (IRP) replaced the existing network partner arrangements by using automated technology to improve the speed and accuracy of manual practices. Following the implementation of IRP, WAST experienced increasing demand to support other UK ambulance services, peaking on the 18th of December 2022 at more than 600 calls being taken in a 24-hour period, equating to 34% of the total calls re-routed across the UK and 22% of WAST's total 999 demand.

Due to wider system pressures and the demand coming into the service, a Critical Incident was declared on 19 December 2022, and because of the significant and sustained pressure on the system, it was decided to withdraw WAST from the IRP. The Operations Directorate Senior Leadership Team (SLT) along with the EMS Coordination team continue to work with colleagues across NHS England and AACE on a solution to safely allow WAST to return to this process without compromising our call handling capacity and performance.

IMTP

Research & Innovation - Upgrade 999 Platform
An upgrade of the 999 platform is required to improve resilience, flexibility, and interoperability for 999 call processing. Discussions continue with ICT regarding funding to support the rollout of the new platform with an expected decision in Q4.

The Assistant Director of Operations, Resourcing & EMS Coordination has been in discussion with the Head of ICT regarding the approach to funding, and discussions are ongoing with the supplier in relation to the actual cost of the upgrade. Progress has been delayed slightly as the supplier has been through a change of ownership during the negotiation discussions.

EMSC Reconfiguration
The EMS Coordination Reconfiguration Project has been ongoing since 2018, and the current key workstreams include:

- Roster review: a collaborative review of rosters in partnership across Wales to better match our staffing profiles to demand and support our teams' wellbeing
- Boundary changes: to provide an improved balanced workload for dispatch staff and greater resilience to the service
- Broader ways of working: an assessment to provide improved productivity and effectiveness while improving processes and procedures for QPS

The first tranche of work in the roster review is complete. This included the provision of roster options for EMDs completed collaboratively with Resourcing, and with voting mechanisms and ratification of preferred options. Revised rosters for EMDs are rolling out in Q4. Work on the boundary changes and broader ways of working have begun but have been paused to allow the EMS Coordination team to react accordingly to managing the industrial action period. The next set of roster reviews is not now anticipated until Q1 of 2023/24.

General Update

Control Room Solution

In line with the Emergency Services Network (ESN) programme, and in collaboration with the Ambulance Radio Programme (ARP), EMS Coordination is supporting the role out of a new Integrated Communication Control System (ICCS) provided by Frequentis. The LifeX solution is due to launch at the end of Q4, and WAST will be the first large scale ambulance service in the UK to go live on the new platform (Isle of Wight has been piloting the solution on a smaller scale).

ICT colleagues, EMS Coordination teams and the ESMCP project managers have been working with ARP to ensure infrastructure, operational plans and testing is completed and to the standard WAST requires to lead the UK with this innovative cloud-based product.

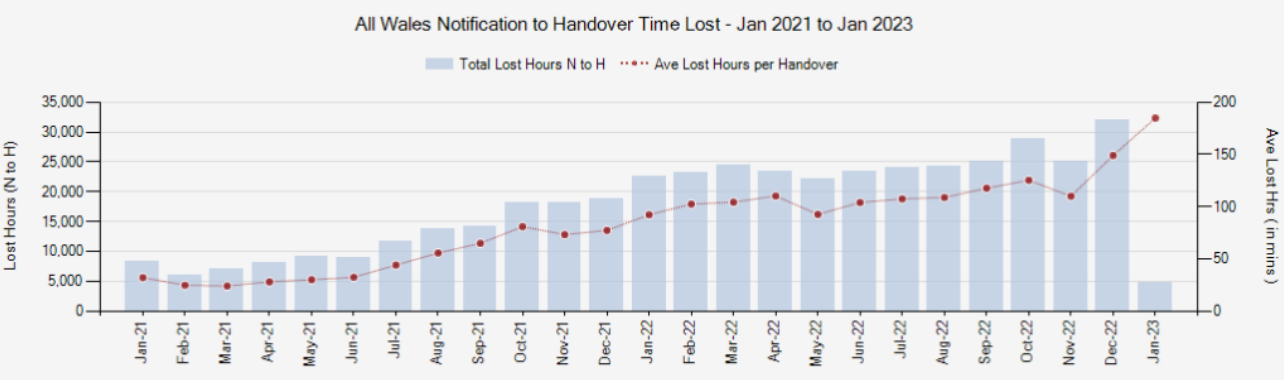
Instructors have been trained in readiness and a training programme has been designed in collaboration with ARP. January 23 will see those instructors and superusers receive refresher training in readiness for the wider rollout of system training to EMS Coordination teams in February and March 23.

Emergency Medical Service

Challenges

Continued System Pressure

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 32,050 hours were lost in December 2022, an increase on the previous month of 7029 and resulting in a c38% loss of conveying capacity in Q3. In addition, several Health Boards across Wales have made business continuity and critical incident declarations in recent weeks.



Targeted Overtime
Following an increase in demand, handover delays outside EDs and the Trust's declaration of a Critical Incident on 19th December 2022, the Trust approved additional overtime payments for overtime worked during anticipated periods of high demand over the Christmas period, resulting in the following production uplift on the 5 enhanced dates:

	17	18	23	24	31	shift hou	unit hours	UHP%
EA	459.5	716	459.5	498	919.5	3052.5	1526.25	9%
CHARU	23	23	23	20	23	112	112	6%
APP	11.5	11.5	21	21	29.5	94.5	94.5	8%
DOM	23	53.5	29.5	45	68	219	219	9%
UCS	168.5	78.5	109.5	110	221.5	688	344	16%
						4166	2295.75	10%
other EMS*	90.5	19.5	93.5	78	46.5	328		
CSD	33.5	48	22	49.5	86.5	239.5	239.5	16%
CCC	55	71.5	28	71.75	95.75	322	322	5%

*CV: MRT,CRU, Triage; BCU: Berwyn Prison; SB: PCT; AB: Falls, PRU

IMTP

EMS Roster Review
The introduction of the **Cymru High Acuity Response Unit (CHARU)** has been deployed to support patients with suspected critical illness or injury. The CHARU has replaced the traditional RRV model and includes responding to an agreed dispatch criteria along with all red category calls.

All EA and UCS rosters are now live with 3 remaining which are still subject to internal processes but will be finalised in the next few weeks. CHARU is now live across Wales with the final part of recruitment taking place. Early indications are that the benefits are being realised with early intervention and leadership at critical incidents and positive feedback from CHARU operatives.

Improving Response Times in Rural Areas
EMT recruitment and recruitment to address the shortfalls in Powys continue. A workshop took place in Q3 with an accompanying paper due to be completed in Q4.

Develop Optimising Conveyance Improvement Plan
This IMTP deliverable is part of the Trust's activities contributing to 'Inverting the Triangle' and is being progressed as part of the Care Closer to Home Programme.

General Update

Business as Usual (BAU) Alongside Industrial Action Planning
It is recognised that with industrial action anticipated to last a number of months, there is also a requirement to service BAU needs in relation to winter pressures and other operational requirements. Following the first GMB strike day, the team is now seeking to balance responsibilities of industrial action planning and BAU workstreams to ensure service delivery is maintained.

Ambulance Care

Challenges

Contract Redesign Process

The implementation of the contract redesign process is progressing well. Of the 30+ contracts awarded, all but two commenced in December 22. The transition to the new providers has been smooth to date with no issues of note to report.

During the awards process, it was decided to not award contracts for 5 lots and to reissue the tenders to reflect an updated set of requirements. These lots were submitted for tender in December 22 and bidding has now closed with evaluation underway. It is proposed to award these as individual lots in line with the Trust scheme of delegation.

Of the two contracts yet to commence, the Cardiff & Vale discharge contract commences on Monday 16 January, and regular assurance meetings have been held with the incoming and outgoing providers as well as locally with the Health Board. There are several staff to transfer under the TUPE process and appropriate arrangements are in place to facilitate this.

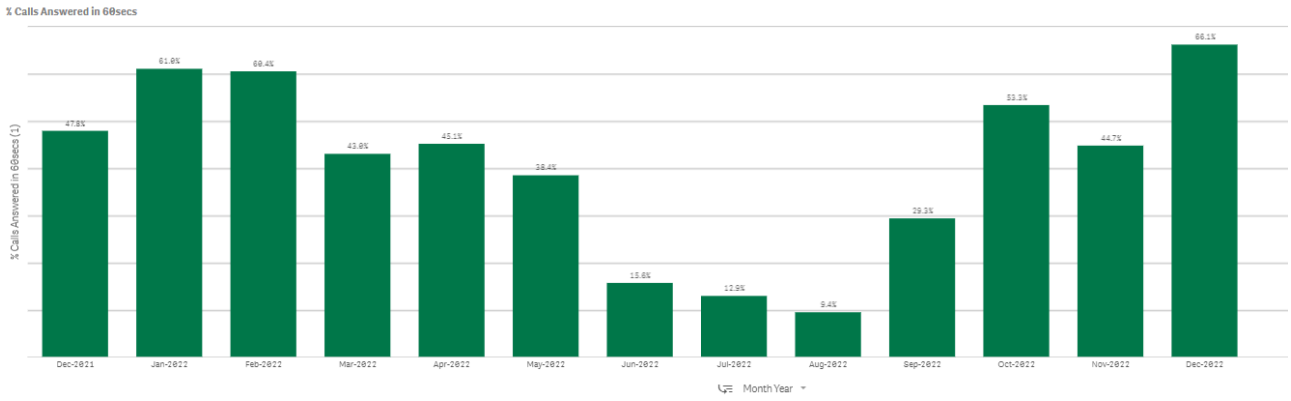
The Swansea renal contract will commence on 1 March 2023. At present, both providers are working through the TUPE process. Whilst this has proved more challenging than anticipated for reasons outside of WAST's control, confidence is high that a smooth transition will occur.

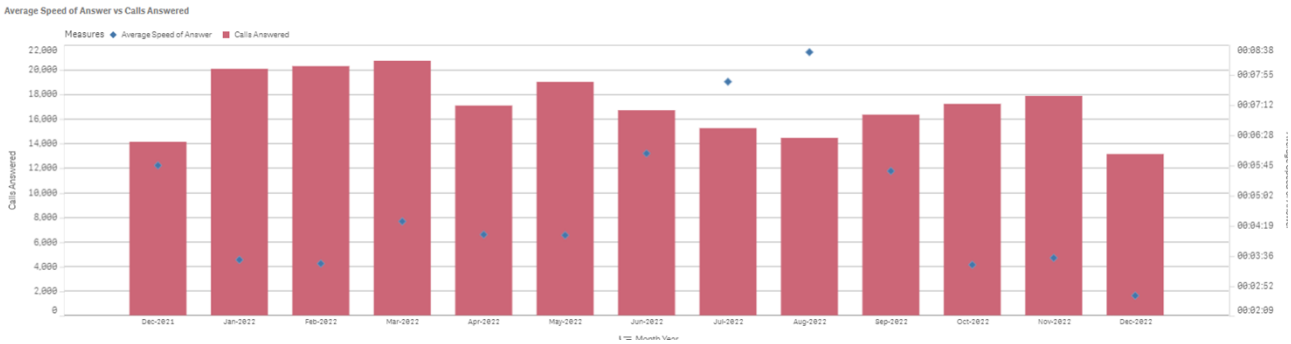
NEPTS Cleric Upgrade
Following completion of the new externally hosted environment for the upgraded NEPTS Computer Aided Dispatch (CAD), the new CLERIC Pink system was due to go live in December 2022. However, this date was delayed to allow the provider to respond to the findings of an audit on the security of the hosted environment. These findings have now been addressed and a new date has been set for the 11 January 2023. Due to industrial action announced for this date, it has been decided to reschedule this date to the end of January 23.

NEPTS Journey Booking Telephony Performance
The performance of the NEPTS journey booking service has at times in 2022 been below expectations. In July 2022, an action plan was implemented to deliver a recovery in the performance of the service.

Whilst there is still more improvement to make, the service is starting to deliver a more consistent level of performance, which can be observed below.

Further actions are underway to continue this improvement including recruitment, changes to HCP booking arrangements and a review of staff rosters to address current hotspots of challenged performance.





IMTP

Demand & Capacity Review
The revised roster keys have been developed. A PDSA has been written to test the ORH keys against the revised keys (ORH+) and the PID was completed in November 2022. The NET centre roster keys are currently being reviewed through the support of Erlang-C modelling from Optima. As this is a small and simple roster, it is not anticipated that there will be a delay on this process beyond the targeted completion date of 31st March 2023 (depending on organisational prioritisation).

NEPTS Operational Improvement
The review and implementation of the Resource Downtime workstream has been completed. The new report is in place and is being reviewed regularly under BAU arrangements. Contact has been made with BCUHB to restart the discharge lounge trial and data is being collated in relation to the oncology booking process PDSA and will be shared at the next ACT programme board.

Transfer and Discharge Service
The project team has been established and the PID has been approved by the transformation board. Work is in progress with regards to the modelling (ToR agreed, now at procurement stage) to help understand the data in support of the development of a concept for consideration by EASC at the end of the financial year.

Ready Times Refresh
One of the largest impacts within the D&C review was aligning the system allocated times for a return journey more closely with the actual position. This will aid planning, improve patient experience and minimise hours lost from crews waiting at sites for patients.

Significant work has been completed to review and refresh this process with 100 clinics reviewed already and a further 250 clinics in the review process, using a PDSA cycle to test the agreed processes. A system generated report has been developed that will allow all clinics to be reviewed and updated en-masse. Providing the latest PDSA cycle test shows the changes made to date have been effective, the process will be rolled out to all clinics nationally.

General Update

Winter Support Vehicles
The Ambulance Care Service was awarded £300k of funding to provide additional resource to support winter pressures. This allocation has been utilised to procure additional resources that are regional based and will be allocated to the areas with the greatest service pressures.

The resource procured is a mix of UCS and NEPTS resource and will be employed to support the service until 31 March 2023.

UCS Demand & Capacity Review
Following completion of the transfer of the Urgent Care Service from EMS to Ambulance Care, a strategic review has been commissioned through ORH to identify and understand how the UCS service works, what work it completes and to consider its role moving forward. This review commenced in November 22 and should be completed in April 23. The outcomes of this exercise will be used to inform decisions on how the service functions in the future. This review will be the first review solely focused on the service.

Integrated Care

Challenges

111 Adastra Outage
While the business continuity incident has ended for the Health Boards and Adastra systems have resumed, the “Concentrator” which joins the Adastra system to the WAST system is still out of action. Until this is resolved, WAST is on a heightened sense of awareness of the issue. The DHCW solution involving “robots” continues to operate to pass calls to the Health Boards, and this is expected to be in place until the concentrator is functional which is now expected in February 2023.

IMTP

Use of Video Consultation in Clinical Support Desk
The video element used within the ECNS triage system in CSD has been successfully implemented in December 2022. Used to enhance the patient/clinician interaction, video enables a closer look at ailments or specific injuries where this will benefit the consultation. We hope to glean intelligence regarding user experience to inform how this functionality is best used.

Clinical Support Desk Roster and Resourcing Review
The team in CSD have initiated a review of the recent update to the rosters. Feedback has been received from TU partners on some changes which are proposed by the staff, and the views have been understood in detail through a staff survey which concluded in December. This will be reviewed, and potentially changes to the existing rosters will be shared with the staff for input with a view to implementation around Easter 2023.

Consult and Close in the WAST surpasses 15%
Late December saw an increase in consult and close activity in CSD, 111 and with APP and HB partners. Coupled with the increased demand for service, consult and close rates of over 17% were seen on some days over the festive period. It is anticipated that consult and close will remain over 15% into 2023. This figure is potentially aided as a consequence of the use of the Clinical Safety Plan, and our operationalisation of the plan in the new version.

General Update

Integrated Care Estate
111 has moved into the new centre in Vantage Point House. The new facility is the main part of the VPH renovations which are still ongoing and has been firmly welcomed by the team. Work continues to provide a new welfare area and training facilities for all centres in VPH with expected completion in February 23. The works at Cardiff Ambulance station will complete in Q4.

AGENDA ITEM No	**6**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Finance & Performance Committee
DATE	16th January 2023
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 10 risks that are relevant to Committee's remit and additionally the Trust's 2 highest scoring risks which are assigned to QuEST for oversight.

2. The principal risks reported within this paper are the same as reported at the last meeting in November 2022 which is due to the timings of the governance arrangements for risk reviews and the Trust Board meetings held during the cycle; however, Committee will receive a full update at the next meeting in March 2023.

3. This is likely to include the closure of **Risk 244** - *Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service* as this risk has reached target. In addition, the Corporate Risk Register is likely to include a new Civil Contingencies Risk which is currently in development and will be presented to Trust Board at the end of January 2023.

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

5. The BAF, in Annex 2, provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those control where applicable. This will assist Members in evaluating current risk ratings.

6. The gaps in controls and assurance are set out on the BAF, as are the actions planned to address any gaps. This detail provides Members with an insight into the planned activity, as much as can be anticipated from time to time, to reduce the risk to a level of tolerance set by the target score. This format will continue to evolve as part of the risk transformation programme.

7. Risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the Corporate Risk Register.

RECOMMENDATION:

8. **Members are asked to consider the contents of the report and:**
   a. **Note the closure of Risk 311 from the Corporate Risk Register.**
   b. **Discuss the risks relevant to Committee.**
   c. **Review the Board Assurance Framework.**

KEY ISSUES/IMPLICATIONS

9. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE

10. This report has been considered by:
    - ADLT – 17th October 2022
    - ADLT – 31st October 2022
    - EMT – 9th November 2022
    - Trust Board – 24th November 2022
    - Audit Committee – 1st December 2022

REPORT ANNEXES

11. SBAR report.

12. Annex 1 - Summary table describing the Trust's Corporate Risks.

13. Annex 2 - 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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of this report is to provide an activity update in relation to the Trust's Corporate Risks, relevant to Committee.

2. A summary report describing each of the corporate risks as of 1st December 2022 is detailed in Annex 1 as an extract from the Corporate Risk Register (CRR).

3. The risk owners have updated progress against the risks in accordance with the review schedule in place across the Trust, with the highest scoring risks reviewed monthly.

4. The Board Assurance Framework (BAF) report is included in the paper in Annex 2.

BACKGROUND

5. The Risk Management Transformation Programme was included in the IMTP (2022/2) with the immediate priority to undertake a detailed review of the Trust's 5 highest scoring risks initially with the remaining corporate risks to follow. The programme of work has been completed to strengthen the articulation of the corporate risks and any new risks including title, summary descriptions, controls, assurances and any gaps or additional actions required.

6. The Assistant Directors Leadership Team (ADLT) continue to review the risk assessments, which have been approved by the Risk Owner, on all new risks in addition to reviewing any changes to existing risks and mitigating actions, reporting activity to the Executive Management Team (EMT), Board Committees and Trust Board.

ASSESSMENT

7. There are currently 17 Corporate Risks on the register, 10 of which are assigned to Committee for oversight, and these are described in the summary table in Annex 1. The table sets out the rearticulation of each of the Corporate Risks including new titles and summary descriptions, utilising an '*if, then, resulting in*' approach, the Executive Owner of the Risk and the Risk score with any changes that have occurred during the period.

8. The EMT has approved the Corporate Risks described in this paper ahead of presentation at Trust Board in November 2022 and Audit Committee in December 2022.

<u>Corporate Risks</u>

9. The full detail of each Corporate Risk, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 2.

10. In addition, Members are asked to note that the actions, which were contained in the July 2022 Board paper on avoidable harm and outlined at the last meeting, are included in the action section of the BAF for the Trust's highest scoring risks 223 and 224 which are both rated 25. These actions seek to mitigate in real time, avoidable harm in the context of extreme and sustained pressure across the urgent and emergency care service.

Closure and De-Escalation of Risks

11. The Executive Risk Owner and ADLT recommended that Risk 311 be closed from the Corporate Risk Register which was approved by the EMT and presented to Trust Board in November 2022.

12. **Risk 311** - Inability of the Estate to cope with the increase in FTEs

IF *the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed*

THEN *there is a risk that the Estate will not be able to cope with the increase in FTEs*

RESULTING IN *potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust*

13. This risk was created to provide an organisational focus that ensured the Trust had sufficient estate to cope with increases in staff associated with the EMS Demand & Capacity Review and the NEPTS Demand & Capacity Review, in particular, closing the relief gap in EMS Response. Managing this risk has largely been discharged through the estate interim plan within the EMS Operations Transformation Programme; therefore the risk can be closed.

14. There is however, a generic and ongoing risk that the Trust's technical planning is not sufficiently integrated to appropriately manage changes to the workforce and the associated knock on impact on the estate. A new risk will be developed during the next reporting cycle to articulate this as a risk.

Transfer of Risks

15. No risks relevant to Committee's remit have transferred during this reporting period.

Changes to Risk Scores

16. There have been no changes to the risk scores since the last meeting in November 2022.

New Corporate Risks

17. No new risks have been assessed or recommended for the CRR during this reporting period.

Development of New Risks

18. **Risk 538** - A risk has been developed to reflect the possible consequence of a further delay to the implementation of the new Integrated Information System (Salus); however, due to ongoing commercial discussions and a delay to some delivery milestones, the detail of this risk will need to be reviewed and finalised to capture the emerging position and differentiate it from any realised issues. An update is expected for presentation to Trust Board in January 2023.

19. **Risk 542** - *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan*

    This risk has been fully articulated and is navigating Trust risk governance processes. It is expected that this will be included on the CRR during the next reporting cycle.

Board Assurance Framework

20. The BAF is included at annex 2 which focusses the Board on the key risks that are mapped to the IMTP deliverables and that might compromise the achievement of the Trust's strategic objectives. Until such time as the more mature and strategic BAF is developed during 2023/24 as part of the risk transformational programme, these key risks are the corporate risks due to their relationship to the IMTP delivery and their risk ratings.

RECOMMENDED:

21. **Members are asked to consider and discuss the contents of the report and:**
    a) Note the closure of Risk 311 from the Corporate Risk Register.
    b) Discuss the risks relevant to Committee.
    c) Review the Board Assurance Framework.

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)** →
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,	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		qualified accounts and impact on delivery of services and reputational damage		
244 FPC	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	**IF** the Trust is unable to increase accommodation capacity **THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives **RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience	Director of Operations	**16 (4x4)** →
245 FPC	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident **THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)	Director of Operations	**16 (4x4)** →
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for	**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	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	recurrent costs of commissioning	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		
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**15 (3x5)** →
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	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 effective ability to deliver essential services		
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 **RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage	Director of Strategy Planning & Performance	**12 (3x4)** →
311 FPC **CLOSED**	Inability of the Estate to cope with the increase in FTEs	**IF** the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed **THEN** there is a risk that the Estate will not be able to cope with the increase in FTEs **RESULTING IN** potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust	Director of Finance & Corporate Resources	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	**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	Director of Strategy Planning and Performance	**12 (3x4)** →

Annex 2 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	18/10/2022	TREND	25 (5x5)
		Date of Next Review:	18/11/2022	➡	

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: 3, 7,9,11, 12, 14,16, 18, 21, 22, 26

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

CONTROLS	ASSURANCES
1. Patient Flow Co-Ordination based in the Grange University Hospital	**Internal** **Management (1st Line of Assurance)** 1. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
2. Regional Escalation Protocol	2. Daily conference calls to agree RE levels in conjunction with Health Boards
3. Immediate release protocol	3. 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)
4. Resource Escalation Action Plan (REAP)	4. 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.
5. 24/7 Operational Delivery Unit (ODU)	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.
6. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	6. 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.
7. Limited Alternative Care Pathways in place	7. 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.
8. Consult and Close (previously Hear and Treat)	8. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance)
9. Advanced Paramedic Practitioner (APP) deployment model	9. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required
10. Clinical Safety Plan	10. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
11. Recruitment and deployment of CFRs	11. Volunteers are another resource for response, Volunteer
12. ETA scripting	12. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
13. Clinical Contact Centre (CCC) emergency rule	13. CCC Emergency Rule is policy that has been signed off by Execs.
14. National Risk Huddle	14. 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.
15. Handover Improvement Plans agreed between Health Boards and WAST	15. Improvement plans are reviewed by EAST
16. Summer/Winter initiatives	16. Monitoring through SLT and STB

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	18/10/2022	TREND	25 (5x5)
		Date of Next Review:	18/11/2022	➡	

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

17. CHARU implementation	17. Monitored via the EMS project Board
18. National Transfer & Discharge Model	18. Task and Finish Group established
19. Conveyance Reduction	19. This is part of the weekly performance review and aligned to Care Closer to Home Programme
20. Access to Same Day Emergency Care (SDEC) for paramedic referrals	20. This forms part of the handover improvement plans in place with Health Boards
21. Mental Health Practitioners in cars	21. Part of the Care Closer to Home workstream
22. Roll out of ECNS	22. Reported through QuEST
23. Clinical Model and clinical review of code sets	23. Reported through QuEST
24. Remote Clinical Support Strategy	24. Strategic Transformation Board – IMTP deliverable
25. 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)	25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	None immediately identified but subject to continual review
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7. Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues	
8. 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 6 months there is a low confidence in attaining this.	
9. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
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	31.12.22	Rural model options are being explored. Discussions have been opened up with one workshop held another scheduled for 28th October 2022 with the aim of producing a set of recommendations for consideration by SLT and EMT.
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Paused	

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	18/10/2022	TREND	25 (5x5)
		Date of Next Review:	18/11/2022		

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

3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Extended from 30.09.22 to 31.12.22	On schedule to implement all EA and UCS rosters by the end of November 2022. CHARU rosters may drift into December 2022 due to recruitment and training.
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. 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]	TBA	TBA	
6. 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	31.12.22	Work undertaken to map influences and progress towards each. Trajectory cast until December 2022 - 15% to be achieved through efficiencies.
7. 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.
8. 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.
9. 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	Ongoing	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.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	TBA	Level 2 Falls Service implemented as a pilot. Awaiting evaluation of the pilot and assessment of outcomes and potential longevity of this initiative.
12. External Controls detailed within the Action Plan presented to Trust Board on 28/07/22: 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 educes 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)			

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	→	

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: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35

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

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 Delivery Unit under the *Framework for the Investigation of Patient Safety Serious Incidents (SIs)* V2.2, dated July 2019.	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 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 commended in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance – next meeting 08.09.2002 – plan to finalise revised approach to Appendix B process by November 2022.
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 monitors, reports 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. Learning from incident reporting processes.
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. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP).	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 via 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
9. 24/7 Operational Delivery Unit (ODU) escalating handover delays / patient condition to Health Board colleagues.	9. Shift reports from ODU & ODU Dashboard received by Exec, 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 Exec, 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, dementia awareness, mental health.	12. Integrated Quality and Performance Report (June 85% target met)

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	→	

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

13. Clinical audit programme	13. Clinical audit programme with oversight from the Clinical Quality Governance Group.
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.
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 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."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board and Board sub-committee oversight and escalation.
	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) and Joint Executive Team meeting 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 CASC
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
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.	1. Strengthen and triangulate patient safety metrics and look back data at ED, service and corporate level for baseline data for improvement projects and WAST reports.
2. Inconsistent review of potentially serious / catastrophic patient safety incidents in line with the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019 (frequently referenced as 'Appendix B' Reports) by Health Boards pan NHS Wales and lack of ownership of system risks. Lack of whole system approach to handling patient safety incidents resulting from system pressures*.	2. Implementation of revised process, engagement and outcome and improvement measures at system level – to be confirmed.
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 from c6000 hours per month at the end of 2018 to in excess of 22000 hours per month during Q4 21/22 and Q1 22/23. This scale of lost emergency ambulance capacity has peaked at 30% per month of the entire emergency ambulance fleet..
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthen patient safety reports and audit processes as system embeds.
5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*.	5. 15-minute handover target is not being achieved pan-Wales consistently.

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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

5. (b) Protracted timescales in the 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 – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.	
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. Health & Care Standards self – assessment in progress.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. 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*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators
	2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026 – Goal 4: Rapid response in physical or mental health crisis.	CEO	• WAST is represented on the Clinical Reference Group by the Director of Paramedicine	Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales
Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• Checkpoint Q4 2022/23	Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF)
Implement nationwide approach to emergency department 'Fit 2 Sit'	CMO/CNO	• Acceptance at meeting of Chairs and CEOs led by Director General for Health and Social Services and the NHS Wales Chief Executive on 08.06.2022 that a national approach to Fit 2 Sit should be adopted. Chief Medical Officer and Chief Nursing Officer to champion development through peer groups • Checkpoint Q4 2022/23	Emergency Department Quality & Delivery Framework final version drafted for consultation / approval.
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	• Checkpoint Q4 2022/23	Incremental improvements to quality and safety data and information to enable triangulation.

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022		

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**

			Access to ePCR data (NEWS) now available.
Continued Health Board interactions – my next patient, patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly	Monthly meetings continue to be held and the content of the health board reports are currently under review
HIW Improvement Plan / Workshop– WAST inputs / influencing improvements Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.	Assistant Director of Quality & Nursing	• August 2022 in progress • Checkpoint Q4 2022/23	
Participation in the CASC led workshop to reform *the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019*.	Assistant Director of Quality & Nursing	• Checkpoint post pilot Q4 2022/23	Revised joint investigation approach agreed which is to be piloted from November 2022.
Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of Workforce & Organisational Development	• Recruitment decision made at EMT on 15.06.2022 for 100 WTE with offers already made to ACA2s and EMTs on hold list • Courses to commence in Q2 2022/23 with first new deployments in Q3 2022/23 • Offers also made to all 61 NQPs from "Big Bang" event • Correspondence to CASC confirming action taken sent 21.06.2022 with request for recurrent funding source set out • End of Q3 and into Q4 2022/23	
Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Bid to Value Based Healthcare Fund made for up to 50 WTE APPs to commence fulltime education for 12 months from January 2023 • Q4 2023/24	
Senior system influencing	Trust Chair Chief Executive Officer	• Ensure that system safety and avoidable harm remain a live topic of discussion in all relevant fora • Seize opportunities as they emerge that can contribute to mitigating avoidable harm • JESG forum used to raise awareness amongst Emergency Service Chief Officers who have written twice to NHS Wales Chief Executive to convey the impact of our inability to respond to incidents in the community on their core service provision	Ongoing
Emergency Department cohorting	Director of Operations	• Provide additional clinical staff and suitable space for patients arriving by ambulance to be held at the emergency department awaiting admission enabling the ambulance to be released • In place at Morriston and The Grange	Ongoing
Transition Plan	Chief Executive Officer	• Formally submitted to Commissioners in December 2021 and subsequently subject to a part year funding request of Welsh Government on 24 May 2022 this plan sought to grow our establishment to a further 294 WTE having forecast the challenges currently being seen • Around two thirds of the growth was to deploy additional response capacity (now provided in part by 4 above) whilst the system took action to reduce emergency department handover delays	Transition now complete. **CLOSE**

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	➡	

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

		• Around one third of the growth was to accelerate the transition to a new model of service delivery (inverting the triangles) – also now subject to a separate bid as in 5 above	
Overnight falls service extension	Director of Quality & Nursing	• Review current extension to falls scheme that has temporarily been running on night duty • Benefit derived but further improvement in utilisation and overall volume of work undertake are necessary in the next 3 months • Scheme extension agreed to 31 March 2023	
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?	Chief Executive Officer	• Conducted in three phases over the next 6 to 9 months 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 • Q1 2023/2024	
Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	• Summer performance forecast complete and winter underway imminently • Discussions underway during Q2 to create new/further schemes to support operational delivery through winter • Q3 2022/23	
National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	• National public awareness campaign funded by Welsh Government to promote appropriate use of services (111 as an alternative to 999/ED where appropriate) • Upgrade to 111 website and symptom checkers also underway • Q3 2022/23	

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	31/10/2022	TREND	16 (4x4)
		Date of Next Review:	30/11/2022		

				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 of 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	4	4	16
			Target	2	4	8

IMTP Deliverable Numbers: 10, 18, 28, 30, 34. 35, 37,38

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

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	2.
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, EMT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	5.
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.	7.
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	10. (a) Monthly monitoring returns to ADLT, EFG, EMT 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, EMT, 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.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	31/10/2022	TREND	16 (4x4)
		Date of Next Review:	30/11/2022	➡	

IF the Trust does:	**THEN** there is a risk that the Trust will fail to achieve all of 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

- 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)

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

	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

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	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	31/03/23 – Checkpoint Date	
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/23 – Checkpoint Date	
3. Embed value-based healthcare working through the organisation	Executive Management Team and Value Based Healthcare Group	31/03/23 – Checkpoint Date	
4. WIIN support for procurement, savings and efficiencies	WAST Improvement and Innovation Network group	31/03/23 – Checkpoint Date	
5. Foundational economy, Decommissioning and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/23 – Checkpoint Date	

Risk ID 244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	Date of Review:	03/05/2022	TREND	16 (4x4)
		Date of Next Review:	30/05/2022	➡	

IF the Trust is unable to increase accommodation capacity	**THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	**RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	3	4	12

IMTP Deliverable Numbers: 1,5,9, 10,18, 28, 30, 34

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Temporary call handling provision in Carmarthen	1. Monitoring of Performance standards for call handling (daily) and dispatch (weekly) to identify impacts on service with further investigation on a monthly basis
2. Maximum use of space at the Bryn Tyrion site	2. All desks have been realigned to 2m physical distancing as part of covid preparations
3. Maximum use of space at the Vantage Point House (VPH) site	3. Review of VPH undertaken – November 2021 Staffing levels are managed according to maximum desk space on each centre. In VPH, because of agile working there is capacity for non-dispatch functions.
4. Prioritisation of space utilisation for each shift by CCC management team and alignment to priorities associated with safe service delivery	4. Business continuity tracker for staffing levels updated daily
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Call handling provision is a short-term solution and not fully resilient	1. Carmarthen solution for call handling is temporary
2. Lack of resilience in temporary accommodation may trigger risk if business continuity plans are invoked	2. Reconfiguration work reviewed by architects during pandemic preparation and earlier have yet to be delivered.
3. Current social distancing plans for EMS CCC do not provide solutions for the dispatch environment in Carmarthen	*3.* Agile working solution would be compromised in an ICT outage and paper-based approach would be used
4. Current social distancing plans for EMS CCC provide limited solutions for call handling and dispatch in Bryn Tyrion	
5. Current social distancing plans for EMS CCC provide limited solutions for dispatch environment in VPH.	
6. Estates Strategy is silent on risk associated with CCC environment	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review current estate to identify moderate workplans to maximise available capacity within existing estate.	Assistant Director of Operations – Resourcing & EMS Coordination	30.09.22 Complete	Review took place to maximise capacity, some additional desks and roster planning supported. Site specific updates are as follows: Capacity within Central & West CCC (Carmarthen) which has been extended to provide extra accommodation for additional EMDs required to comply with Covid regulations. South East CCC (VPH) is currently undergoing renovation, but there are plans to provide additional capacity for EMS CCC when it is completed in January 2023 – this is to be achieved by the Ambulance Care Team (NEPTS CCC) moving upstairs to create some additional space. In terms of the North CCC, a plan has been submitted for consideration at the Estates SOP. In addition, the ADO Integrated Care has been part of a broader discussion as

Risk ID 244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	Date of Review:	03/05/2022	TREND	16 (4x4)
		Date of Next Review:	30/05/2022	➡	

IF the Trust is unable to increase accommodation capacity	THEN there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	RESULTING IN EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	3	4	12

			part of a T&F group. There are longer term plans to potentially move to more suitable and spacious accommodation in the North but there are technology requirements to enable the move away from the current Airwave equipment, which is projected to be affected at the end of 2023.
2. Develop digital solutions for remote supervision and clinical support to maximise virtual network of CCC reducing capacity required in existing sites.	EMS CCC Area Manager	12.07.22 Complete	Remote supervision implemented 12.07.22. Action Complete.
3. Option appraisal required to review options for increasing CCC capacity. This should be aligned to the HIW review recommendation for the North CCC estates strategy and expanding this to support the pan-Wales estates position.	Assistant Director – Capital & Estates	31.12.22 – Checkpoint Date	Task and Finish group appointed into Estates to complete this work. Checkpoint later in Q3 2022-23.
4. Based on modelling data under D&C review explore any efficiencies that can be gained in CCC estates through revised dispatch models maximising use of digital technology	CCC SE Manager	30.06.22 Checkpoint Date	Checkpoint review complete. Project change is being developed and revised action/date to be added.

Risk ID 245	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	Date of Review:	03/05/2022	TREND	16 (4x4)
		Date of Next Review:	26/05/2022	➡	

IF	THEN	RESULTING IN
CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident	there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities	potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)

	Likelihood	Consequence	Score
Inherent	3	5	15
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers: 1, 5, 9

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Trust Business Continuity Procedure and Incident Response Plan	1. Debrief from significant business continuity incidents which are put into organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. This is currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
2. National EMS CCC Business Continuity Plan (reviewed in March 2021)	2. Business Continuity Plan is up to date and has been reviewed and is currently waiting sign off. Business continuity exercise undertaken on 9.03.22.
3. Clinical remote working arrangements	3. SOP in place with respect to Clinical Remote Working – this is being reviewed at present moment
4. Single instance CAD allowing virtualisation which enables staff to work anywhere	4. CAD alerts if there are systems issues
5. ITK (Interoperability Toolkit) technology in place which provides connectivity with other UK ambulance Trusts. This is used on a daily basis	5. Monitoring undertaken locally at least weekly
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• If CAD is not functional then any impact of current controls would be negated by need to move physical staff	• Business continuity plan requires increased duties for existing staff as a result of lack of physical accommodation (link to risk 244)

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

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:	31/10/2022	TREND	16 (4x4)
		Date of Next Review:	30/11/2022	➡	

				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: 2, 12, 16, 18, 23, 24, 25, 26, 28,30, 34, 37, 38

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P 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 e.g. November 2021 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 on a monthly basis	**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.	Deputy Director of Finance	31.12.22	
1. 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	31.12.22	

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:	31/10/2022	TREND	15 (3x5)
		Date of Next Review:	30/11/2022		

				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

IMTP Deliverable Numbers: 7,8,9,10,12, 16,18,21,23, 24,25, 26, 38

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

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.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	External **Independent Assurance** 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

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:	31/10/2022	TREND	15 (3x5)
		Date of Next Review:	30/11/2022		

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Not all information security procedures are documented	1. No regular Cyber/Info Security KPIs are reported to senior management committees
2. Lack of understanding and compliance with policy and procedures by all staff members	*2.* Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly
3. No organisational information security management system in place	
4. IT Disaster Recovery Plan does not include a cyber response	
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	31.12.22	Draft KPIs have been agreed and produced for quarterly reporting. Q1 and Q2 are currently being reviewed within ICT prior to wider circulation .
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 - Ongoing	Exercise reports being drafted
5.Formalise Cyber Incident Response Plan	Head of ICT	31.12.22 – Checkpoint Date	Ongoing
6.Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	31.12.22 – Checkpoint Date	Ongoing

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	31/10/2022	TREND	15 (3x5)
		Date of Next Review:	30/11/2022		

				Likelihood	Consequence	Score
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	**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

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.
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.
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 • 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 Checkpoint date	
2. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 Checkpoint date	
3. Cyber Essentials assessment to be completed	Head of ICT	31.12.22 Checkpoint date	

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:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

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

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 stakeholders 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. Health Boards are not sending Patient Safety Incidents that are National Reportable Incidents to the Delivery Unit (identified within a Delivery Unit audit)
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
3.	7. This is a new structure that has been established and is yet to be embedded and tested for assurance
Xx WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	
Xx Funding does not flow in a manner to balance demand with capacity (this is outside of WAST's control)	

	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	31.12.22 – Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23.
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	31.12.22 – Checkpoint Date	30.09.22 4 hour handover backstop agreed and -25% reduction in handover from October 2021 baseline.
3. Increased understanding of NEPTS by EASC	Director of Strategy Planning and Performance	31.12.22 – Checkpoint Date	30.09.22 "Focus on" session at May 2022 EASC and NCCU represented on Ambulance Care Programme Board.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	31.12.22 – Checkpoint Date	30.09.22 Meeting in place and meeting regularly.
5. Utilising the engagement framework to engage with the stakeholders	Director of Partnerships & Engagement AD Planning & Transformation	31.12.22 Checkpoint date	30.09.22 Significant engagement through roster review briefings.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

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: 3, 7, 17, 18, 19, 20, 27

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

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
11.	**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
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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	31.12.22 – Checkpoint Date	30.09.22 Significant engagement through roster review project.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022		

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

2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	31.12.22 – Checkpoint Date	30.09.22 Transition plan not funded, but +100 FTE agreed.
3. Engage with key stakeholders to reduce handover delays	CASC	31.12.22 – Checkpoint Date	30.09.22 Reduction commitments agreed, but trend is still upwards.
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	31.12.22 – Checkpoint Date	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100.
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	31.12.22 Checkpoint Date	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date.

Risk ID 311	Inability of the Estate to cope with the increase in FTES	Date of Review:	22/08/2022	TREND	12 (3x4)
		Date of Next Review:	21/11/2022	⬇	

IF the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed	**THEN** there is a risk that the Estate will not be able to cope with the increase in FTEs	**RESULTING IN** potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust

	Likelihood	Consequence	Score
Inherent	**4**	**4**	**16**
Current	**3**	**3**	**9**
Target	**2**	**3**	**6**

IMTP Deliverable Numbers: 1,3, 9, 10, 17, 18, 28, 30, 34

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Programme governance and reporting structures in place e.g. Estates SOP Delivery Group and EMS Operational Transformation Programme Board, Integrated Strategic Planning Group Technical subgroup	1. Highlight report goes to Estates SOP Delivery Group every other month, report to EMS Operational Transformation Programme Board every 6 weeks, Technical Group meet monthly and there is an agenda, minutes and an action log
2. "Mega" spreadsheet combining all information into total cumulative impact on estate (and fleet) held by Assistant Director, Commissioning and Performance	2. Information is sense checked by AD Commissioning and Performance and reviewed by Integrated Technical Planning Group
3. Programme risk register sits with EMS Programme Board.	3. On agenda of meetings of Board
4. Risk logs held with respect to delivery of aspects of the project	4. Regional meetings are held regularly, and projects are discussed
5. Project Manager in place (for delivery of the solutions identified)	5. This resource is allocated to projects
6. Interim estates solution project	6. Regional meetings are held regularly, and projects are discussed
7. Finance and Corporate Resources directorate delivery plan	7. Reports go every 6 weeks to the Strategic Transformation Board
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. NEPTS D&C Review – Ambulance Care Programme Board	**1.** Information is received in an ad hoc and fragmented manner as opposed to a regular method from Operations
2. NEPTS Covid recovery planning	
3. Finance may be a constraint to delivery of solutions when problem is identified	

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
2. NEPTS and EMS – confirmation required from Operations functions about current and future numbers	Senior Management within Operations, Workforce & OD, Strategy Planning & Performance	31.12.22 – Checkpoint Date	
TBC			

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

IF	THEN	RESULTING IN
resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	there is a risk that there is insufficient capacity to deliver the IMTP	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	3	4	12
Target	1	4	4

IMTP Deliverable Numbers: 5,9,10, 17, 28

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

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
	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. Head of Transformation vacancy	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	31.03.23 – Checkpoint Date	
3. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant Director, Commissioning & Performance	Extended from 30.09.22 – To 31.03.23 Checkpoint Date	Reviewed action and extended checkpoint date. Work ongoing.

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

IF	THEN	RESULTING IN
resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	there is a risk that there is insufficient capacity to deliver the IMTP	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	3	4	12
Target	1	4	4

4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Deputy Director of Finance	31.12.22	

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service

23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation
26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

AGENDA ITEM No	7
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – November 2022

MEETING	Finance & Performance Committee
DATE	16th January 2023
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning and Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance Melanie O'Connor – Commissioning & Performance Officer
CONTACT	Hugh.bennett2@wales.nhs.uk Melanie.O'Connor@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **November & December 2022** (with the exception of Sickness where November 2022 is reported).

This Report contains information on 24 key indicators. The indicators used at this high-level show, in many areas, a continued poor picture in terms of the quality and safety of the service that the Trust can provide to patients.

RECOMMENDATION

Finance & Performance Committee is asked to: -

- **Consider** the November & December 2022 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
16 Jan-23	Finance & 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 & December 2022.**

BACKGROUND

2. This Integrated Quality & Performance Report contains information on 24 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 a 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 our plans (IMTP) and strategies. This annual review is complete and was endorsed at the July 2022 Finance & Performance Committee and Trust Board meetings; some final amendments are still required in the next iteration.

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 answering times have been challenged through significant increases in call demand. The median and 65th percentile performance remain good; however, the call answering tail increased in November 2022 to 1 minutes 11 seconds, which is higher than the Trust would want. An Intelligent Routing Platform (IRP) was switched on in November 2022. The IRP enables BT to re-route 999 calls between different ambulance services in the UK. These re-routed 999 calls accounted for up to 9% of the Trust's daily 999 demand. This percentage continued to increase during December and on the 21 December 2022 it was suspended, with a clear uplift in the Trust's performance as a result.

7. No additional funding was secured into 2022/23 for 999 call handlers (relief gap 39 FTEs). Forecasting and modelling has been completed and fed into the EMS Co-ordination Reconfiguration project with a re-rostering project on target for completion by March 2023, although this may now be delayed by maximum

escalation in December 2022. The roster review is proceeding without the funding for the relief gap in call handlers.

8. 111 call answering performance remains poorer than the Trust would want. Negotiations with commissioners earlier in the year suggested that the Trust has broadly the right number of commissioned and funded call handlers in post, however, there has been a recent agreement to uplift numbers by 10 WTE and work is ongoing to recruit these additional staff. Further work is required to reduce capacity lost through sickness absence, aligning capacity with demand and improving efficient of use of resource. A peer review of the 111 service has just been completed, which the Trust is currently considering; a key area of focus is likely to be re-rostering and moving to fixed roster patterns. A project initiation document is currently being developed for the potentail re-rostering project.

9. **111 Clinical response:** whilst the Trust continues to see achievement of the clinical call back times for the highest priority 111 calls, and improvements have been made in the last three month for other priorities, there is still much to do. Recruitment and retention of clinicians remains a priority, with significant numbers of clinical vacancies currently. An urgent set of actions within a focused plan are now in place to increase clinician numbers. This includes introduction of a new base for staff within the Cardiff area, a more focussed recruitment campaign and consideration of expanded numbers of clinical professions. The commissioned number of clinicians for 111 is 140 FTEs i.e. the funded establishment, but the modelled need is higher at 168 FTEs (based on a 40% Clinical Advice Line – CAL – rate from call handlers). The modelled need will be below the recent spike in 111 call volumes.

10. **Ambulance Response** (safety / patient experience): Red response times remained below 50% in December 2022 (39.5%). Amber response also declined in performance across the percentiles; with, Amber 1 waiting times remaining far too long, for example, the 95th percentile was fifteen hours 45 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 has received an additional £3m (payment on results) in 2022/23 which will allow the Trust to recruit 100 FTEs over and above the existing establishment. The Trust is on target to deliver this uplift in quarter four, but not for the 23 January 2023 milestone date due to higher levels of attrition as identified in this report. However, even when this increased number of staff is in place, there will remain a relief gap of 64 FTEs against the new rosters, which includes the Cymru High Acuity Response Units (CHARUs).

- Additional Unscheduled Care Service (UCS) Capacity: the Trust has received additional funding for third party capacity that it can procure for the UCS. Four vehicles a day, seven days a week have been secured with funding through to the end of the financial year.

Efficiency (rosters, abstractions/sickness absence and post production lost hours):

- The Ambulance Response roster review completed its go live in November 2022. This has been a complex large-scale project involving 1,800 staff, 146 rosters, and 60 working parties. This will have had the equivalent performance impact of +72 FTEs. A project evaluation is planned for quarter four.

- A Managing Attendance Programme has been agreed with EMT, which includes seven work-streams. This is now live and being reported to EMT every two weeks. The aim is to reduce sickness absence in line with a trajectory included in the IMTP (8% by March 2023). Whilst there have been some spikes, there is a clear downward trend, with particular improvements noticeable in long term sickness.

- Discussions with trade union partners on a range of other potential workforce efficiencies; however, dialogue between the Trust and TU partners on options for change has paused due to the level of work required to manage industrial action.

Demand Management

- The Trust has prioritised 41 additional clinicians into the Clinical Support Desk, with 36 Paramedic FTEs and five mental health practitioners successfully recruited and now in place. As well as improving the safety of the calls that are waiting, this investment will also mean an increase in consult and close rates, with the Trust now aiming to achieve a 15% rate by December 2022, an increase in the previous target of 10.2% which has been delivered. The Trust achieved 12.5% in November 2022; however, early indications are that the December performance is close to the 15% benchmark. A possible reason the Trust not yet attaining the ambition of 15% is a reduction in lower acuity verified demand.

11. One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. 32,049 hours were lost in December 2022 which represents 37% of the total number of conveying resource hours produced for the month. The levels are so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss. Urgent and high-level discussions have taken place between the Trust, Health Board CEOs and the CEO of NHS Wales. A number of mitigating actions have been agreed and a target of no >4 hour waits and a reduction of 25% in minutes per ambulance arrival (from Oct. 21 baseline). Whilst this is a target and trajectories are in place, improvements have not yet been seen and the position has actually significantly worsened. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus. Immediate Release figures for November were: Red 263 accepted and 44 declined; and Amber 1 193 accepted and 329 declined.

12. **Ambulance Care (formally NEPTS) (Patient Experience)**: performance remains above target for enhanced renal patient arrivals prior to appointment in December 2022 and improved for patients requiring discharge. Overall demand for the service continues to increase, although it has not yet recovered to pre CoVID-19 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).

13. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported two NRIs to the Delivery Unit in November 2022, compared to eight in October 2022; and seven serious patient safety incidents were referred to health boards in November 2022 under the "Appendix B" arrangement, decreasing from the previous month of October 2022. It should be noted that the relatively small numbers may represent a delay in referral across rather than an actual drop in numbers of serious cases. In November 2022 complaint response times decreased to 24%, failing to meet the 75% target. In the main, many of these incidents will be because of continued longer response times and the actions outlined above therefore are key. The Trust is putting more capacity into the Putting Things Right team.

14. **Clinical outcomes**: the Trust is unable to fully report on the performance of all clinical indicators whilst work continues to link ePCR with the CAD and quality assure metrics. The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 80.10% in November 2022**,** below the 95% performance target. The introduction of ePCR enables the collection and sharing of information and data in a more timely and accurate manner. This will enable the Trust to better showcase clinical care provided to patients. Work is ongoing on the new call to door time-based metrics for STEMI and Stroke using the following roll out plan:

    - Q3 (Oct – Dec 2022) – a decision will be made on the criteria to define 'call to door' and a reporting dashboard will be developed.
    - Q4 (Jan – Mar 2023) – the data will be tested internally to include data from April 2022.
    - April 2023 – approve for ASI reporting.

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

15. **Hours Produced**: 112,225 Ambulance Response ambulance unit hours were produced in December 2022. The emergency ambulance unit hours production (UHP) was 91% in December 2022 and CHARU UHP increased from the previous month of 55% (note: the CHARU service was coming on stream in November, so this UHP figure needs to be treated with caution; December's CHARU UHP was 79%). Key to the hours produced are roster abstractions which remain high and completing the planned recruitment into the CHARUs and the 100 FTEs. It is important to note that the Trust is not fully funded on the CHARUs.

16. **Response Abstractions:** Abstraction levels remained at 40% in November 2022, but are significantly improved from the high in March 2022 of 49%, however, they remain much higher than the 30% benchmark. COVID-19 has had a significant impact on abstractions with sickness abstractions being 9% in November 2022 (benchmark 5.99%). The training abstraction is also high, driven by internal movements linked to recruitment (more than 6% currently).

17. **Trust sickness absence:** the Trust's overall sickness percentage was 8.77% in November 2022 which represents an improvement. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level. A specific Managing Attendance programme has been established, led by the Deputy

Director of WOD, to identify and implement actions across a range of areas to improve sickness absence and alternative duties.

18. **Staff training and PADRs:** Stat / Mand training compliance rates have been improving again achieving the 85% target. PADR levels are also improving steadily although remain below target.

Finance and Value

19. **Financial Balance**: the Trust has reported outturn performance for November 2022 with a surplus of £3,000, and a forecast to the year-end of breakeven. At present the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit for 2022/23.

20. **Post-production lost hours**: the efficient and effective use of the capacity that the Trust produces is a key indicator. This is measured within the EMS service by the calculation of post-production lost hours (PPLHs). The reasons for PPLHs are many and varied. The EMS Demand & Capacity Review identified that the Trust benchmarked favourably on all elements of PPLH other than return to base meal breaks. Dialogue between the Trust and TU partners on options for change has paused due to the significant work on industrial action.

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 12.5% in November 2022, compared to the benchmark of 10.2%, which was exceeded during 2021/22. The benchmark has been revised up to 15%, to be achieved by December 2022, but as above early indications are that performance in December is close to the ambition of 15%.

22. The Trust **conveyed** 34% of patients to emergency departments in November 2022. This figure needs to be treated with caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In December, over 11,612 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 2,650 callers. In the longer term, as the Trust knows, the system needs to transform if it is to become more sustainable. A formal programme to take forward "inverting the triangle" has been established. A bid was submitted to Welsh Government to start to increase numbers of APPs being trained; this was not successful, but the Trust has decided to proceed with the option of an additional 10 MSC places from September 2022 and a further eight later in the year. The Trust has also appointed a Head of Strategic Development to take forward the "inverting the triangle" work, with the appointee now having started in the role. The Trust has agreed with CHCs that it will undertake an 8–12-week public engagement in spring of next year. Prior to that, further work will be required to engage with stakeholders.

Summary

26. The indicators used at this high-level show, in many areas, a continued poor picture in terms of the quality and safety of the service that the Trust provides to its patients. Patient demand across the 111 and EMS services increased in November 2022, however, other factors such as the continuation of the CoVID-19 variants, levels of sickness (including CoVID-19 related absence) and extreme handover lost hours continue to impact on the Trust. EASC, WG and the 111 Programme Board have been very supportive of the Trust through the pandemic, investing in a range of mitigations; however, funding for further initiatives is currently limited and is expected to worsen significantly in 2023/24. For 111 and Ambulance Care (NEPTS) the Trust can look to take a range of actions to optimise the balance between patient demand and capacity; however, for EMS the Trust cannot take sufficient actions within its control to mitigate the impact of the extreme handover lost hours. As a result, all three committees have expressed serious concern about the impact of handover lost hours on patient safety and staff well-being. The Trust has received further funding (£3m) for +100 FTEs into EMS, which is welcome, but it remains critical to patient safety that handover lost hours are reduced in line with Ministerial expectation.

RECOMMENDATIONS

Finance & Performance Committee is asked to: -

- **Consider** the November & December 2022 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.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

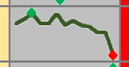
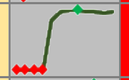
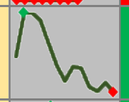
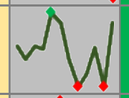
Welsh Ambulance Services
NHS Trust

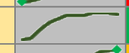
Monthly Integrated Quality & Performance Report

January 2023

Annex 1 – Top Indicator Dashboard

Section 1: Monthly Indicators / Top Indicators Dashboard

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Oct-22	Nov-22	Dec-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience							
NHS111 Abandoned Calls	< 5%	18.60%	14.8%	13.6%	-		R
999 Call Answer Times 95th Percentile	95% in 00:00:05	00:52	01:03	01:11	-		R
999 Red Response within 8 minutes	65%	55.2%	48.0%	48.0%	39.5%		R
999 Amber 1 Median	00:18	01:10	01:42	01:34	03:30		R
Stroke Patients with Appropriate Care	95%	TBD	78.20%	80.20%	-		R
Acute Coronary Syndrome Patients with Appropriate Care	95%	TBD	37.50%	42.30%	-		R
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	79%	74%	75%	74%		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	81.00%	85%	90%	-		G
National Reportable Incidents reports (NRI)	Reduction Trend	5	8	2	-		G
Concerns Response within 30 Days	75%	61%	28%	24%	-		R

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Oct-22	Nov-22	Dec-22	2 Year Trend	RAG
Our People							
Capacity							
EMS Abstraction Rate	29.92%	42.00%	40%	40%	-		R
Hours Produced for Emergency Ambulances	95%	95.0%	90%	92%	-		A
Health and Wellbeing							
Sickness Absence *(all staff)*	8.00%	10.48%	9.48%	8.77%	-		R
EMS Operations Sickness Rates	8.00%	7.76%	10.12%	9.45%	-		R
Staff Turnover Rate	TBD	8.71%	11.11%	10.70%	-		R
Statutory & Mandatory Training	>85%	82.3%	85.58%	85.40%	-		G
PADR/Medical Appraisal	>85%	60%	80.49%	80.75%	-		A
Value							
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	100.00%	-		G
Post-Production Lost Hours (EA, RRV, UCS)	Reduction Trend	TBD	9382	9224	-		A
Partnerships / System Contribution							
NHS111 Consult and Close	Improve	7,843	17,695	15,362	-		G
Combined 999 & NHS111 Consult & Close	15.0%	10.4%	12.8%	12.5%	-		A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Improvement Trend	TBD	10.65%	11.04%	-		TBD
Number of Handover Lost Hours	25% reduction from Oct-21 position	15,955	28,038	25,020	32,049		R

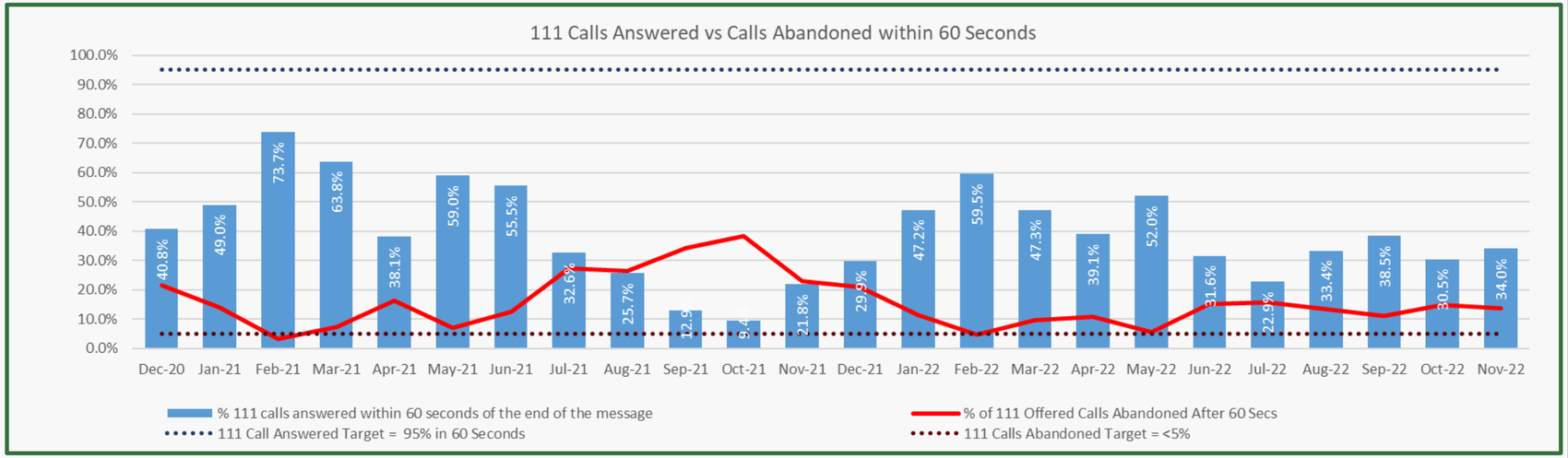
In-Month RAG Indicates =
Green: Performance is at or has exceeded the target *(Indicates no action is required)*
Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)
Amber: Performance is at or within 10% of target *(Indicates some issues/risks to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

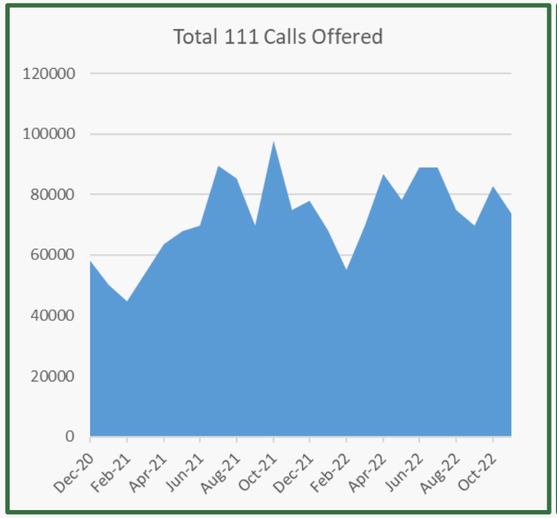
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

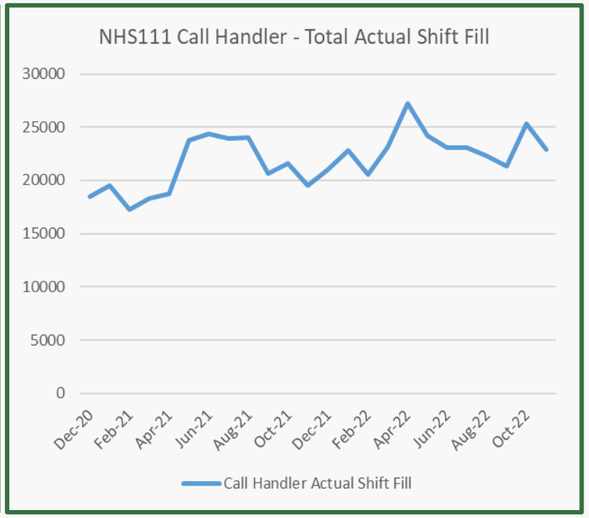
R

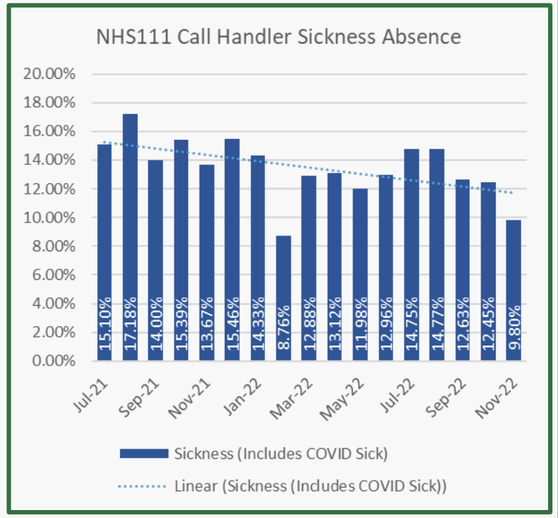
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

111 call abandonment is a key patient safety indicator for the service**. November 2022** saw an abandonment rate of 16.6%, therefore failing to meet the 5% target.

The percentage of 111 calls answered within 60 seconds of the end of the message increased in November 2022 to 34%. 111 call demand decreased when compared to October 2022, however higher volumes of patients continue to receive a poor patient experience. December data is unavailable due to Qliksense issues.

Capacity (staff hours) has generally been increasing in line with the roll-outs and as planned, however a slightly lower level of shift fill was seen in November. This does continue to be impacted on however by sickness which was at 9.80% in November. Demand increased in November but so has capacity which is why performance has remained relatively stable this month. It is worth noting that in response to the ongoing Business Continuity incident as a result of the Adastra outage, additional Call Handlers have been necessary to support manual processes as the Trust is unable to pass calls to Health Boards electronically.

Remedial Plans and Actions (No update received)

- 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 had been reached with commissioners that 178 WTE call handlers will be funded this year. We are currently broadly at that number, and further recruitment is planned to meet anticipated attrition levels to maintain levels at the funded WTE figure. Recently, approval has been given to recruit an additional 10 WTE to take it to 188.
- Work continues with sickness absence in line with the Trust's managing absence work programme to increase capacity.
- Work is underway to look at the rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week and at weekends. Consideration is being given to how this programme of work could be resourced.
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore the time spent is related to clinician availability. At present there are high levels of clinical vacancies. Further detail in next sheet

Expected Performance Trajectory(No update received)

With call handler numbers broadly at commissioned levels, call answering times will only be improved through improved efficiency gains (reducing sickness absence, re-rostering, reducing time for CAL line). This work is underway but will take some time to come to fruition.

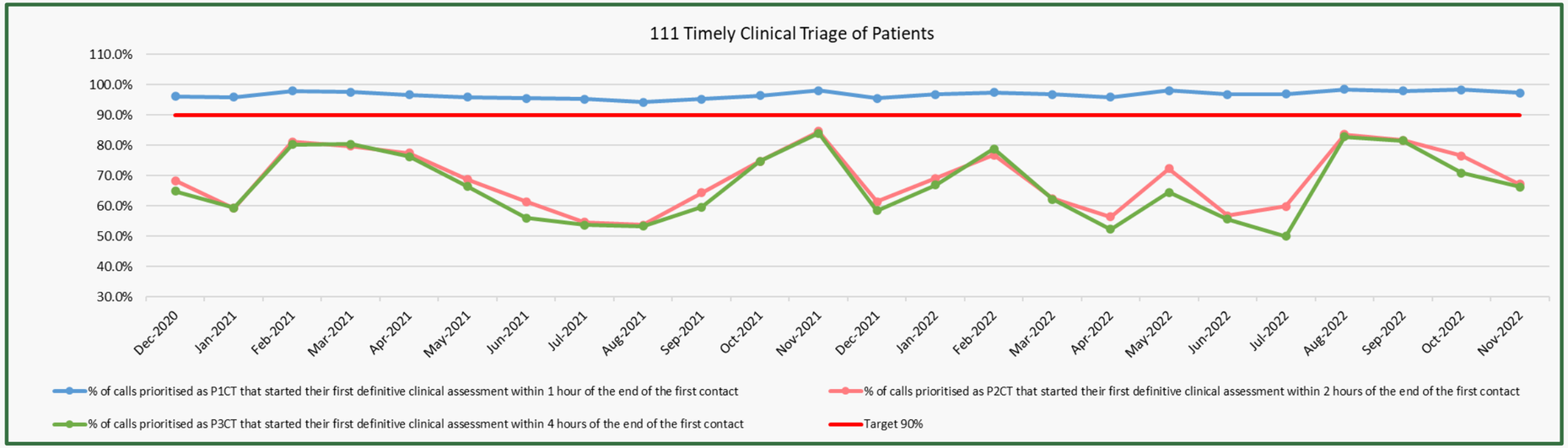
NB: December data is unavailable due to Qliksense issues.

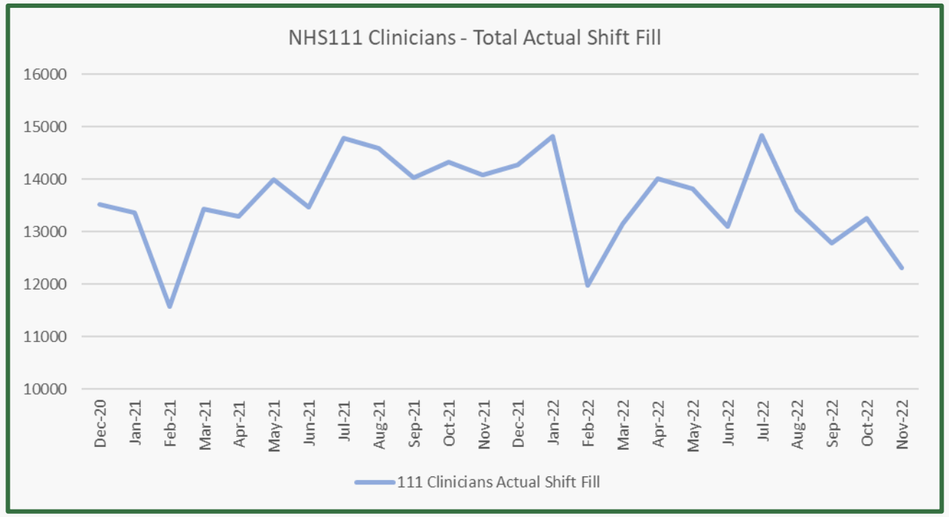
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

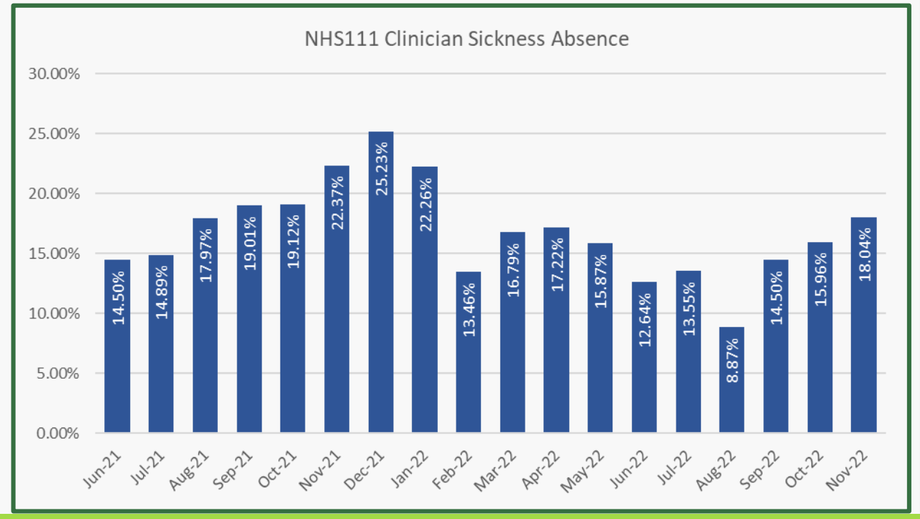
P1CT G

FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

The performance of **111 calls receiving a timely response to start their definitive clinical assessment has seen improvements across the priorities. The highest priority calls, P1CT, continue to receive a timely response** which has continuously achieved the 90% target over the last 2 years.

For lower category calls the Trust is not meeting the 90% target, but there has been a significant improvement in performance in recent months Demand for the service has grown significantly as service has been rolled out, and there was an increase in demand in November above that seen in October.

Recruitment and retention of clinical staff is the key issue .

12,311 hours were filled by clinicians in November 2022 a decrease when compared to 13,260 in October 2022. Clinician sickness absence increased from 15.96% in October to 18.04 % in November. At present there are 100.1 (FTE) nurses and paramedics employed within NHS111 and 39.1 FTE Vacancies *(data correct as of 16/09/22 and therefore subject to change).*

Remedial Plans and Actions (No update received)

The main driver of improved performance will be the correct number of clinicians in post to manage current and expected demand. At present there are significant numbers of clinical vacancies. Urgent actions are in place now to increase recruitment this winter, including:

- Utilisation of other clinicians to fill vacancies
- Maximising opportunities through remote / agile working
- Review of existing staff bases including agreement to creating an additional Cardiff base, operational from mid December
- Review of service model following Adastra outage / BCI
- Targeted recruitment drive, which has commenced

Expected Performance Trajectory (No update received)

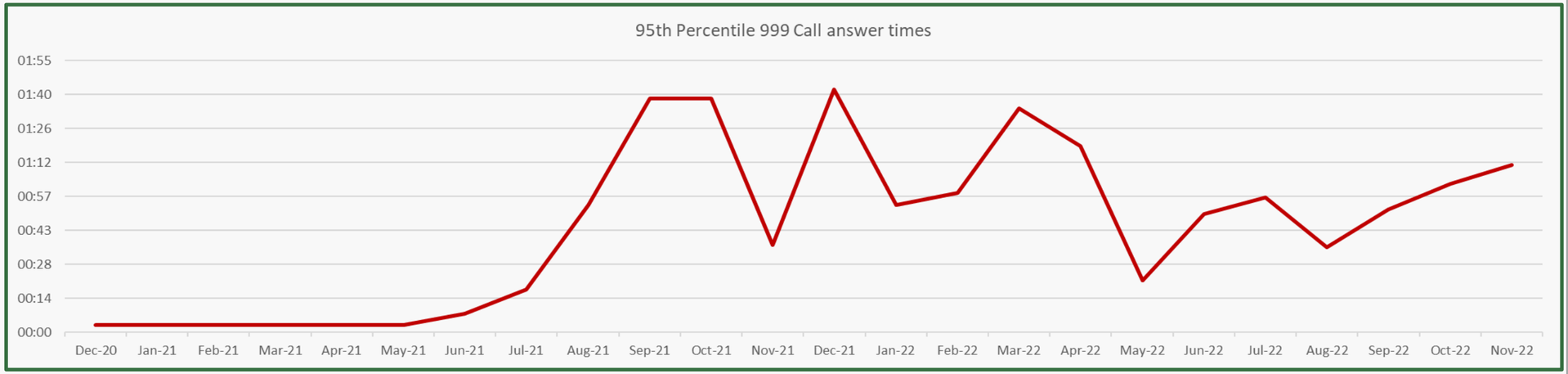
Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Although urgent actions are in play as set out above, performance is likely to be below levels expected until these bear fruit into Q4. Demand for the 111 service is also more difficult to forecast as it is often linked to government announcements or media coverage.

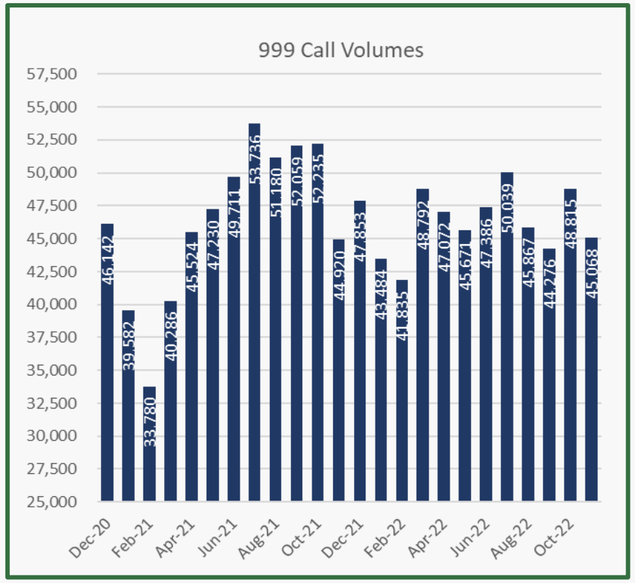
NB: December data is not yet available due to reporting dates

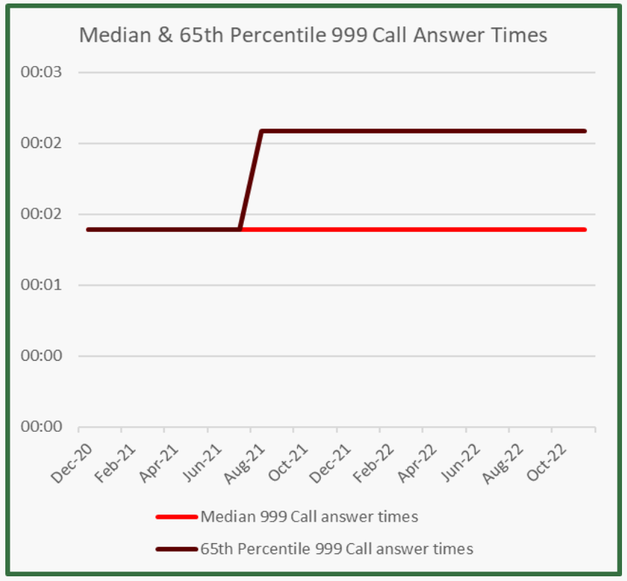
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

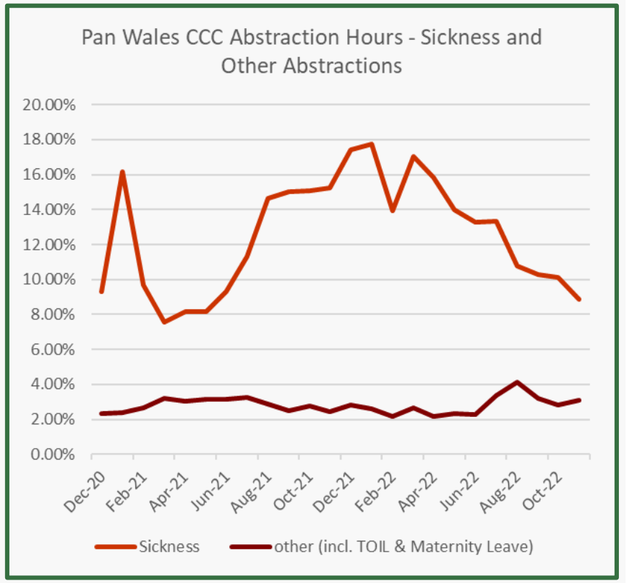
Influencing Factors – Demand and Hours Produced

R FPC CI









Analysis

The 95th percentile 999 call answering performance increased in November 2022 to 1 minute 11 seconds, compared to 1 minute 3 seconds in October 2022. Delays in call answering times are a significant concern in relation to patient safety. 83.5% of calls were answered within 6 seconds in November 2022.

The median call answer times for 999 services remains consistently at 2 seconds. In November 2022 65th percentile continued to average at 3 seconds.

The Trust received 45,068 emergency 999 calls in November 2022, an decrease compared to October 2022. November 2022 saw a reduction in sickness abstractions, in line with the planned trajectory.

A continuing higher level of call volumes could be as a result of repeat callers, as a direct result of long wait times, prompting people to call back or conditions to deteriorate.

Remedial Plans and Actions (No update received)

- EMS CCC meet twice weekly to review demand profiles and align staffing levels appropriately. Resources teams are focussing on balancing capacity across the 7-day period, targeting overtime to weekends and Mondays where patterns of demand and reduced UHP are identified.
- No additional funding is available this year to increase numbers of call handlers.
- Increased pressure and sustained levels of 999 demand above baseline is impacting on staff attrition and wellbeing.

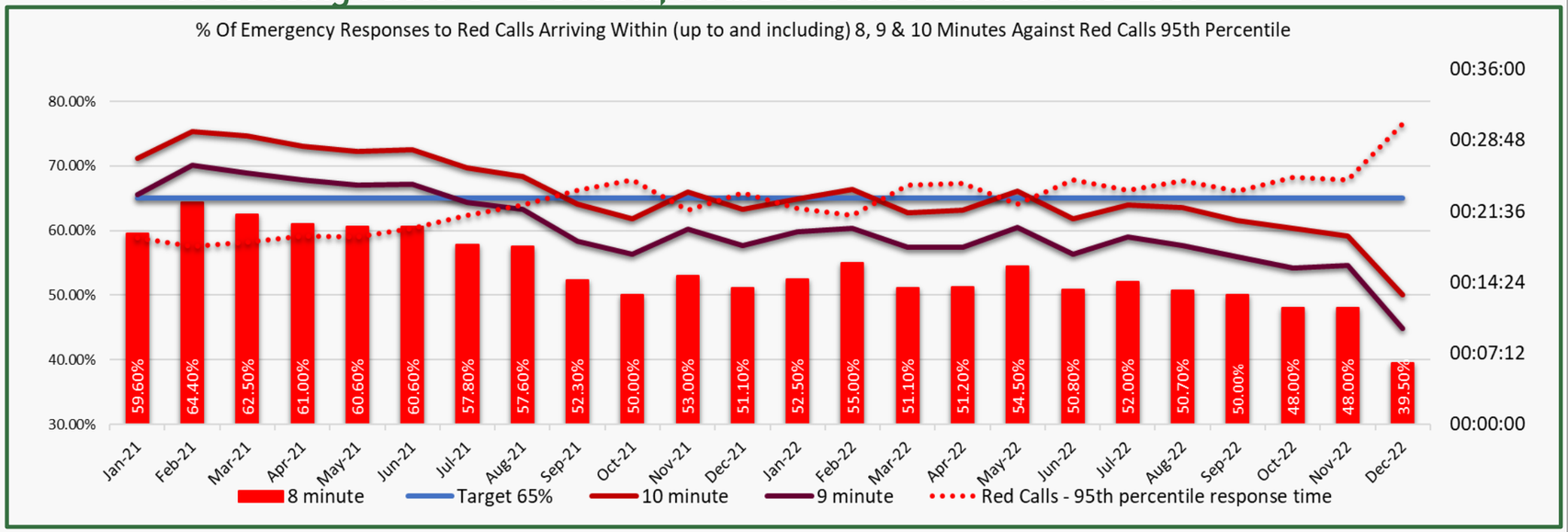
Expected Performance Trajectory (No update received)
Performance is expected to continue to be difficult with call demand forecasted to increase throughout the fiscal year. EMS Coordination continue to focus on proactive recruitment to mitigate the impact of current attrition rates.
NB: December data is not yet available due to reporting dates

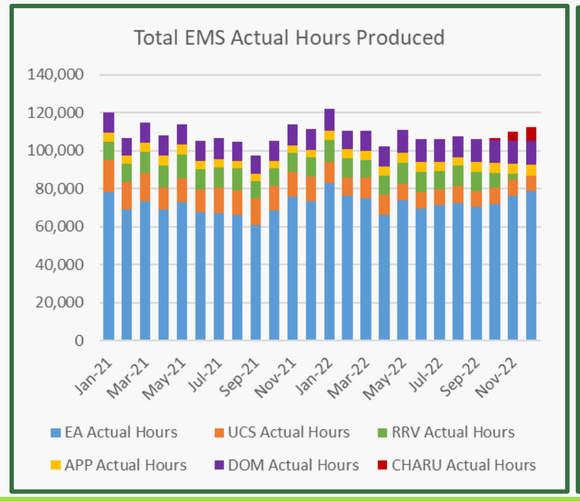
Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

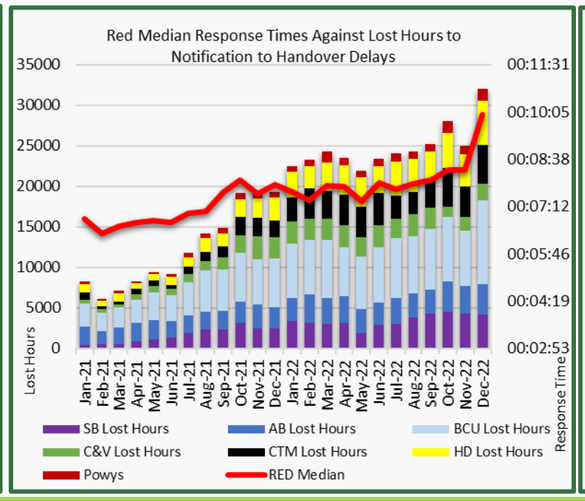
65% R | 95% R

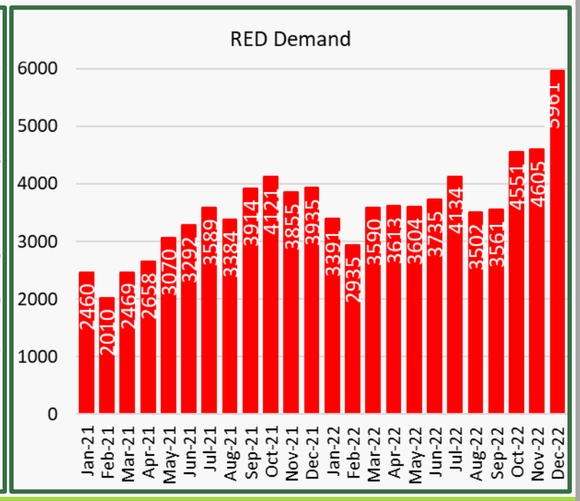
CI | QUEST | FPC

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Red performance decreased in December 2022; remaining significantly lower than the 65% target; the target has not been achieved since July 2020. There was also significant health board level variation with none of the seven health board areas achieving the 65% target. A continuing level of poor performance was forecast based on predictions of demand, lost hours and hours produced. Red 10-minute performance was 50.1% in December 2022.

Three of the main determinants of Red performance are Red demand, unit hours produced, and handover lost hours.

Red demand in the last 2 years has seen a particular increase, outside of normal expected variation which is impacting on response times. The change in DCR tables implemented in October has led to a further step up in demand as expected.

The lower centre graph demonstrates the correlation of performance with hospital handover lost hours, with extreme levels of losses continuing to be seen with 32,050 hours lost in December.

There are many other factors which affect Red, including additional time taken to don level 3 PPE to Red calls relating to some respiratory disease/issues (this requirement remains in place).

Remedial Plans and Actions

The main improvement actions are:

- Increase capacity where funded - recruitment of 100 FTEs, EMTs and ACA2s during 2022/23 (off target for all operational by end of Jan 2023, now end of February 2023);
- Reduce hours lost through sickness absence through managing attendance programme – trajectory for improvement in place as part of IMTP;
- Plans are in place and work continues with partners to reduce hours lost at hospital. Handover reduction plans and trajectories are currently being developed by health boards facilitated by the NCCU. Agreement on immediate release and fit to sit, together with commitment to no >4 hour waits and a reduction in 25% overall. These have not yet had any impact in most areas;
- Improving efficiency; the role out of new Response rosters, will provide the equivalent of 72 WTE additional staff (action complete);
- A clinical review of Red demand using ePCR data (underway);
- Tactical responses linked to escalation including: clinical managers responding, DOMs responding, targeted overtime on demand hot spots;
- Modelling of additional tactical resource required to achieve a higher level of Red performance; and
- Modelling of full roll out of Same Day Emergency Care (SDECs) by health boards..

Expected Performance Trajectory

Winter modelling (March 2023) indicates that without reductions in handover in line with the Welsh Government directives, the Trust can expect to see Red 8 minute performance reduce to below 40% without the application of the Clinical Safety Plan to levels 3 and above and the recruitment of the +100. This is what has started to happen in December.

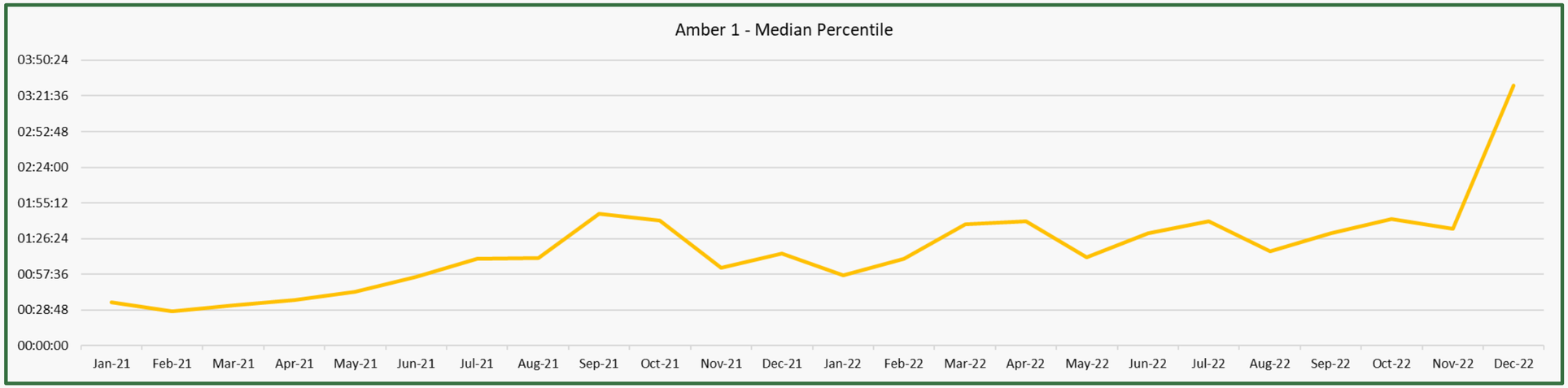
NB: Data correct at time of abstraction

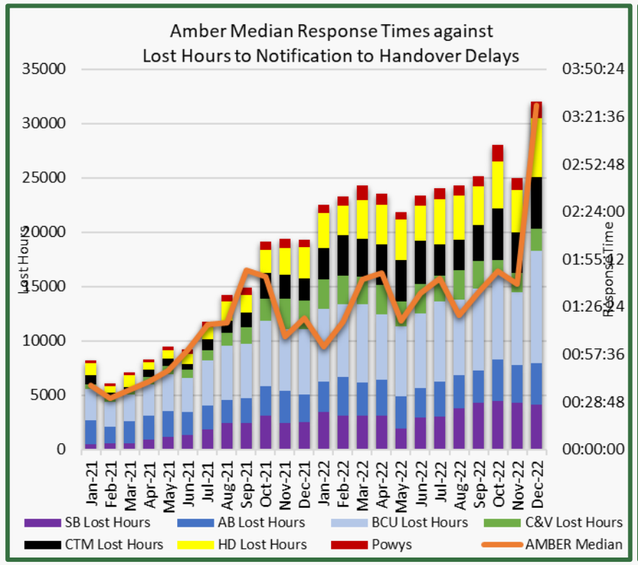
(Responsible Officer: Lee Brooks)

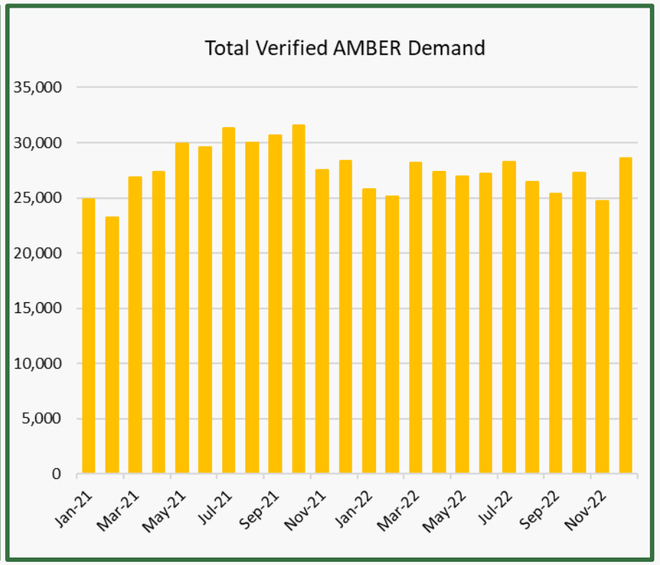
Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

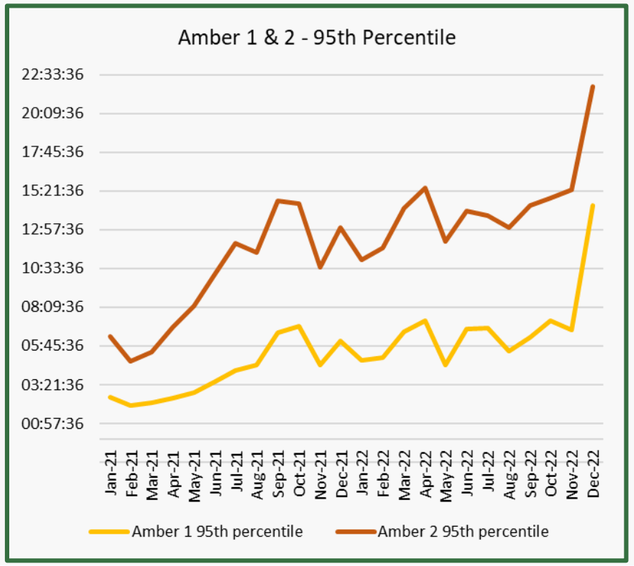
Influencing Factors – Demand, Hours Produced and Hours Lost

R CI FPC QUEST









Analysis

Amber response times declined across the percentiles in December 2022. In addition, there were some some very long patient waits in November (see below). The ideal Amber 1 median response time is 18 minutes, in December 2022 the Trust recorded median response times of 3 hours 30 minutes.

In November 2022, 800 patients (all categories, not just Amber) waited over 12 hours, a decrease when compared to October 2022, continuing to represent a very poor quality and experience of service. 702 of these patients were in the Amber category. Due to reporting dates, December data is not yet available.

Amber demand increased in December 2022 although has been broadly stable.

There is strong correlation between Amber performance and lost hours due to notification to handover delays. The number of hours lost to notification to handover delays in December 2022 were extreme at 32,050, going over 30,000 for the first time.

Remedial Plans and Actions

The Trust carefully monitors long response times and their impact on patient safety and outcomes. The Trust supplies regular information to the CASC and EASC; and from November 2020 the Trust began producing monthly quality, safety & patient experience (QSPE) reports for each health board. 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, efficiencies and system efficiencies, not all of which are within the Trust's control, and which are unlikely to show improvement in the coming months.

NB: December ***2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change.***

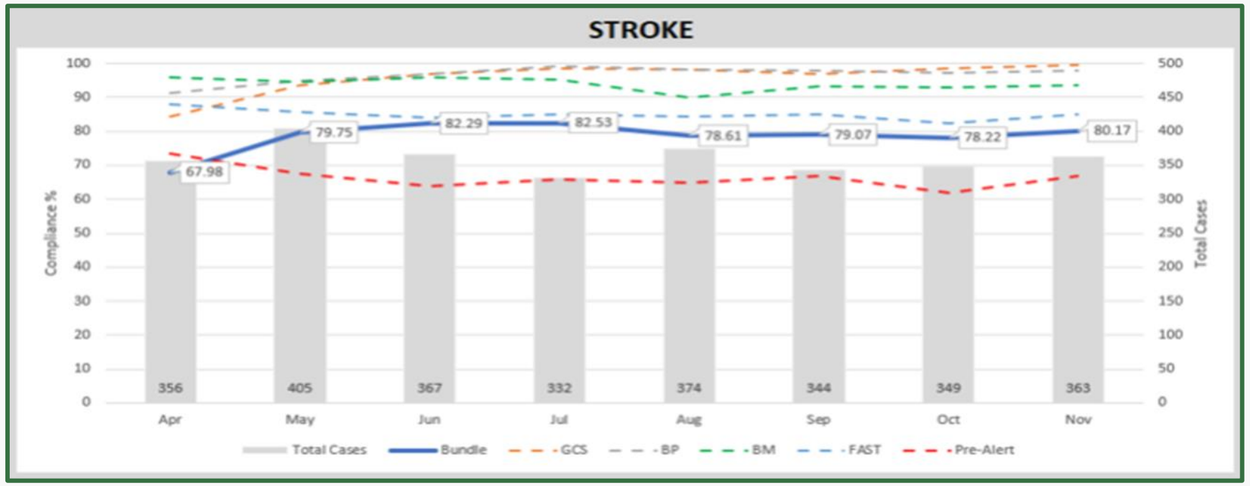
Our Patients: Quality, Safety & Patient Experience
Clinical Outcomes Indicators

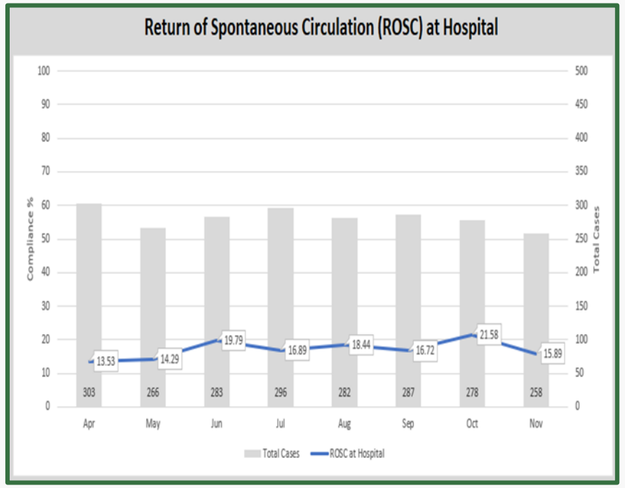
Stroke/Hip Fracture/Hypo glycaemic.
R

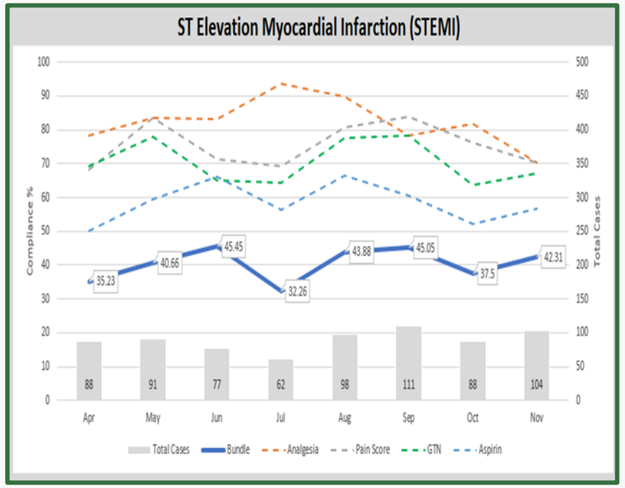
Self Assessment: Strength of Internal Control: Moderate

QUEST

Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, Acute Coronary Syndrome Patients with Appropriate Care







Analysis

Clinical: The Trust currently uses ePCR to report on five clinical indicators (CI) to the Emergency Ambulance Service Committee (EASC) , Fractured Neck of Femur (#NOF), Stroke, ST elevation Myocardial Infarction (STEMI), Hypoglycaemia and Return Of Spontaneous Circulation (ROSC at hospital). Work continues to develop, and quality assure metrics.

It is likely that as the system continues to embed within clinical practice, that users are still getting used to an adjusted workflow and data points might be missed. An improvement approach has been taken and a series of 'Top Tips' posters have been circulated and specifically shared with Senior Paramedics to support their conversations with WAST clinicians as part of the ride-out process. This is based on deep dive audits conducted for each of the CIs and reported through the Clinical Intelligence Assurance Group prior to approving publishing CI data as Ambulance Service Indicators to EASC. In addition, the deep dive audits are contributing to recommending improvements that can be made to the ePCR user interface to enable better data capture in future versions of the application.

Mortality Review: The Trust participates in Health Board led mortality reviews as appropriate, with attendance from the patient safety team and clinical colleagues. Work is currently underway to address a backlog of mortality reviews with oversight from the Clinical Quality Governance Group.

Following discussions this month with the Lead Medical Examiner Officer for Wales the expected timeline for the Medical Examiner Service to review all non-coronial deaths in Wales (including those occurring in community) is from Spring 2023.

Remedial Plans and Actions

Clinical: The introduction of ePCR enables the collection and sharing of information and data in a more timely and accurate manner. This will enable the Trust to better showcase clinical care provided to patients. The Clinical team are focussing on reporting of key clinical indicators and themes within reporting to ensure that good clinical practice is captured and reported.

New agreed indicators for this year (commissioning intention) include call to door time for STEMI and Stroke, and Reporting on Outcomes (by response type). There is a lot of work required to agree and then report on these indicators, with the following roll out plan:

Q3 (Oct – Dec 2022)

A decision will be made on the criteria to define 'call to door' and 'at hospital 'for the STEMI & Stroke time-based metrics and begin developing a reporting dashboard.

Establish initial requirements with the NCCU for Reporting on Outcomes (by response type).

Q4 (Jan – Mar 2023)

Finalise the time-based metrics dashboard and test the data internally to include data from April 2022.

Review potential data points for use as test data/discuss with NCCU

Test reporting with initial data points/discuss with NCCU

April 2023

Approve time-based metrics for ASI reporting

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. This commenced in October 2022 in some areas, but there have been some issues with recruitment into the funded CHARU roster lines and the Trust is only currently partially funded for CHARUs. An evaluation is expected in quarter four.

Mortality Review: The Trust's 'Learning from Mortality Reviews Framework' adopted from the All-Wales Mortality Framework was approved at the Clinical Quality Governance Group on 30 September 2022 and has been shared with the All-Wales Mortality Review Steering Group. The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach. Meeting dates for the All-Wales Mortality Working Group have been shared recently by the NHS Wales Delivery Unit, at which WAST are represented.

Expected Performance Trajectory

Clinical: As shown throughout the UK, the implementation of CHARUs will aid the Trust in successfully increasing ROSC rates. Once CHARU has been implemented it is anticipated that ROSC rates should increase.

Mortality Review: Whilst the multiple benefits of the ME process 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 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 PTR processes internally, however there is currently a backlog of ME cases on the Datix system which require addressing.

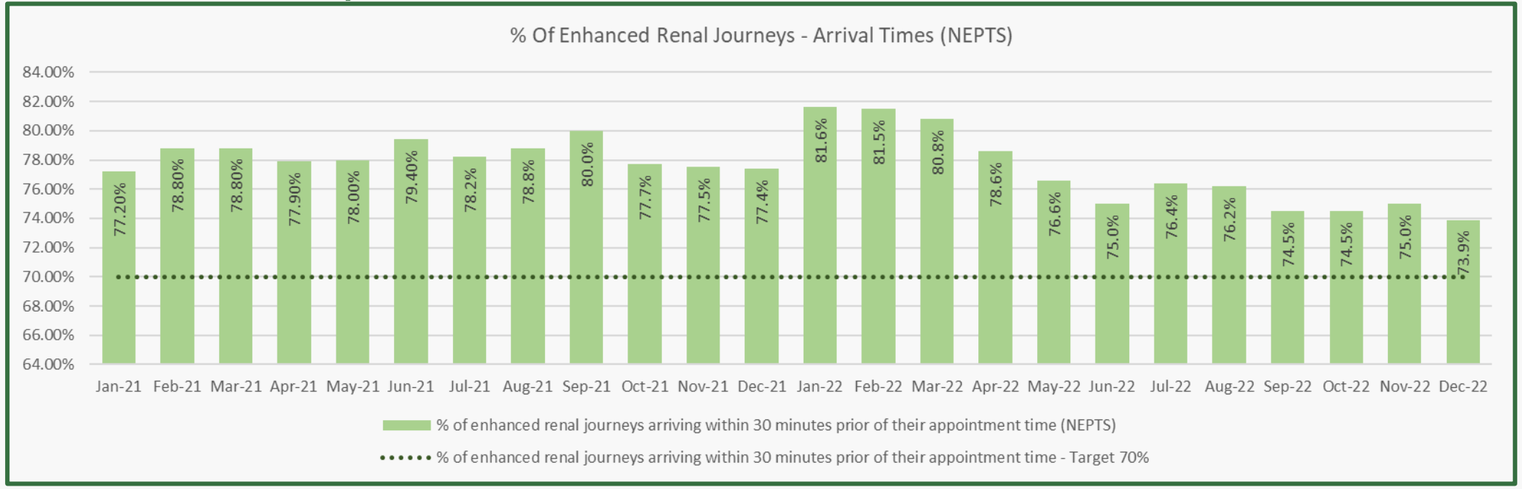
Mortality Reviews Data source: Internal Web Application

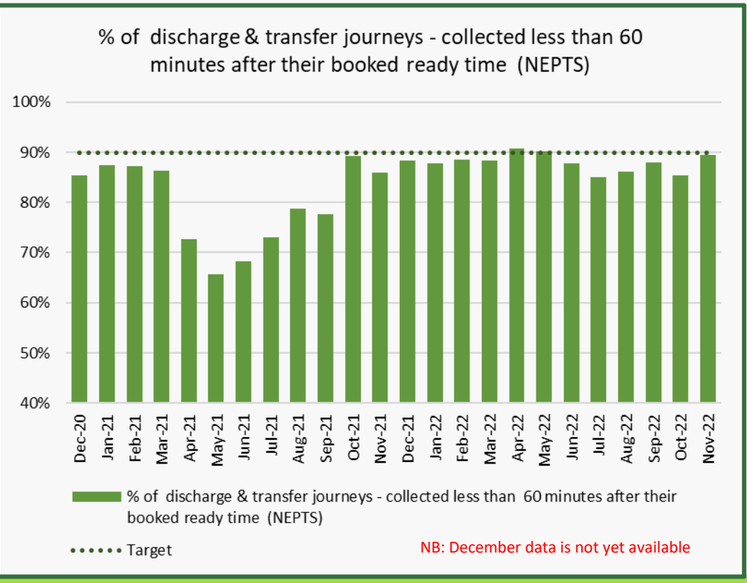
Our Patients: Quality, Safety & Patient Experience
Ambulance Care Indicators

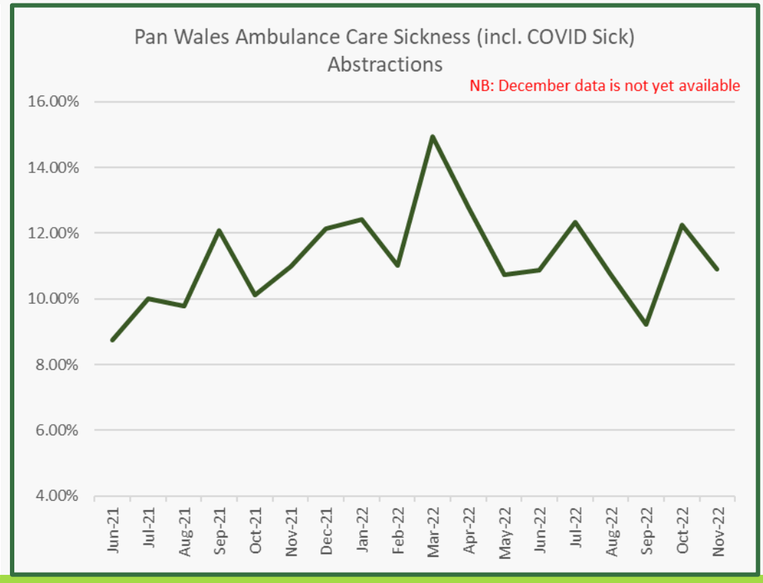
Renal	D&T
G	G

CI FPC

Patient Experience







Analysis

Ambulance Care (NEPTS element) is stable. 73.9% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target in December 2022.

89.5% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, therefore not achieving the 90% target, however an increase compared to October 2022 (85.3%).

Key factors affecting these indicators are demand and capacity:

- **Capacity** continues to be adversely affected by other factors such as sickness absence levels, however, this improved in November 2022 to 10.89%. Annual Leave returned to levels below the 20% cap at 11.34%.
- Overall demand has been increasing since the initial reduction at the beginning of the pandemic, but overall it is still not quite at pre-pandemic levels.
- As the Trust emerges out of pandemic response and the health system is "re-set" it is anticipated that further demand increases could be experienced at which point capacity may be an issue. This has been modelled and mitigations put in place.

Remedial Plans and Actions

- D&C Project: currently awaiting feedback from tests of change for revised roster keys. Once received, the draft PID will be completed. Aim was to deliver by Nov-22, but delayed linked to escalation levels.
- NEPTS Operational Improvement: Discharge Lounge trial restarted on 21st November. Work finalising the standardised guidance has temporarily stopped as the lead resource has been assisting Health Boards with online booking training in line with December deadline.
- Transfer and Discharge Project:
- Transfer and Discharge Service: work is in progress with regards to the modelling (ToR created and a proposal from supplier is being reviewed) and understanding the data in order to develop a concept for consideration by EASC by the end of the financial year.
- Transport Solutions: training of Health Boards for the online booking system is on track to be completed by December 2022, after which telephone bookings will no longer be accepted. A position paper on eligibility is being created and will be shared with NCCU and WG.
- NEPTS Plurality Model: majority of lots have been awarded, with a few exceptions; contracts due to commence on 01/12/22 and 16/01/23.

NEPTS CAD Upgrade: second penetration (PEN) test took place on 28th November and the go live is scheduled for second in week in January to address issues raised.

Expected Performance Trajectory

The Trust does not have the functionality to predict NEPTS performance in the same way that it has for EMS Response; however, NEPTS is not subject to seasonality in the way EMS is, so it is reasonable to think that performance should continue to be stable, subject to demand returning to pre-pandemic levels or some erosion of capacity. Ambulance Care (UCS) is not stable.

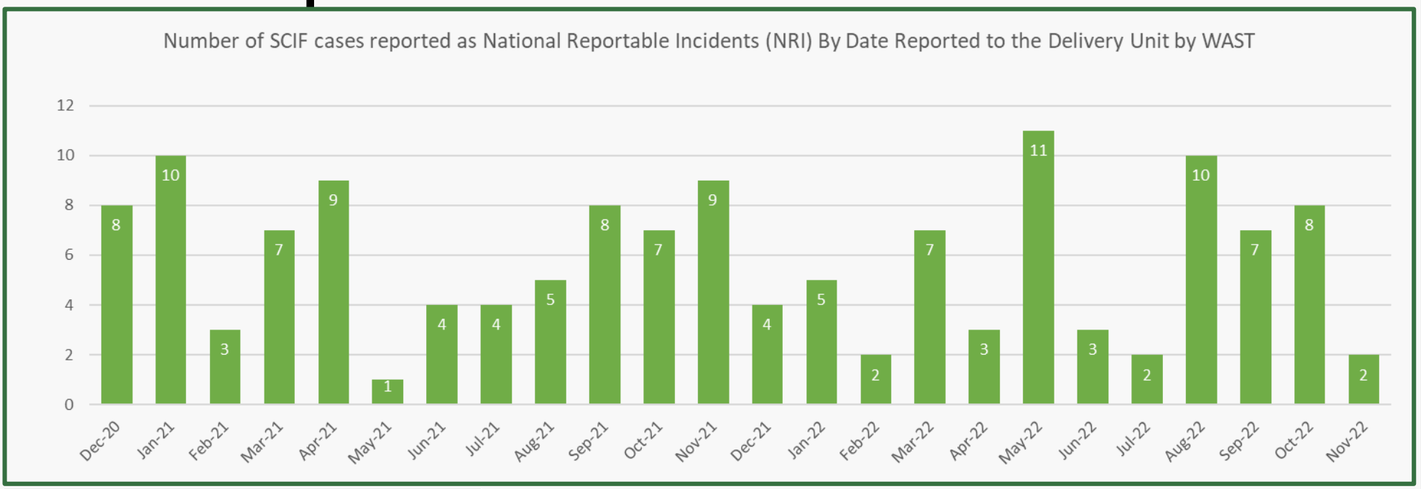
Our Patients: Quality, Safety & Patient Experience
Patient National Reportable Incidents & Patient Concerns Responses Indicators

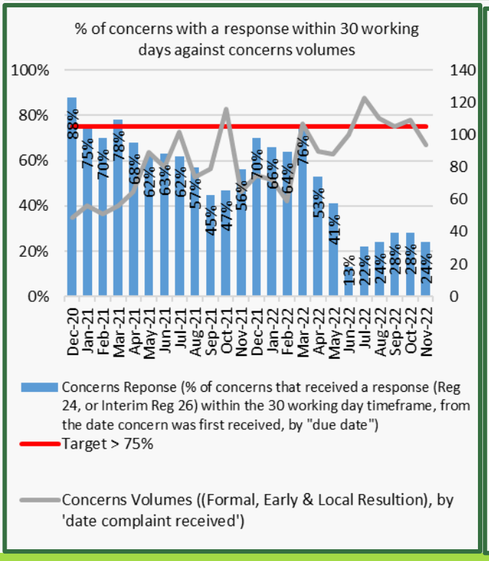
SCIF. A

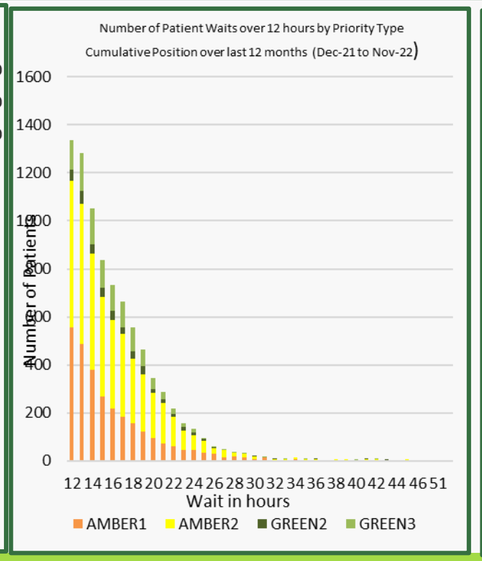
Self Assessment: Strength of Internal Control: Moderate

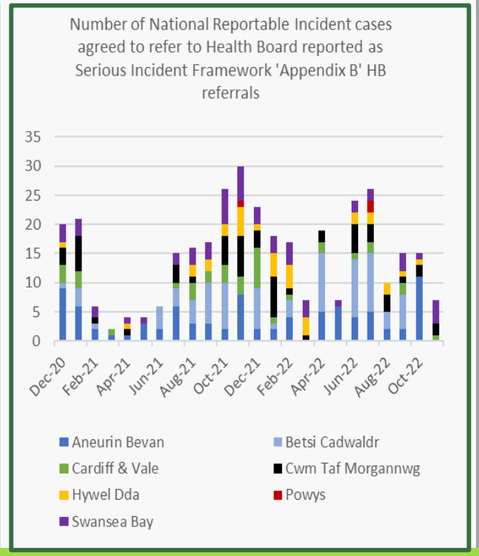
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

The percentage of responses to concerns remains static in November 2022 at 24% against a 75% target. 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 decreased slightly in November (94) when compared to October 2022 (109).

In November 2022 there were five Serious Case Incident Forums (SCIF), and 22 cases were discussed. 2 cases were reported to the NHS Wales Delivery Unit and seven cases were referred to Health Boards for investigation under the appendix b framework.

Themes relating to incidents reported to the NHS Wales Delivery Unit as Nationally Reportable Incidents (NRIs) include call categorisation and clinical aspects of care including misdiagnosis and subsequent management. The ineffective breathing descriptor remains a theme, as it does UK wide. Year on year the overall volumes of NRIs remains static with the same volume recorded in 2021-22 as 2020-21 (Nov-Dec). In November 2022 there were 0 NRIs relating to Red calls, 2 relating to Amber calls and 0 in relation to Green calls. There were 0 NRIs as a result of calls prioritised Amber which should have been Red.

As reported earlier, in November 2022, 800 patients waited over 12 hours for an ambulance response, an increase month on month, also an increase when compared to 417 in November 2021 and 331 in November 2020.

47 Compliments were received from patients and/or their families in November 2022, an increase compared to the previous month (39).

Remedial Plans and Actions

A range of actions are in place:-

- The general theme in relation to the Trust's concerns portfolio remains timeliness to respond. Additional resources for complaints handling administration has been agreed by the Executive Management Team. Recruitment and redeployment of staff is currently in progress.
- The Joint Investigation Framework pilot (to replace the appendix b process) has recently commenced with good engagement from system partners to date. Early feedback from health boards is there are some challenges regarding the 72-hour timeframe to arrange a meeting including all relevant system partners.
- Immediate improvement actions following the SCIF include education and training for individual staff, updates to operating procedures and circulation of bulletins to share learning and provide updates.
- Health care professionals (HCPs) diagnosing patients with life threatening conditions (Amber1) with protracted waits has been identified as a theme at the Serious Case Incident Forum (SCIF) also. In response a new HCP call task and finish group, led by the Assistant Director of Quality and Nursing is meeting currently to review the cases and determine any improvement actions.
- Health Board specific quality and safety reports are shared with each respective Health Board Directors of Nursing & Quality and regular meetings are held between the Trust and respective Health Boards on a monthly basis. The content of these reports is currently under review.

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.

NB: November 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change. At present reporting accurate data is not possible due to implementation of the Once For Wales Datix RL system.

****NB: Complex Cases will always report one month in arrears***

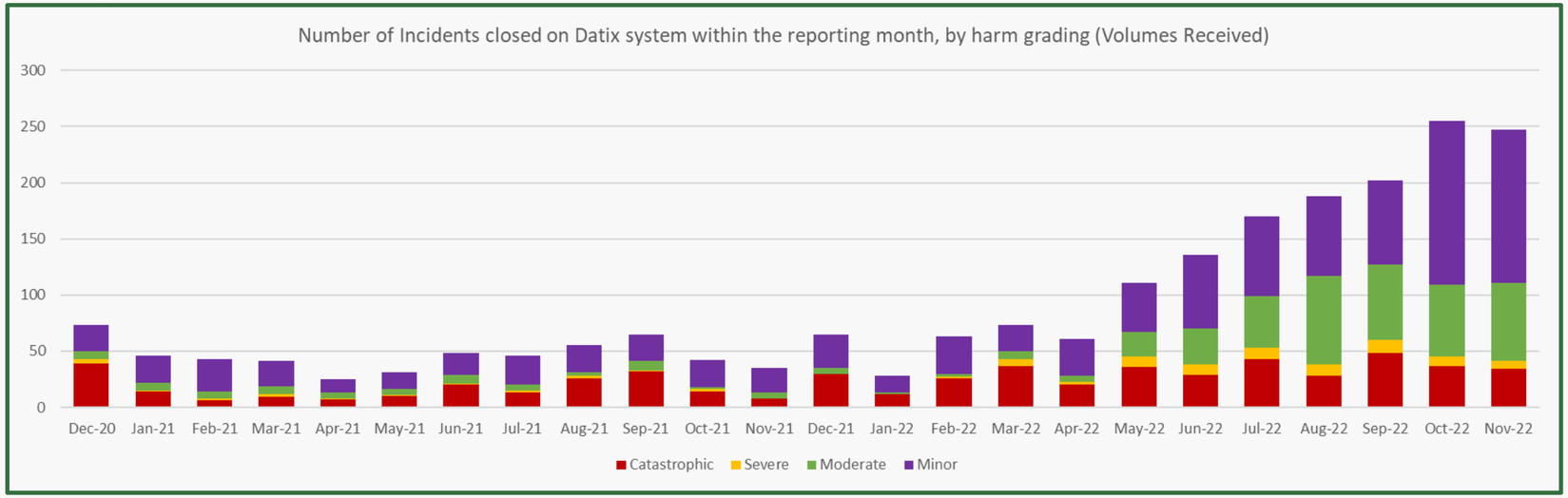
NRI & Concerns Data source: Datix / Longest Waits Data Source: Report Manager

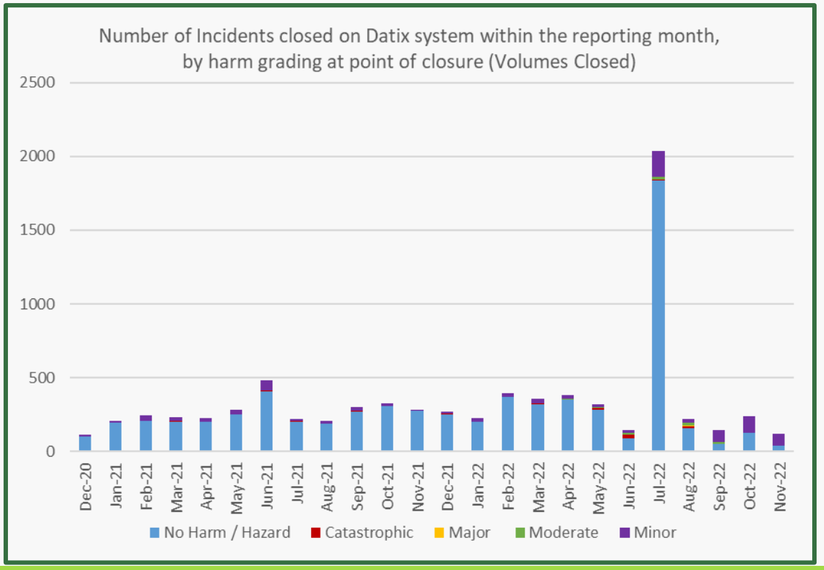
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

Self Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Slide under Development: Future iterations of the report will include: 12 Month Rolling Percentage RIDDOR Reported Within HSE Timescale

Analysis

The number of patient safety adverse incidents volumes submitted on Datix Cymru via frontline crews, health boards, the Operational Delivery Unit (ODU) and CCC within November 2022 decreased to 448 when compared to 558 in November 2022. The 448 reports relate to incidents where the outcome for our patients was:

- No harm or hazard – 3,201
- Minor harm – 136
- Moderate harm - 70
- Severe Outcomes - 7
- Catastrophic - 34

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; 122 cases were closed in November 2022. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example; 2 crews submitting the same incident), however the increase in incident volumes is attributed to the current rise in hospital handovers.

The rise seen in the number of cases closed in July 2022 is largely attributed to the transition from Datix Web to Datix Cymru when a risk-based review of all incidents on the system (including Covid related incidents) was undertaken by patient safety and health & safety teams, with oversight by the Executive Management Team.

Remedial Plans and Actions

Capacity issues have impacted the ability of some teams to support investigations due to ongoing operational pressures. Additional resources have been agreed by the Executive Management Team to support concerns functions in the Clinical Contact Centres and Corporately. Recruitment / redeployment of staff is in progress.

Expected Performance Trajectory

The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

***NB: November 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change.**

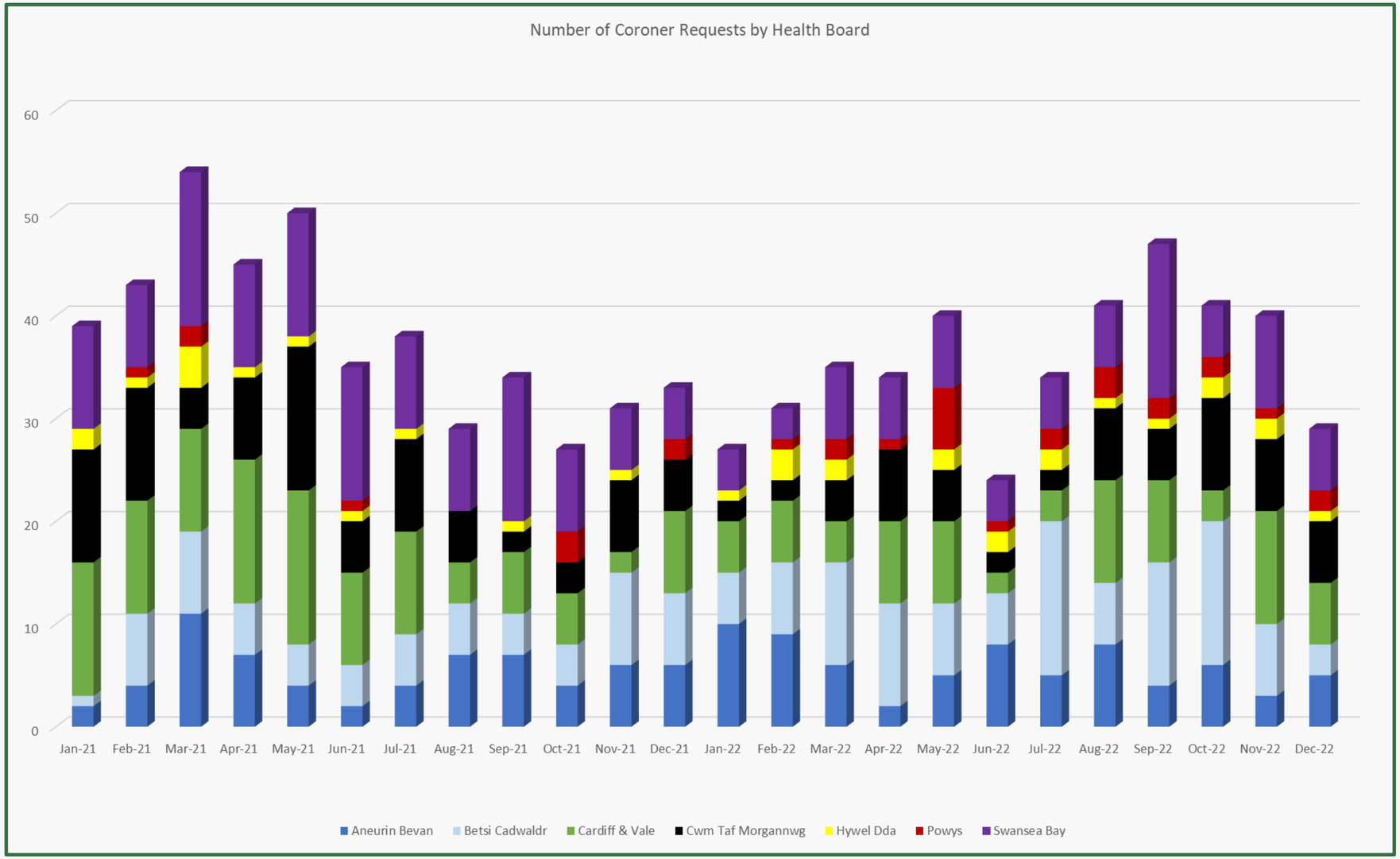
Data source: Datix

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

Self Assessment: Strength of Internal Control: Strong

QUEST

Health & Care Standard
Health – Safe Care



Analysis

Coroners: The number of in month request continues to be higher than pre pandemic. December 2019 the Trust received 13 requests. That being said the increased numbers have continued and are now the norm, rather than the exception.

At the end of December 2022 there are 432 claims open; these relate to Personal Injury (77 Claims); Personal Injury - Road Traffic Accidents (47 Claims), Clinical negligence (120 claims); Road Traffic Accident (180 claims) and Damage to Property (8 claims).

Ombudsman: There are currently 11 open Ombudsman cases in December 2022. At present cases are not being investigated, which supports the Trusts actions.

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed in a timely manner. If there is likely to be a delay in responding the Trust ensures that the coroner is kept informed of the expected date of response. Inquests are now being arranged into Feb & March 2023. The Team has now recruited to vacancies, and following some training , the numbers on hand have started to reduce.

Ombudsmen: All cases are recorded and monitored on the Datix System.

Expected Performance Trajectory

Coroners: The number of cases on hand remains high due to some delays in obtaining statements, which require an MPDS audit.

Ombudsmen: A report in relation to lessons learned is prepared and taken to the Patient Safety and Experience Learning and monitoring Group.

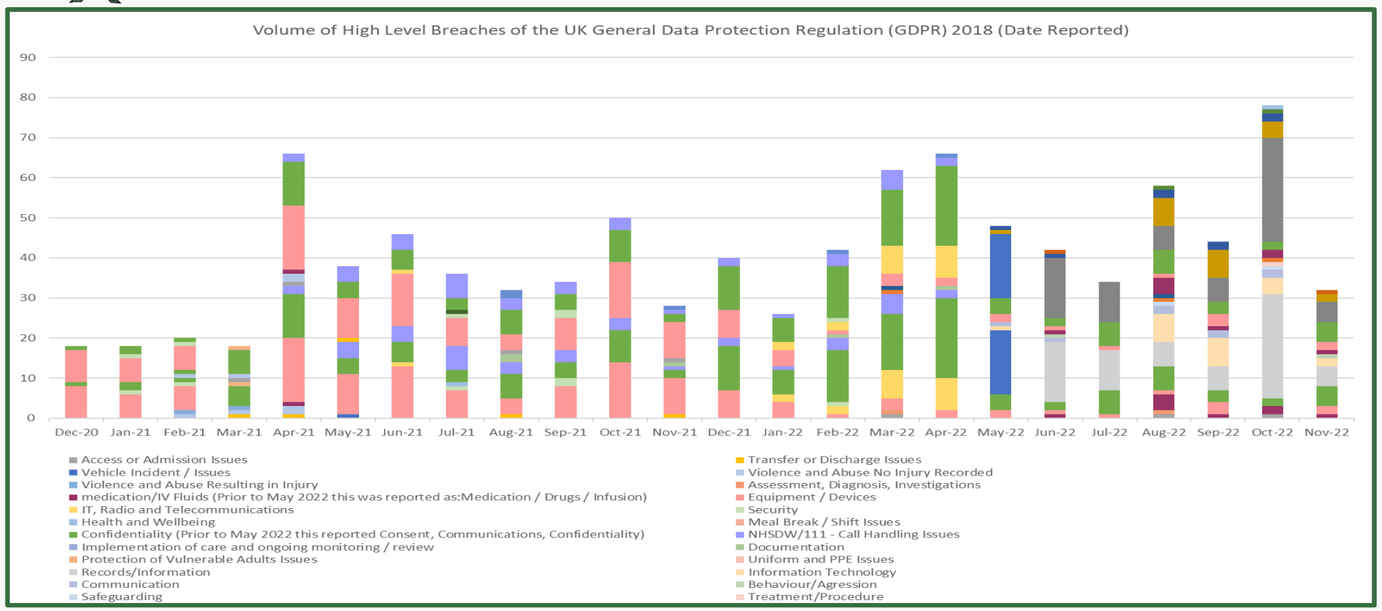
Data source: Datix

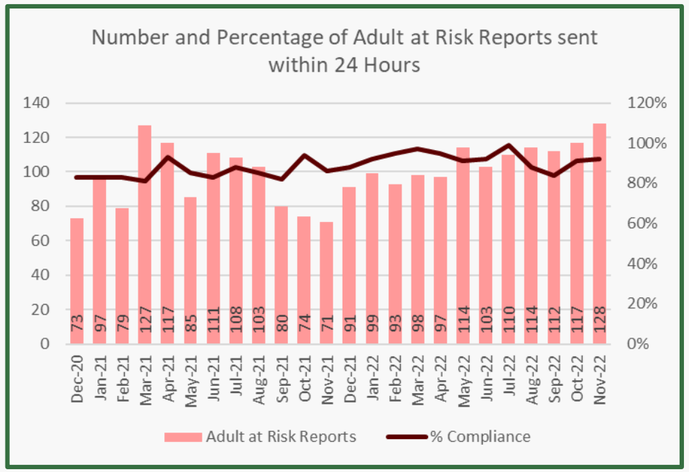
Our Patients: Quality, Safety & Patient Experience
Safeguarding, Data Governance & Public Engagement Indicators

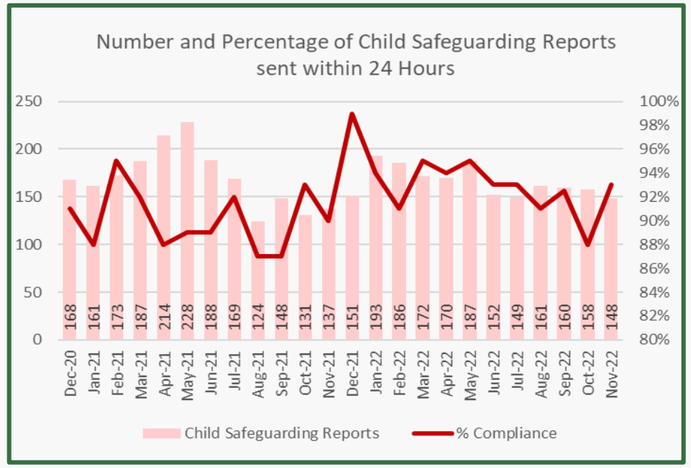
Health & Care Standard
Health – Safe Care

Self Assessment: Strength of Internal Control: Strong

QUEST







Analysis

Safeguarding: In November 2022 staff completed a total of 128 Adult at Risk Reports, 92% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 402 referrals were received and processed to the local authority during this reporting period. There have been 148 Child Safeguarding Reports in September 2022, 93% of these were sent within 24 hours.

Data Governance: In November 2022 there were 16 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach, a decrease when compared to October 2022. Of these 16 breaches, 2 related to Information technology, 5 records/information, 5 Confidentiality, 2 equipment / Devices, 1 behaviour / aggression and 1 medication/IV Fluids.

Public Engagement: During November, the PECI Team attended 12 engagement opportunities, engaging with 340 people. Our community engagement permits meaningful conversations with people about using the services we provide; helping communities feel listened to and empowered to drive change. Outcomes of our engagement with people and communities across Wales remain consistent to those previously reported. With people continuing to tell us that long waits and delays remain their primary concern. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs, especially when accessing GP Out of Hour Services. Visitors to the NHS 111 Wales website have reported an increase in overall satisfaction. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience long delays when making their initial telephone booking.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks 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 16-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). Incidents have been reviewed and investigated where necessary by the IG team and remedial actions taken where appropriate. Digital notices have been issued to continue to raise awareness on various IG and confidentiality matters to help prevent future data breach occurrences. Guidance on actions to take to avoid data breaches have been issued to relevant teams where incidents have been reported.

Public Engagement: Though we continued to engage with communities across Wales throughout the coronavirus pandemic, this was done in a much more digital way, holding online events and joining online forums and meetings. Whilst this online engagement was crucial and allowed us to maintain connections, it was widely acknowledged that for many, online engagement was a barrier, and some felt excluded from participating in online activities in general. A return to in person community engagement is very welcome and allows to re-start having rich conversations with people about their experiences and expectations. It is acknowledged that coronavirus cases in the community are rising again, the PECI Team will continue to take measures to ensure staff and communities safety during engagement events.

Expected Performance Trajectory

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

Data Governance: Progress continues to be made with the IG Toolkit improvement actions. The next submission is due to open in January 2023.

Public Engagement: Outcomes of our engagement with people and communities across Wales remain consistent to those previously reported. With people continuing to tell us that long waits and delays remain their primary concern; though the transport, care or treatment they ultimately receive is good. This theme is repeated across all services delivered by the Welsh Ambulance Service - 999 emergency care, Non-Emergency Patient Transport and NHS 111 Wales. The PECI Team will continue engaging with communities, proactively communicating with people and communities, sharing important information regarding Trust services and appropriate use of these during the current period of increased demand. Learning from our engagement will be shared with partners, stakeholders and colleagues and will be used to help influence quality improvement.

NB: December data is not yet available due to reporting dates

Safeguarding Data source: Doc Works

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

(Responsible Officer: Liam Williams)

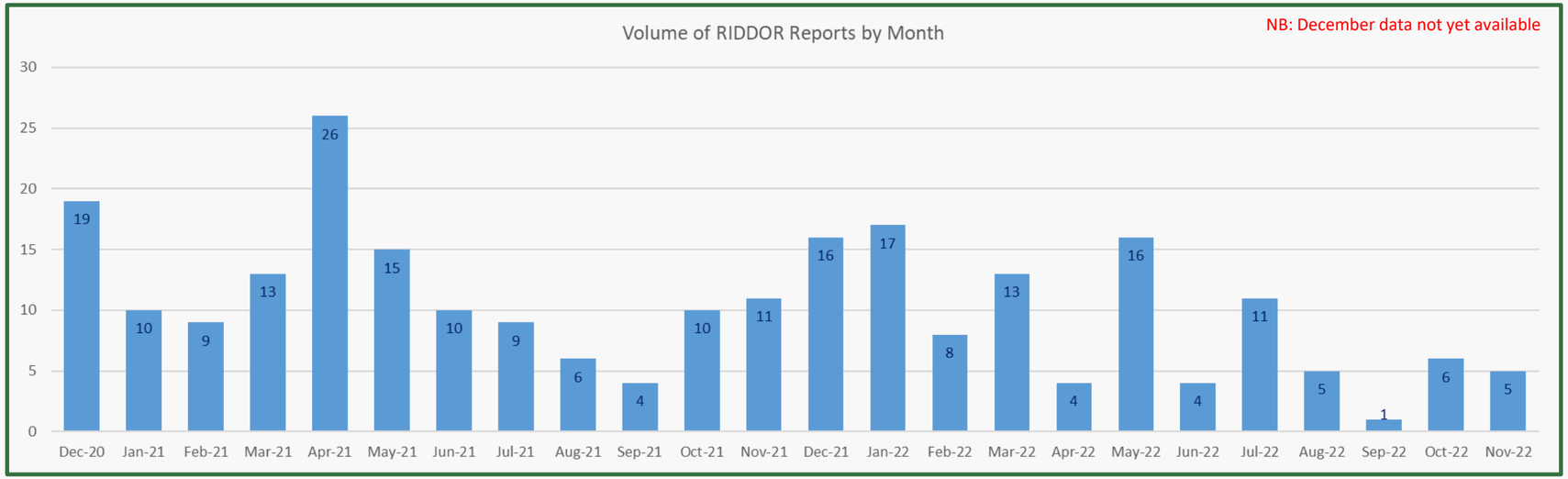
Welsh Ambulance Services NHS Trust

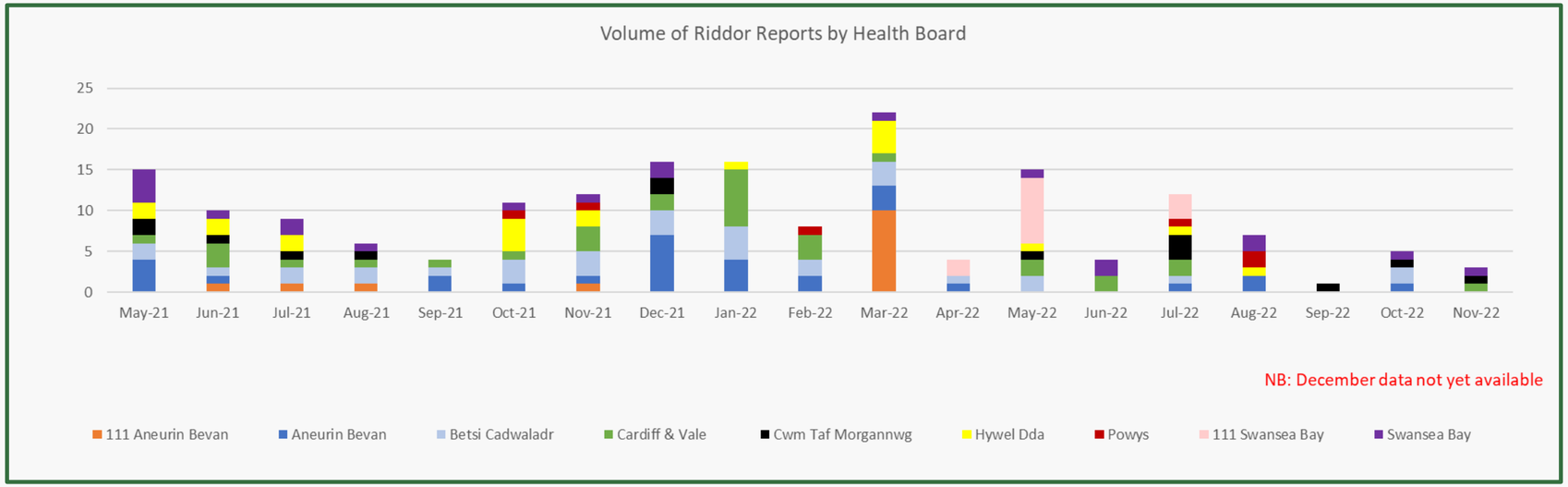
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

Self Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Analysis
Whilst there is a strong level of internal control with respect to metrics provided to the Health & Safety Executive (HSE), there are moderate levels of internal control. Challenges around incident reporting times or handlers confirming staff sickness absence to the H&S function continue to impact on the timeliness of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS) to the Health and Safety Executive (HSE).

Risk 199 is currently rated as 15. This was reduced in Q2 as a result of work undertaken via the Working Safely Programme and funding secured for the Workforce review which commenced on 3rd October 2022. This risk is reviewed monthly.

In November 2022 there were RIDDORs reported. As shown in the bottom graph these related to BCUHB (1), CVUHB (1), HDUHB (2) and PUHB (1).

Remedial Plans and Actions
DATIX incident review meetings continue to be held on a weekly basis to review non-patient safety incidents to check for potential RIDDORS and associated coding and allows for further scrutiny. RIDDOR performance is presented in monthly reports and service units business meetings .
The Working Safely Programme (IMPT deliverable) 'Pump Prime' phase ceased on 31st September 2022. A closure report is to be presented to the Working Safely Strategic Board in Q3 2022 with recommendations on the transition of outstanding program actions into business-as-usual activities.

Expected Performance Trajectory
The Workforce review was fully implemented with the new structure came into force on 3rd October 2022. This will allow for the embedding of expertise within the organisational and increase in capacity to support operational structures to influence performance positively.

Increased focus by the Health and Safety Managers and visible presence of newly appointed Health and Safety Advisors at local levels should additionally improve the Trusts RIDDOR performance by 30% during Q3-Q4 2022.

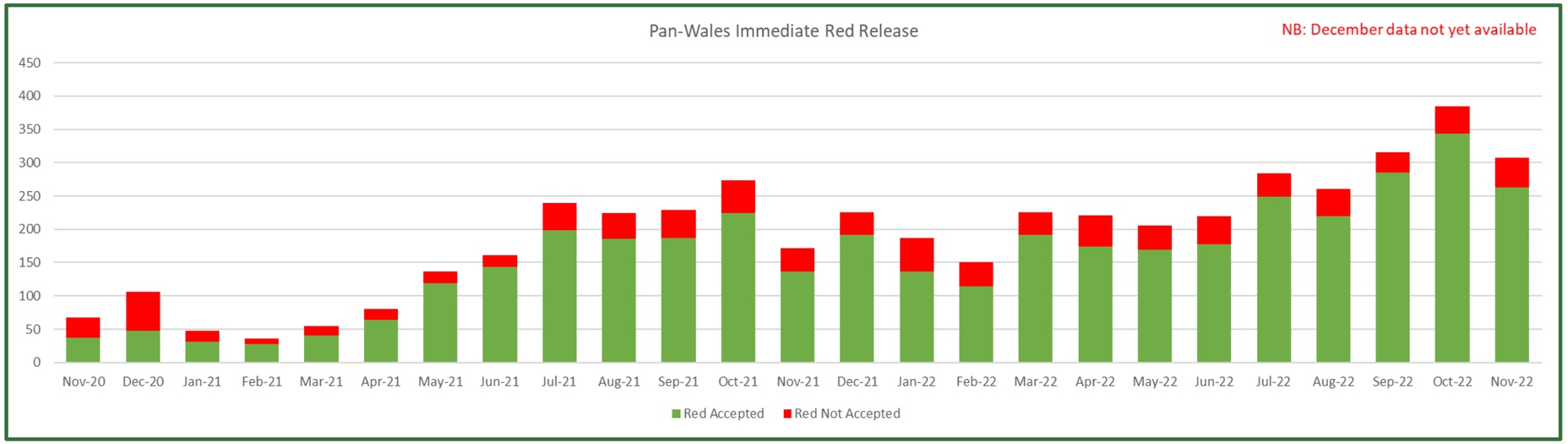
NB: November 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change
NB: Reporting processes are currently under review and an update is expected for next months report.

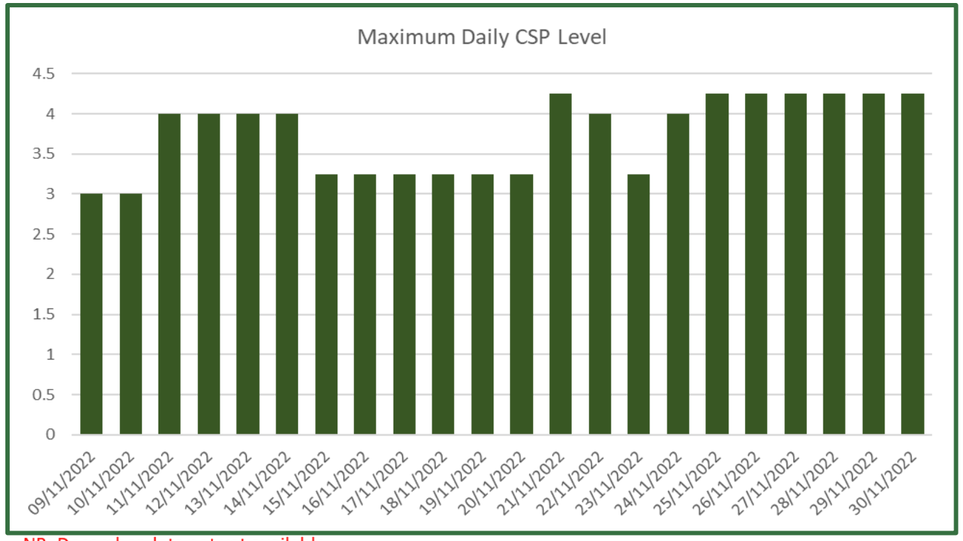
Data source: Datix

Our Patients: Quality, Safety & Patient Experience
Escalation and Patient Experience

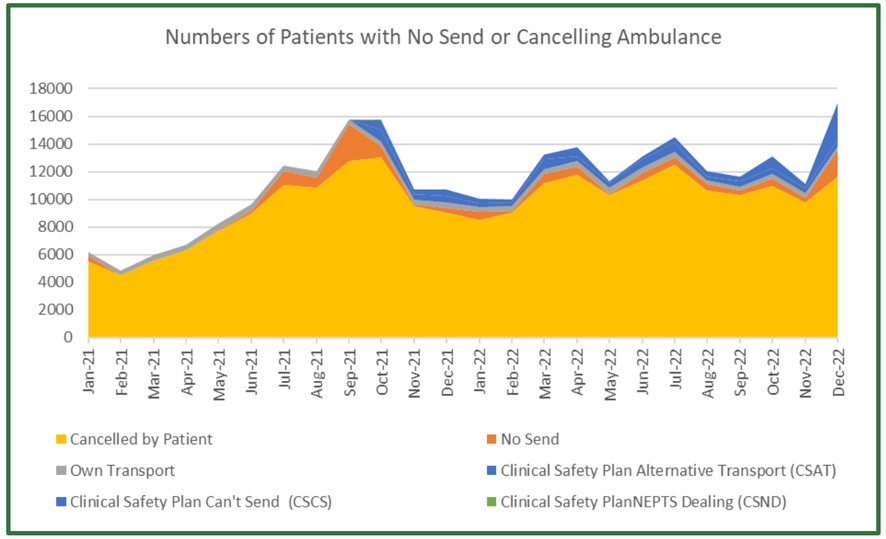
TBD

FPC





NB: December data not yet available



Analysis

There were 829 request made to Health Board EDs for immediate release of Red or Amber 1 calls in November. Of these 263 were accepted and released in the Red category, 44 were not accepted. In conjunction to this, 193 ambulances were released to respond to Amber 1 calls, but 329 were not.

During November 2022, the Trust has not seen any days at CSP level 1, Business as Usual (BAU) or CSP 2a. 6 Days were spent at CSP level 3a resulting in the Trust only responding to Red calls and with some exceptions Amber 1 and 2 calls. 11 days were spent at CSP level 3b, therefore seeing the Trust only being able to respond to Red and with some exceptions, Amber 1 calls, with Amber 2 calls being clinically screened and the Trust unable to respond to Green and HCP calls. Six days were spent at Clinical Safety Plan (CSP) level 4a, resulting in clinical screening of Amber 1 calls and the Trust being unable to respond to calls in the Amber 2 and Green categories advising these patients to contact their GP, 111 Online or make their own way to a Minor Injury Unit (MIU), those callers within the HCP category are advised to make their own way to hospital. Seven days were spent at CSP level 4b, resulting in clinical screening of Red and Amber 1 calls and the Trust being unable to respond to calls in the Amber 2 and Green categories advising these patients to contact their GP, 111 Online or make their own way to a Minor Injury Unit (MIU), those callers within the HCP category are advised to make their own way to hospital.

In November 2022, 325 ambulances were stopped due to CSP alternative transport and 372 were stopped as a result of CSP Can't send options. In addition, 9,750 ambulances were cancelled by patients (including patients refusing treatment at scene) and 371 patients made their way to hospital using their own transport.

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.

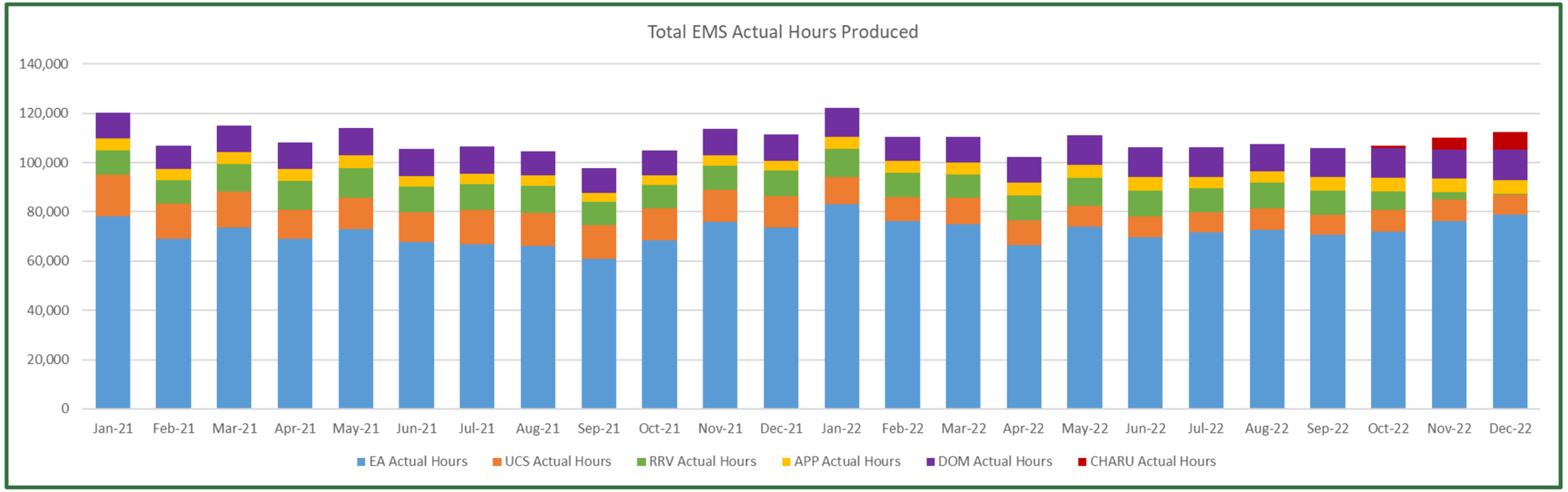
Expected Performance Trajectory

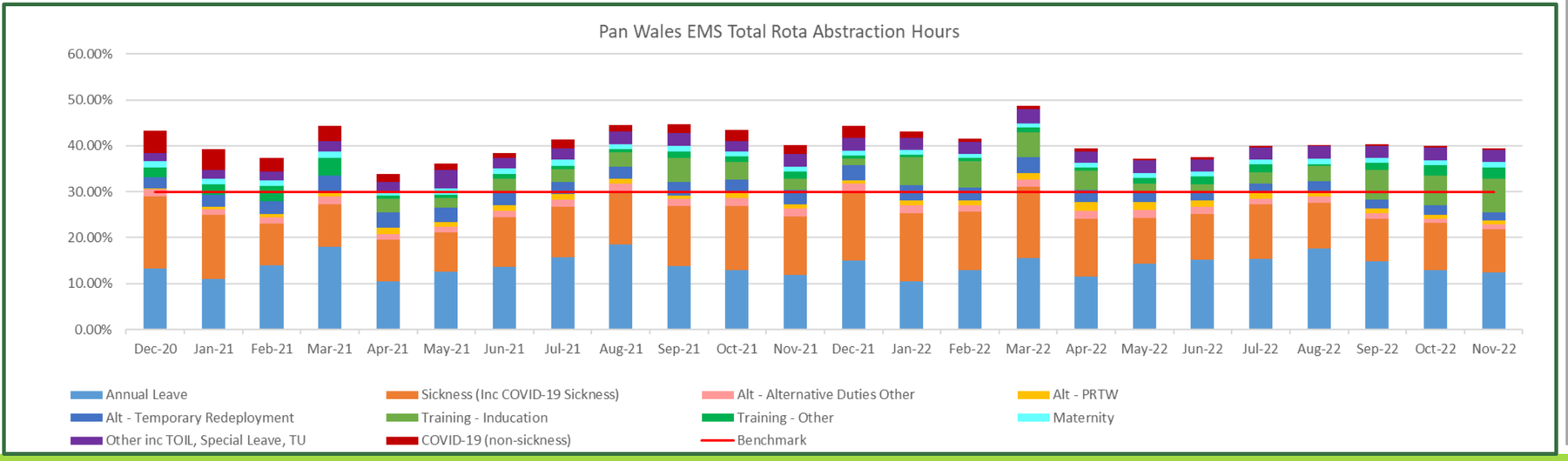
The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Winter pressures will impact the Trust and seasonal planning is being used to prepare for this.

***NB: November 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change**

Our People
Capacity - Ambulance Abstractions and Production Indicators

EA Production: A | Abstractions: 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 2022, total abstractions stood at 39.45%. This compares to a benchmark set in the Demand & Capacity Review of 30% which the Trust was achieving pre-COVID-19. The highest proportion was Annual Leave at 12.45% and sickness at 9.45%. Sickness abstractions for November 2022 were lower when compared to the previous year (11.40%). COVID-19 (non-sickness) related abstractions decreased in November 2022 when compared to the previous month and when compared to the same period last year accounted for 0.32% of overall abstractions.

Emergency Ambulance Unit Hours Production (UHP) was 91% in December 2022 (78,660 Actual Hours), therefore failing to achieve the 95% benchmark. CHARU UHP achieved 79% (7,070 Actual Hours) compared to 55% in November 2022. The total hours produced is a key metric for patient safety. The Trust produced 112,225 hours in December 2022.

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 has a budgeted establishment of 1,661 FTEs for 2022-23. The key actions to maximise production will continue to be the EMS Demand & Capacity Review with an additional 100 WTE to be recruited this year. This is expected to be achieved by 23 January 2023.

The new EMS Response rosters are now live; implementation of rosters, which concludes a two and a half year project.

Expected Performance Trajectory
Subject to the longer-term impact of COVID-19 the benchmark is a UHP of 95% across the Trust's three main resource types and an abstraction rate of 30%.

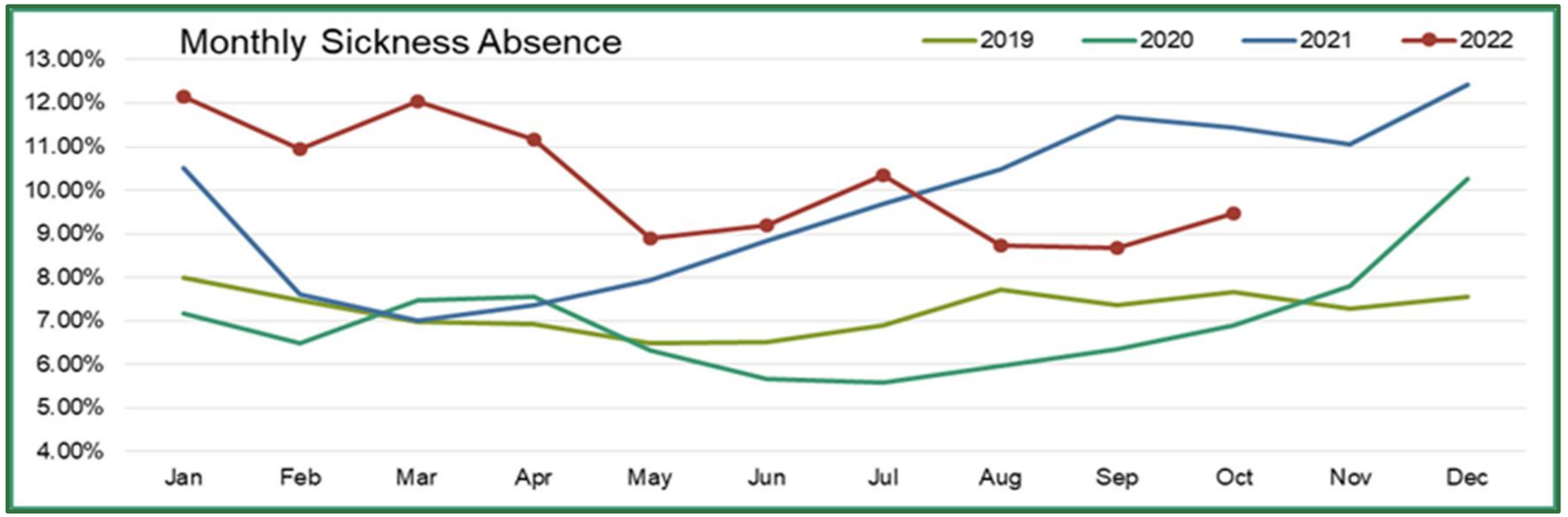
***NB: December data not yet available due to report cycle dates.*

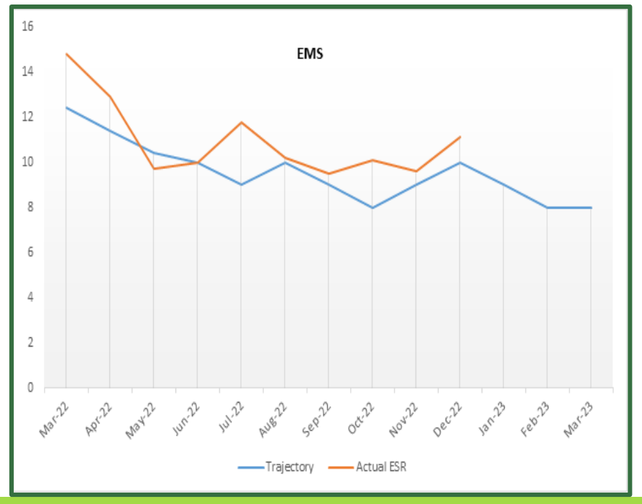
Our People
Health & Wellbeing - Sickness Absence Indicators

R

CI

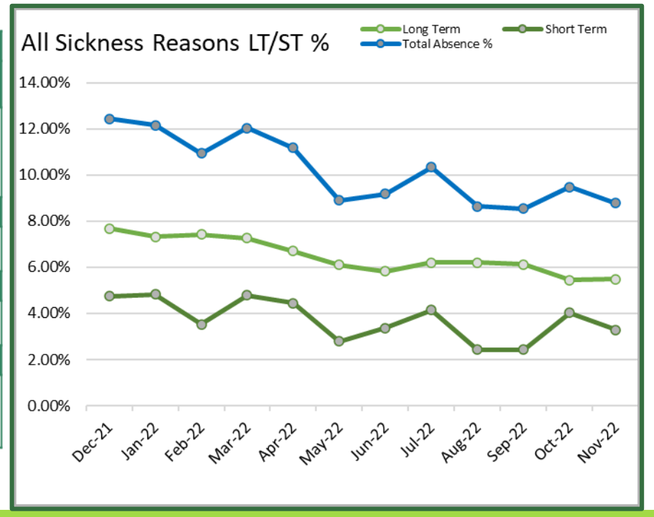
NB: Sickness data will always be reported one month in arrears (except for ESR reported Sickness Trajectory)





Average working days lost per FTE (Annual)	
23.30	days
Single month Absence %	
8.78%	
Long Term	**Short Term**
5.49%	3.29%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.44%	1.06%

November 2022



Analysis

- There was a decrease in sickness absence in November, going from 9.48% to 8.77%. There has also been an increase in short-term sickness absence due to COVID and seasonal illnesses
- Indicative figures show an increase in sickness absence for December. Figures indicate an increase in COVID related absence in December as well
- Sickness absence was low at the start of November but has increased throughout.
- Physiotherapy: 37 referrals were received in November 2022. This is 10 more than in November 2021

Remedial Plans and Actions

- Targeted support is being directed to current 'hotspot' areas with a recent case review in one health board area which is an outlier. Investigations noted the need for more accurate reporting of reasons for absence and that most absences last 8-14 days. Additional support for effective welfare calls is being delivered and managers in the region attended training on 01 December 2022.
- 16 training sessions have been delivered with 546 managers attending.
- Long term sickness case management continues. Internal audit report received for MAAW – meeting to agree actions scheduled for January 2023.
- Team are analyzing data in different ways e.g. average length of short-term absences and absence by role. When complete this will be shared with the organisation.
- Occupational Health continue to engage with Health Board colleagues to fast track appointments and treatment to reduce length of absences
- Long COVID cases are reducing – five compared to 15 in July 2022, with comprehensive RTW plans are developed

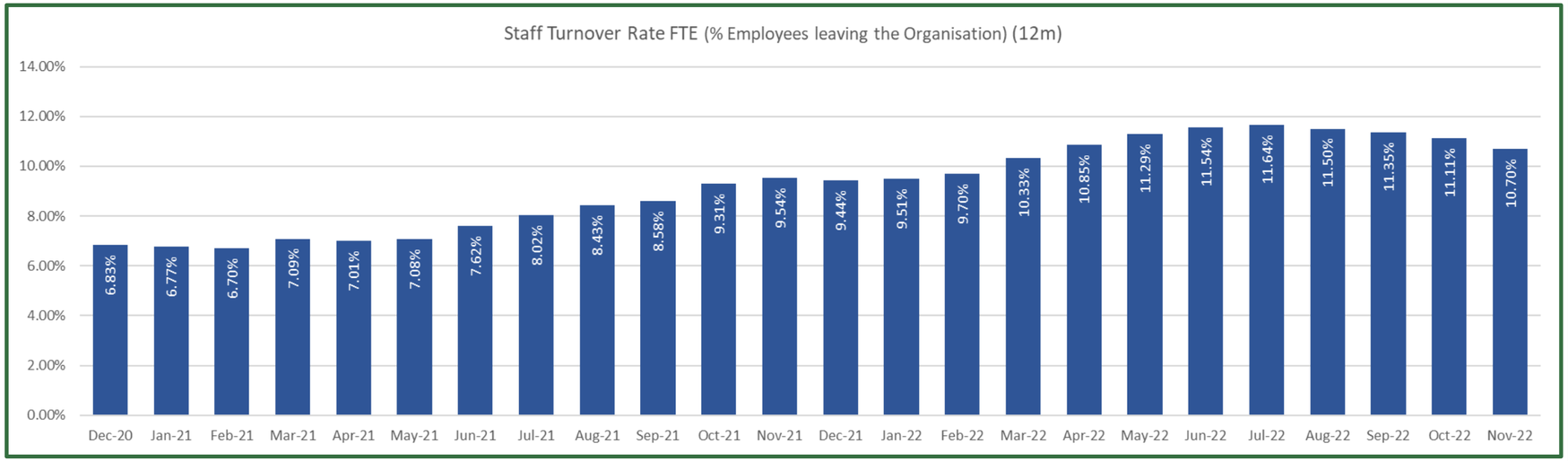
Expected Performance Trajectory

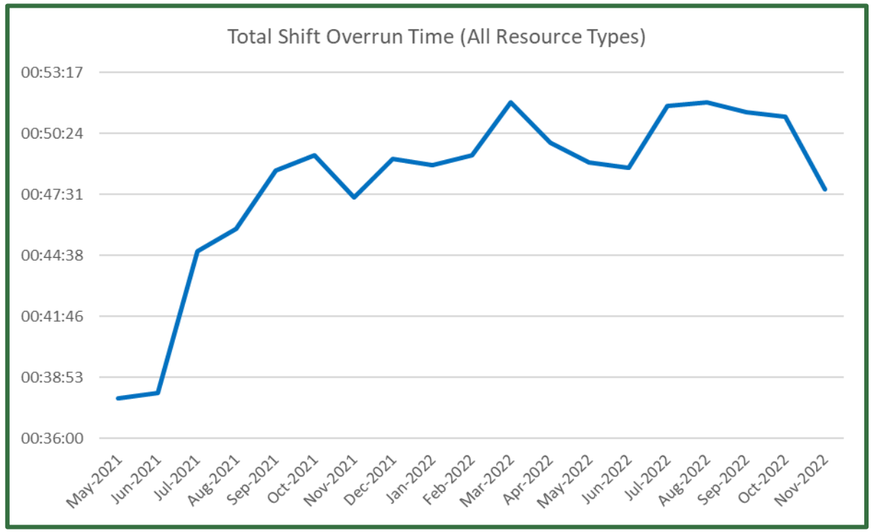
The Trust is aware that some staff may need more time to recover due to long-CoVID and may require a longer phased return to work alongside putting in place other supporting mechanisms. Work is also ongoing to consider the mental health aspects of COVID-19 and working from home and the Trust is actively seeking ways to consider the possibility of hidden health and wellbeing issues. It is therefore difficult to forecast or predict performance against this indicator, but the expectation is that the target is unlikely to be achieved in this financial year.

***NB: Not all December is currently available due to report cycle dates.*

Our People
Health and Wellbeing - Turnover

R





		FTE by Month		
Org L4		**2022 / 09**	**2022 / 10**	**2022 / 11**
020 Ambulance Care L4 (NX10)		794.07	782.33	838.67
020 Emergency Medical Services L4 (DX04)		1,801.24	1,805.56	1,816.22
020 Integrated Care L4 (DX03)		435.01	430.61	424.29
020 National Operations & Support L4 (DX02)		154.77	153.52	154.92
020 Resourcing & EMS Coordination L4 (DX05)		327.70	345.70	364.27
Grand Total		**3,512.79**	**3,517.72**	**3,598.37**
Ambulance Response:				**1564.08**

Analysis

Staff turnover rates in November 2022 were 10.70%. In comparison staff turnover rates were 6.64% in November 2021. As highlighted in the Staff & Wellbeing Deep Dive presented to People and Culture Committee on 06 September 2022 the number of staff leavers has increased over the last 3 years and were lower pre-pandemic; staff leave the Trust for a variety of reasons including promotions, relocations and due to pressures of NHS working.

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.

Wellbeing levels remain low for a range of reasons such as wider system challenges, COVID and population issues (cost of living crisis), the Trust continues to address these circulating communication for wellbeing opportunities and groups, such as women's health, menopause and pensions presentations and through training, including Carers Wales Workplace Champion training in October 2022.

Remedial Plans and Actions

Cost of living champions are being identified across the Trust to act as a support system over the winter months in relation to the cost of living crisis. This network will support colleagues in signposting to local services and events within their local areas.

A direct survey was undertaken with colleagues across the Trust in November 2020 which identified that colleagues would like to see improvements in:

- Improved training and development opportunities
- Managers who listen more
- More focus on staff wellbeing
- An end to bullying and harassment
- Increased professionalism and positive behaviours

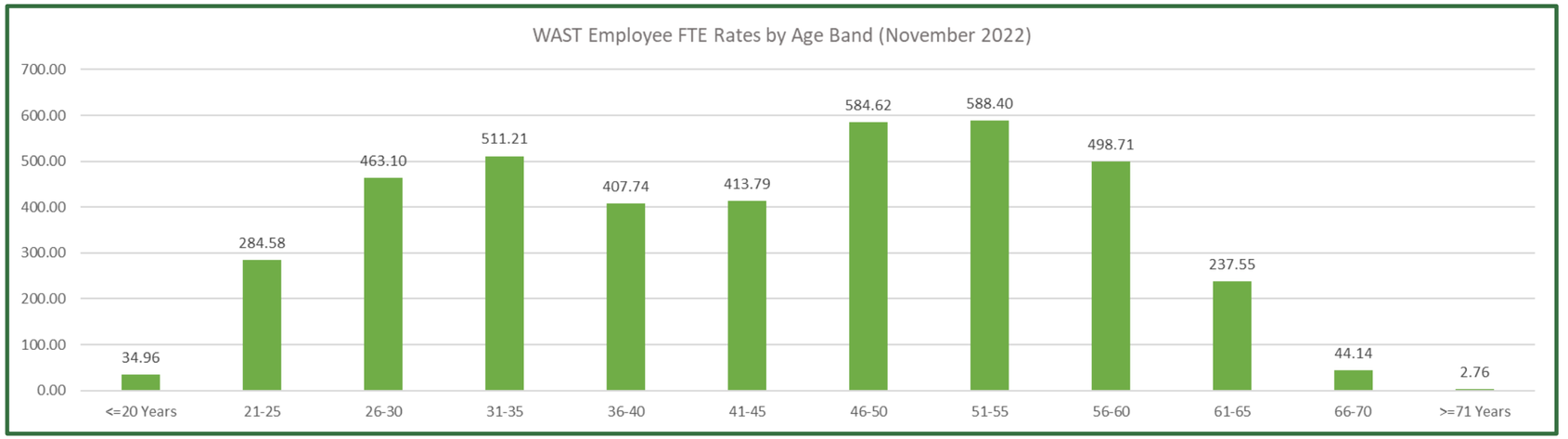
Expected Performance Trajectory

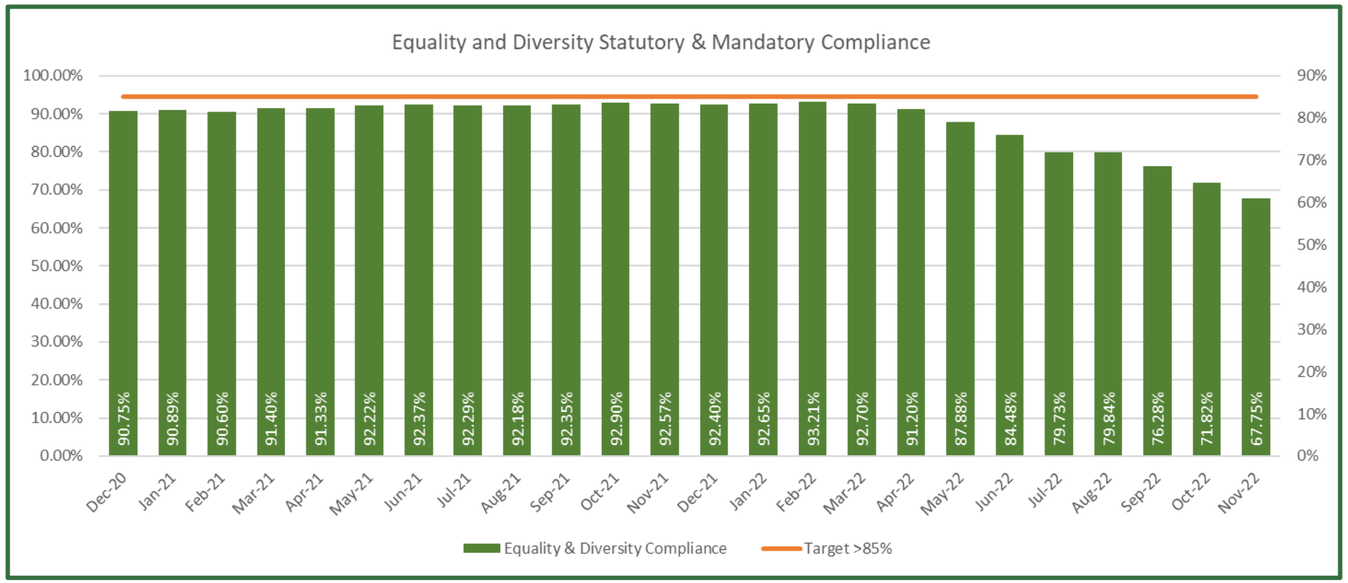
The situation regarding wellbeing of staff remains challenging, many of the difficulties and frustrations are difficult to influence and change. Management development will continue with a focus on people skills and support with robust wellbeing offers so colleagues know where to get support, financial advice and the Trust will work at a local level recruiting champions. The People and Culture Strategy will continue with its wellbeing focus.

Other key metrics will be determined for reporting in future iterations.

***NB: December data not yet available due to report cycle dates.*

Our People
Inclusion and Engagement





	Female	Male
Band 2	1.40	1.59
Band 3	16.73	14.23
Band 4	8.44	10.72
Band 5	4.93	4.14
Band 6	12.10	13.34
Band 7	2.88	5.08
Band 8 - Range A	0.91	1.21
Band 8 - Range B	0.51	0.42
Band 8 - Range C	0.17	0.51
Band 8 - Range D	0.13	0.11
Other	0.23	0.25

Analysis

In October 2022 of the 4,071 employees at the Trust, 0.80% fall in the under 20 category and 0.34% in the over 71 age category. 85.73% of staff employed at the Trust define themselves within the White ethnic grouping; with 70.61% of staff identifying in the White, British category, 0.11% identify within black ethnic groups, 0.32% within Asian ethnic groups and 0.76% are of mixed heritage. 0.19% of staff fall into other ethnic groups. 4.53% fall in the unspecified category and 9% have not stated ethnicity.

As of November 2022, 67.75%, of staff have completed mandatory Equality and Diversity Training a decrease compared to October 2022, therefore failing to meet the 85% target.

Gender pay as a percentage of the workforce indicates that in October 2022 for those employed within bands 2 - 5 employment is more equally distributed, with 31.49% of females and 30.68% of males fulfilling those roles; however, there are higher levels of men employed within the more senior grades. 14.97% of females are employed in Band 6 and 7 roles compared to 18.42% of males and of those employed within Band 8 roles 1.71% are females and 2.24% are males.

100 colleagues have begun Allyship journeys, including Board members, and the programme continues to be well received; work is underway to ensure the programme is updated and bespoke wherever possible to ensure greater engagement.

Remedial Plans and Actions

EMT focused on the fall in E&D compliance. This is currently under investigation, initially checking there is no issue with the data. Once this is completed mitigations will be developed. The roll out of the Allyship programme has been positive and it is now being reviewed to ensure it is fit for purpose and valuable to staff.

The slide will be developed further with metrics around Welsh language. The accuracy of the various metrics available to the Trust is currently being assured.

Expected Performance Trajectory

Having listened to feedback from communities, stakeholders and colleagues the Trust has developed seven new behaviours to ensure we can always be our best and is more committed than ever to improving the future and embracing new ways of working.

The Trust continues to follow guidance issued for Welsh Language standards (2015) to ensure compliance when advertising vacancies, which are advertised in both the English and Welsh language for any posts where Welsh language skills are essential or desirable.

***NB: December data not yet available due to report cycle dates.*

Our People
Staff Vaccination Indicators

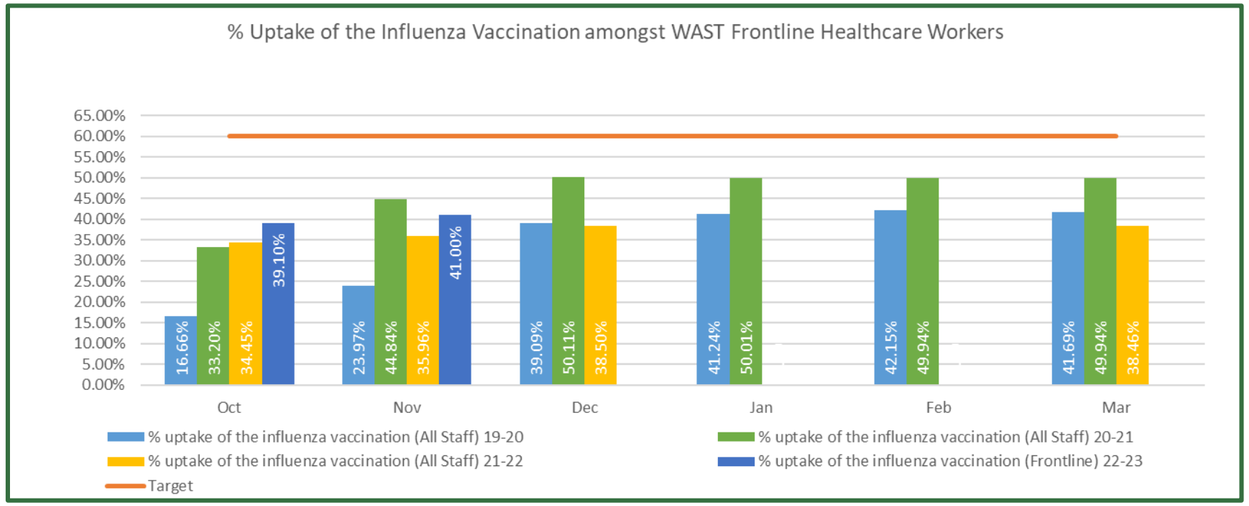
Self Assessment: Strength of Internal Control: Moderate

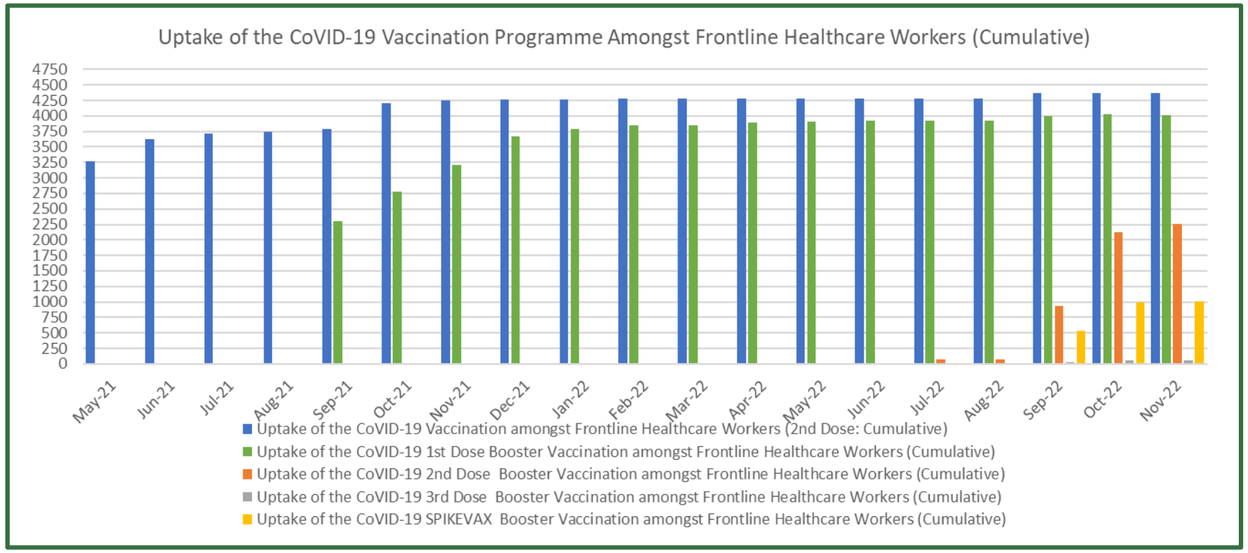
Flu R

CI

PCC

Health & Care Standard - Health (PPI)





Analysis

1,656 flu vaccines have been administered by Occupational Health Vaccinators and Peer Vaccinators (this includes flu vaccines administered to PHW staff / Students / HCS staff etc.) since the launch of the 2022/23 campaign.

1,507 WAST staff received their flu vaccine in a WAST setting with further 238 WAST staff receiving the vaccine elsewhere (i.e. GP Surgery / COVID-19 Booster Setting). A total of 1,745 WAST staff are now protected against the flu, equating to 41.0% of the overall workforce. Since the launch in September, we have surpassed the overall flu vaccine uptake figure of 38.5% from last year's Flu Campaign.

201 WAST staff have completed the Microsoft Form indicating that they have chosen to opt-out of having the flu vaccine.

In September 2022 an up-to-date staff list has been used to calculate COVID, with extraction of 485 leavers and 619 new staff added, therefore there are 4,667 staff currently employed (All staff), 2,913 of these are front line. As of November 2022 front line (Patient Facing and Non-Patient Facing staff), 94% (4,400) of staff have received a first dose COVID-19 vaccination, 94% (4,374) have received a second dose and 35% (1009Staff) have received the SPIKEVAX booster vaccination.

Remedial Plans and Actions

- Staff are required to complete mandatory training for flu through Flu One e-learning modules via ESR.
- Planning commenced earlier than ever for the 2022/23 campaign, with 48 Flu Leads (across all EMS localities and all Directorates, unlike previous years) being appointed in July 2022.
- Monthly Flu Update meetings (with Flu Leads) commenced earlier than ever too, with the first taking place on Monday 12th September to ensure all were ready for the delivery of the flu vaccines
- Vaccines were delivered in September in a bulk order to 4 delivery points (Matrix One, Ty Elwy, Hensol and Caernarfon), as opposed to being delivered over several months and therefore, preventing vaccine supply issues that have occurred in previous years
- The Flu Siren page launched, with all details of clinics, Flu Leads, Peer Vaccinators.
- The Digital Directorate is currently creating an online booking page for staff to directly book flu vaccinations with the Occupational Health Department (this is a new idea, as previously if staff wish to have their flu vaccine with OH, they have had to phone a booking line)
- The Trust aim to have 146 signed off and competent Peer Vaccinators for the 2022/23 campaign as opposed to (Approx.) 50 in previous years
- The flu consent / opt-out form has been simplified with fewer questions in a bid to encourage the staff who do not wish to have the flu vaccine or have had the vaccine elsewhere to let us know, which will hopefully increase engagement across the Trust.

Expected Performance Trajectory

An evaluation of the 2021-22 flu campaign has concluded. Early indications from the southern hemisphere are that there has been more flu trough the winter of 2022. The Trust is currently developing forecasts for the winter period that build in CoVID-19 and flu.

NB: *Due to a technical error in the downloading of data for the Trust are unable to report monthly flu data for January & February 2022.*

NB: COVID Vaccinations are reported using the WAST definition of Frontline Pacing Facing employees and therefore includes those employed within Clinical Contact Centres.
NB: Flu data accurate as of 25th November 2022

Date source: Cohort Electronic System / Welsh Immunisation System (WIS)

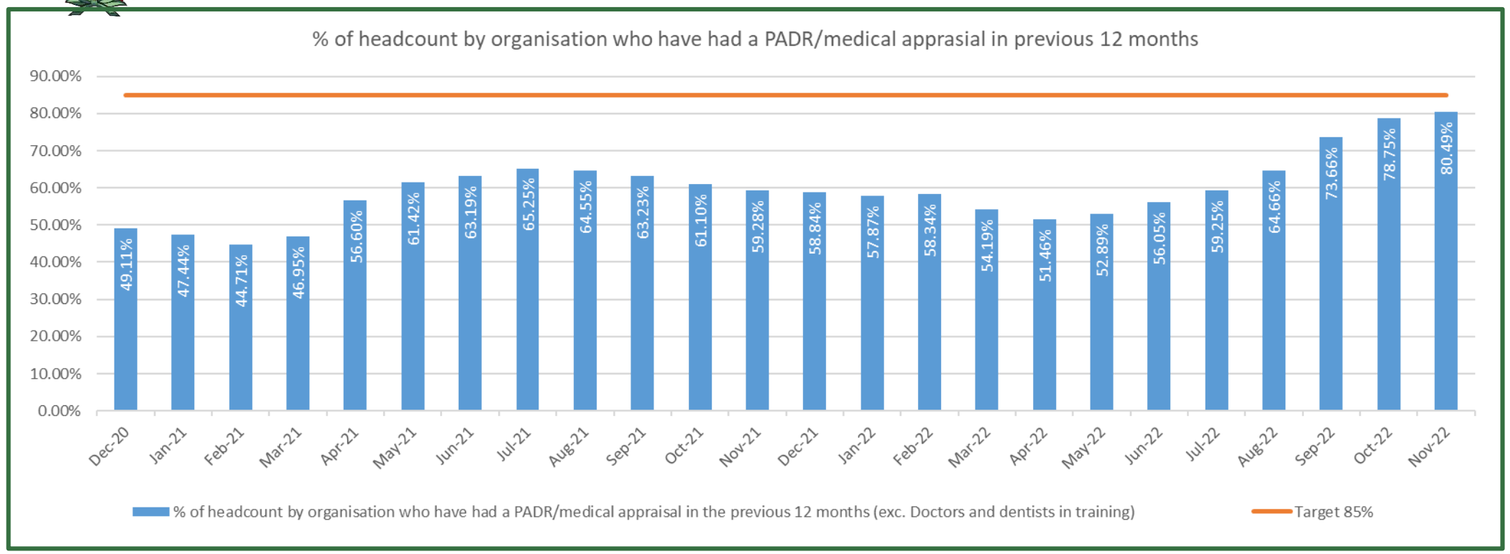
Our People
Health and Wellbeing - PADR and Training Rates Indicators

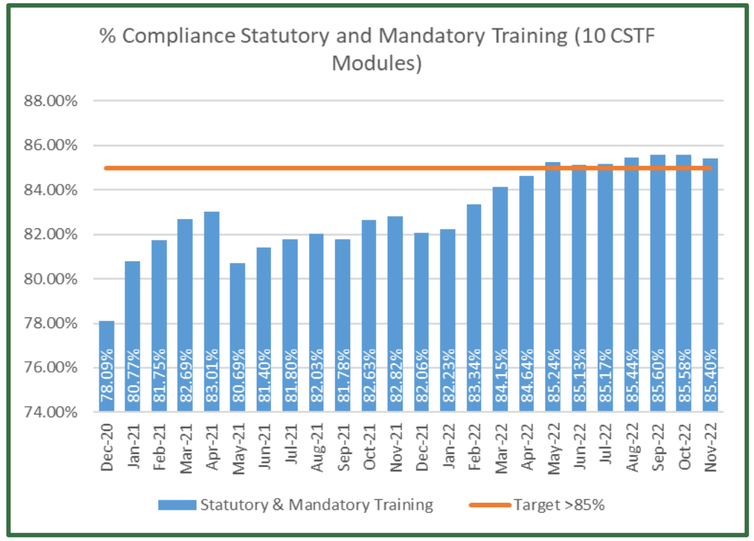
A

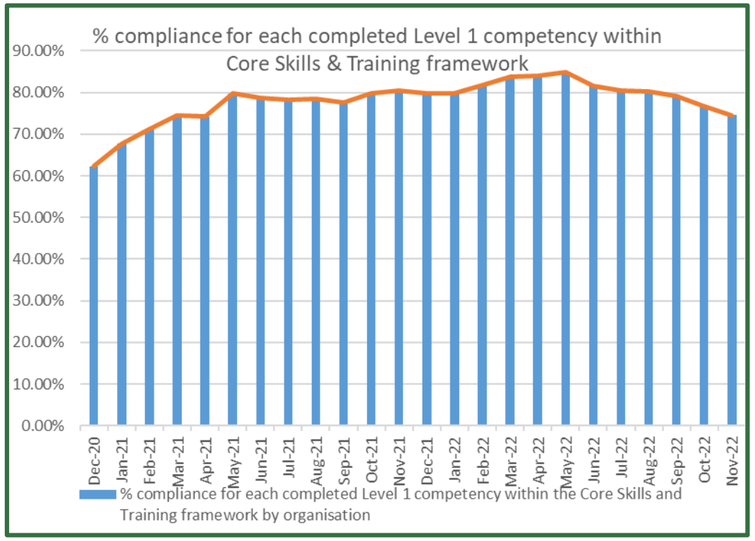
Self Assessment: Strength of Internal Control: Strong

CI PCC

Health & Care Standard
Health – Staff & Resources







Analysis

PADR rates for November 2022 improved for the eighth consecutive month to 80.49% and are on an upward trajectory, however they continue to remain below the 85% target.

November 2022 Statutory & Mandatory Training rates decreased by 0.18 from the October 2022 figure, however, it still achieved the 85% target for the sixth consecutive month. Fire Safety (67.96%), Moving & Handling (82.54%), Information Governance (82.12%) and Equality & Diversity (67.75%) failed to achieve the 85% target; however, Dementia Awareness (88.14%) and Safeguarding Adults (88.85%) achieved the target in November 2022.

There are currently 2 (13 for Admin &Clerical Staff) Statutory and Mandatory courses that all NHS employees must complete in their employment. These are listed in the table to the right.

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
Environment, Waste and Energy **(Admin & Clerical staff Only)**	Yearly

Remedial Plans and Actions

We have run several MIST days in November 2022. We have had 73 colleagues attend the 10 scheduled days; we are planning for 10-12 per session but appreciate that this is only starting and anticipated that uptake would be slow to begin.

PADR: The rate of completion continues to increase across the organisation to 76.86% - Over the last 2 quarters this is an increase of 24.55%. Phase 2 of the PADR Refresh process is underway with a toolkit and bitesize session developed in order to support colleagues and managers through the revised PADR process. This bite colleagues and is designed to improve the completion rate of PADRs.
Work on Phase 3 of the revised process has begun. This involves the PADR form being available digitally on ESR which will ensure real time reporting and organisational training can take place. This is due to be piloted in the new year and the managers toolkit will be adapted to reflect this change.

Expected Performance Trajectory

Uptake in the e-learning based topics continues to be very positive and staff of all grades have embraced the concept and are engaged with this new concept. Staff seem to have bought into the "new normal" and the Trust expects to continue to see improving compliance figures across the Trust.
***NB: December data not yet available due to report cycle dates.*

Data source: ESR

Finance, Resources and Value
Finance Indicators

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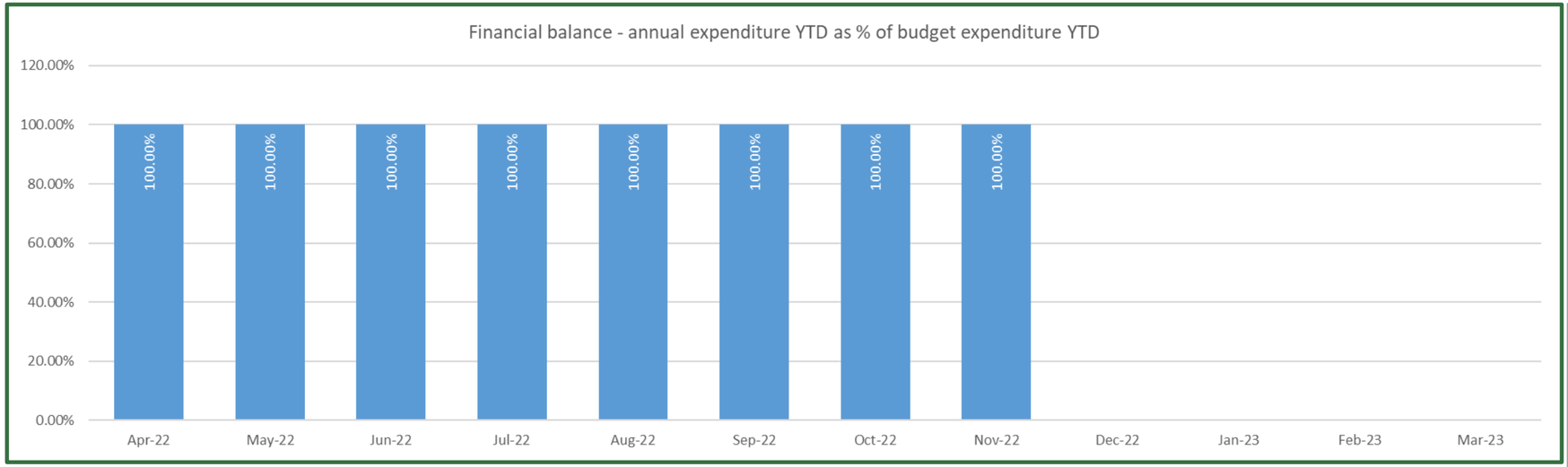
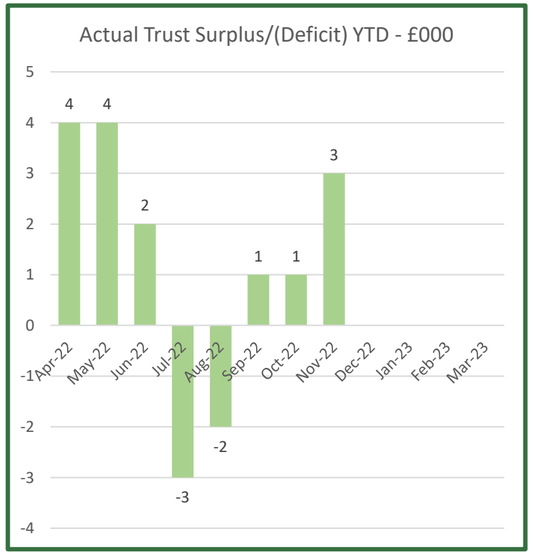
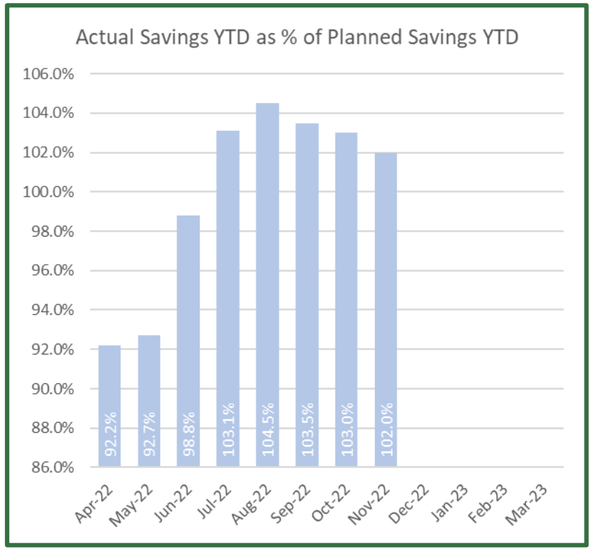
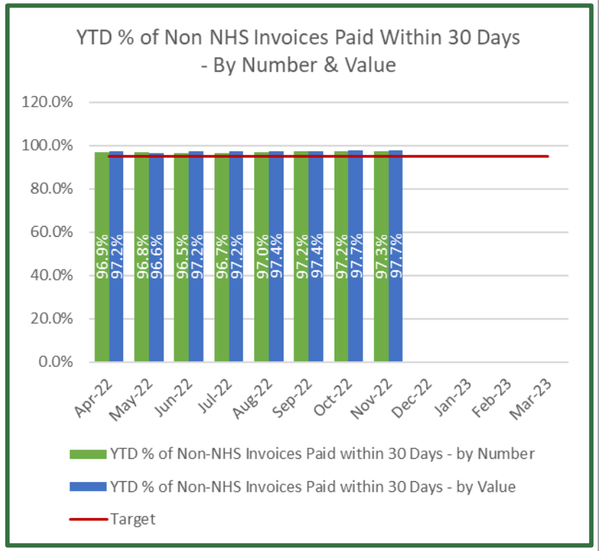
FPC









Analysis

The reported outturn performance at Month 8 is a surplus of £3k, with a forecast to the yearend of breakeven.

For Month 8, the Trust is reporting planned savings of £2.872mand actual savings of £2.945m (an achievement rate of 102.5%).

The Trust's cumulative performance against PSPP as at Month 8 is 97.3% against a target of 95%.

As of November 2022, the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions (No update received)

The Trust's financial plan for 2022-25 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 2022-25 financial plan was submitted to WG following Board sign off on 31st March 2022.

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 include:

- Continuing financial support from Welsh Government in relation to CoVID-19 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;

Expected Performance Trajectory (No update received)

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to continue to deliver further planned savings further into the 2022/23 financial year.

***NB: December data not yet available due to report cycle dates.*

Finance, Resources and Value
Resource and Value Indicators

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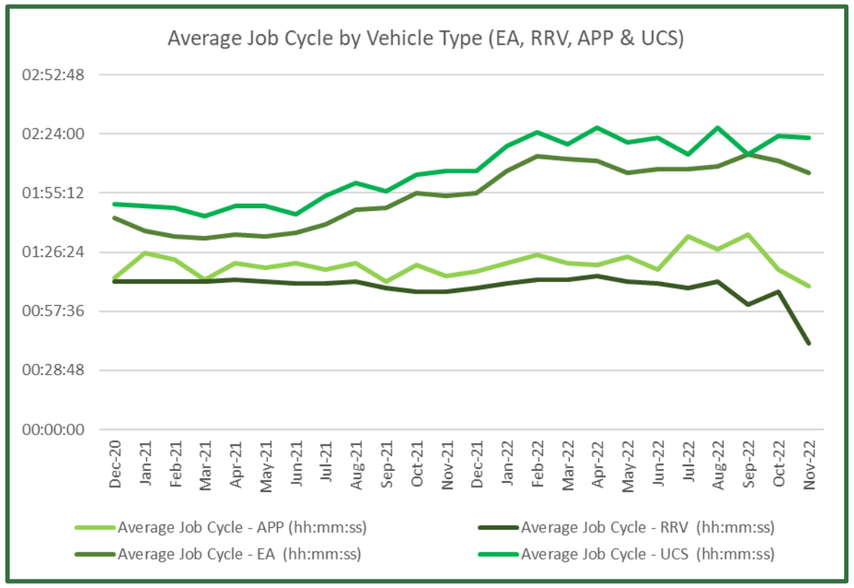
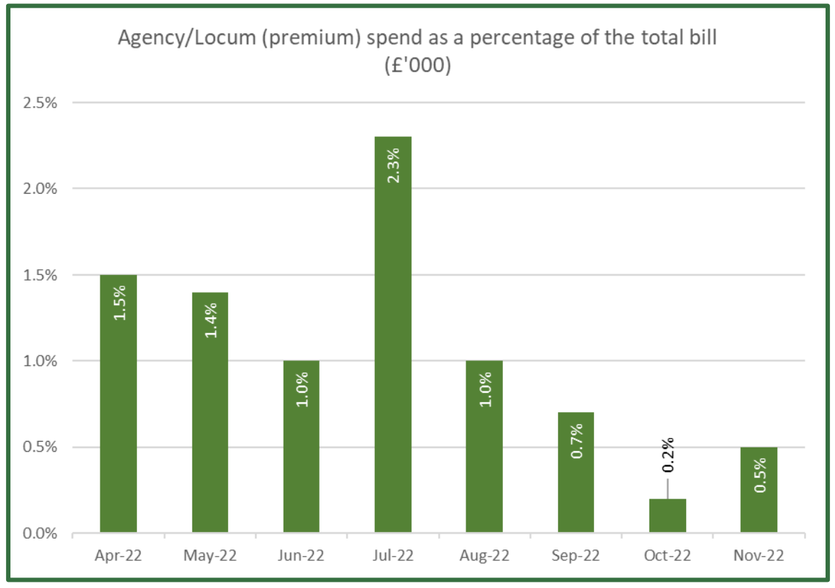
Slide under Development: Future iterations of the report will include emissions data





NB: CHARU data is not yet available

Analysis
The Trust has deployed 23 plug in hybrid Rapid Response Electric Vehicles (EV) across Wales as part of the 2022/23 fleet replacement programme in an ongoing commitment to decarbonisation and in line with actions identified in the Decarbonisation Action Plan.

As demonstrated in the bottom left graph, the average job cycle decreased in November 2022 for Advanced Paramedic Practitioners (APP), and EA calls but increased for UCS. EA calls averaged 2 hours and 5 minutes in November 2022 , a slight decrease in the usually increasing trajectory.

There was an increase seen in agency spend in November 2022 from the October 2022 position.

Remedial Plans and Actions (No update received)

In terms of physical infrastructure, WAST Information Communications Technology (ICT) is heavily involved in both the expansion of Fleet and Estates. All new buildings require fitting out with the latest ICT equipment, networking, and audio-visual equipment to enable hybrid working, whilst the Trust continues to modernise the digital offer within both EMS and NEPTS fleet to provide connected workspaces wherever our people need to be. In terms of digital infrastructure, there is also a constant requirement to ensure that our critical services are supported by modern, resilient, and secure technology.

Expected Performance Trajectory(No update received)
The Welsh Government targets of a net-zero position by 2030 pose real and complex challenges for WAST. In response to this, a key action over the next year will be to develop our Sustainability and Infrastructure Strategic Outline Programme, which will outline the financial and resource implications for the move to a carbon-neutral ambulance Trust. This will need significant input from our colleagues across the Trust and will require additional investment within the Finance and Corporate Resources Directorate to manage this. The relevant business cases in support of Estates and Fleet developments will continue to reinforce the importance of this agenda, and to push us towards a position of carbon neutrality, maximising our use of new technology and responding in a flexible and agile way to the changing external environment.
***NB: December data not yet available due to report cycle dates.*

Value / Partnerships & System Contribution
EMS Utilisation & Postproduction Lost Hours Indicators

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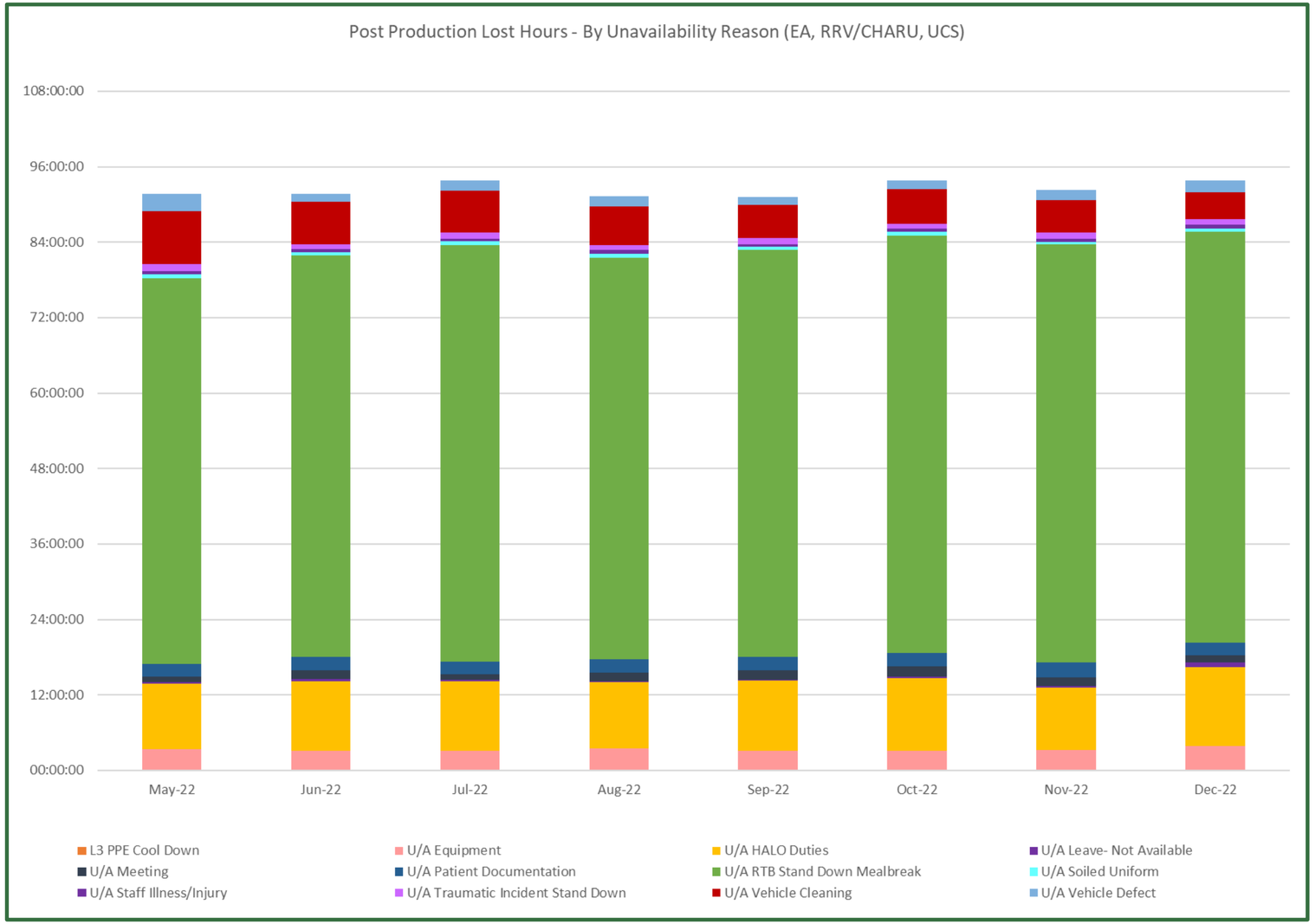

Analysis

There were 9,379 postproduction lost hours (PPLH) across EA, RRV/CHARU & UCS vehicles in December 2022; a slight increase when compared to November 2022 (9,224).

PPLH are due to numerous factors as outlined in the bar chart. There was an identified issue with the data set in relation to the U/A RTB Stand Down Meal break reason whereby the data was not being pulled through correctly and was being under reported. The issue was previously fixed; however, this was only for data being reported after the fix and not retrospectively. A retrospective fix has now taken place from May 2022 inclusive which is when the revised/amended codes were implemented. The bar chart demonstrates that PPLH have remained relatively consistent from May 2022 albeit with some smaller variations mostly attributed to the unavailable RTB Stand Down Meal break reason.

The Operations Directorate is working in partnership with Health Informatics to undertake extensive investigations to ensure reliable reporting which has resulted in more accurate reporting of unavailability through PPLH and 90th percentiles for codes, including soiled uniform, vehicle cleaning, equipment and meetings.

Remedial Plans and Actions

The Trust will not be able to eliminate PPLH, however, efficiency options continue to be worked through, and PPLH are monitored and scrutinised closely, forming part of the weekly performance meeting. Other PPLH reasons remain at a relatively consistent trajectory. Current work is ongoing in relation to the U/A RTB Stand Down Meal break reason and is currently at the TU engagement stage.

Expected Performance Trajectory

The current data needs to be treated with a degree of caution. As stated above, the Trust will not be able to eliminate PPLH, and the data prior to May 2022 has not had the retrospective fix. The reasons for the rise in PPLH from 2021, which is also attributed to the U/A Stand Down Meal break reason, is that during the pandemic and with less handover delays at hospitals, resources were returning to base for resting in the meal break window. The resource would not be assigned an unavailable status as it would still be available for certain category of calls (RED) and, therefore, would not have contributed to PPLH

*****NB: PPLH Data correct at time of extract***

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

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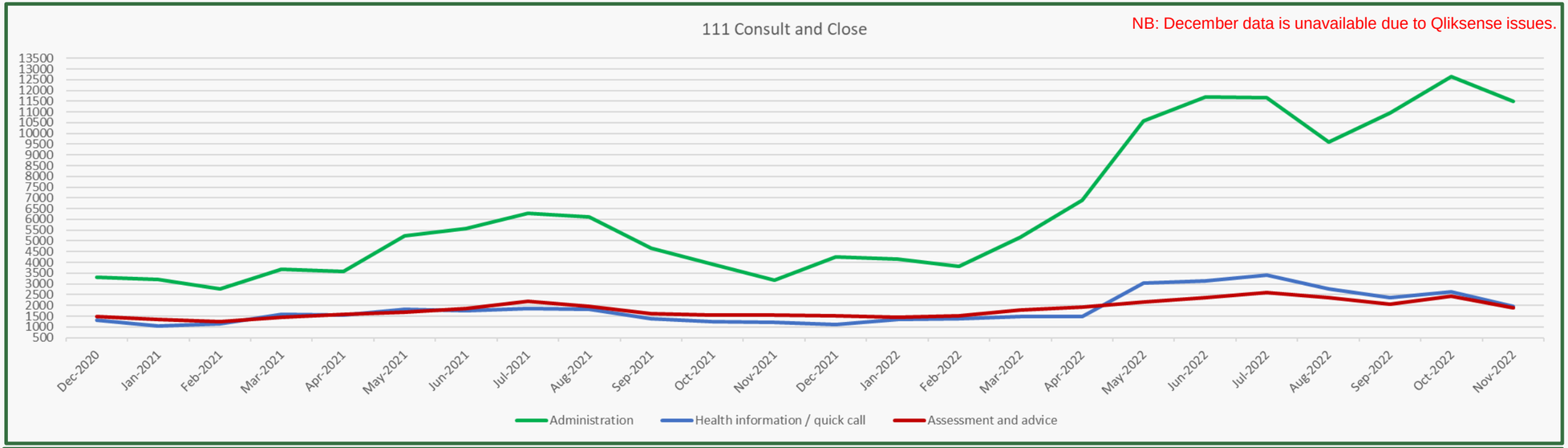
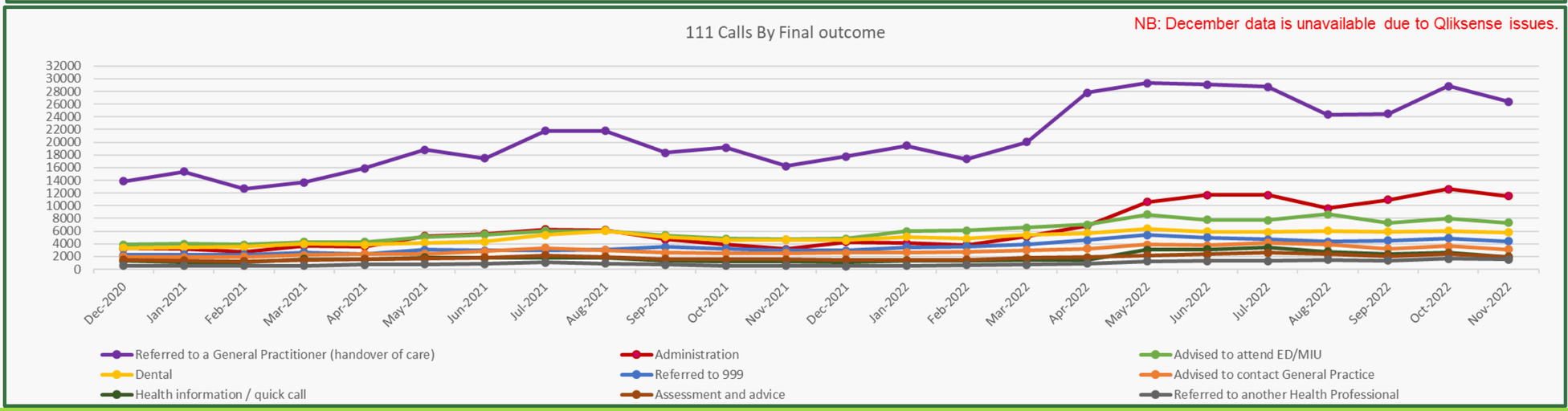
Influencing Factors – Demand and Clinical Hours Produced





Analysis

The top graph depicts the outcomes for calls handled through NHS111 Consult and Close with administration calls (those calls resulting in no action) accounting for the highest volume (11,505 calls); callers requiring health information accounted for 1,970 calls and callers requiring assessment and advice accounted for 1,887 calls.

In November 2022 calls Referred to General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 39% of calls.

In November 2022 63,993 calls were received in the 9 categories displayed in the bottom graph, an decrease when compared to 70,726 in October 2022; however, a significant increase when compared to 28,420 in November 2020 and 37,611 in November 2021.

Remedial Plans and Actions

Work is underway to develop live informatics which provide real time information on clinician availability to allow improved understanding and management; this will enable the Trust to report more meaningful metrics and accurately monitor patient outcomes.

A new NHS111 Consult and Close dashboard is in development to report more accurate and specific data in relation to calls ending in alternative transport, referral and self care.

Expected Performance Trajectory

A Contract Analyst is currently undertaking work to improve 111 data metrics available; this will allow us to report more meaningful and relevant data in relation to whether patients are directed to the most appropriate and best outcomes.

Partnerships / System Contribution
Consult & Close Indicators

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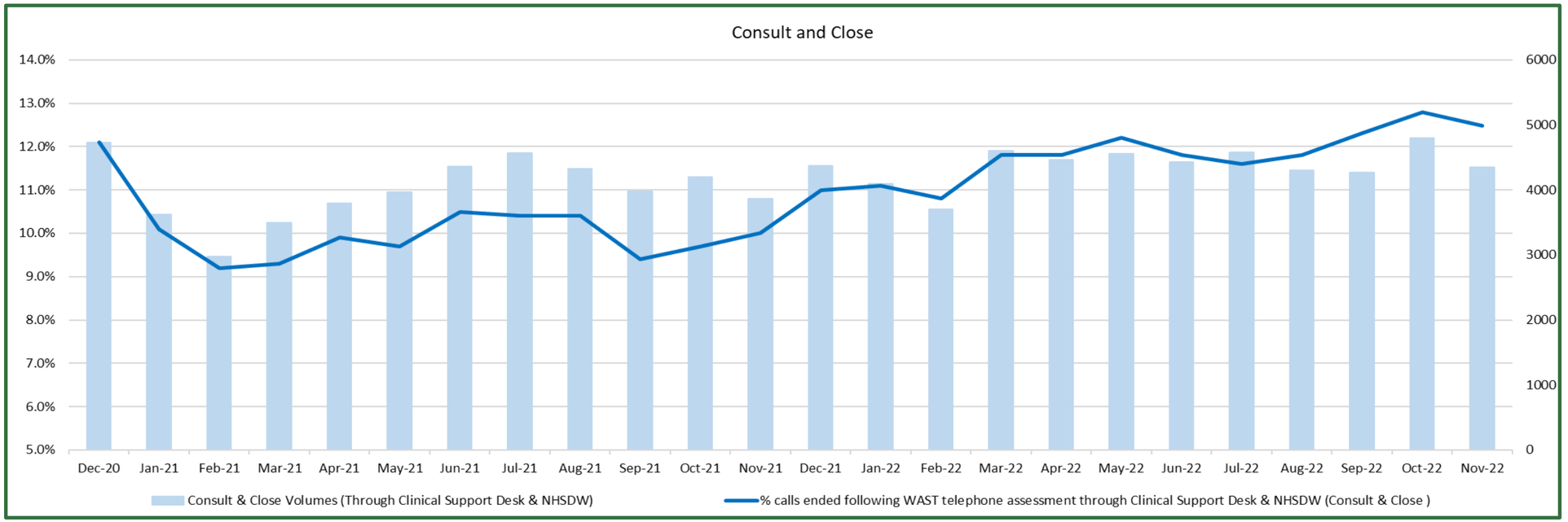

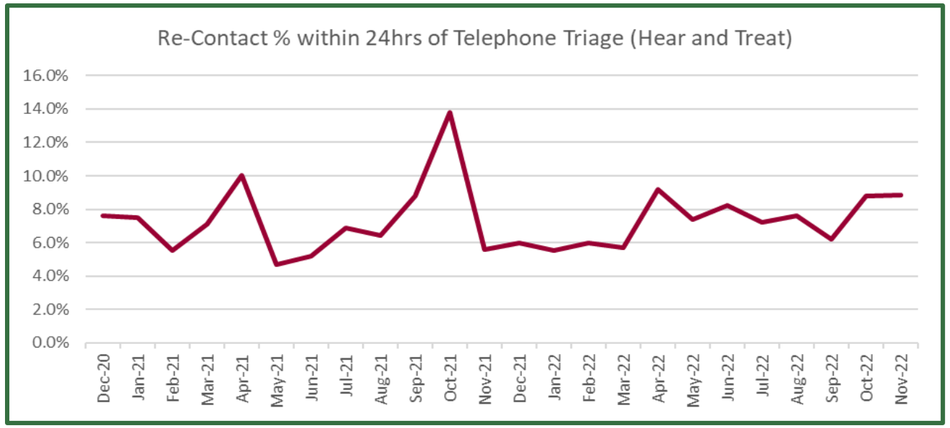

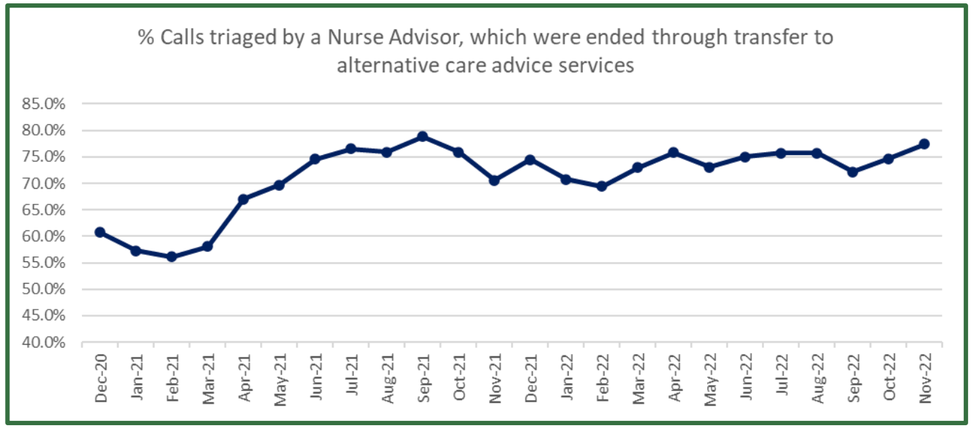

Analysis

The **Clinical Service Desk (CSD) and NHS111 (Consult & Close)** achieved 12.5% performance in November 2022, therefore continuing to achieve the historical 10.2% benchmark and working towards the mew benchmark of 15%.

9.1% of consult & close volumes were achieved by the CSD in November 2022. In comparison, 3.4% of consult & close was by NHS111.

The percentage of re-contacts within 24 hours of telephone hear and treat has fluctuated over the last two years, peaking in Jun-20 to 15.7%.

Re-contact rates in November 2022 were 8.9% an increase compared to 8.8% in October 2022 and compared to 5.6% in November 2021.

The percentage of calls triaged by nurse advisor ended through transfer of alternative care advice services increased month on month to 77.4% in November 2022; by comparison, this figure was lower in November 2021 at 70.6%.

Remedial Plans and Actions

- Funding was agreed to double the size of the CSD, including introduction of 5 mental health practitioners. These staff are now in place.
- The team are also undertaking detailed process maps of the work that they do in order to identify where improvements can be made
- The revised establishment is 96 FTEs with current in post 90 FTEs.

Expected Performance Trajectory

The current target for this year is 15% hear and treat rate for 2022/23 as part of the development of the 2022-25 IMTP and associated forecasting and modelling. We would hope to be achieving this in the second half of the year.

NB: December data is unavailable due to Qliksense issues.

Partnerships / System Contribution
Conveyance to ED Indicators

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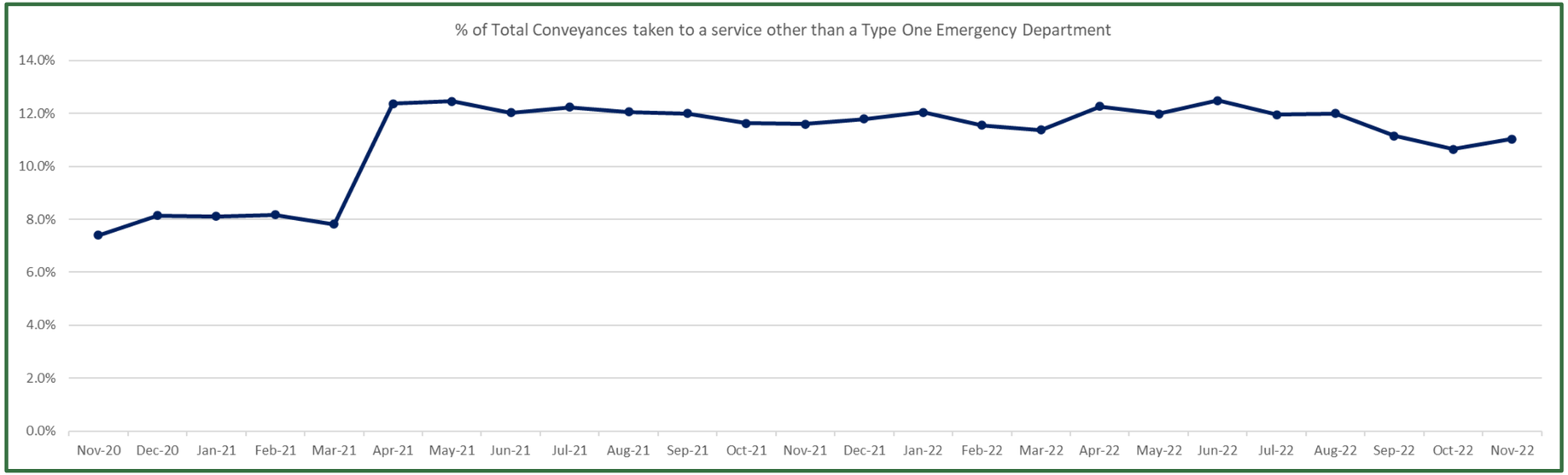
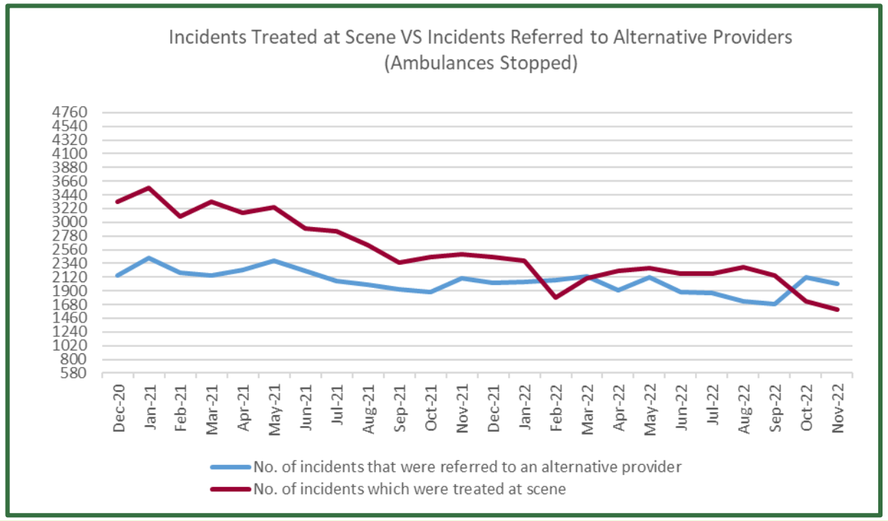
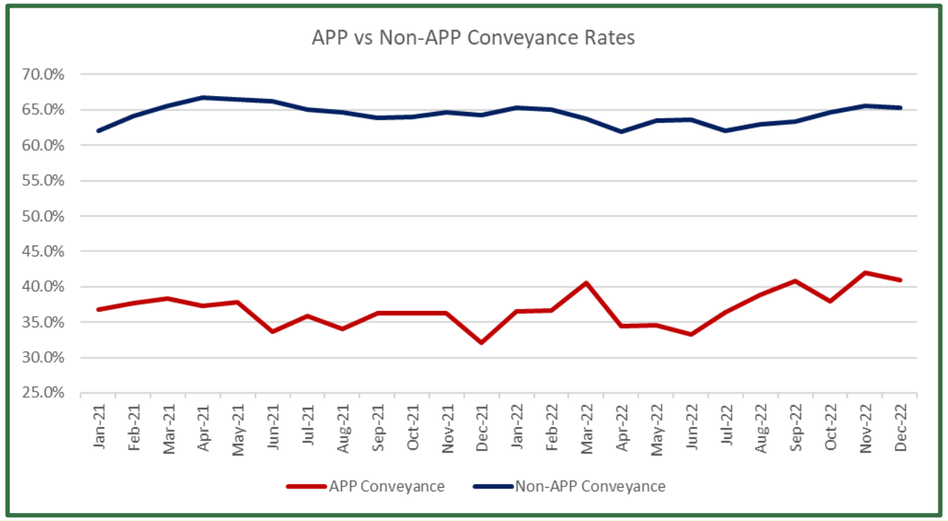
Ministerial Measure







NB: December data not yet available

Analysis

In November 2022 11.04% of patients (1,488) were conveyed to a service other than a Type One ED. Although not shown here, the percentage of patients conveyed to EDs increased (i.e. declined) compared to the same period last year. In November 2022 conveyance to EDs as a proportion of total verified incidents was 34.27% (compared to 36.57% in November 2021).

The combined number of incidents treated at scene and referred to alternate providers increased marginally in November 2022. 2,009 incidents were referred to alternative providers in November 2022 and 1,602 incidents were treated at scene; however, a review of other outcomes shows that there are a number of incidents where there was a no send due to escalation of the Clinical Safety Plan (CSP).

Remedial Plans and Actions

The Head of Strategic Development has been appointed to lead on the "inverting the triangle" strategic transformation. Key actions include: formal consultation with stakeholders, a new strategic demand & capacity review, evaluating the results of various pilots e.g. Swansea Bay APP, prescribing etc.

One of the Trust's commissioning intentions is to develop an optimising conveyance strategy, which will bring forward clearer proposals linked to further work on the EMS Demand & Capacity Review.

Additional same day emergency care (SDEC) services are due to go live; however, inclusion/exclusion for SDEC may be limiting appropriate patients and opening hours vary amongst the units available. Work is underway to ensure appropriate use of SDEC services by clinicians, missed opportunities and better use of ePCR.

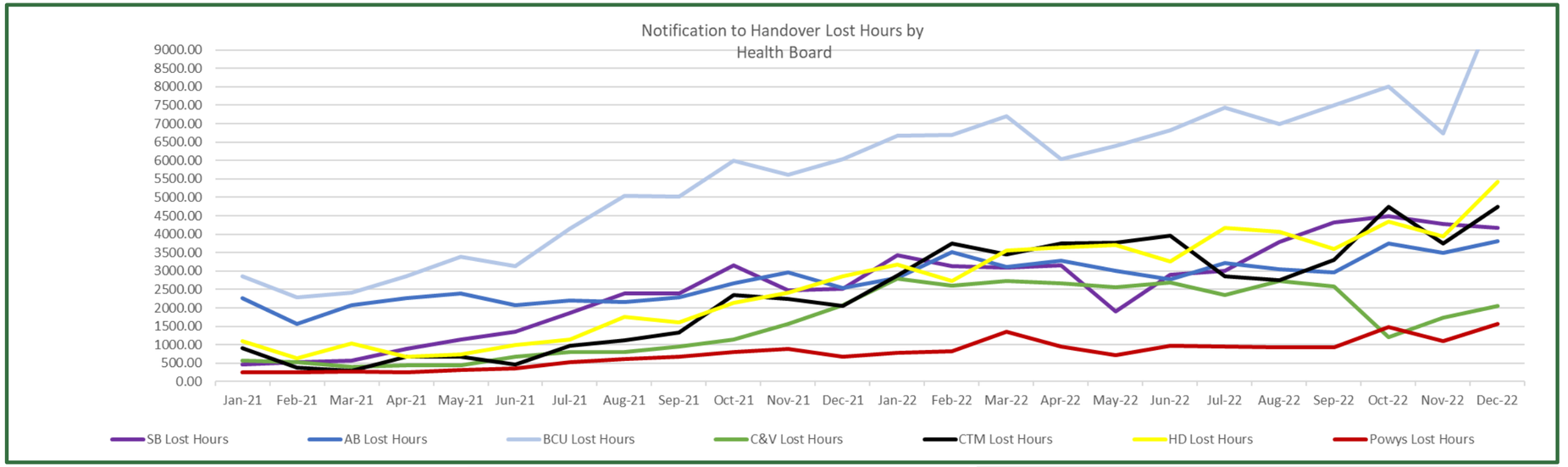
Expected Performance Trajectory

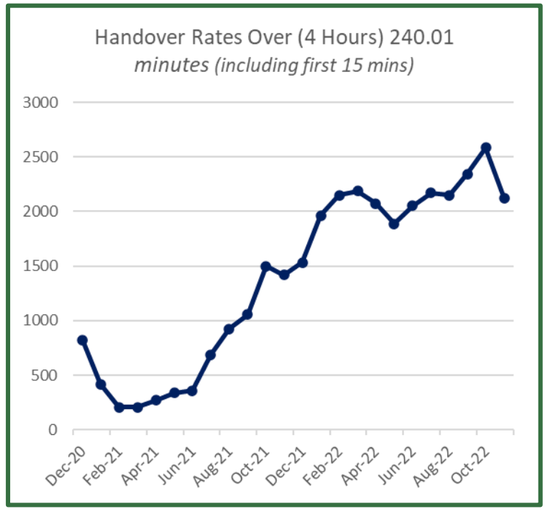
The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes 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 a starting position of 67).

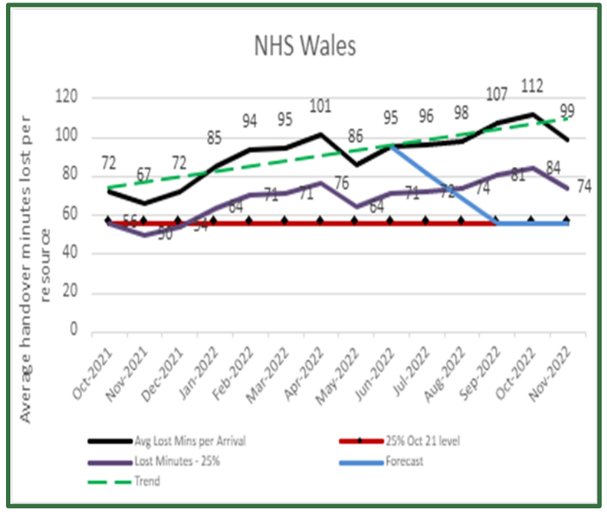
NB: December 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change.

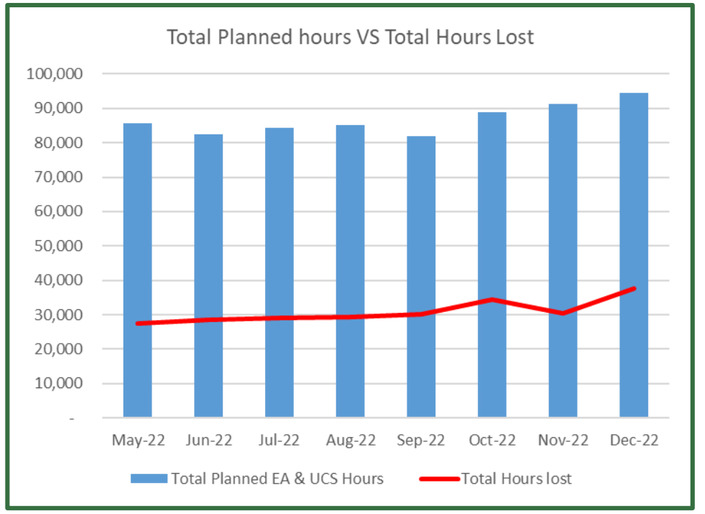
Partnerships / System Contribution
Handover Indicators

R CI QUEST









NB: December data not yet available

Analysis

298,605 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months, compared to 142,812 in same period a year ago (January 2020 to December 2021). 32,049 hours were lost in December 2022, an increase compared to 18,773 lost hours in December 2021. The hospitals with highest levels of handover delays during December 2022 were:

- Morriston Hospital (SBUHB) at 4,299 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) 3,622 lost hours
- Glan Clwyd Hospital Bodelwyddan (BCUHB) at 3,607 lost hours
- The Grange University Hospital (ABUHB) at 3,488 lost hours

Notification to handover lost hours averaged 1,033 hours a day in December 2022.

In December 2022 the Trust could have responded to approximately 10,110 more patients if handovers were reduced.

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). 60 ideas have been received through the WIIN platform from staff in August 2022.

Expected Performance Trajectory

The Ministerial direction is that handover lost hours should return to 25% of their Oct-21 levels, just under 14,000 hours, that there should be no waits over 4 hours and non-release for Immediate Release Requests should become a Never Event.

NB: Data correct at time of abstraction.

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.	**Post Production Lost Hours**	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
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 scute 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

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	Heath 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		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

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Welsh Ambulance Services
NHS Trust

Finance & Performance Committee

Ambulance Care (including NEPTS) Deep Dive

16th January 2023

Opening Remarks for Committee

- Due to REAP4 the pre-Xmas meetings associated with the committee's request to prepare a deep dive were cancelled.
- HOWEVER, it is routine method for the Trust to develop demand & capacity reviews to aid service improvement, in this case the NEPTS Demand & Capacity Review. A demand & capacity review for UCS, the other part of the new Ambulance Care service, is currently being undertaken.
- Also, it is normal business for the Trust to develop transformation programmes out of findings from demand & capacity reviews (and also other business drivers), so there is an established Ambulance Care Transformation Programme.
- The Trust also routinely reports quality and performance on its three patient pathways: 111, Ambulance Care and EMS to Operations Senior Leadership Team and EMT. These reports are more granular than what committees normally see and in effect are a deep dive into each of the pathways.
- The following slides have been produced at pace, but provide committee with a) an overview of the Ambulance Care (NEPTS and UCS) service linking back to the NEPTS demand & capacity review and b) the latest iteration of the Ambulance Care Integrated Quality & Performance Report, with a slide at the end on UCS performance.
- What should be apparent from these slides is that there are clear arrangements for managing quality & performance, clear arrangements for managing transformation, but also the scale and complexity of Ambulance Care; it is not like EMS!

Executive Summary

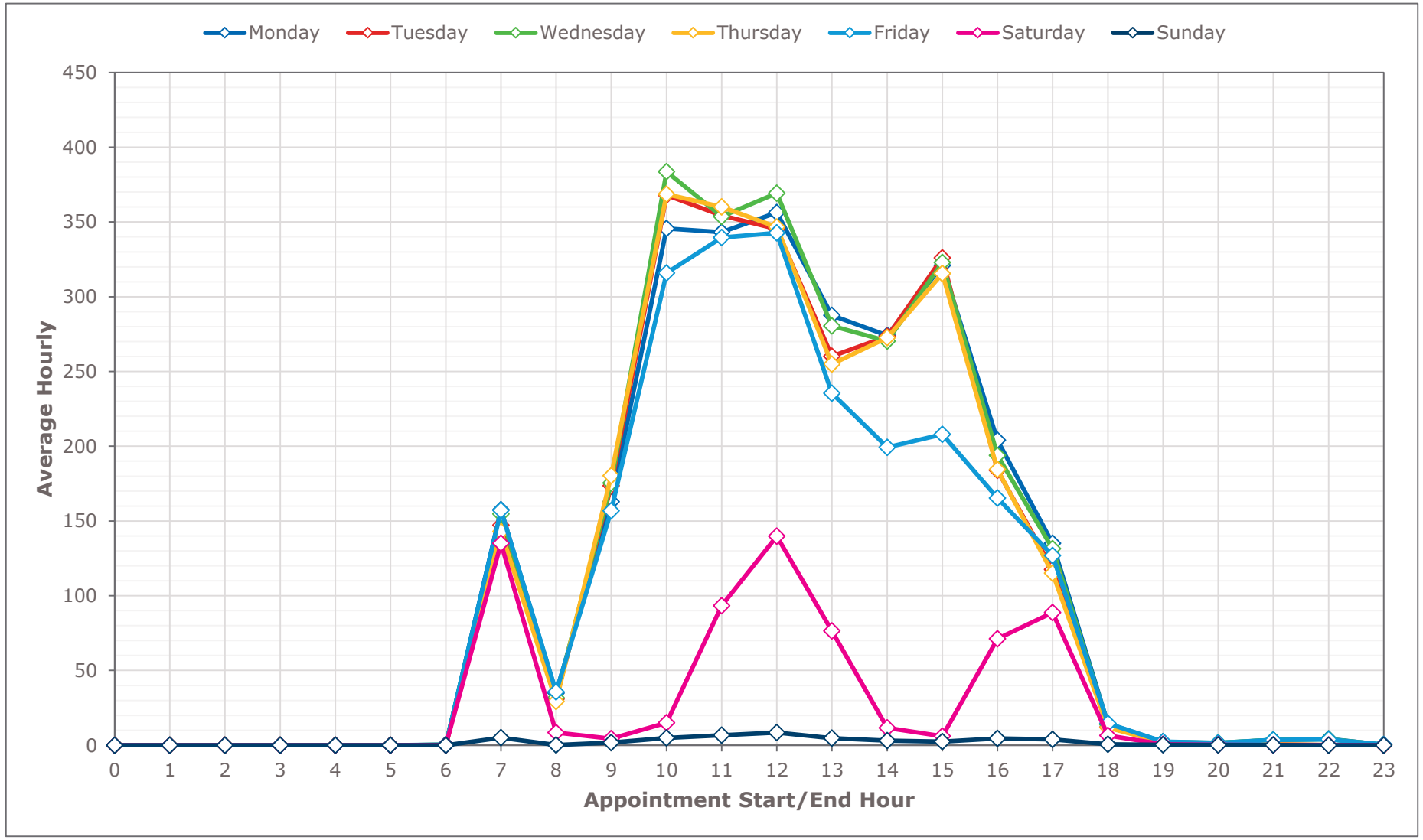
- Ambulance Care combines the Non-Emergency Patient Transport Service (NEPTS) and Unscheduled Care Service (UCS).
- The NEPTS team was created in 2015/16 following approval of a ministerial business case which described a dedicated service delivering all NHS Wales NEPTS work. Prior to this, the service was managed by the EMS management structure. UCS followed in July 2022 to create the Ambulance Care service.
- Both services get much less exposure than 111 or EMS, but they are a critical part of the health care system, NEPTS is particularly complex and services more than double the responded demand of EMS.
- There are established arrangements for modelling, reporting the quality and performance and transforming NEPTS. By contrast the arrangements for UCS are underdeveloped.
- NEPTS performance is generally stable, but the NET Centre and Oncology are two areas of current concern. Although Net Centre performance is on an upward trend, a more stable workforce and re-rostering is required. Oncology requires an Oncology Hub and change to the performance standard.
- UCS is about to undergo a demand and capacity modelling exercise. This will help rebase the service and act as a guide to future decisions on shaping the service going forward. Prior to modelling the Trust needs to clarify the purpose of the UCS to allow for more detailed modelling.

‘It’s not like EMS’

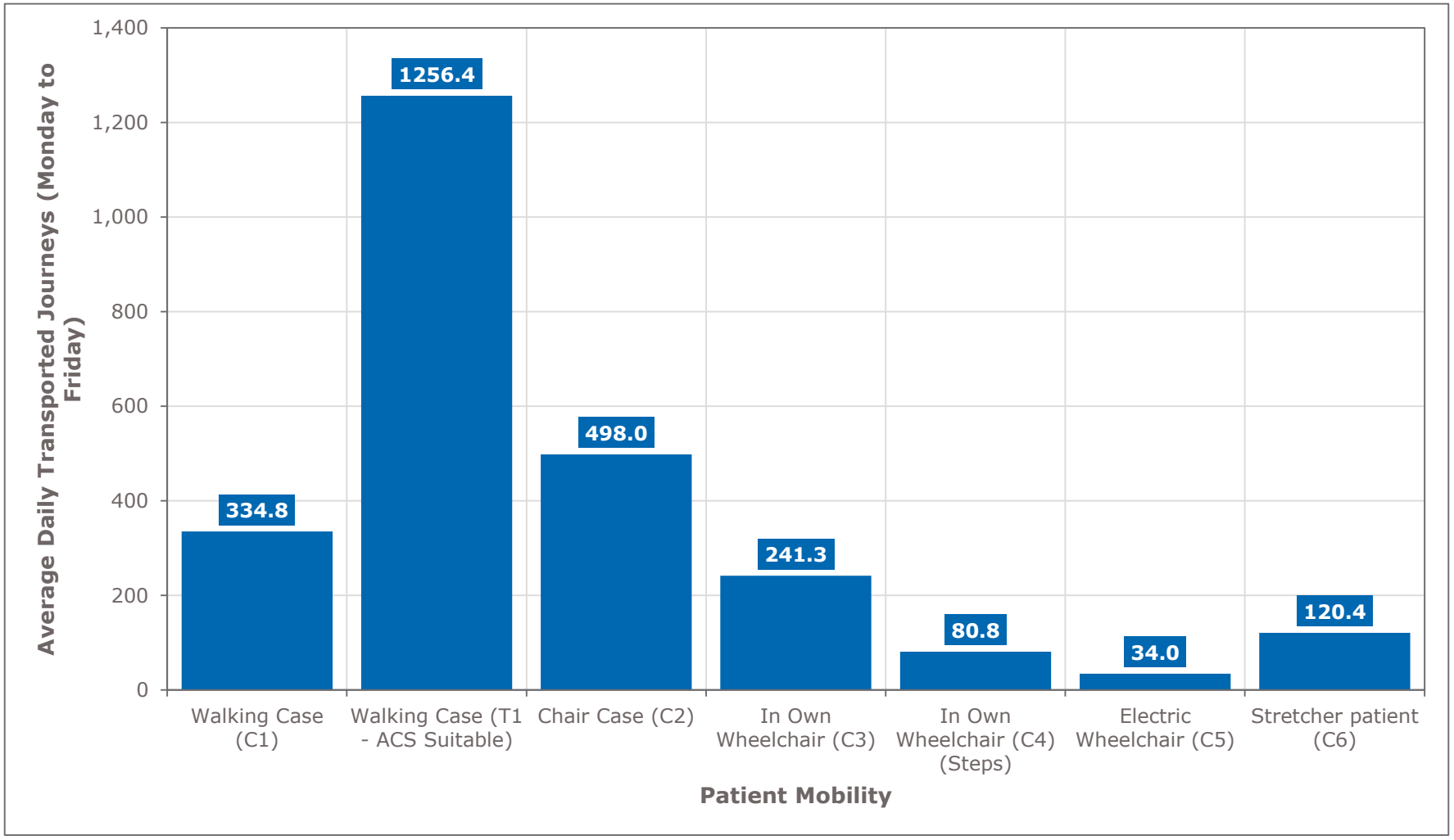
There are many significant difference between NEPTs and EMS across wales:

- Daily patient volumes are significantly higher (c 3000 per weekday compared to c. 1000 in EMS).
- Resource levels are lower than EMS (c 1,500 vehicle hours per day compared to c. 3,500 in EMS)
- Patients have differing mobility requirements and multiple patients can be loaded onto one vehicle
- There are multiple providers of NEPTs transport, not just WAST
- A significant proportion of patients are booked in advance, however, patients are often not ready at their collection time

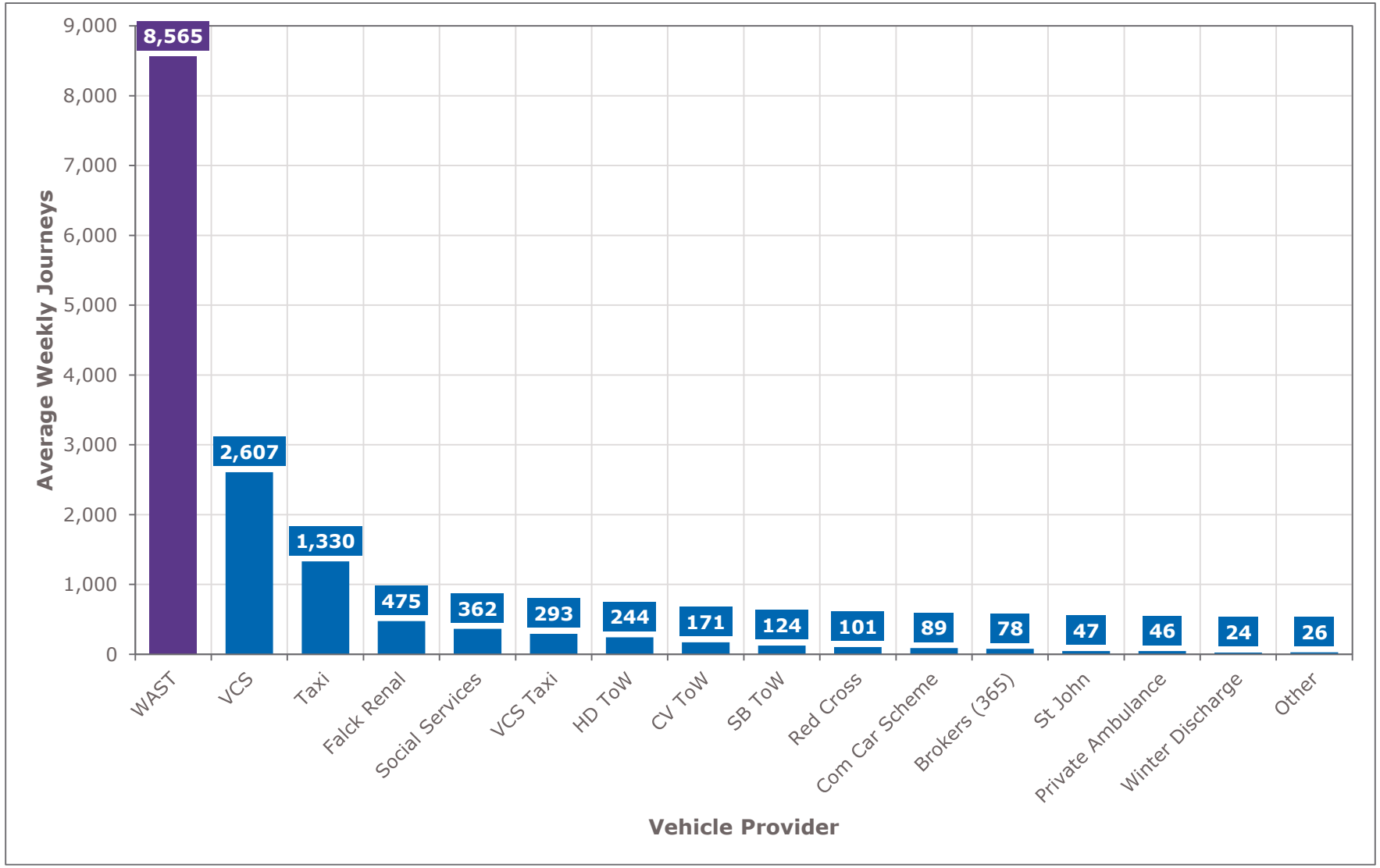
Completed Journeys by Day and Hour



Journeys by Mobility Type



Non-WAST Vehicle Journeys



Funded Frontline FTE

Area	HB	Ops ACA	OTL	Total
Central & West	Abertawe Bro Morgannwg	71.0	3.0	74.0
	Hywel Dda	44.4	1.8	46.2
	Powys	28.8	1.2	30.0
North	Betsi Cadwaladr	93.6	4.2	97.8
South East	Aneurin Bevan	83.1	3.6	86.7
	Cardiff & Vale	55.9	2.4	58.3
	Cwm Taf	45.0	1.8	46.8
Overall		421.7	18.0	439.7

Note: Includes 60% OTL FTE assumed operational

Combined Sensitivities

Based on the individual set of sensitivities, a combined run has been undertaken which shows the potential timeliness if each of the following could be achieved:

- Re-roster
- Future demand
- Add 10% FTE
- 15% reduction in T1 core walker demand
- 50% reduction in late make ready times
- 30% same day booking rate for discharge and transfers
- ToW demand and staffing
- 6-day renal in BCU

The review identified a relief gap of 30 FTEs. 10% would give an increase of 42 FTEs. Neither is expected to be funded.

Combined Sensitivities: Performance

KPI Name	Target	Current FTE: Re-roster		
		WAST Vehicles	Non-WAST Vehicles	All Vehicles
		Performance	Performance	Performance
Core Inbound 1	70%	68.5%	73.8%	70.4%
Core Inbound 2	90%	97.5%	97.0%	97.3%
Oncology Inbound 1	70%	47.6%	52.7%	50.9%
Oncology Inbound 2	90%	83.1%	88.1%	86.3%
Renal Inbound 1	70%	63.5%	72.3%	67.2%
Renal Inbound 2	90%	95.1%	94.0%	94.6%
Core D&T Outbound Advance	90%	80.2%	89.7%	82.0%
Core D&T Outbound Same Day	90%	99.2%	96.9%	98.0%
Core Other Outbound	80%	92.8%	89.5%	91.6%
Oncology Outbound 1	70%	70.1%	78.4%	75.7%
Oncology Outbound 2	90%	89.6%	91.6%	90.9%
Renal Outbound 1	70%	77.1%	82.8%	79.6%
Renal Outbound 2	90%	96.8%	94.7%	95.8%

Note: Not all non-WAST vehicle journeys have the timestamps required to calculate performance

KPIs

- The KPIs used in the NEPTS demand & capacity review are **“performance parameters”** used for modelling purposes, agreed by the Steering Group, which included a patient representative and health board. These are not formally agreed at this time, with a paper expected to EASC Management Group in February 2023.

Name	Measure		Measured Against	Performance Parameter
Core Inbound 1	Arrive prior to appointment within 45 minutes and up to 15 minutes late	-45 <= T < 15	Appointment Time	70%
Core Inbound 2	Arrive no more than 60 minutes late	T < 60	Appointment Time	90%
Oncology Inbound 1	Arrive prior to appointment within 30 minutes	-30 <= T < 0	Appointment Time	70%
Oncology Inbound 2	Arrive no more than 15 minutes late	T < 15	Appointment Time	90%
Renal Inbound 1	Arrive prior to appointment within 30 minutes	-30 <= T < 0	Appointment Time	70%
Renal Inbound 2	Arrive no more than 15 minutes late	T < 15	Appointment Time	90%
Core D&T Outbound Advance	Collected within 60 minutes	T < 60	Latest of Ready Time and Appointment Time	90%
Core D&T Outbound Same Day	Collected within 240 minutes	T < 240	Latest of Ready Time and Appointment Time	90%
Core Other Outbound	Collected within 60 minutes	T < 60	Latest of Ready Time and Appointment Time	80%
Oncology Outbound 1	Collected within 30 minutes	T < 30	Latest of Ready Time and Appointment Time	70%
Oncology Outbound 2	Collected within 60 minutes	T < 60	Latest of Ready Time and Appointment Time	90%
Renal Outbound 1	Collected within 30 minutes	T < 30	Latest of Ready Time and Appointment Time	70%
Renal Outbound 2	Collected within 60 minutes	T < 60	Latest of Ready Time and Appointment Time	90%

Control Summary

NET Centre (Call Taking)

- With staff re-rostered and no demand increase, KPIs can be achieved within the funded staffing level (19.6 FTE).
- Taking on Ty Elai and Powys calls requires 4.2 FTE (funding/people will transfer from existing providers).
- **Up to 6 additional FTE are required by 2024**, with potential for around 4.5 FTE to be saved through efficiencies.

Planning/Day Control

- Current desks are well suited to NEPTS, with workload well balanced, requiring no significant change to the configuration.
- Ystradgynlais vehicles would be more appropriately controlled from the Swansea Bay desks.
- Proposed day control additions take the requirement to 50.3 FTE, **an increase of 12.2 FTE from the funded position**.

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Welsh Ambulance Services
NHS Trust

Fortnightly EMT
Integrated Quality & Performance Report

Ambulance Care

04th January 2023

Summary

- Call answering and abandonment rates continue to remain challenging, and the percentage of calls answered within 60 seconds saw a decrease in November 2022 to 44.7%, compare to October 2022 (53.3%). However, the overall projection in the last few months shows a positive trend.
- The % of Discharge & Transfer bookings made after 12 noon the day before travel has decreased by 20% year on year and averaged 48% in 2021-22 (43.2% November 2022). This is due to a reduction in the proportion of discharge & transfer journeys which are traditionally booked late.
- There continues to be monthly variation in the number of patient journeys undertaken in each of the category's (Discharge & Transfer; Core (Other); Enhanced Renal & Enhanced Oncology), there were increases in the number of Core, Enhanced Renal journeys Discharge & transfer and Enhanced oncology journeys in November 2022.
- The % of Enhanced Renal Journeys arriving within 30 minutes prior to their appointment time consistently exceeds the 70% performance target (74.9% November 2022). In comparison the % of Enhanced Oncology journeys arriving within 30 minutes consistently fails to achieve the 70% target (46.7% November 2022). Core in-bound journeys continue a mostly downward trajectory (improvements seen July and August 2022) has been declining since February 2022 and is below target (64.3% in November 2022). Overall performance is above target or near target on core, renal, oncology and discharge and transfer.
- Taxi utilisation saw a significant increase because of the pandemic; however, social distancing measures have now been relaxed on NEPTS vehicles (except for respiratory). November 2022 saw a very small increased in taxi use; however, overall is on a reduction trend, largely because of work underway to address this linked to the in-year funding the Trust is receiving. In November 2022 4.4% journeys were undertaken by taxis compared to more than 15% at its peak.
- There are ongoing challenges with the accuracy of ready times for Core, Oncology and Discharge & Transfer Outbound journeys. This is being addressed through one of the transformation workstreams
- Sickness reduced in November 2022 to 10.89% compared to October 12.25%. Annual Leave in November (11.34%) also reduced compared to October (11.97%).

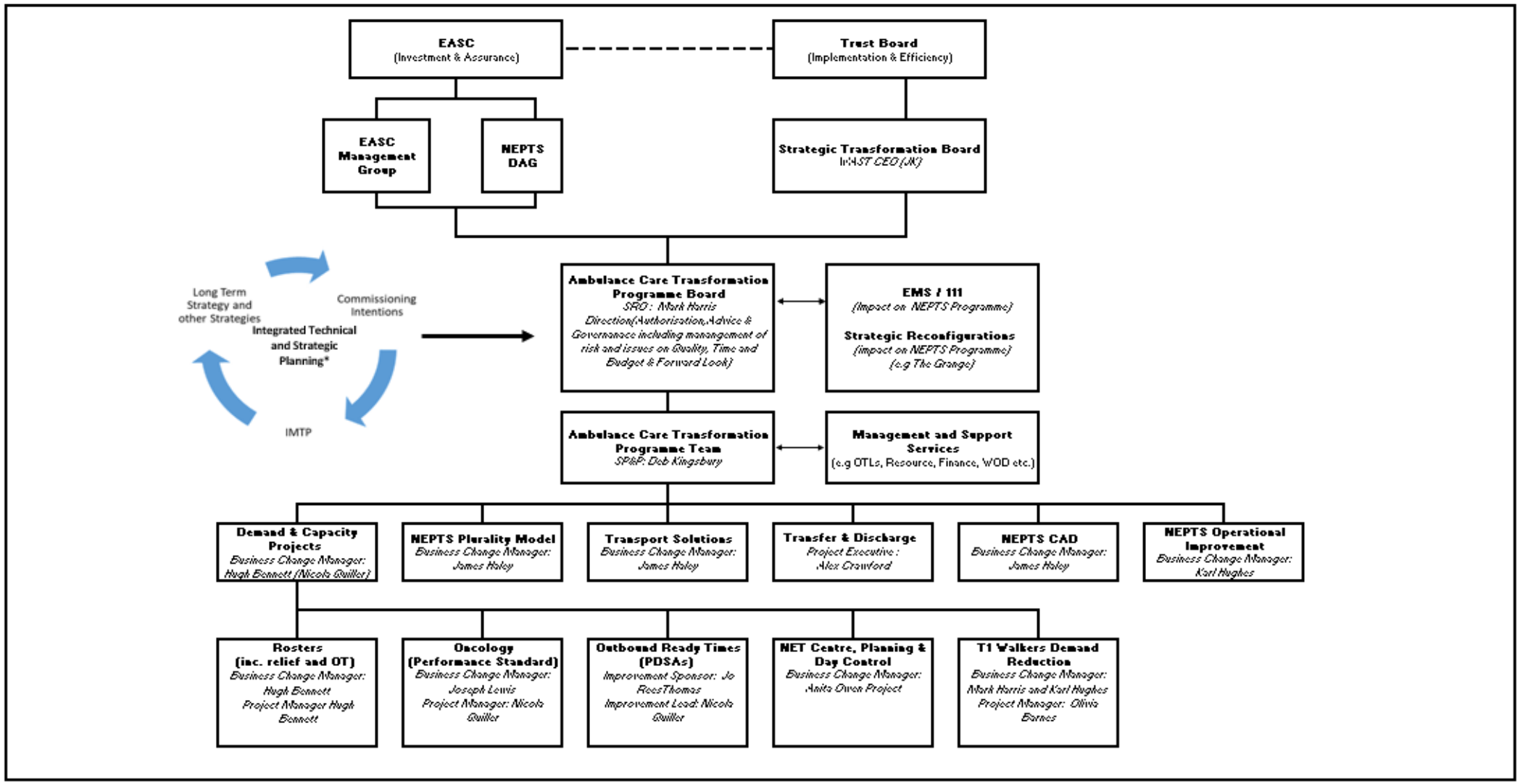
Transformation

- D&C Project: the revised keys are currently being developed. A PDSA has been written to test the ORH keys against the revised keys (ORH++) and the PID is expected in November 2022.
- NEPTS Operational Improvement: it has been agreed at ACT programme board that the Resource Downtime workstream is complete; the new report is in place and is being reviewed regularly as 'business as usual'. Contact has been made with BCUHB to restart the discharge lounge trial and data is being collated in relation to the Oncology booking process PDSA and will be shared at the next ACT programme board.
- Transfer and Discharge Project:
  - Major Trauma Network: this workstream is now complete. WAST has responded to the peer review paper and the recommendations from this are being considered within the Transfer and Discharge project.
  - Transfer and Discharge Service: the project team has been established and the PID has been approved by ACT. Work is in progress with regards to the modelling (ToR drafted) and understanding the data in order to develop a concept for consideration by EASC at the end of the financial year.
  - Vascular Network in SE Wales: this workstream is complete as the network went live on 18 July 2022. Ongoing attendance at operational meetings have not identified any significant issues.
- Transport Solutions: Health Boards have been engaged with training for the online booking system, in line with the deadline of end of December 2022 after which telephone bookings will no longer be accepted.
- NEPTS Plurality Model: the procurement process has continued and whilst this has taken longer than expected, contracts less than 12 months in length will be awarded by 30th November. Providers have been procured for the interim period.
- NEPTS CAD Upgrade: whilst there have been challenges to the timeline for this project, the new go live date is confirmed 11th January, this is under review due to the announcement of GMB strike action.

Transformation (continued)

- Alignment of clinic ready times and ambulance availability: 100 clinics live with another 250 in the pipeline.
- Quality and performance standards: paper drafted, which will go into the EASC governance mechanisms in Q4 with expected go live 01 April 2023.
- Oncology: SBAR for change of oncology performance indicators and enhanced services hub drafted. With AD Commissioning & Performance for review.
- A paper will be developed to share with the commissioner and Welsh Government in the weeks ahead that sets out the current position on eligibility and the measures the service uses to manage patients that are not-eligible based on our interpretation of the Welsh health circular. This paper will be used to request that clarity is provided on the way forward and how commissioners plan to address subsequent funding impacts.
- UCS modelling: terms of reference agreed, project team established, ORH procured, data currently being collected.

Transformation: Ambulance Care Programme



*Integrated Technical and Strategic Planning includes Fleet, Estates, WOD and Resourcing

Transformation: Projects Explained

- D&C Projects: these include the re-rostering of the NEPTS ambulances, looking at efficient ways to improve oncology performance, aligning the patient ready times at clinics with our ambulance availability, re-rostering the NET Centre (and delivering other efficiencies e.g. line automation), capacity improvements to planning (not funded) and a tighter focus on eligible patient demand.

- Plurality Model: this is about driving out economies of scale (efficiencies/effectiveness) from WAST being the sole provider/purchaser of non-emergency patient transport for NHS Wales.

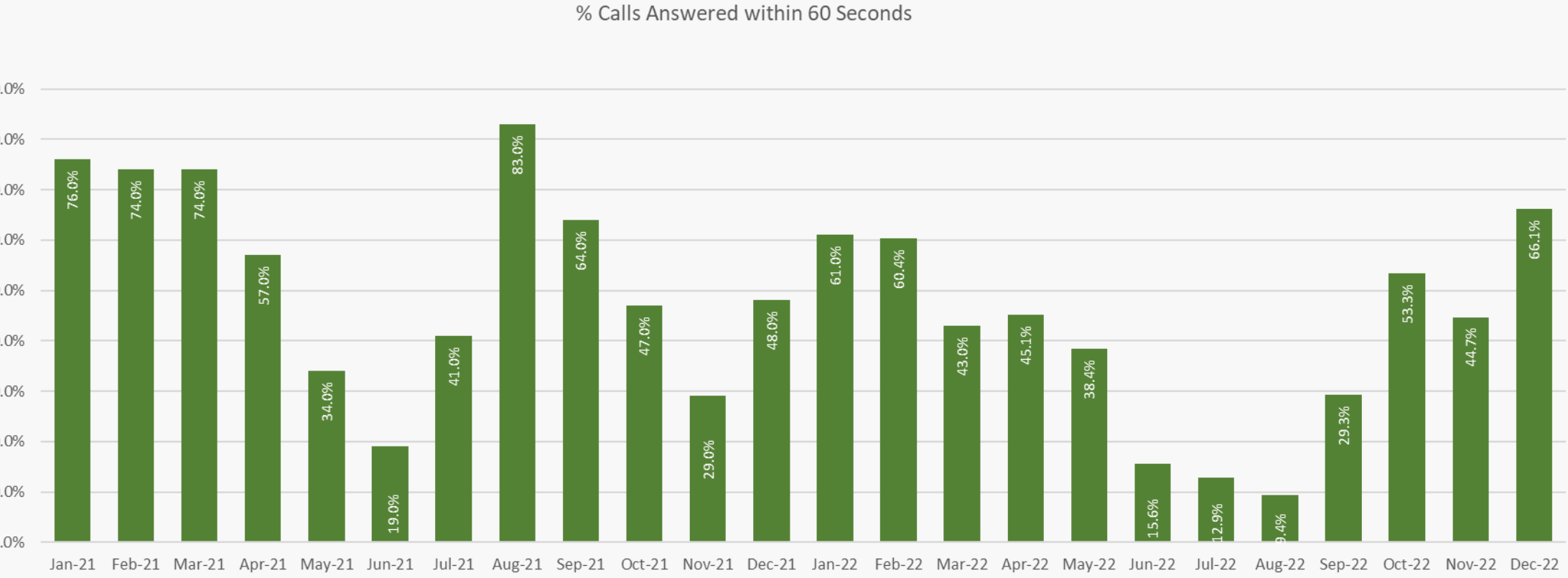
- Transport Solutions: patient eligibility criteria for using NEPTS.

- Transfer & Discharge: the potential national (commissioned) discrete service.

- NEPTS CAD: the upgrade of Cleric and its potential replacements.

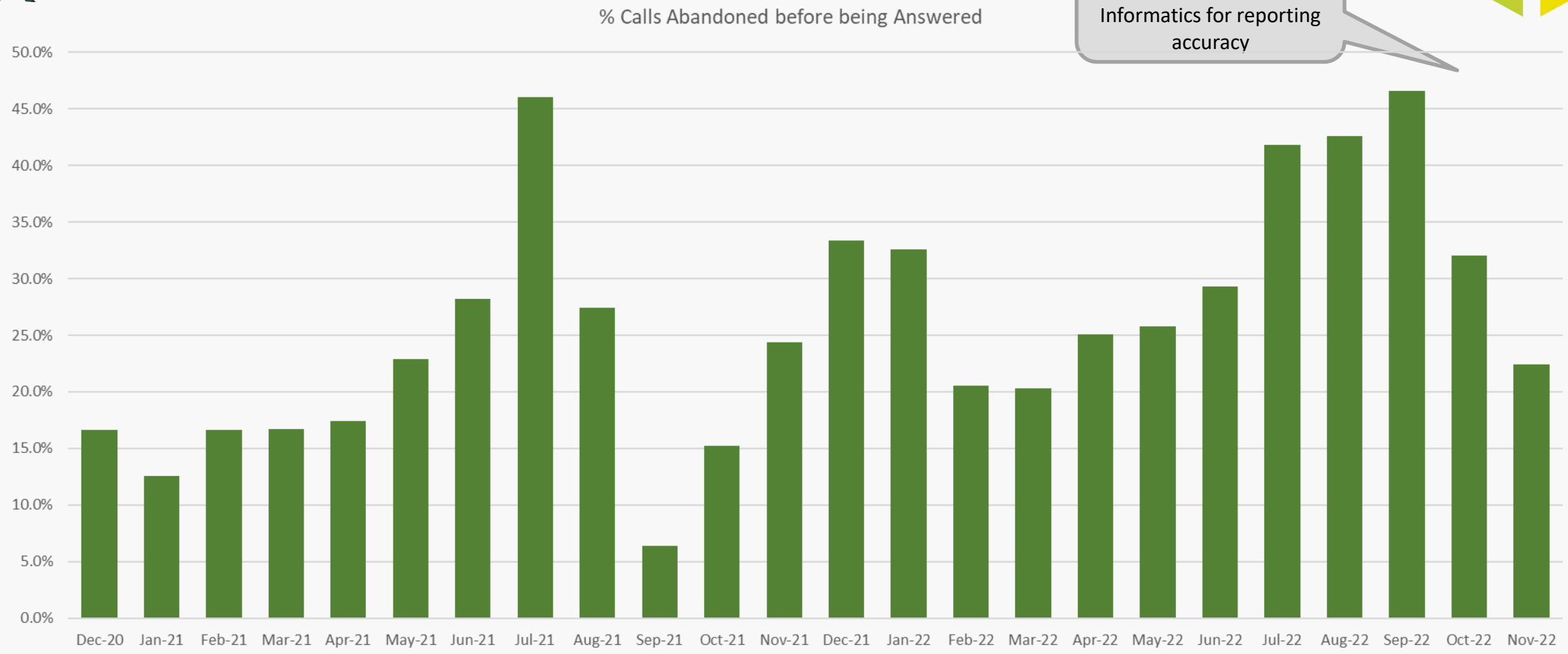
- NEPTS Operational Improvements: efficiencies, for example post production lost hours, discharge lounge trial etc.

Our Patients: Quality, Safety & Patient Experience
Ambulance Care



Our Patients: Quality, Safety & Patient Experience
Ambulance Care

Figures currently under review with health Informatics for reporting accuracy



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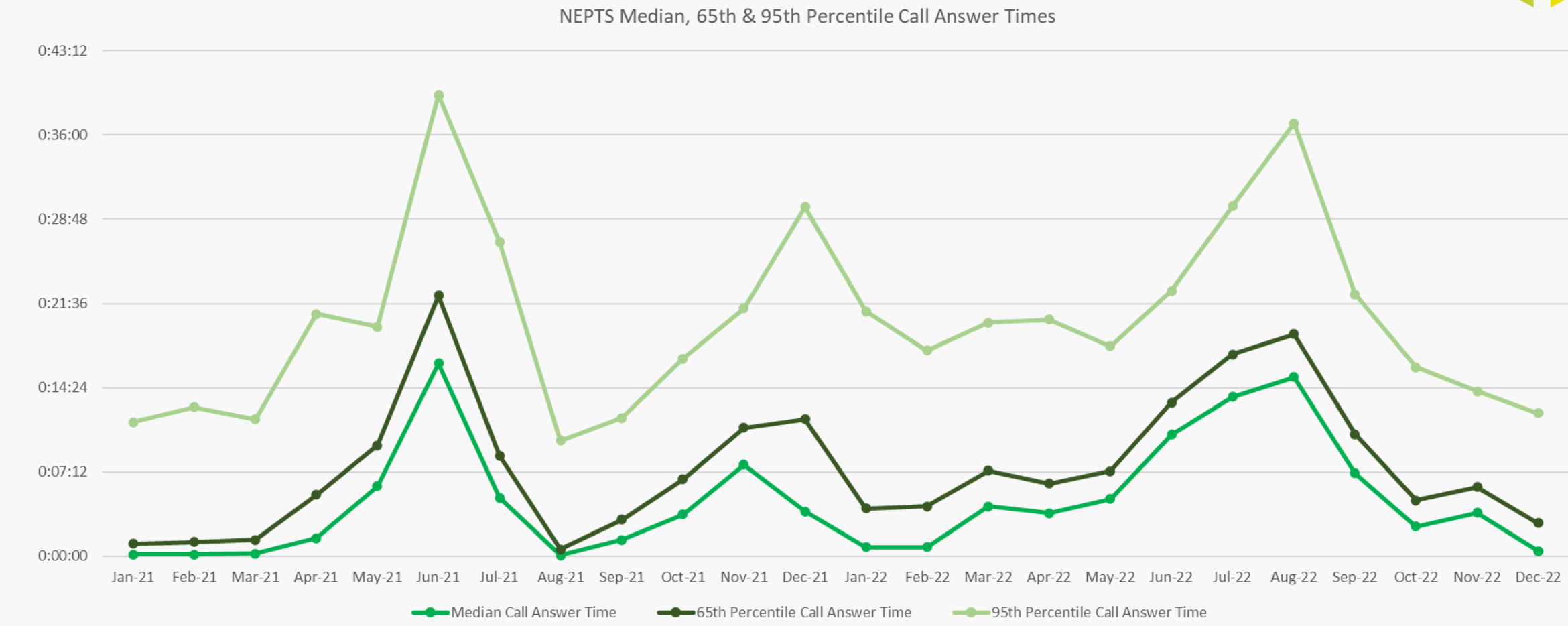
Ambulance Care



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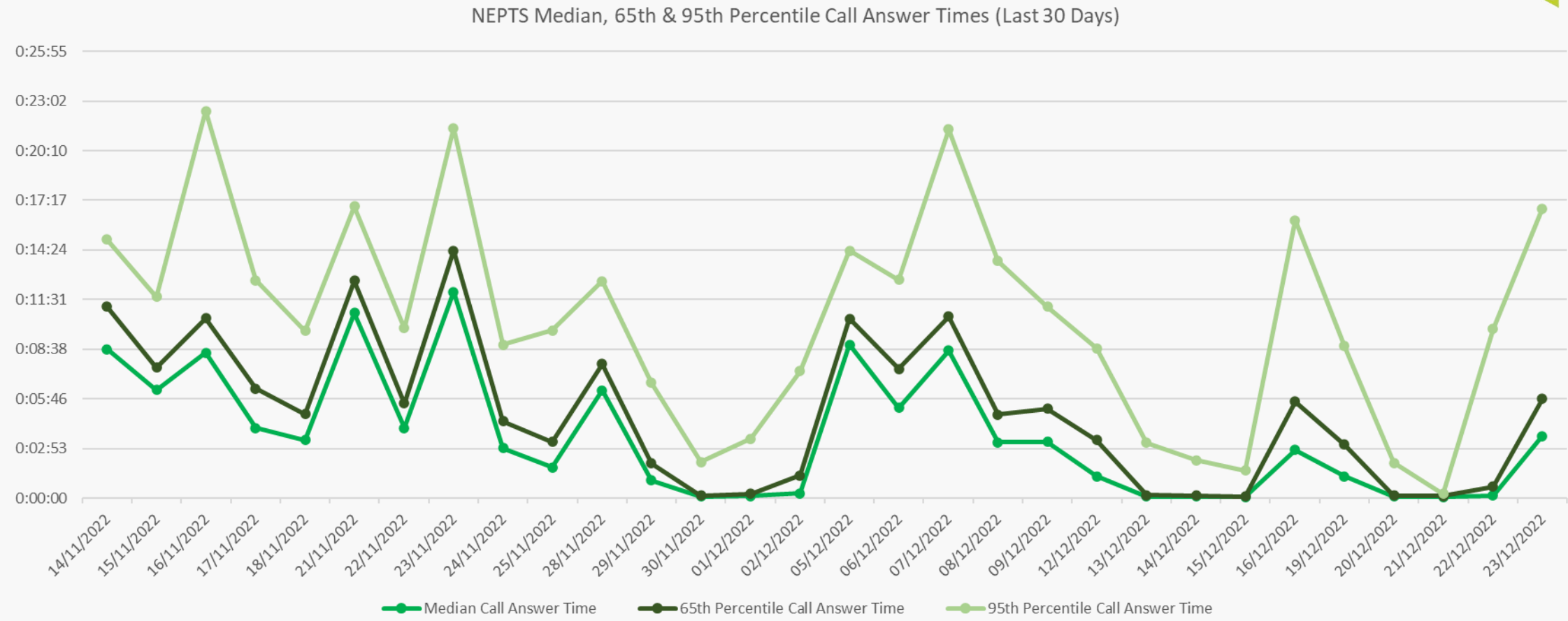
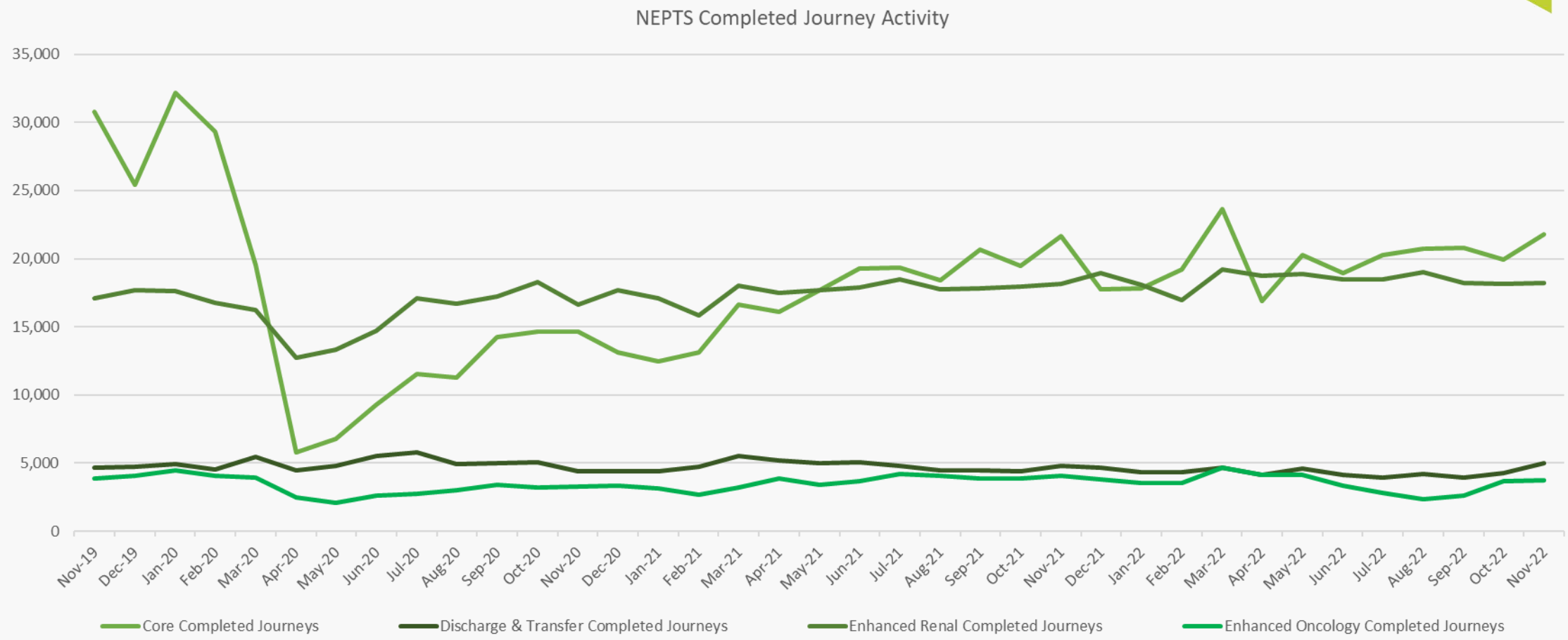


NB: service does not operate on a Saturday or Sunday

Our Patients: Quality, Safety & Patient Experience
Ambulance Care



Our Patients: Quality, Safety & Patient Experience
Ambulance Care

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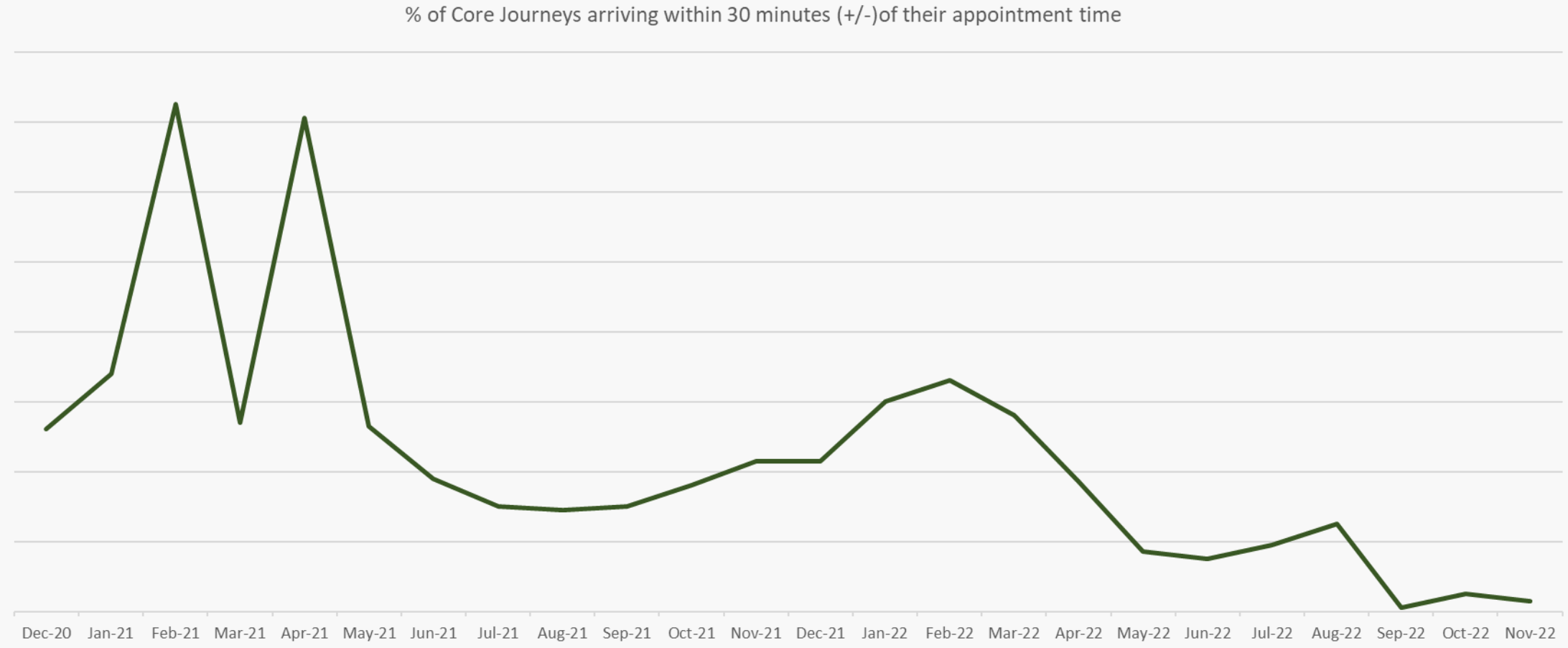

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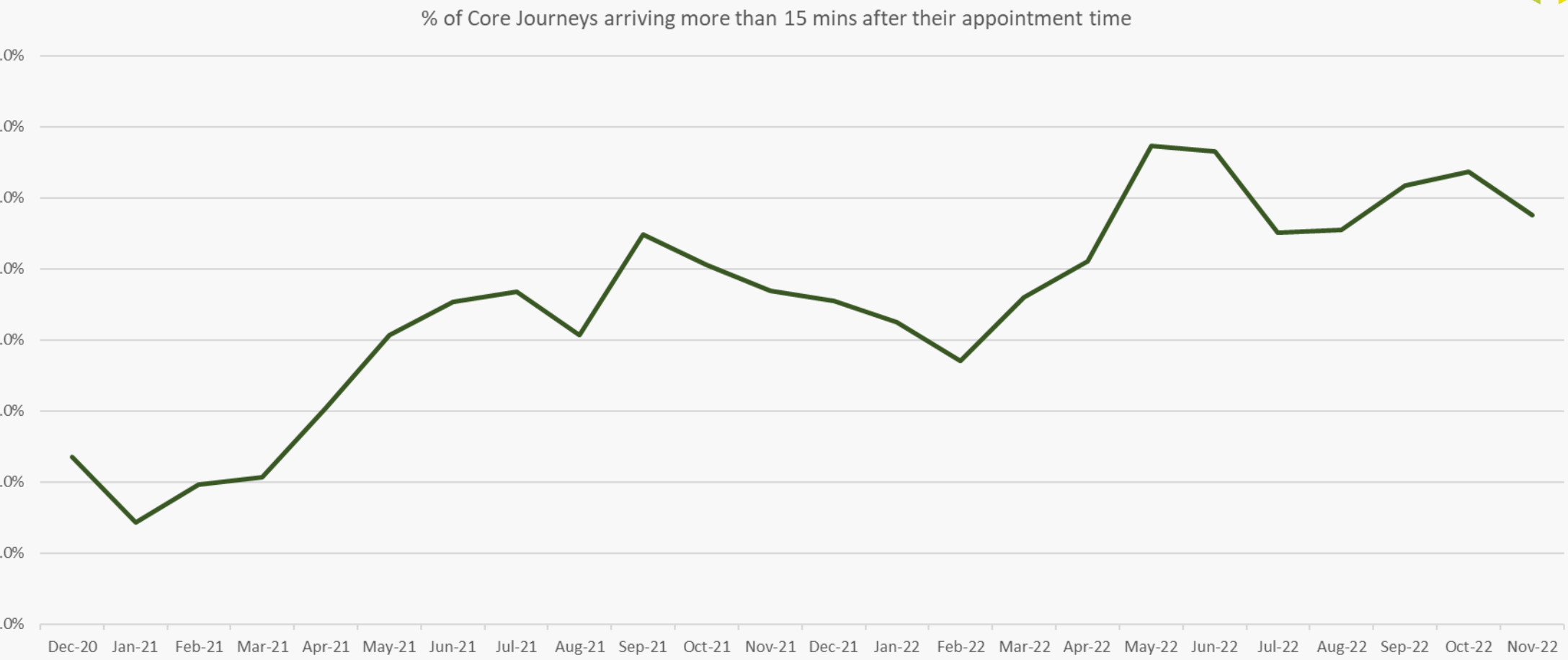
Ambulance Care



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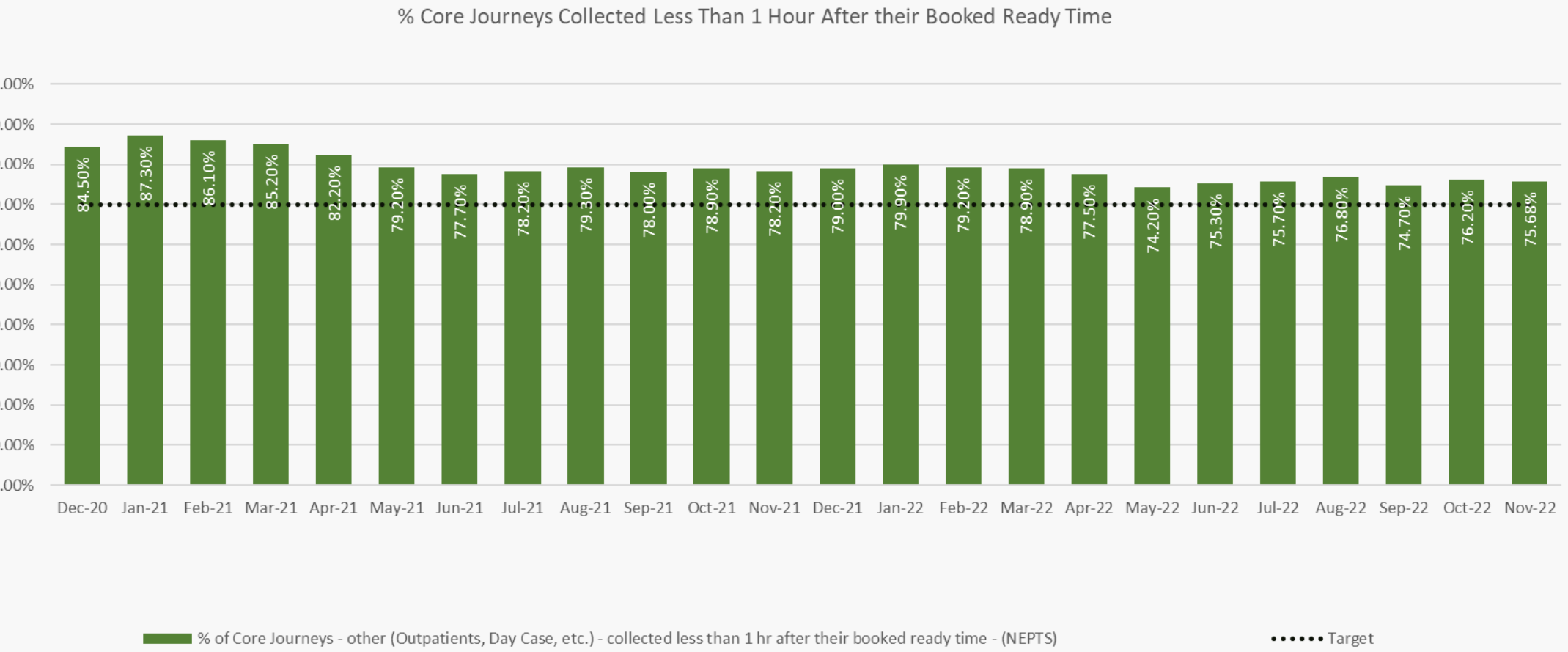
Ambulance Care



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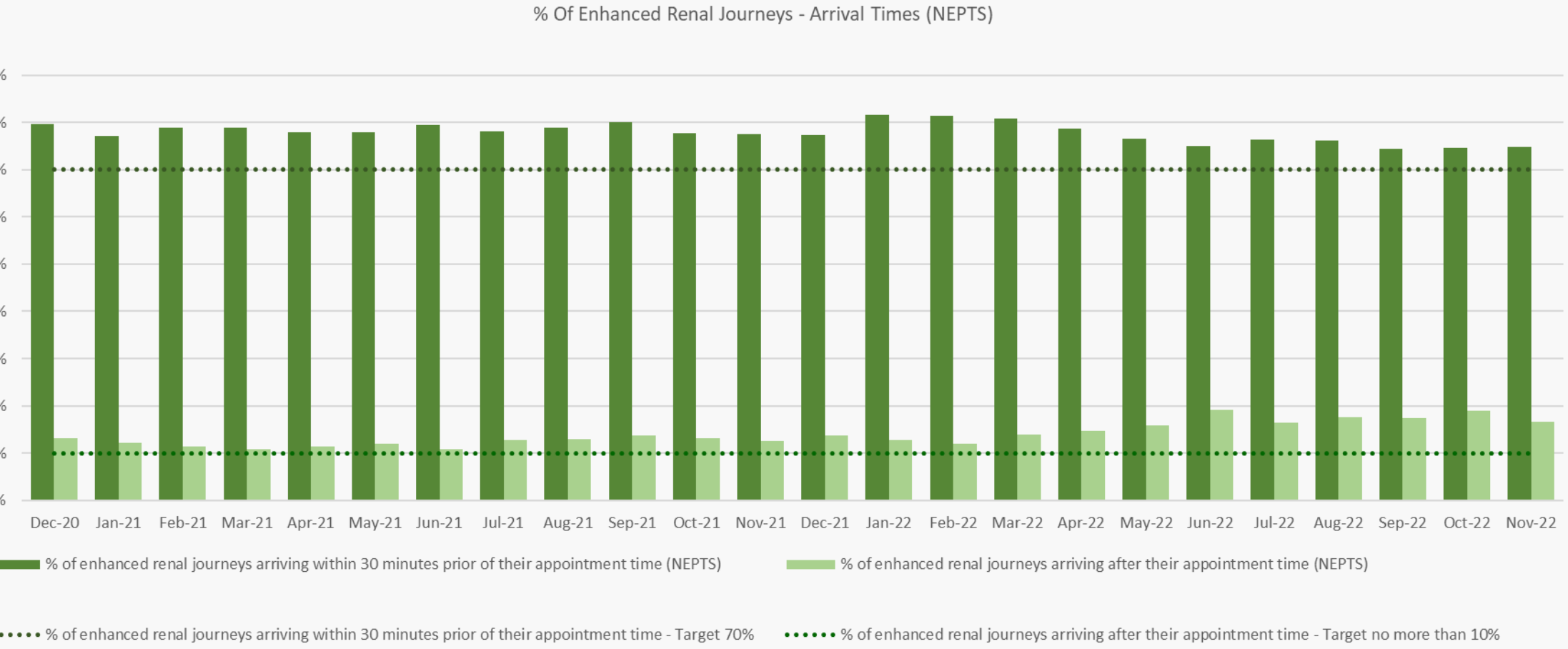
Ambulance Care



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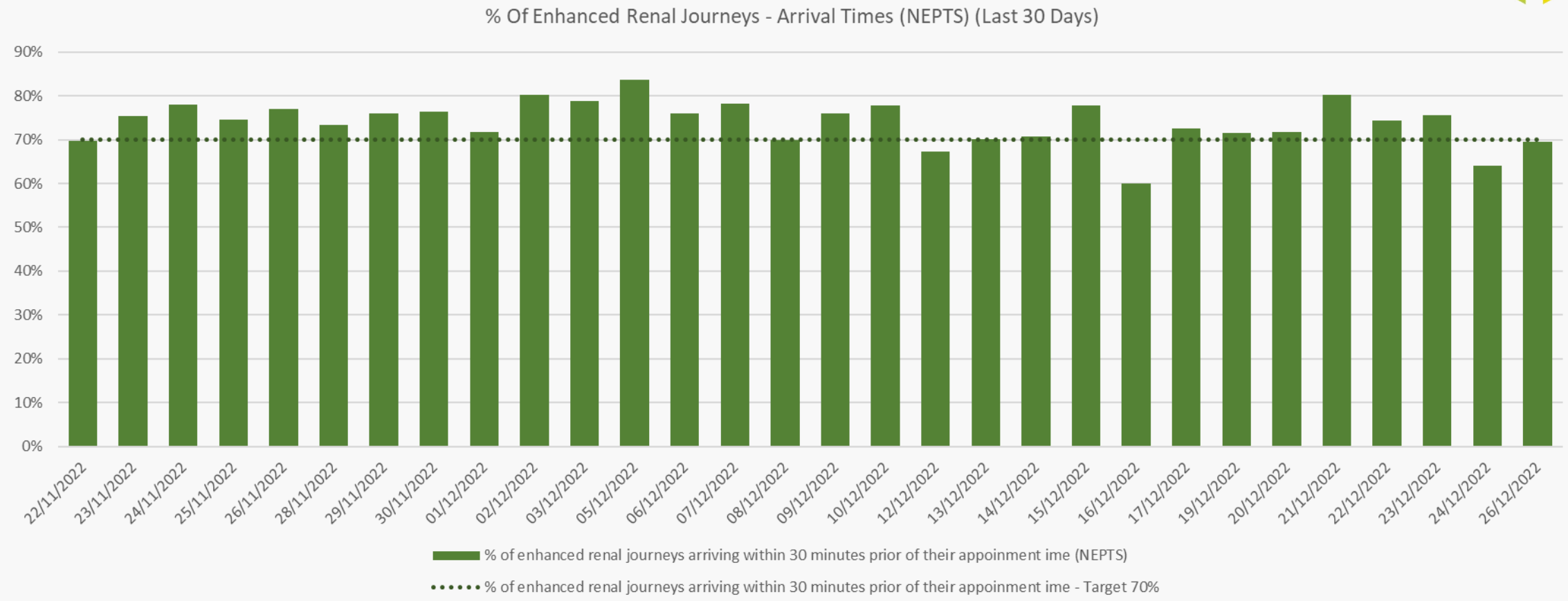
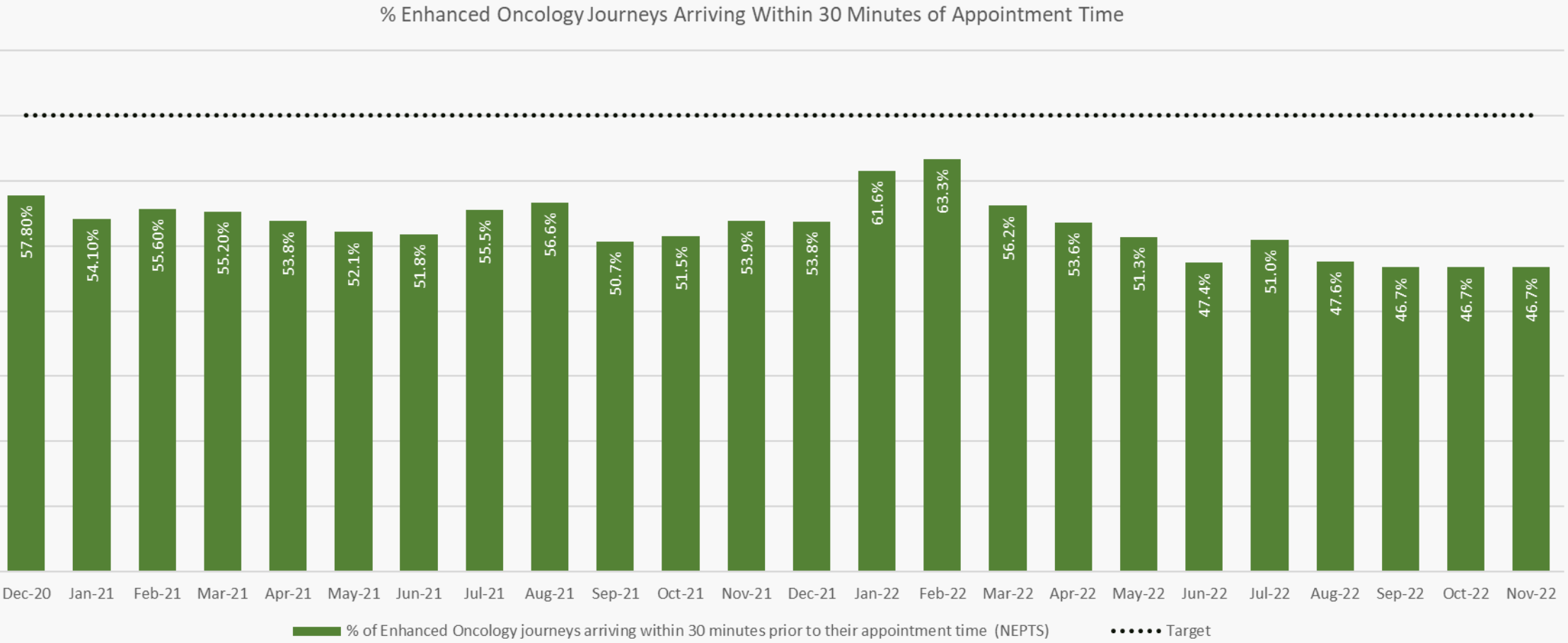
Ambulance Care



NB: service does not operate on a Sunday

Our Patients: Quality, Safety & Patient Experience
Ambulance Care



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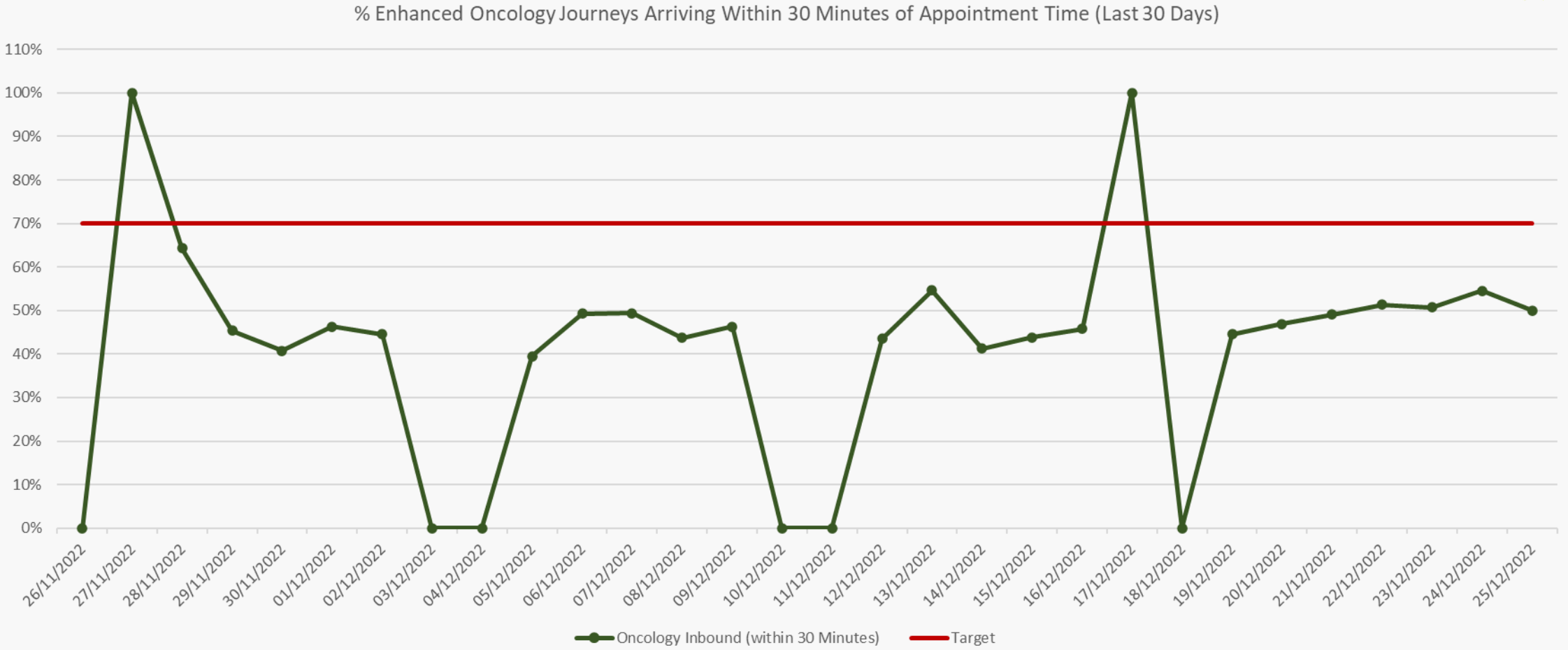
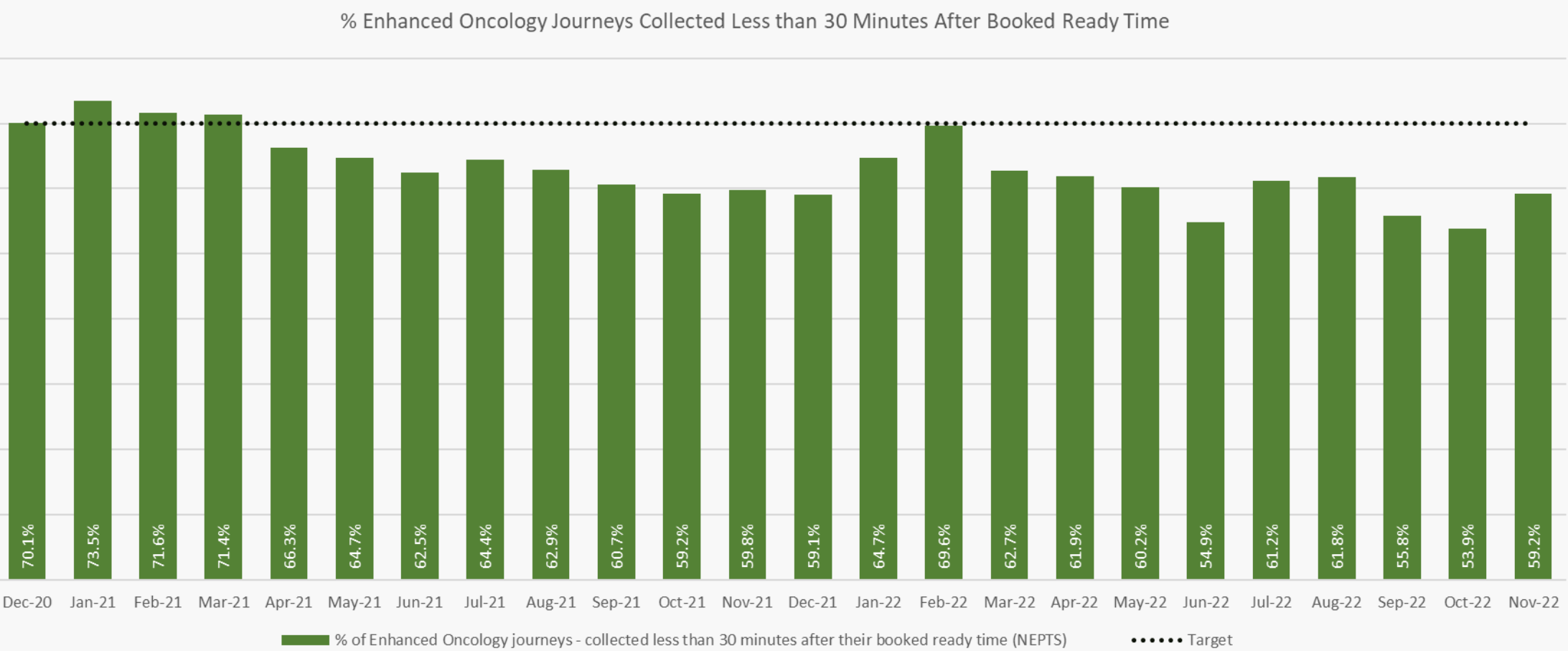


Our Patients: Quality, Safety & Patient Experience
Ambulance Care



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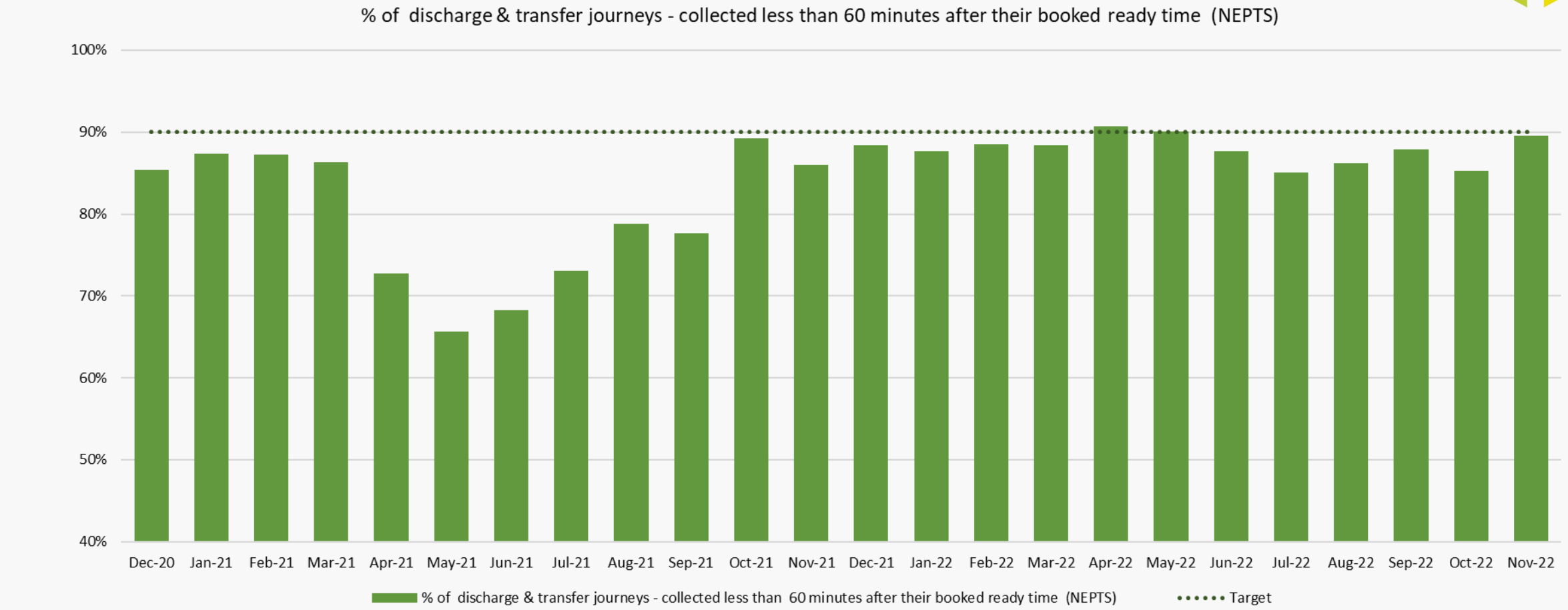

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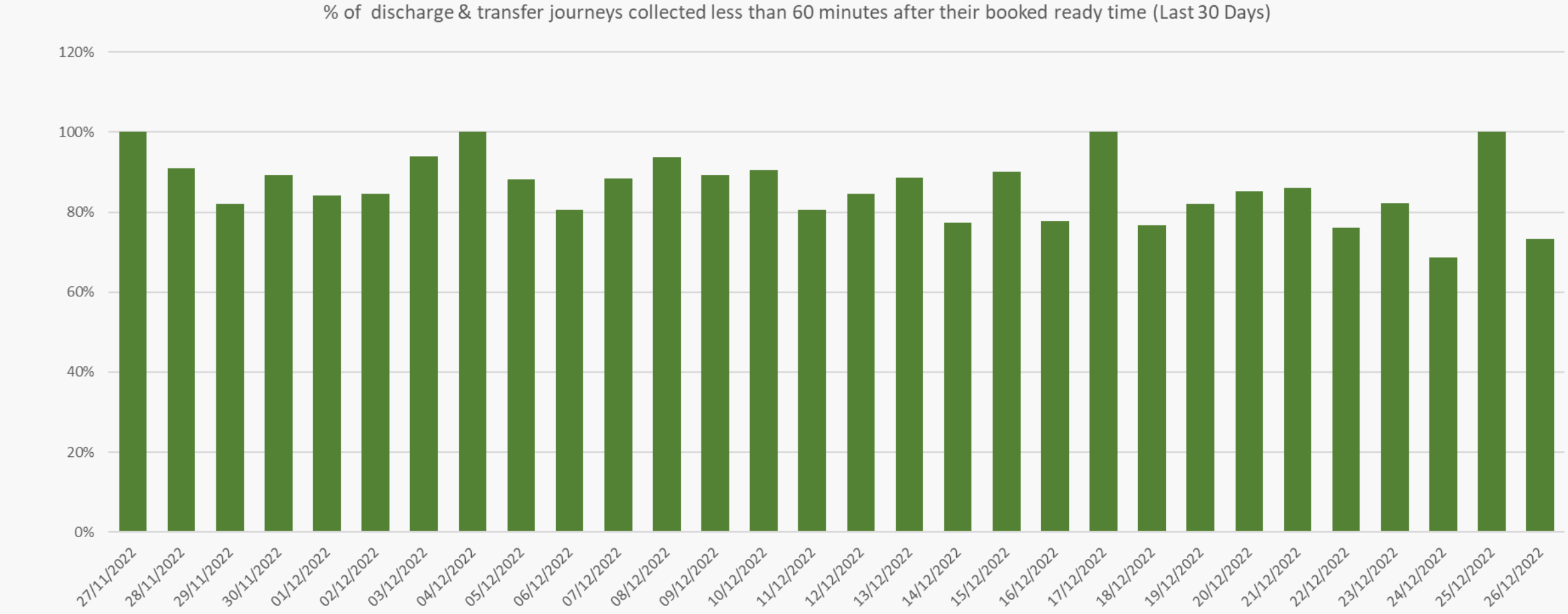

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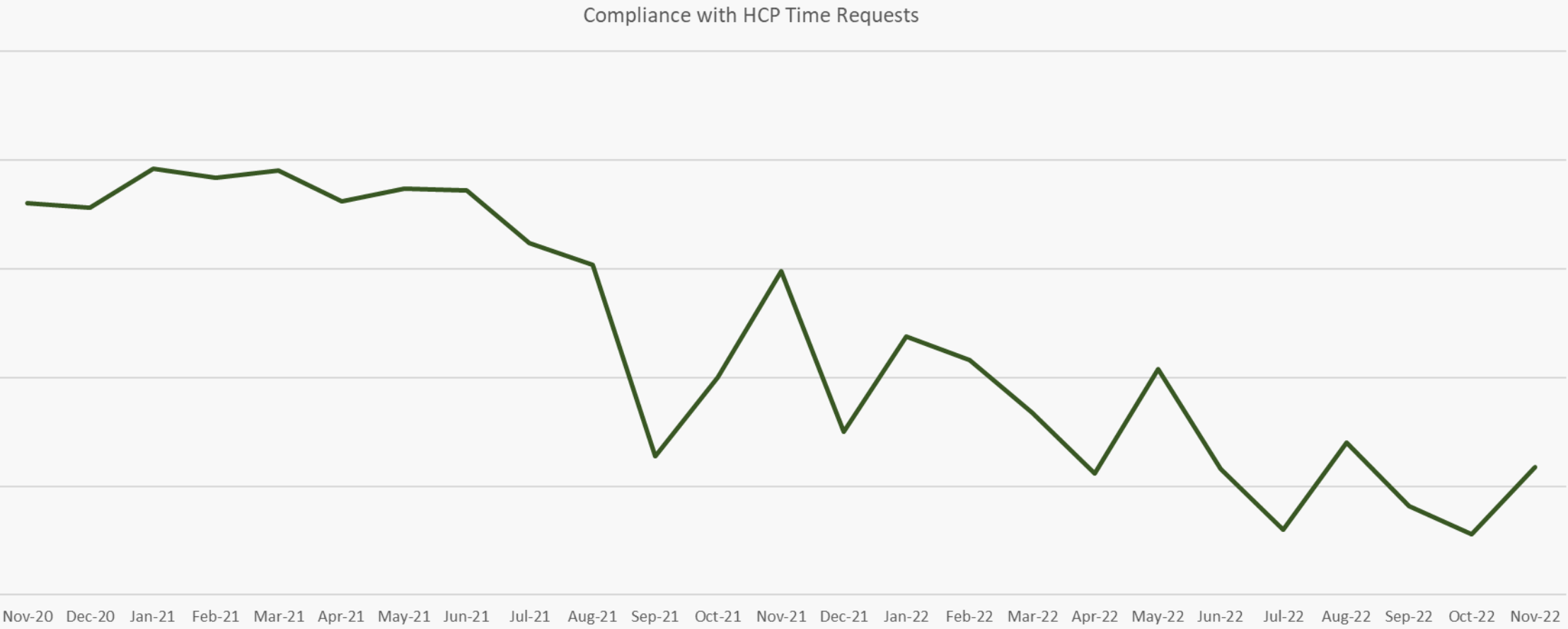

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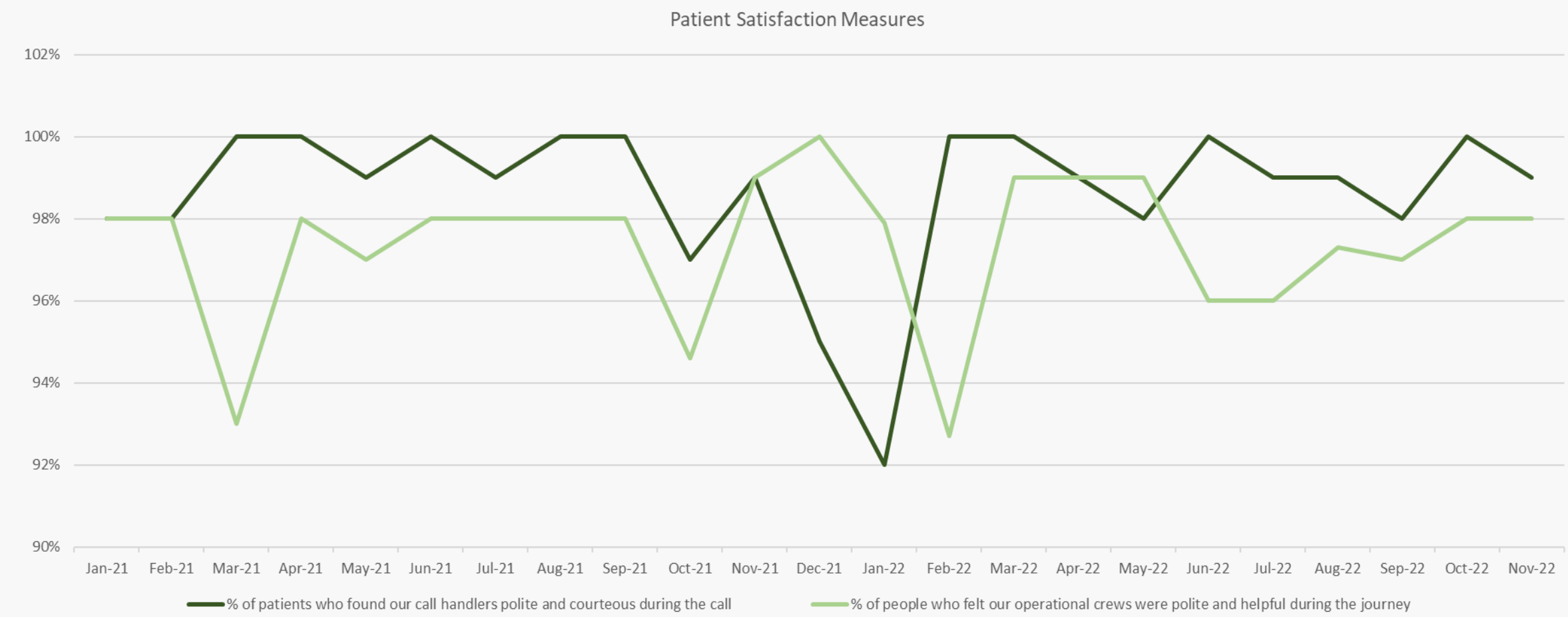

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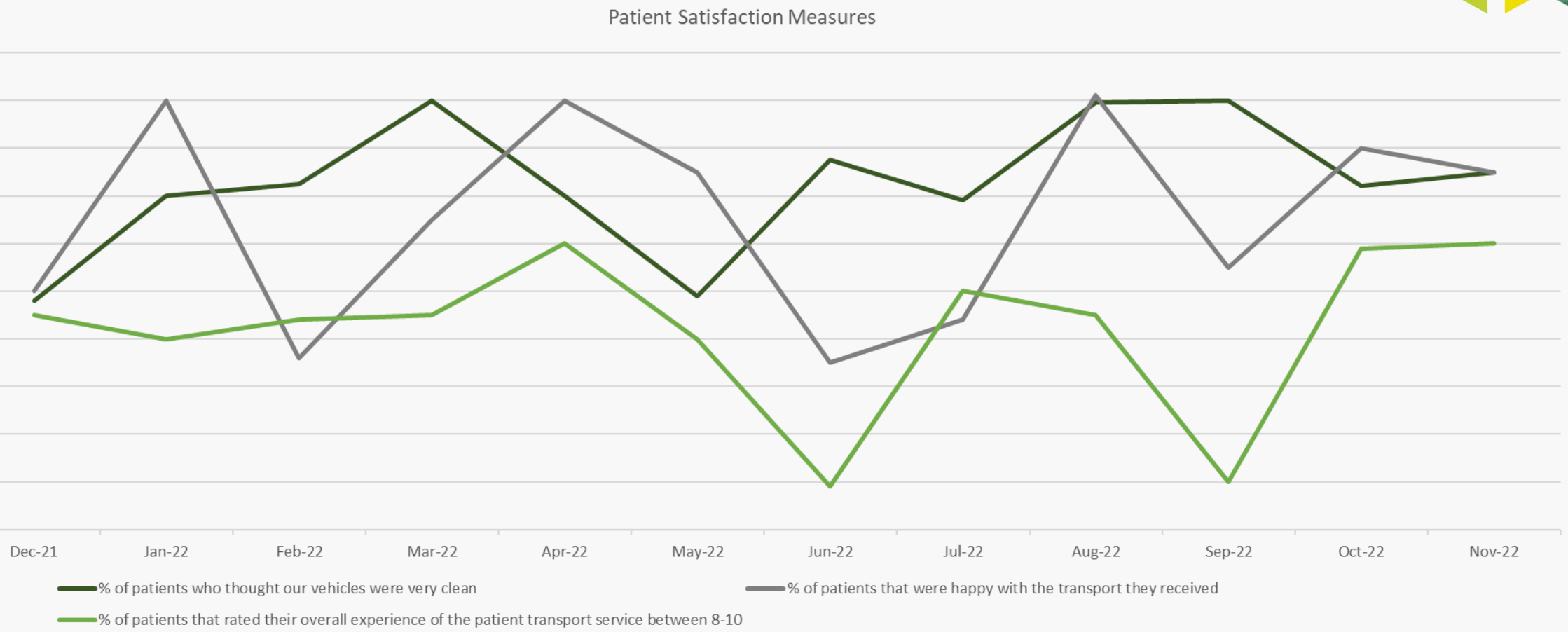
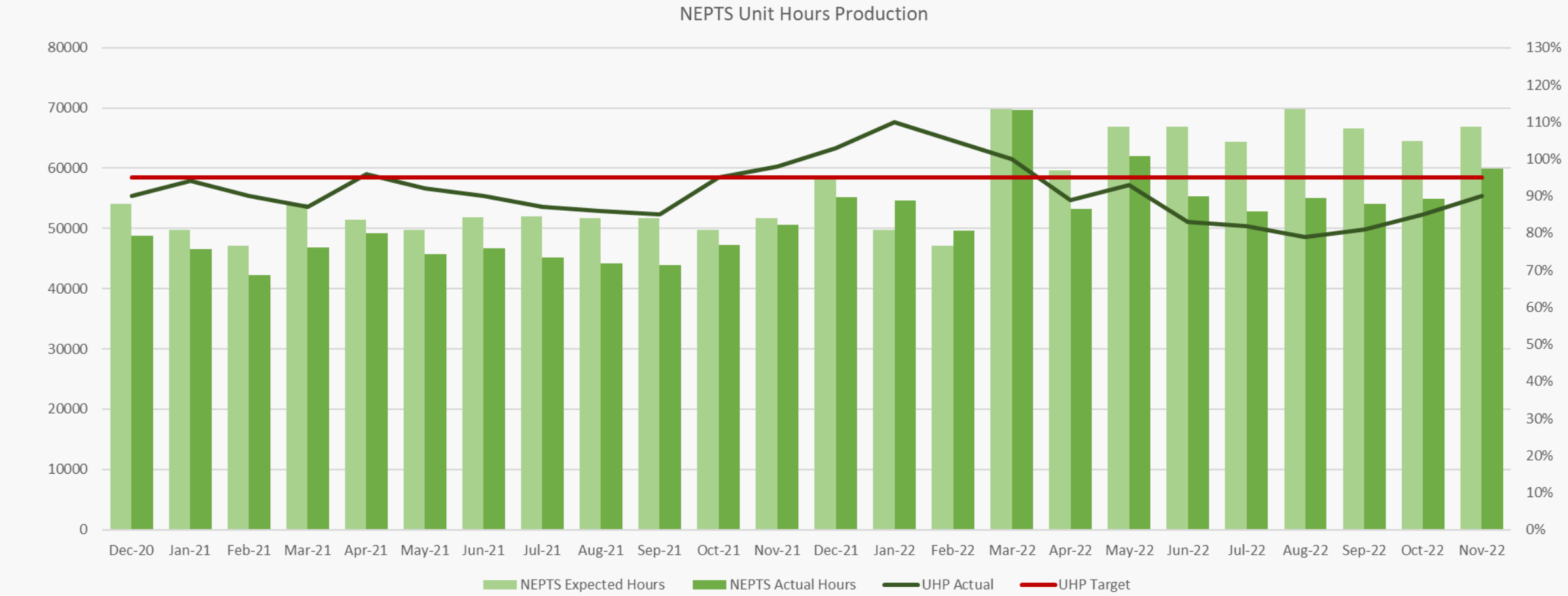
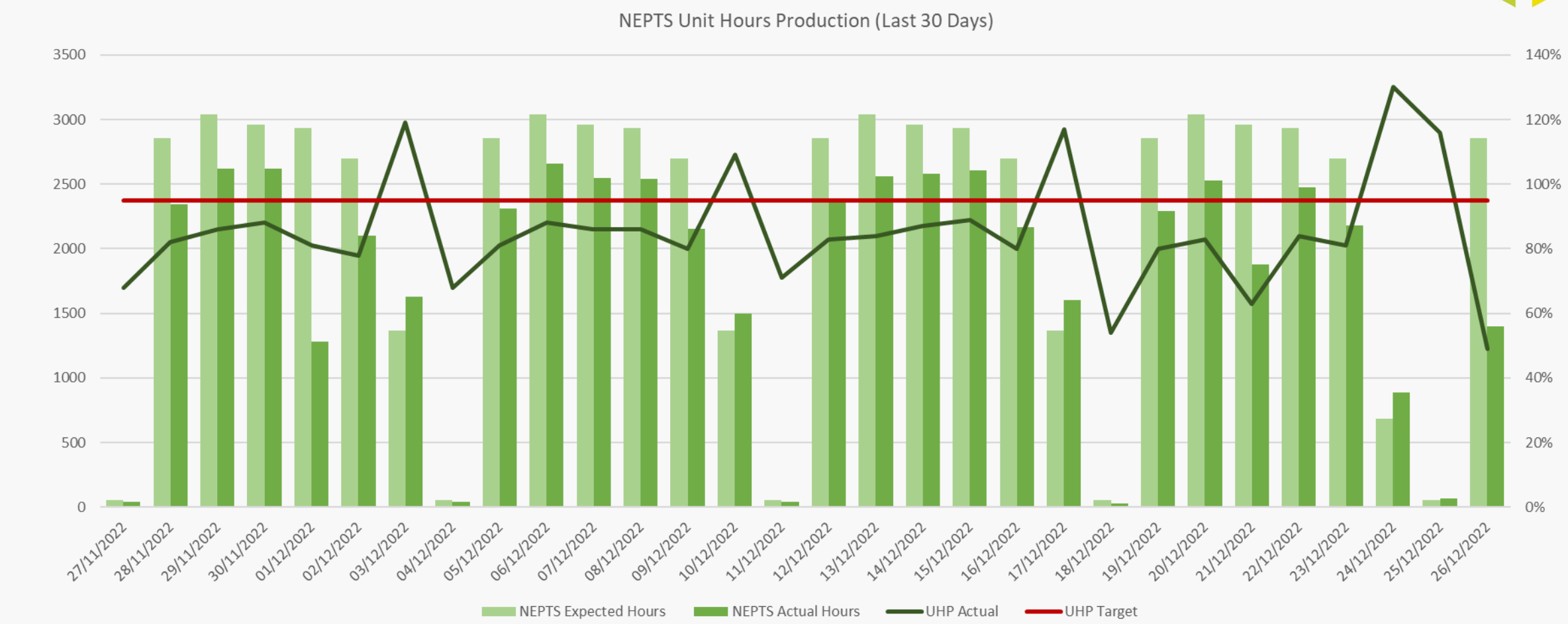


Our Patients: Quality, Safety & Patient Experience
Ambulance Care

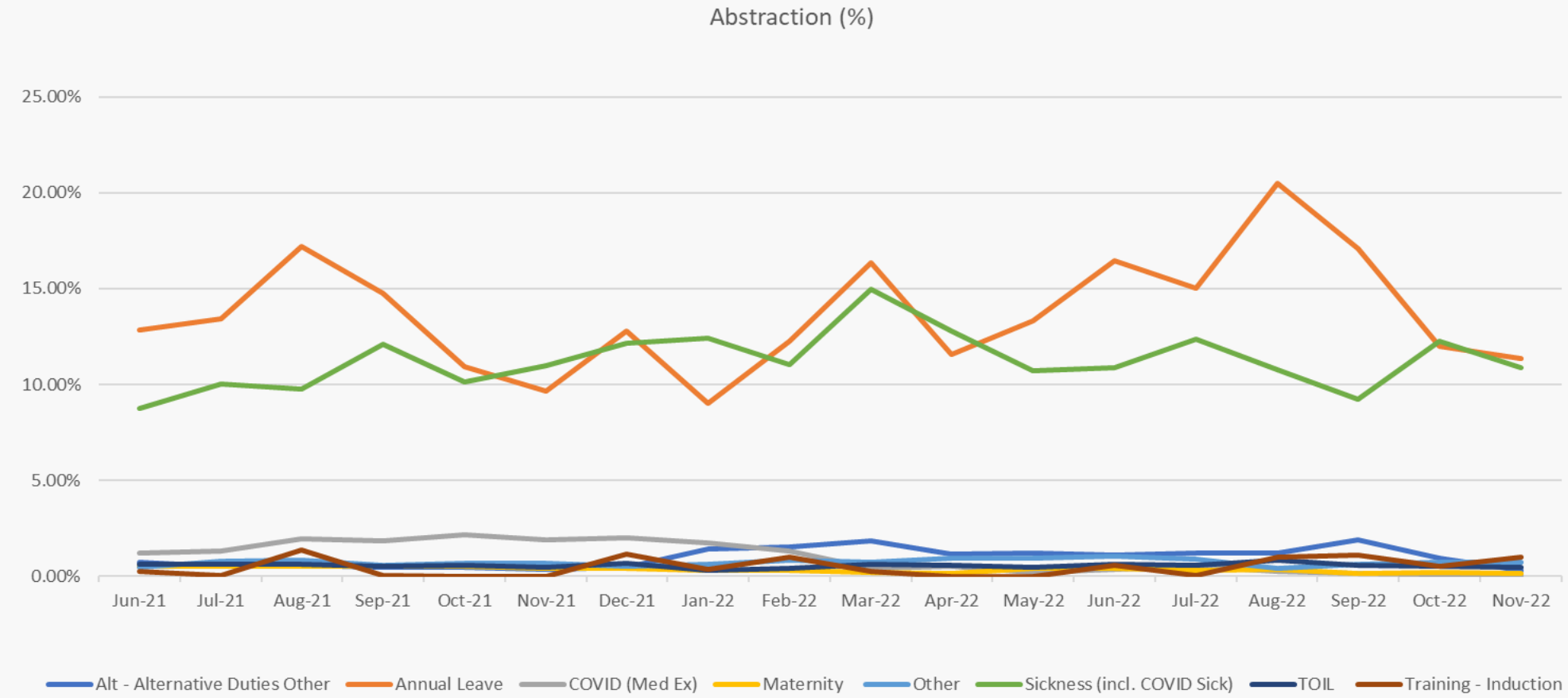
Our People
Ambulance Care Hours Produced



Our People
Ambulance Care Hours Produced

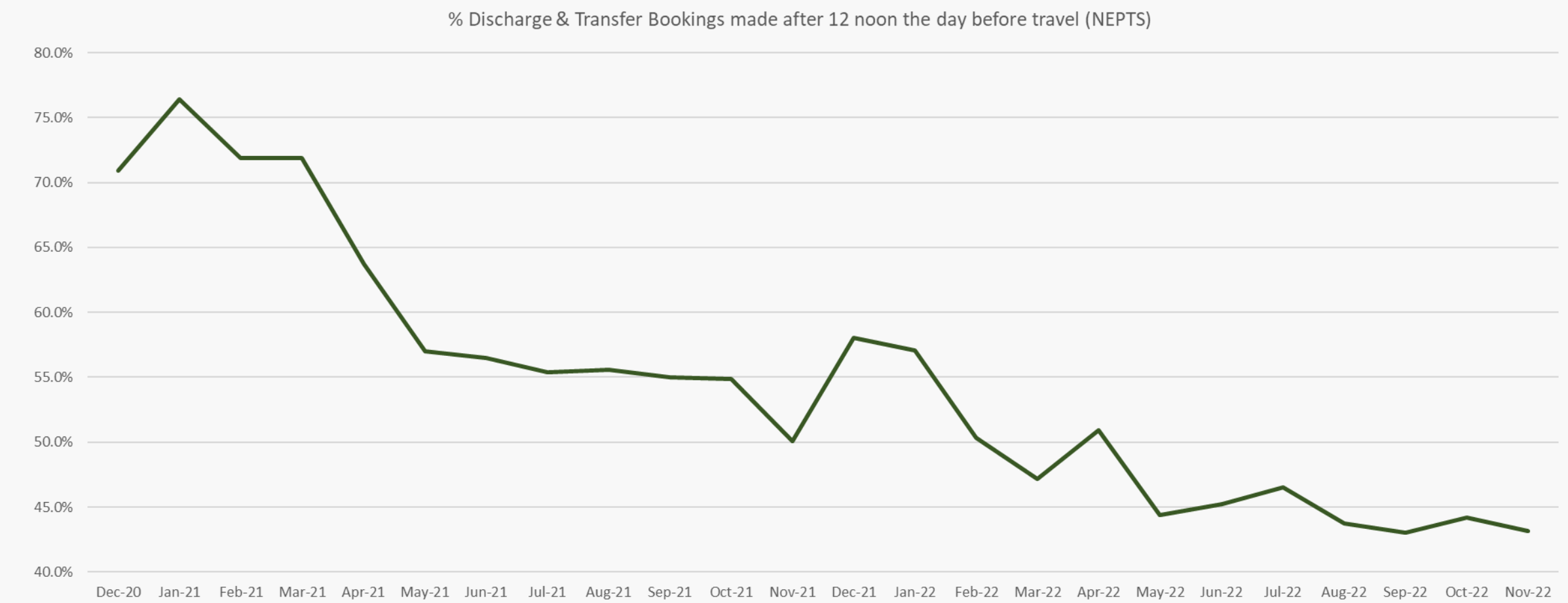


Our People
Ambulance Care Abstractions

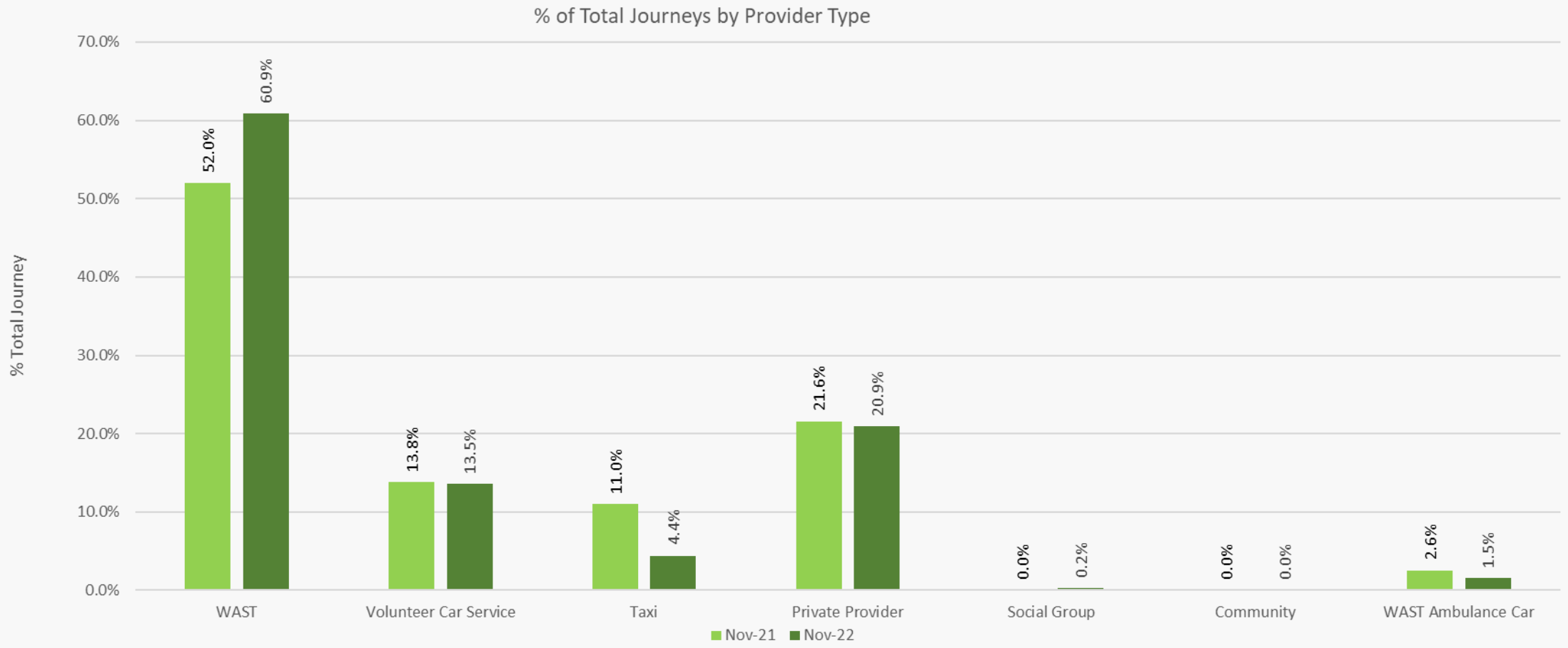


Abstraction Reason	Nov-22	Target
Alt - Alternative Duties Other	0.29%	3.00%
Alt - PRTW	0.28%	
Alt - Temporary Redeployment	1.13%	
Annual Leave	11.34%	15.73%
COVID (Med Ex)	0.09%	0.00%
Maternity	0.16%	1.20%
Other	0.55%	1.00%
Sickness (incl. COVID Sick)	10.89%	5.99%
TOIL	0.44%	0.00%
Training - Induction	0.96%	3.00%
Training -Other inc CPD	0.18%	
All (29.91%)	26.32%	

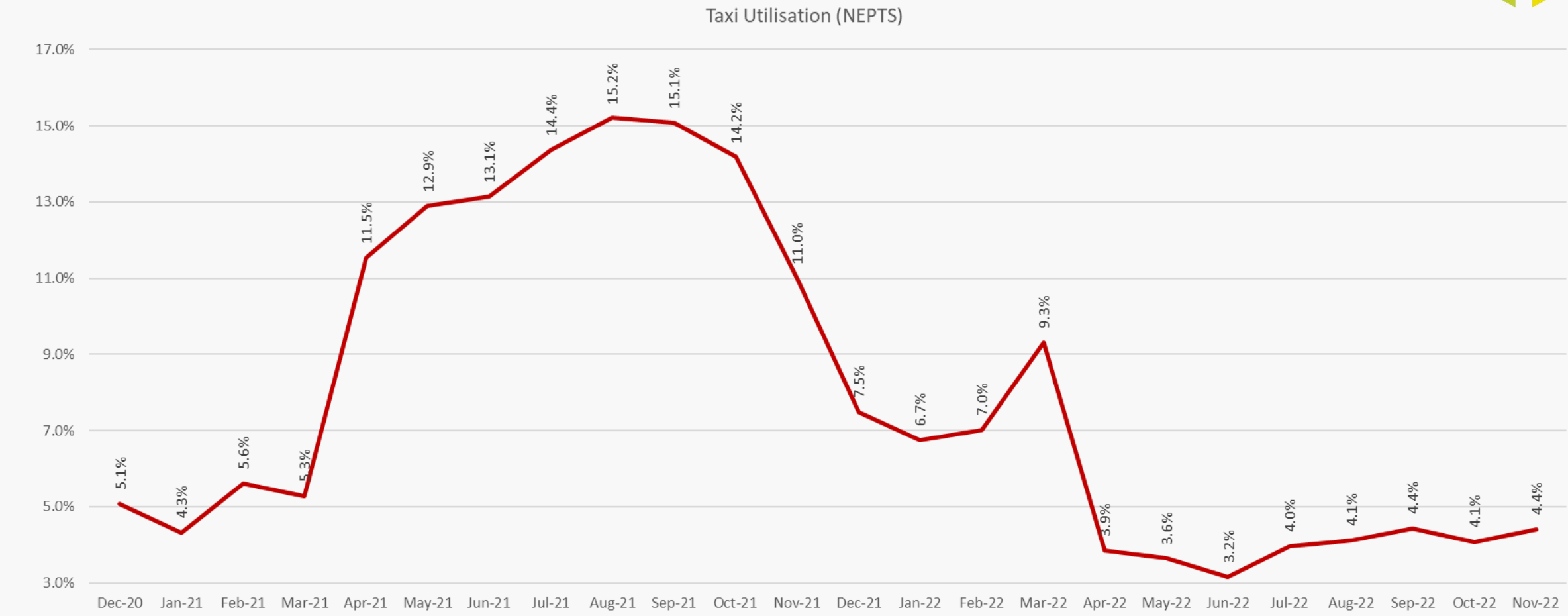
Value / Partnerships & System Contribution
Ambulance Care



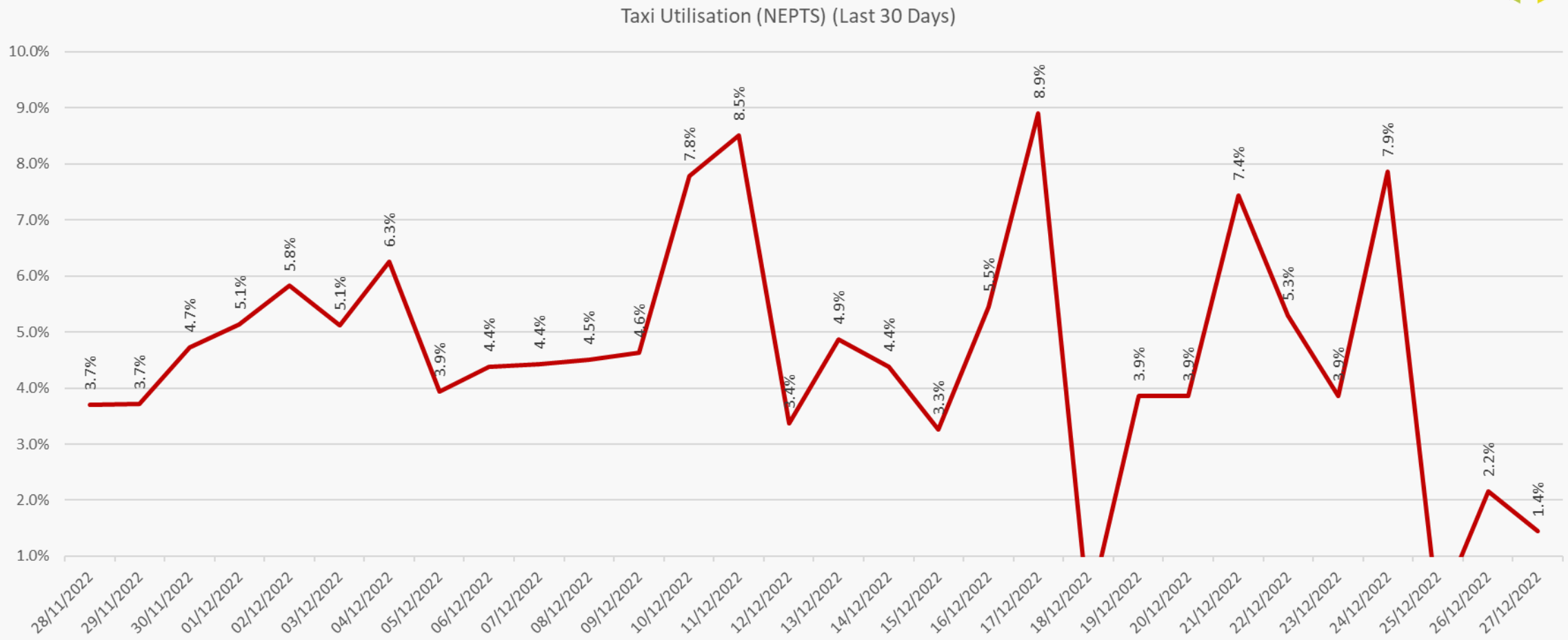
Value / Partnerships & System Contribution
Ambulance Care –Journeys by Provider Type



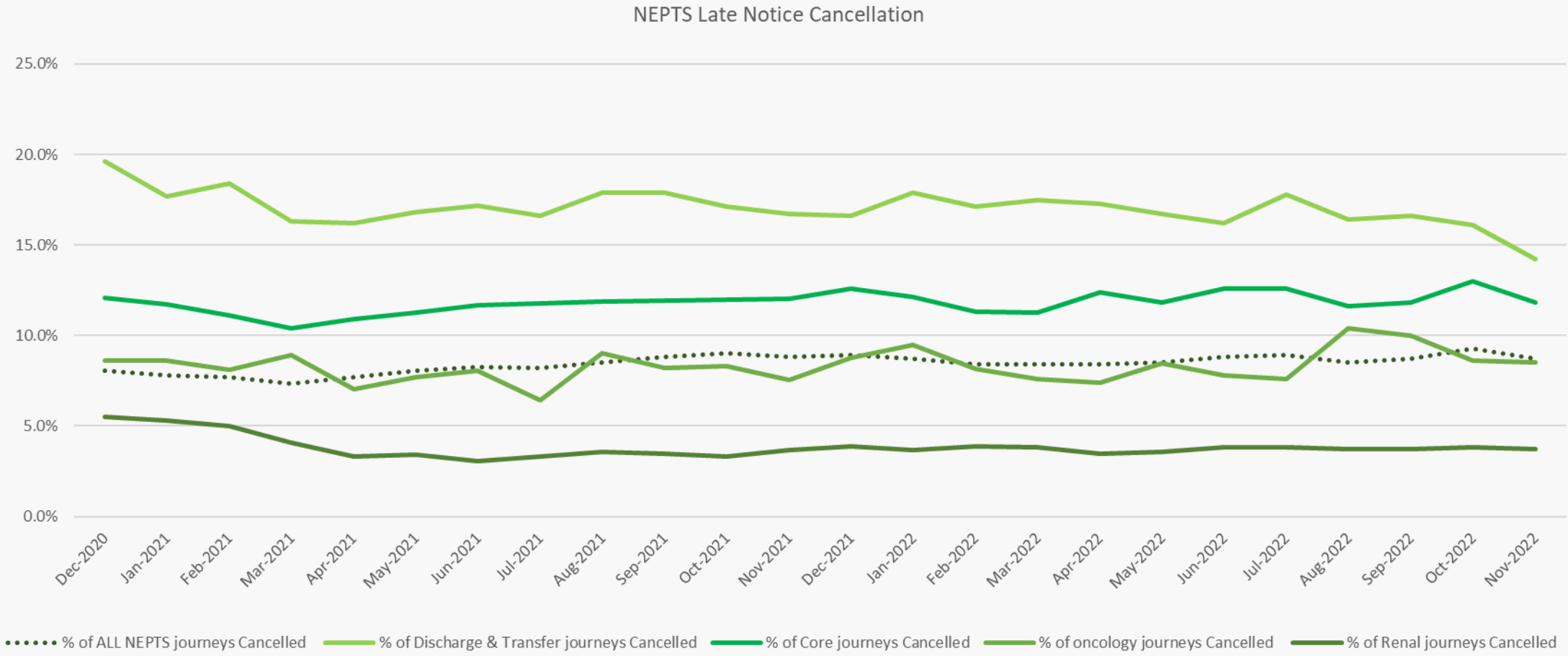
Value / Partnerships & System Contribution
Ambulance Care – Taxi Journeys



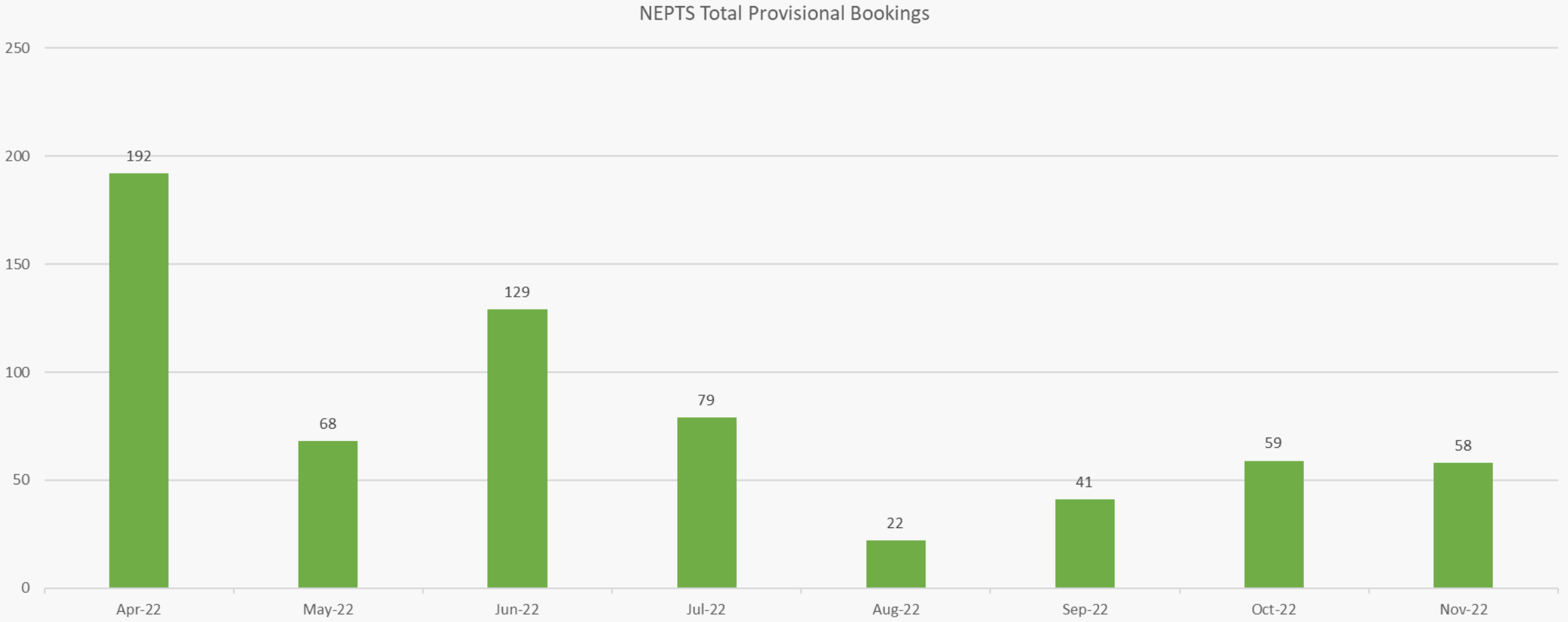
Value / Partnerships & System Contribution
Ambulance Care – Taxi Journeys



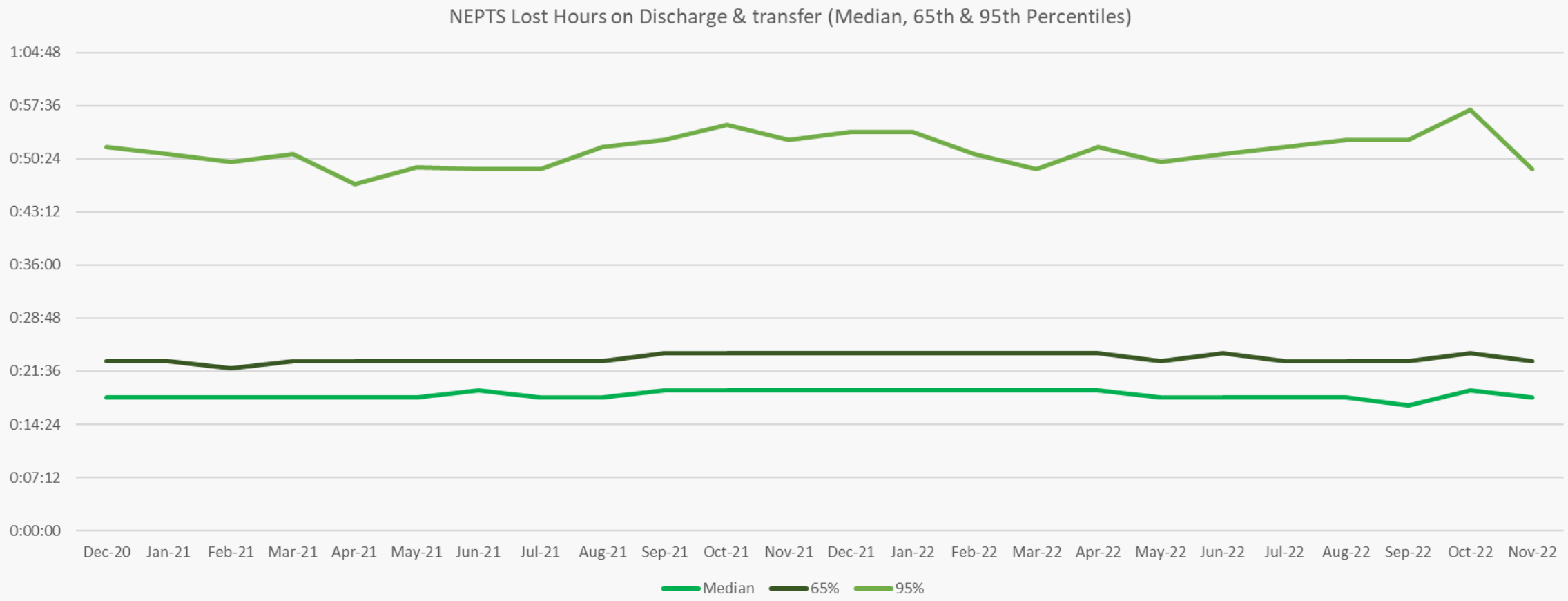
Ambulance Care
Value- Late Notice Cancellation



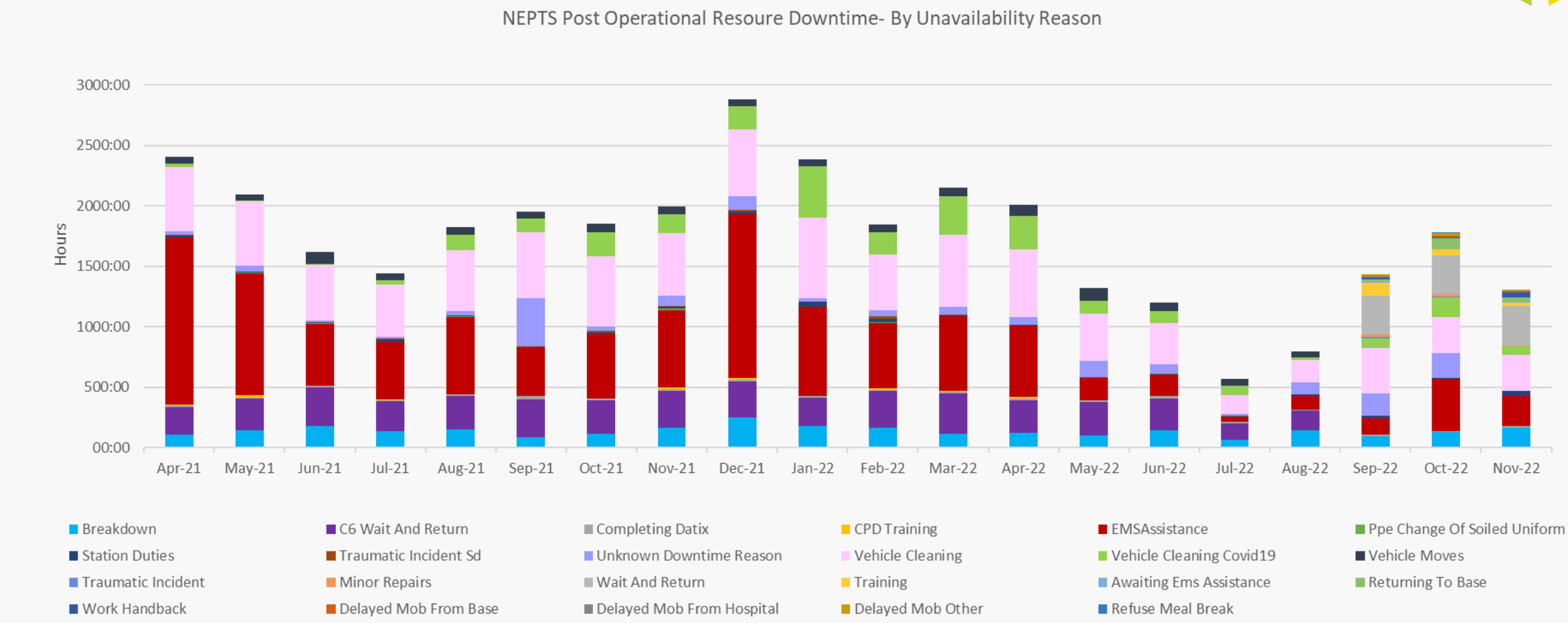
Ambulance Care
Value– Capacity Management



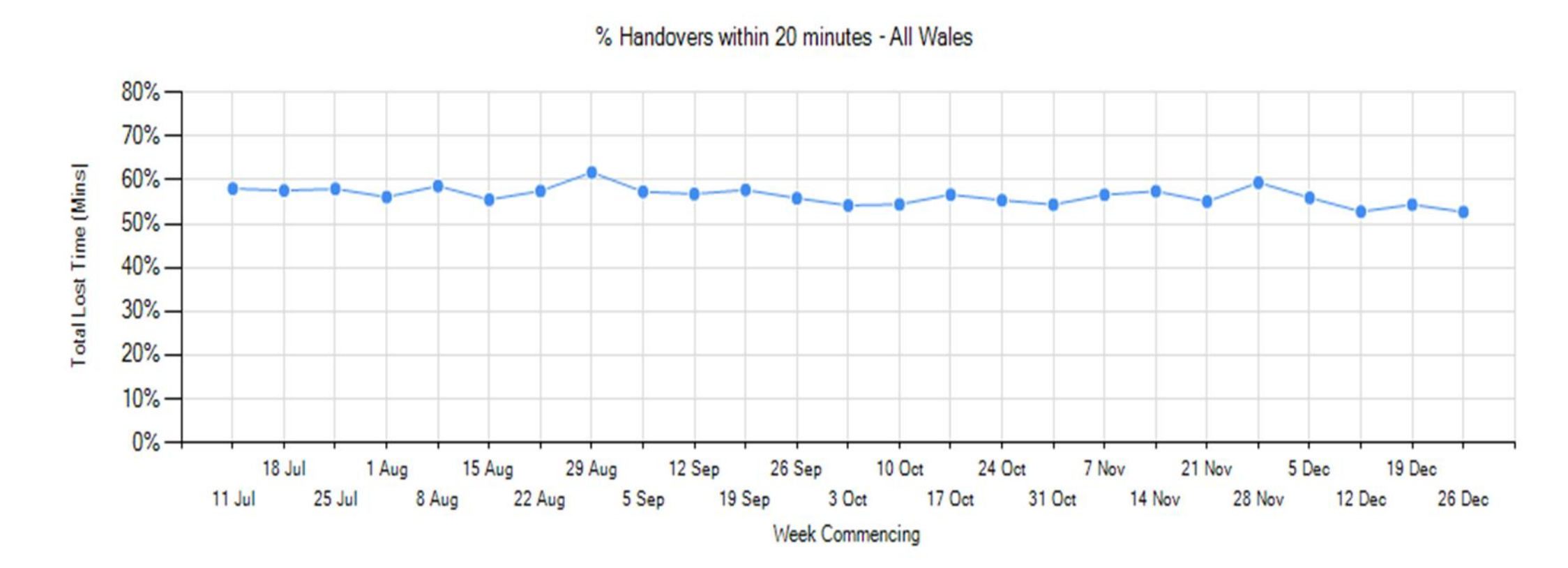
Ambulance Care
Value- Lost Hours to Discharge & Transfers



Ambulance Care
Value – Operational Resource Downtime

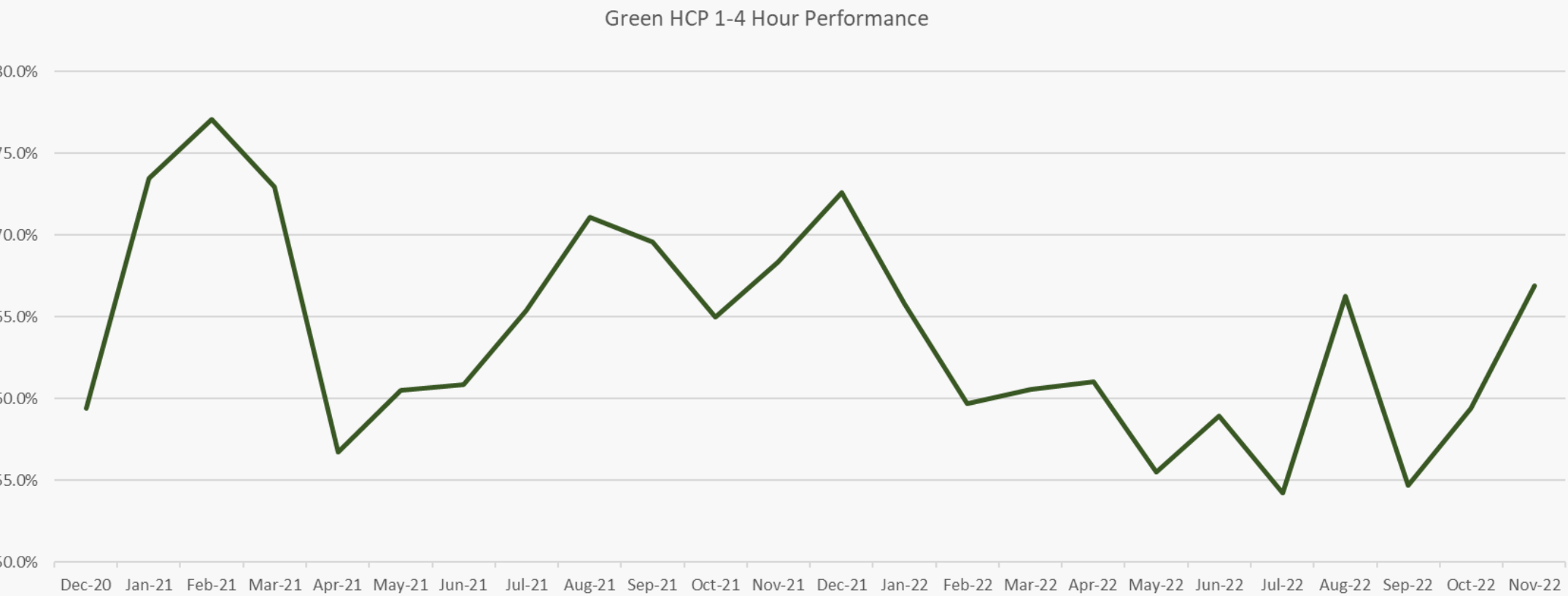


Ambulance Care
Value- Lost Hours to Handover



Unscheduled Care Service

Our Patients: Quality, Safety & Patient Experience
Ambulance Care



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

Integrated Medium Term Plan (IMTP) 2022-2025
Quarter 3 Progress Report

MEETING	Finance & Performance Committee
DATE	16 January 2023
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Planning and Transformation Heather Holden – Head of Transformation
CONTACT	Heather.holden@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to update the Committee on the progress and delivery of actions in the IMTP 2022-25 to date in Q3 2022/23 including the Accountability Conditions set by Welsh Government.

RECOMMENDED:
That the Committee:
1. Notes the update against WAST's IMTP Accountability Conditions;
2. Notes the overall delivery of the IMTP detailed in this paper

KEY ISSUES/IMPLICATIONS

The WAST IMTP for 2022-25 was approved by Welsh Government on 13 July 2022 with the following conditions set out in a subsequent accountability letter dated 22 July 2022:

- Six Goals for Urgent and Emergency Care – requirement to articulate how our actions relating to the six goals programme will translate into improved outcomes and performance;
- Value Based HealthCare – strengthen our approach to Value Based HealthCare;
- Minimum Data Set (MDS) – further expansion of the data provided through the MDS quarterly refreshes;
- Improvement of sickness and absence rates;
- Delivery of workforce efficiencies, notably the delivery of the Emergency Medical Services (EMS) roster review project.

Progress against these specific conditions are as follows:

Six Goals	Further updated the mapping into six goals programmes. The programme structure nationally is being embedded, and WAST now has presence on goals 2, 5 & 6 at delivery board level and on the clinical advisory board. At a local health board level WAST engages in a range of meetings and is working with the National Collaborative Commissioning Unit (NCCU) on the development of Integrated Commissioning Action Plans. These were predominantly developed around Goal 4, however present an opportunity for WAST and health boards to discuss local commissioning opportunities across the breadth of the 6 goals programmes.
Value Based Healthcare	The Value Based Healthcare working group continues to develop its work programme alongside Financial Sustainability Programme and other key areas of work, such as Inverting the Triangles benefits. Lead execs have met with members of the working group to update on progress and ensure link across work on all aspects of value based healthcare. There has been some slippage in implementation of Patient Level Information and Costing system (PLICs), this is not anticipated to have any adverse impact on next year's IMTP. The work to trial Patient Reported Experience Measures (PREMS) with Aneurin Bevan University Health Board is due to go live in December 2022. WAST has also started work with the Value in Health Centre to explore the opportunity to develop Patient Reported Outcome Measures (PROMS).
Minimum Data Set	This is now being refreshed quarterly with the required data applied. A new MDS will be required as part of the IMTP development for 2023/26.
Improvement in sickness absence	The Managing Attendance programme is working through the actions required to address absences with regular reporting through EMT and assurance provided at People and Culture Committee. This will also be a key metric at Board level through the Monthly Integrated Quality and Performance Report. Winter has been difficult and there is some adverse movement against trajectory, however this is anticipated to be a result of short term sickness due to high circulation of viruses in the community.
Delivery of workforce efficiencies	A range of efficiencies in EMS have been delivered and resulted in the increase of around 1200 additional shifts. This includes the EMS re-rostering, sickness absence reduction, additional WTEs and increase in consult and close rates.

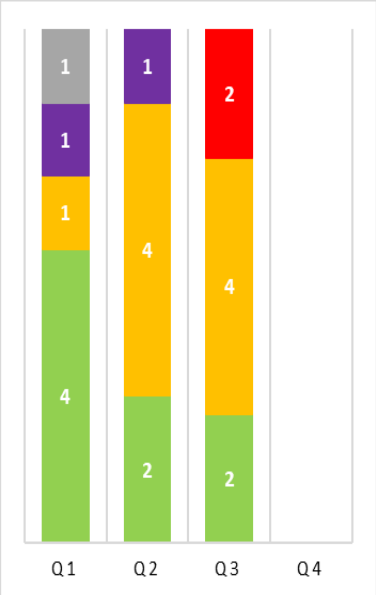
Appendix 1 is a full assurance report which provides detailed information about transformation and enabling programme activity which commenced in quarter one, two and three and any risks going into future quarters, covering:

- Programme Governance;
- IMTP Delivery;
- Achievements;
- Escalation of barriers and challenges to Strategic Transformation Board (STB);
- Key risks to delivery in line with strategic risks that will be raised and monitored through the Corporate Risk Register;
- Remedial actions against any deviation from IMTP delivery timescales.

An IMTP delivery tracker is also in place which maps back all 2022-23 priorities into the agreed transformation and enabling programmes established within the IMTP delivery structure. The following sets out the end of Q3 position of IMTP delivery priorities that commenced quarters one, two, and three:

Transformation Programmes

EMS Operational Transformation



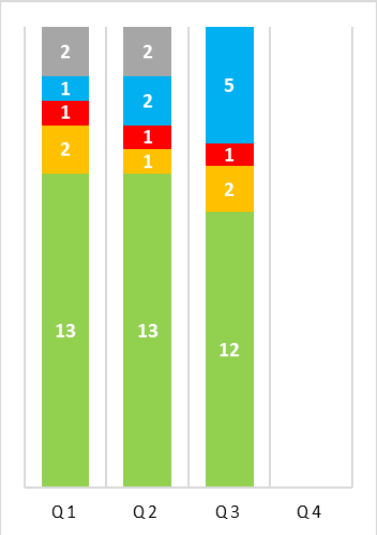
8 ongoing actions; 3 Green, 3 Amber, 2 Red: Recruitment and Training plan off track as attrition rates higher than forecast, however mitigation is in place with revised forecast to deliver establishment by end of Q4. Roster abstractions due to sickness are above forecast trajectory but on a downward trend, however Red Amber Green (RAG) status changed from Green to Amber to reflect high sickness rates in Cwm Taf Morgannwg University Health Board (CTM UHB). Work to reduce handover delays continues through Health Board Handover Improvement meetings but RAG status changed from Amber to Red to reflect extreme, and rising delays heading into Winter. Challenges continue with recruitment in rural areas impacting red response times and implementation of Cymru High Acuity Response Unit (CHARU).

Final batch of EMS rosters went live mid-Nov, marking the end of a 2.5yr project including 146 rosters, 80 working parties, and 1,800 staff. The project will now be evaluated to support longer-term benefits realisation and learning.

Ambulance Care Transformation

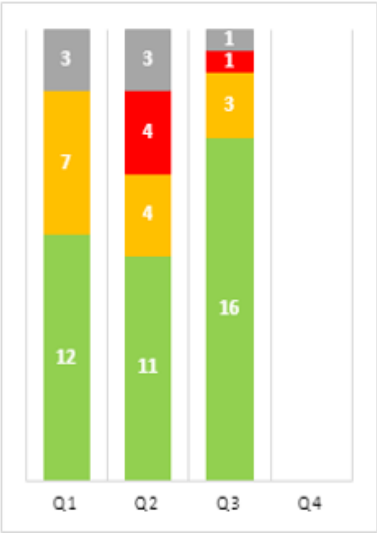
9 ongoing actions; 3 Green, 5 Amber, 1 Complete (in-month): The ambulance care service trial is now complete and further opportunities for wider adoption will be explored by the Senior Operations Team. The re-roster of NET centre staff is now on track. Transfer of Patient Needs Assessment (PNA) to Business As Usual (BAU) is now Amber to Green; updated PNA rolled out with ongoing benefits realisation during Q4. Whilst work to maximise discharge lounge usage remains paused at the request of BCUHB, a lead contact has been identified and a meeting arranged for early December. Work finalising the standardised guidance has been delayed due to lead capacity, however work is expected to accelerate during Q4 as lead capacity is released.

Gateway to Care



18 ongoing actions; 12 Green, 2 Amber, 1 Red, 3 Complete (in-month): 111 peer review recommendations have been received and will be incorporated into next years IMTP. 111 strategy day/IMTP planning session arranged for 12th December. Review of 22/23 actions has been undertaken with two projects closed (111 core service evaluation (delivered) and roll out of 111 First (not funded)). SALUS implementation remains Red, with request to Capita for a revised delivery plan to the Authority by early-Dec, demonstrating that SALUS can be delivered into live by Autumn 2023.

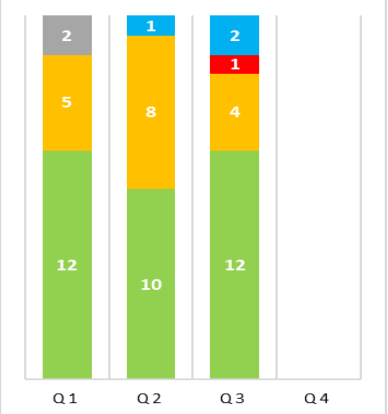
Clinical Transformation



20 ongoing actions; 16 Green, 3 Amber, 1 Red, 1 Not Started: Development of a Faculty of Emergency MH Practice remains Red and continues to be delayed awaiting a funding decision and will likely need to be re-scoped, however mental health practitioner pilot has progressed and a Project Initiation Document (PID) developed with the RAG rating reduced from Red to Amber. TerraPACE application is now in full operational use, with access to Welsh GP records commencing with APPs in late November. DigiPen de-commissioning is now on track and reduced from Amber to Green as the rate of Patient Clinical Record validation has been doubled.

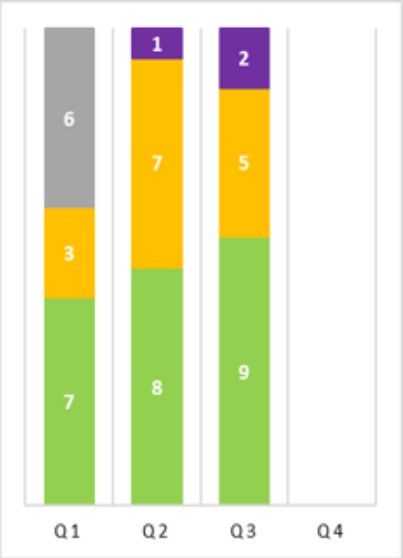
Enabling Programmes

Our People



17 ongoing actions; 12 Green, 4 Amber, 1 Red: Recruitment and Training plan off track as attrition rates higher than forecast, however mitigation is in place with revised forecast to deliver establishment by end of Q4. ACAS report received and recommendations are under review. Roster reviews are being implemented with general positive feedback i.e. work/life balance. Some concerns raised via R&R and informally via TUs and are being investigated. Change management training is being progressed to develop change capacity and expertise in the WOD team.

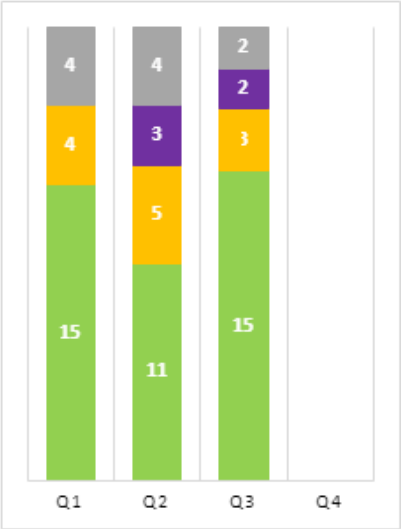
Innovation & Technology



14 ongoing actions; 9 Green, 5 Amber: end date for delivery of the new control room solution has been extended to Q4, but is on track to go-live before the end of the financial year. EMS Mobile Data Vehicle Solution now in Service User Acceptance Testing (SAT) and progressing well and remains on target for roll-out to commence in late Q4, however action remains Amber due to risk of slippage as several component actions remain to be delivered.

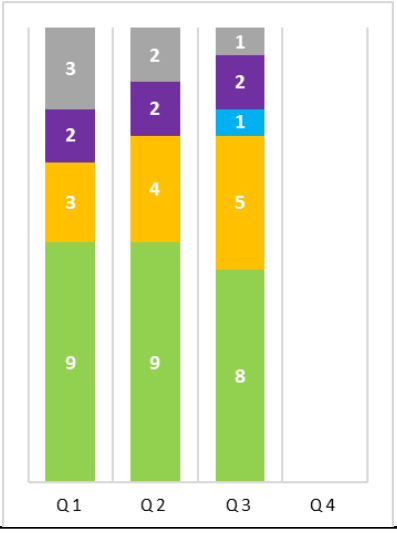
Delivering our part of the National Data Resource Programme is progressing and has changed from Amber to Green as work towards the agreed deliverables is now underway and on track with submitted plans. An audit has also been completed, cataloguing all existing HI reports, allowing for a more structured review cycle. Unused & duplicate reports will start to be considered for decommission, helping simplify access to intelligence.

Infrastructure



18 ongoing actions; 15 Green, 3 Amber: Business Case development for Llandrindod Wells and Bangor Street Workshop (AWC) is expected to commence in Q4 as interviews for project support have been held and a secondment agreed; awaiting start date in the New Year. Several actions have had planned delivery dates extended from Q3 to Q4. This is due to a combination of planning permission, lease agreement, and external funding decision delays. A permanent solution for EMS/NEPTS in Dolgellau (DC) is proving challenging due to planning permission concerns and limited site options; an update will be taken to Capital Development Board and will be highlighted for discussion.

Fundamentals (including Risk Management)



Quality: Work to embed the Trust Quality Management System (QMS) continues, but digital development will require investment; proposal in development. Implementation of the Once For Wales user experience system is on track. Civica system training planned following which the Quality, Safety and Patient Experience Directorate can commence using the system for all PREMS surveys. A successful Civica engagement event was held in Cardiff (Nov-22) with great feedback from network members.

Value Based Healthcare: Awaiting IG approval for data sharing between HBs (PROMS). Meeting to be arranged to understand WG expectation around Value in Health during FY23/24. PREMS plan is on track; survey developed with collection due to commence with AB GUH in December.

Corporate Governance: Whilst Datix development has progressed, the delivery date will need to be extended. A delivery road map is being developed by the provider but there is currently no revised delivery date in place. Risk management policy has been drafted and will be presented to Audit Committee in March 2023 with delivery date amended from Q3 to Q4. The refresh of the risk management strategy and procedures is taking place in conjunction with the policy review (N.B. also extended from Q3 to Q4).

All Red, and Amber rated actions, and any actions completed in the current reporting period are presented within Appendix 1, along with the identified mitigations. These actions will continue to be monitored by the relevant programme boards and STB.

Risk to delivery in Q4

Due to the continued and ongoing pressures, EMT has undertaken a prioritisation exercise to prioritise resources for IMTP delivery where this will make a tangible and significant difference to patients and our people during quarter 4. This may mean some project milestones, that do not fall within these priority areas, will not be met as set out in the IMTP but this will be monitored through Strategic Transformation Board and milestones carried forward into next year as required.

REPORT APPROVAL ROUTE
The executive summary and associated appendices were approved by STB on 06 December as the Q3 position.

REPORT APPENDICES
Q3 - IMTP Assurance Report - IMTP & Programme Delivery

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Assurance Report:
IMTP Delivery Programmes
Finance & Performance Committee
16th January 2023

IMTP Reporting
Complete and Planned Changes

What's changed? (housekeeping)

- Timeline developed for STB updates, submission dates, report development, and distribution of papers
- Consolidated 3 reports into a single MS Powerpoint report with hyperlinks for navigation
- Reported in two halves – progress against IMTP delivery (with STB summary), and Transformation Programme Highlight Reports
- Report presents all Amber, Red, or closed IMTP actions within the current reporting period, but also stacked bar charts for each programme that show overall RAG distribution by Quarter
- Refined Programme Highlight reports for major change (transformation) programmes

Planned Refinements (short term)

- Explore options for action tracking to move away from MS Excel i.e. MS Project? MS Forms? Task Allocation?

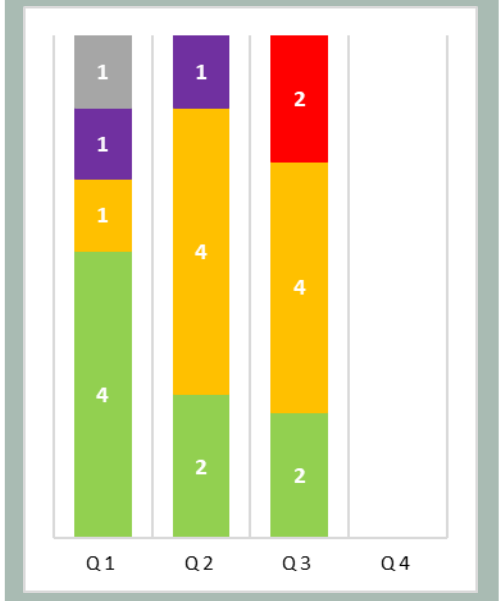
Planned Changes (mid-long term)

- Mapping projects/programmes for FY23/24 delivery – including identification of projects due for closure/handover to BAU
- Consider opportunities to consolidate
- Production of logic models for each programme with clearly defined outputs, outcomes and impacts
- Identification of key milestones; supports reporting by exception
- Set SMART goals and focus on data!

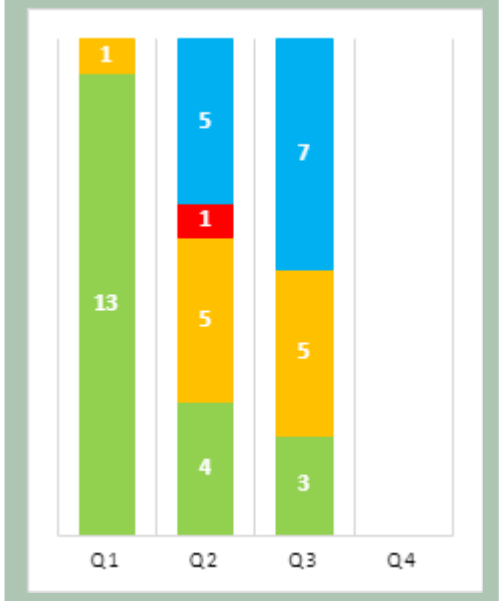
IMTP Progress Against Actions
Transformation Programmes – Navigation Panel

Green
Amber
Red
Complete
Paused
Not Started

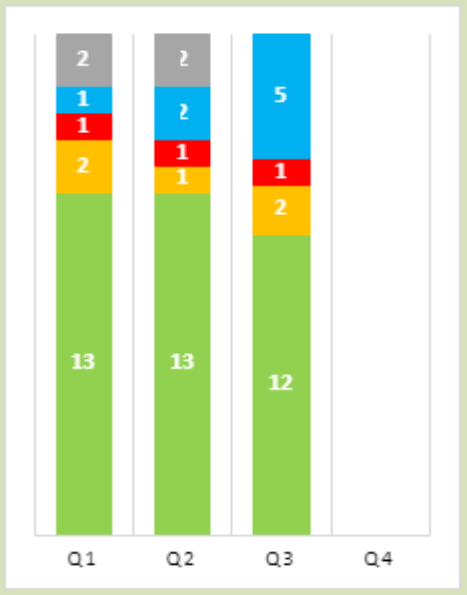
EMS Operational Transformation



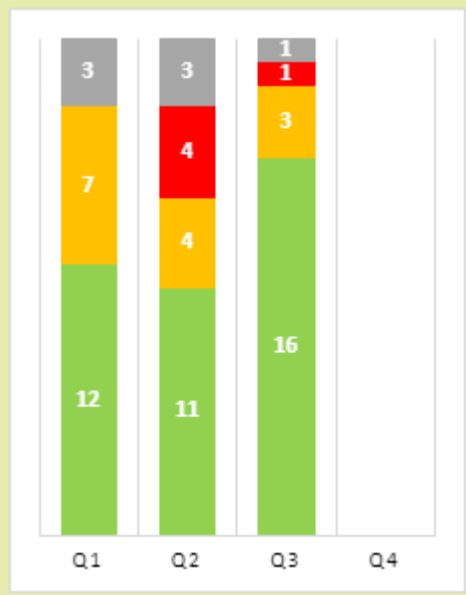
Ambulance Care Transformation



Gateway to Care Transformation



Clinical Transformation



IMTP Deliverables – EMS Operational Transformation

Navigation Panel

Report Period:	Noted at STB *(includes Red, Amber, and Completed actions within the current reporting period only)*
Quarter 3–22/23	**8 ongoing actions; 3 Green, 3 Amber, 2 Red:** Recruitment and Training plan off track as attrition rates higher than forecast, however mitigation is in place with revised forecast to deliver establishment by end of Q4. Roster abstractions due to sickness are above forecast trajectory but on a downward trend, however RAG status changed from Green to Amber to reflect high sickness rates in CTM UHB. Work to reduce handover delays continues through Health Board Handover Improvement meetings but RAG status changed from Amber to Red to reflect extreme, and rising delays heading into Winter. Challenges continue with recruitment in rural areas impacting red response times and implementation of CHARU. Final batch of EMS rosters went live mid-Nov, marking the end of a 2.5 project that included 146 rosters, 80 working parties, and 1,800 staff. The project will now be fully evaluated to support longer-term benefits realisation and organisation wide learning.

IMTP Deliverables 2022/25	Actions in 2022/23	Q1	Q2	Q3	Q4	Comments
We will increase and balance response capacity and capability across urban and rural areas of Wales	Maintain closure of relief gap and implement transition plan, increasing by up to 294 WTE subject to funding					**Amber to Red** Q3 attrition higher than forecast; mitigation in place with revised projections showing Amber status for Feb-23, and Green status by Mar-23 with delivery to plan by end of Q4.
	Continue to work with rural areas to improve red response times					Pre work completed, SBAR was due at EMT on 02/11/22, however this has been delayed and will now be reviewed at EMT early December. Remains **Amber.**
	Consider appropriate and achievable reductions in PPLHs					TU partners are not supportive of the automation of RTB (return to base) meal break process. The Trust is currently considering next steps. Remains **Amber.**
	Reduce roster abstractions due to sickness absence through implementation of robust action plan					**Green to Amber** Sickness is above forecast trajectory but on a downward trend. The managing attendance programme is going directly into EMT every two weeks. CTM UHB has very high sickness. LB has met with CTM management team.
Patients who ring 999 but who don't have a life threatening or emergency need receive the appropriate level of care and access to the most appropriate pathway 24/7	Work with partners to significantly reduce handover delays					**Amber to Red** Ongoing through Health Board Handover Improvement meetings - RAG rated red as levels are extreme and rising. Ministerial summit 28/11/22.
We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience	Implement a CHARU model to improve clinical outcomes, ROSC rates and response times					Challenges to recruitment in more rural areas. SBAR due at EMT early December, including work to improve red response times in rural areas (as above). Papers outline scale of challenge and action plan. Remains **Amber.**

IMTP Deliverables – Ambulance Care Transformation

Navigation Panel

Report Month:	Noted at STB *(includes Red, Amber, and Completed actions within the current reporting period only)*
Quarter 3–22/23	**9 ongoing actions; 3 Green, 5 Amber, 1 Complete (in-month):** The ambulance care service trial is now complete and further opportunities for wider adoption will be explored by the Senior Operations Team. The re-roster of NET centre staff is now on track. Transfer of PNA to BAU is now Amber to Green; updated PNA rolled out with ongoing benefits realisation during Q4. Whilst work to maximise discharge lounge usage remains paused at the request of BCUHB, a lead contact has been identified and a meeting arranged for early December. Work finalising the standardised guidance has been delayed due to lead capacity, however work is expected to accelerate during Q4 as lead capacity is released.

IMTP Deliverables 2022/25	Actions in 2022/23	Q1	Q2	Q3	Q4	Comments
We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand	Prepare and agree PID for Roster review pan-Wales (NEPTS ambulance staff)					Currently awaiting feedback from tests of change for revised roster keys. Once received, the draft PID will be completed. Aimed to deliver by Nov-22, now likely to be Q3-end. Remains **Amber**.
	Reduction in T1 walkers demand – work with commissioners on eligibility criteria					Discussed with NCCU; position paper being created and discussed with WG. Remains **Amber**.
	Review and consider use of ambulance car service					Trial **complete**. SOT will explore the opportunities of replicating the ambulance car service across all operational services. Consideration being given to management going forwards.
We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery	Work with Commissioners on agreement and implementation of eligibility criteria					Discussed with NCCU; Position paper to be created and discussed with WG. Remains **Amber**.
We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience	Work with a local hospital to maximise the usage of the discharge lounge, to reduce cancellations					Discharge lounge trial remains paused at the request of BCUHB. However, a contact for BCUHB has been provided from NCCU and meeting scheduled for early December to discuss trail recommencement. Remains **Amber**.
	Finalise the national standardised guidance and risk assessments					Work finalising the standardised guidance has temporarily stopped as the lead resource has been assisting Health Board's with online booking training in line with December deadline. Once online booking training is complete, work on will recommence with expected acceleration during Q4. Remains **Amber**.

IMTP Deliverables – Gateway to Care Transformation

Navigation Panel

Report Month:	Noted at STB *(includes Red, Amber, and Completed actions within the current reporting period only)*
Quarter 3–22/23	**18 ongoing actions; 12 Green, 2 Amber, 1 Red, 3 Complete (in-month):** 111 peer review recommendations have been received and will be incorporated into next years IMTP. 111 strategy day/IMTP planning session arranged for 12th December. Review of 22/23 actions has been undertaken with two projects closed (111 core service evaluation (delivered) and roll out of 111 First (not funded)). SALUS implementation remains Red, with request to Capita for a revised delivery plan to the Authority by early-Dec, demonstrating that SALUS can be delivered into live by Autumn 2023.

IMTP Deliverables 2022/25	Actions in 2022/23	Q1	Q2	Q3	Q4	Comments
We will work with partners to promote and expand use of 111 across Wales	Evaluate core 111 service					Meeting arranged for 12th December with 111 programme team to discuss Commissioning arrangements and 111 IMTP Planning. 111 Peer Review: Recommendations report received and worked into 111 work plan for 2023/24. Team to consider and review findings, and formally respond in Dec. Action to be **closed**.
	Roll out of 111 First across Wales (subject to further discussions)					Long term funding has not been approved by Welsh Government. Project is being **closed** down; lessons learnt captured to be approved by the Programme Board.
We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team	Increase proportion of 999 callers who have a clinical assessment and increase consult and close rates for physical and mental health patients – 15% used in modelling					Physician Triage Assessment and Streaming (PTAS): Aneurin Bevan, Betsi Cadwaladr and Hywel Dda are live with PTaS. Swansea Bay have signed the MOU and JCA and this has been passed for signature within WAST. Go live is to be confirmed as soon as documentation is signed. Remains **Amber**.
	Develop a case for change on the integration of clinical teams across 111 & 999					Recommended for closure as G2C action; SBAR being taken to G2C Board(02/12), as action is part of CCC recommendation consolidation exercise. Board decision this action is to remain open Remains **Amber**.
We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations	Identify pilot opportunities to test direct booking system for 111 patients to Health Board services					CTM Six Goals MIU meeting held on 18/11 tasked YCR management team with moving to a walk-in-centre on 05/12; booking system no longer required. Action **closed** to as immediate IMTP action; to be rescoped as year 2 action for digital enablers for 2024/25.
	Implement the new 111 system; SALUS					Senior Capita Executives submitted a revised draft plan on (21/10) proposing go-live in early 2024. Revised plan requested to meet Autumn 2023 deadline as requested in IIG Board (27/09). Capita submitted a further draft plan ahead of a Joint CEO meeting on 14/11. The outcome of the CEO meeting was for Capita to review and submit one final Delivery Plan to the Authority by early Dec-22. Remains **Red**.

IMTP Deliverables – Clinical Transformation

Navigation Panel

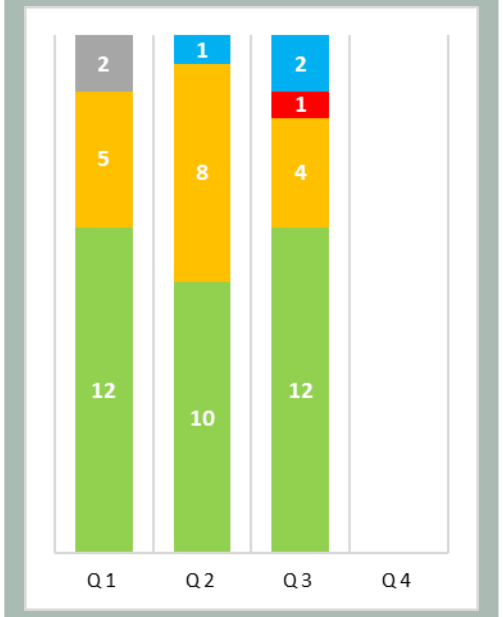
Report Month:	Noted at STB *(includes Red, Amber, and Completed actions within the current reporting period only)*
Quarter 3–22/23	**20 ongoing actions; 16 Green, 3 Amber, 1 Red, 1 Not Started:** Development of a Faculty of Emergency MH Practice continues to be delayed and will likely need to be re-scoped, however mental health practitioner pilot has progressed and a PID developed. TerraPACE application is now in full operational use, with access to Welsh GP records commencing with APPs in late November. DigiPen de-commissioning is now on track and reduced from Amber to Green as the rate of PCR validation has been doubled.

IMTP Deliverables 2022/25	Actions in 2022/23	Q1	Q2	Q3	Q4	Comments
We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients	Work in partnership with HEIW on developing a Faculty of Emergency Mental Health Practice					Continued delays on Welsh Government funding decision; low confidence securing funding. Timeline likely to be extended into FY23/24 due to delays with revised scope to focus on a smaller scale approach. Initial draft of Level 7 Project Initiation Document developed. Remains **Red**.
	Pilot use of Mental Health Practitioners in Response Cars					**Red to Amber** Progressed: Programme Initiation Document developed. Consideration given to the evidence from London Ambulance Service and how this can be applied and tested in Wales.
	Deliver and implement the Clinician/Therapist Falls & Frailty Response across Wales, seeking collaborative programmes/services through partnerships and alliances with external stakeholders					**Green to Amber** <u>Establishment of Level 2 Response Teams</u> **BCUHB:** East - 1 x Paramedic/Occ Therapist Team, 4 days/week service, looking to expand to 7 days/week. Funding has been secured for 5 years. Central - Additional funding received for Paramedic/Physio Team, aimed start date 19/12/22 **CVUHB:** Discussions commenced, pending funding agreement. **HDUHB:** Discussions ongoing <u>Other Workstreams</u> **Modelling:** Continued discussions with WAST Commissioning Team and Optima to consider parameters for forecasting and testing (impact on patient response time and conveyance) **Electric Vehicles:** Ongoing discussions with Environmental & Sustainability Manager, Capital & Estates and Finance. Risk noted as per of these discussions. Initial development of Discretionary Capital Bid, further work to be undertaken before submitting. **National SOP:** First draft developed, awaiting review
We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover	Scope opportunities for and benefits of eReferral mechanisms for frontline patient facing clinicians					TerraPACE Change Request Form was approved by CC2HG (16/08/22) to reflect updated Paramedic Fieldguide criteria within the application. ACP Database updates complete. Outsource Automated Solution Team have built RPA and DPIA complete. Aim to go live with Non Injury Falls Pathway mid-Dec. Remains **Amber** as RPA for Hypoglycemia and the Epilepsy referrals is still required to support pathway development; exploring feasibility as GP generic email addresses required to deliver.

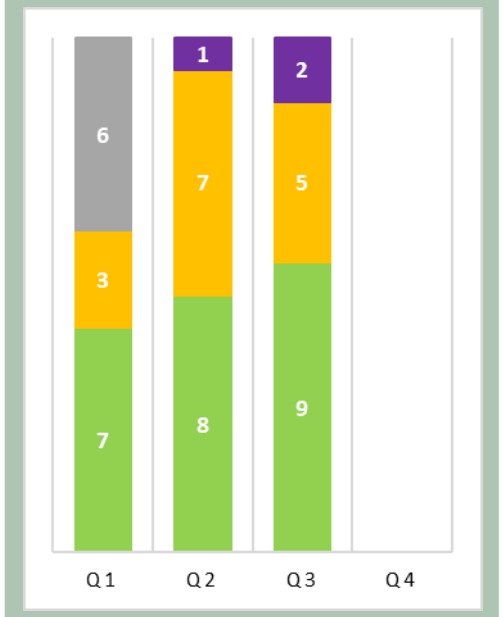
IMTP Progress Against Actions
Enabling Programmes – Navigation Panel

Green
Amber
Red
Complete
Paused
Not Started

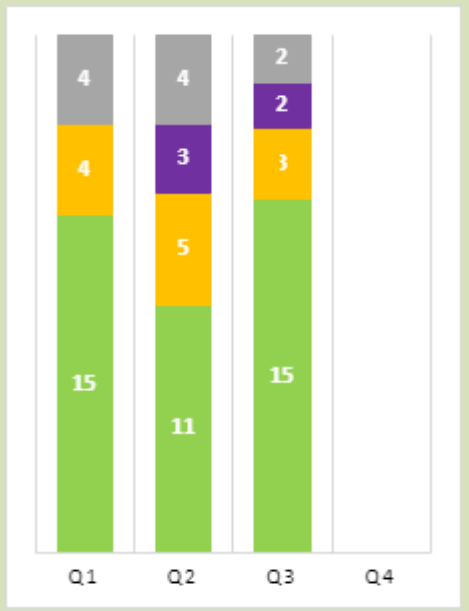
Our People



Innovation & Technology



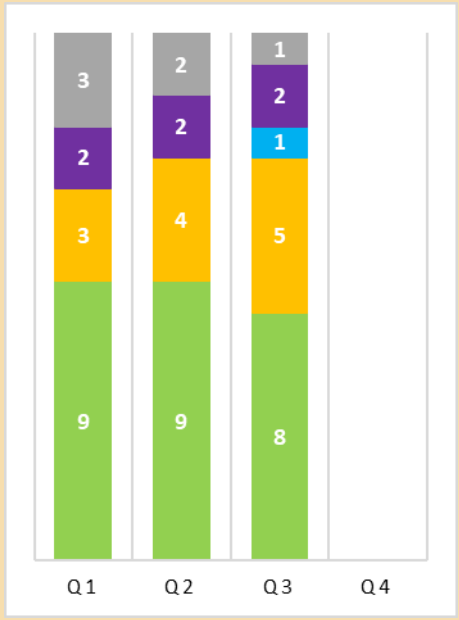
Infrastructure



Strategic Development

Only 1 amber action identified against IMTP delivery plan, **'refresh and embed the brand and positioning of our 111 service, reflecting the completion of its roll-out across Wales';** awaiting the outcome of the workshop on 12/12/22 to consider the national 111 strategy.

Fundamentals



IMTP Deliverables – Our People

Navigation Panel

Report Month:	Noted at STB *(includes Red, Amber, and Completed actions within the current reporting period only)*
Quarter 3–22/23	**17 ongoing actions; 12 Green, 4 Amber, 1 Red:** Recruitment and Training plan off track as attrition rates higher than forecast, however mitigation is in place with revised forecast to deliver establishment by end of Q4. ACAS report received and recommendations are under review. Roster reviews are being implemented with general positive feedback i.e. work/life balance. Some concerns raised via R&R and informally via TUs and are being investigated. Change management training is being progressed to develop change capacity and expertise in the WOD team.

IMTP Deliverables 2022/25	Actions in 2022/23	Q1	Q2	Q3	Q4	Comments
We will take actions to increase the level of resources and support available to our people in relation to their well-being	Deliver the Recruitment and Training plan for the EMS Operational Transformation programme in the context of the transition plan.					**Amber to Red** Q3 attrition higher than forecast; mitigation in place with revised projections showing Amber status for Feb-23, and Green status by Mar-23 with delivery to plan by end of Q4.
	Find opportunities to create operational efficiencies so the workforce can maximise productivity by working smarter, exploring creative, longer term workforce solutions to forecast needs and planned growth.					ACAS report received on 17/11; recommendations under review and draft plan completed. Plan to be socialised with TU's and leadership team for feedback. WASPT meeting re-established, next scheduled for Jan-23; development of supporting framework progressing. Roster reviews are being implemented across stations with several R&Rs received and under investigation (9 heard, 1 appeal, 2 not accepted). TU advise that colleagues are in financial hardship (roster change during cost of living crisis) no names yet provided and positive feedback coming back to the WOD teams from conversations on the ground - e.g. better work/life balance. Discussions are underway (follow-up arranged 24/11) to discuss shift overruns and the impact of late finishes on health and safety (i.e. driving). Remains **Amber**.
	Work on our approach to succession planning for future senior leadership posts including development centres.					An approach to the succession plan will be drafted/agreed at a meeting between KW&FT in December 2022. Remains **Amber**.
	Develop a strategic workforce plan that defines the shape and skill mix of the workforce needed to deliver our long-term ambitions including transferrable and digital skills.					**Green to Amber** and end date revised to Q4; Second meeting to be scheduled; delays around capacity as the team has been required to prioritise other work. Expect this to be accelerated during remainder of Q3/early-Q4.
We will take actions to foster a culture of belonging and wellbeing where our people can engage, feel supported and represented.	Develop opportunities to listen, such as pulse surveys, to temperature check how people are feeling and act on feedback by using a 'you said, we did' approach.					**Green to Amber:** waiting opportunity to meet with IT colleagues to discuss best options through M365. Currently Amber as feasibility of using MS Forms is assessed.

IMTP Deliverables – Innovation & Technology

Navigation Panel

Report Month:	Noted at STB *(includes Red, Amber, and Completed actions within the current reporting period only)*
Quarter 3–22/23	**14 ongoing actions; 9 Green, 5 Amber:** end date for delivery of the new control room solution has been extended to Q4, but is on track to go-live before the end of the financial year. EMS Mobile Data Vehicle Solution now in Service User Acceptance Testing (SAT) and progressing well and remains on target for roll-out to commence in late Q4, however action remains Amber due to risk of slippage as several component actions remain to be delivered. Delivering our part of the National Data Resource Programme is progressing and has changed from Amber to Green as work towards the agreed deliverables is now underway and on track with submitted plans. An audit has also been completed, cataloguing all existing HI reports, allowing for a more structured review cycle. Unused & duplicate reports will start to be considered for decommission, helping simplify access to intelligence.

IMTP Deliverables 2022/25	Actions in 2022/23	Q1	Q2	Q3	Q4	Comments
Improved digital tools and services to empower our teams to do their best. **We will use modern technology to reduce repeat tasks and improve processes.**	Deliver the new Control Room Solution as part of ESMCP					End date revised to Q4; Work to implement before end of the financial year continues – go-live confirmed w/c 20/03/23. Remains **Amber** due to delays with ARP and WAST being the first Trust to go live. Associated risks are being worked through and external readiness assurance being undertaken.
	Mobile Data Vehicle Solution					EMS solution currently in Service Acceptance Testing (SAT). Revised estates proposal being worked through following discussions with supplier. Potential solution for NEPTS under development. Still on target to commence in late Q4 but roll-out is planned for 12 months. Remains **Amber** as several outstanding actions need to be completed ahead of planned go-live, however project is on track overall.
	Pilot Microsoft Viva as part of the national centre of excellence.					Licences for Viva is outside scope of the NHS Wales deal. Meeting in early December with Microsoft to discuss the cost and potential for pilot to a group of Trust staff. Remains **Amber**.
Standardised information architecture and common approach to data and analytics across the organisation. **We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation.**	Deliver a modernised, more stable data warehouse.					End date revised to Q4; Migration has been delayed due to operational pressures in previous months and the need for discussion with Microsoft more broadly on SQL Server licensing. ICT meeting with Microsoft due to occur in Q3; remains **Amber** pending the outcome of discussions.

IMTP Deliverables – Infrastructure

Navigation Panel

Report Month:	Noted at STB *(includes Red, Amber, and Completed actions within the current reporting period only)*
Quarter 3–22/23	**18 ongoing actions; 15 Green, 3 Amber:** Business Case development for Llandrindod Wells and Bangor Fleet Workshop (AWC) is expected to commence in Q4 as interviews for project support have been held and a secondment agreed; awaiting start date in the New Year. Several actions have had planned delivery dates extended from Q3 to Q4. This is due to a combination of planning permission, lease agreement, and external decision delays. A permanent solution for EMS/NEPTS in Dolgellau (DC) is proving challenging due to planning permission concerns and limited site options; an update will be taken to Capital Development Board and will be highlighted for discussion. The NEPTS Hub in Bennett St Bridgend is now open with staff relocated on 30/11/2022 – it should be noted that this project was completed within challenging timescales.

IMTP Deliverables 2022/25	Actions in 2022/23	Q1	Q2	Q3	Q4	Comments
We will deliver the Estates Strategic Outline Plan	Development of business case for Llandrindod Wells (AWC)					Whilst both actions are still due to start, project support is now due to commence in the New Year. Interviews have been completed and a secondment agreed; awaiting start date. **Not started**, but expected acceleration in Q4.
	Development of business case for Bangor Fleet Workshop (AWC)					
	Develop long term solution for EMS CCC at Llangunnor (DC)					Discussions ongoing with Dyfed Powys Police regarding funding. Part of wider CCC Task and Finish Group work. Remains Amber with delivery date revised from Q3 to Q4.
	Complete the redevelopment of VPH as an Operational Hub including enhanced facilities for CCC staff					Phase 2 of the works practically complete. Some snagging issues to be resolved at time of writing. However, disruption to operational services from the next phase of works is currently being considered and the programme will need to be further considered. Remains Amber with delivery date revised from Q3 to Q4; expected Feb-23.
	Implement a permanent solution for EMS/NEPTS in Dolgellau (DC)					Included in presentation to EMT; alternative options explored, however this is the only feasible site. Planning permission issues are currently being worked through - concerns raised re drainage, bats, asbestos. Decision to be taken on basis of planning permission feedback. Remains Amber with update due to Capital Management Board to flag; Remains Amber with delivery revised from Q3 to Q4.
	Implement a medium term solution for NEPTS in Bridgend (DC)					Complete

IMTP Deliverables – Fundamentals

Navigation Panel

Report Month:	Noted at STB *(includes Red, Amber, and Completed actions within the current reporting period only)*
Quarter 3–22/23	**Quality:** Work to embed the Trust Quality Management System (QMS) continues, but digital development will require investment; proposal in development. Implementation of the Once For Wales user experience system is on track. Civica system training planned following which the QSPE Directorate can commence using the system for all PREMS surveys. A successful Civica engagement event was held in Cardiff (Nov-22) with great feedback from network members. **Value Based Healthcare:** Awaiting IG approval for data sharing between HBs (PROMS). Meeting to be arranged to understand WG expectation around Value in Health during FY23/24. PREMS plan is on track; survey developed with collection due to commence with AB GUH in December. **Corporate Governance:** Whilst Datix development has progressed, the delivery date will need to be extended. A delivery road map is being developed by the provider but there is currently no revised delivery date in place. Risk management policy has been drafted and will be presented to Audit Committee in March 2023 with delivery date amended from Q3 to Q4. The refresh of the risk management strategy and procedures is taking place in conjunction with the policy review (N.B. also extended from Q3 to Q4).

IMTP Deliverables 2022/25	Actions in 2022/23	Q1	Q2	Q3	Q4	Comments
We will secure and implement Quality Management and control systems	Embed the Trust Quality Management System (QMS), evaluate and mature					QSPE Quality Assurance and Quality Improvement teams have formally commenced OCP consultation, seeking to align resources to deliver Quality Management System; expected conclusion December 2022. Work to support the development of the Trusts QMS is ongoing in terms of the requisite digital development; investment will be required and a proposal is being developed. Remains **Amber**.
	Evaluate the Trust Quality Governance Sub-structure to our Quality, Experience and Safety Committee (QuESt)					CQGG Sub-Group workshop was held in early Q3 for review of sub-groups; output presented to CQGG on 31/10/2022 for endorsement. Sub-group structures have been reviewed and approved however ToR have been delayed to Dec-22 to allow the EMT Effectiveness review to conclude. Remains **Amber**.
We will revisit and implement the Public Health Plan	Review and redraft the Public Health Plan in light of COVID and the health inequalities that have arisen as a result.					Commencement of work (Nov-22) in consideration of activities contributing to Public Health contribution. Early Exec/Senior level engagement with PHW undertaken to align strategic direction. Remains **Amber**; limited of capacity to allocate to this work.
We will deliver a value-based approach	Work with the NCCU and Finance Delivery unit to develop a strategy and approach to Value-Based healthcare which links outcomes, patient experience and use of resources					Remains **Amber** PROMS: Work ongoing around data linkage between HBs, but delays around information governance. Currently awaiting governance approval for sharing and transfer of data. Next steps to follow. PREMS: Currently on track. Draft survey developed in November as planned with AB GUH data collection due to commence in December.
We will deliver strong risk management processes and embed an enterprise wide risk culture that underpins the principles of good governance	Implement the new Once for Wales Datix Risk Module					Whilst there has been some progress with Datix's development, the improvements suggested by the Once For Wales Task and Finish Group will not be realised by the provider as planned. A road map is being created with the providers to achieve implementation and roll out; however, the implementation date is now extended as a result with no agreed date in place. Remains **Amber**.

Programme Highlight Report – Working Safely

Navigation Panel

Report Month:	Current RAG	Previous RAG	STB Action Required
Quarter 3-22/23			Note the closure of the Pump Prime Phase and review of ToR for Programme Board.

SRO:	Liam Williams
Business Partner:	Deborah Kingsbury
Project Manager:	Richard Baxter

Description	Status	Current Position	Forward View
1. Pump Prime Phase of the Programme Complete	Complete	Closure report for Pump Prime Phase in draft	Final report to be noted by STB
1. Integration of H&S Business Partner Model 2. Roll out of the IOSH Leading Safely training Programme 3. Roll of the IOSH Managing Safely training Programme	Complete	All items in place and progress to be monitored	
1. Trust Health and Safety Policy Review 2. Process for H&S premise inspection scheduling and reporting mechanisms 3. COSHH Assessment Procedure Review and Database creation	On Track	H&S Premise inspection programme underway and providing valuable data on workplace hazards and risk control	Inspection process to be streamlined with aid of software applications to improve reporting and data gathering.
1. Legal Compliance Register Assessment 2. Hazard Register Assessment	Off Track	H&S Team Members assigned to all aspects of the Registers and receiving input from staff members across a range of Directorates, majority assessed and on track to complete by end of Q3	ADLT to review the completed register and identified action integrated into the Working Safely Programme

Risks and Issues

Title	Description	Score	Mitigation / Actions
RL007	Delay in Compliance Register completion due to lack of focus time for assessment	12	H&S Team Members assigned to all aspects of the Registers and receiving input from staff members across a range of Directorates, diarised meetings undertaken to assess majority of register to date.
RL008	Delay in creation of the Hazard Register due to lack of time available to undertake the assessment	12	H&S Team Members assigned to all aspects of the Registers and receiving input from staff members across a range of Directorates.

Highlight Reports
Transformation Programmes – Navigation Panel

Programme Highlight Report – EMS Operational

Navigation Panel

Report Month:	Current RAG	Previous RAG	STB Action Required
Quarter 3–22/23			For noting only.

SRO:	Hugh Bennett
Business Partner:	Kelsey Rees-Dykes
Project Manager:	Richard Baxter

Description	Status	Current Position	Forward View
Recruitment and Training To recruit to 1,761FTE target	Off Track	• Q3 attrition higher than forecast; mitigation in place	• Revised projections showing Amber status for Feb-23, and Green status by Mar-23 with delivery to plan by end of Q4
EMS Rosters To align EMS response rosters to the demand pattern (146 rosters)	On Track	• All roster will go-live by 21/11/2022 with the exception of three live Respect & Resolves (R&R's)	• Q4 will focus on lessons learnt and benefits realisation
CCC Reconfiguration Re-rostering of call takers; Realignment of CCC divisional desks and station areas in line with demand; Reviewing the standardisation of practices across the three CCC sites	On Track	• **CCC Re-rostering:** re-rosters for call takers is on track to go live by the end of March-23. Voting for options will go live on 18/11/2022 • **Boundary Changes:** progressing well with engagement with key stakeholders taking place • **Broader Ways of Working:** site visits have taken place with more planned	• Continue to monitor progress via Programme Board and Project Team Board
CHARU Replacement of RRV's with new CHARU resourcing	Off Track	• Go live as planned. Recruitment into Colwyn Bay, Dobbs Hill and Welshpool proving challenging. Some issues around SP Rostering to CHARU shifts	• Increase the focus on recruitment into the more challenging areas. Having completed the first wave, the team will complete an evaluation and consider options on expansion in line with demand
Integrated Technical Planning To ensure that fleet, estate, workforce, and budgets are integrated	On Track	• Key area of focus is blending the +100 into the estate. Looking at rural imbalance and crewing mix. Papers have been delayed, but due in Q3 for EMT	• Possible rural action plan required

Risks and Issues

Title	Description	Score	Mitigation / Actions
Levels of Handover Delays	Levels of handover delays continue to increase which is now impacting on the overall improvements achieved to date within WAST.	25	CEO level discussions with key stakeholders taking place
TU Partnership working	Some gaps in TU project meeting attendance with subsequent lack of quoracy.	15	Taking advice from Director of WOD

Programme Highlight Report – Ambulance Care

Navigation Panel

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Mark Harris
Quarter 3–22/23			For noting only.	Business Partner:	Deb Kingsbury
				Project Manager:	Annabel Harrhy

Description	Status	Current Position	Forward View
Demand and Capacity Project			
Rosters (NEPTS Ambulance Staff) Workstream	Off Track	• A test of the revised roster keys has taken place. Initial feedback received suggests the outcomes are similar to ORH modelling however further feedback is to be collated.	• To collate feedback of test of change of revised roster keys • Complete PID, due November.
Oncology (Performance Standard) Workstream	On Track	• Paper drafted and shared for review, explaining the value and benefits of an Oncology hub • Work on the SOP for the Oncology hub is on hold, pending the outcome of the above paper	• Paper to be taken through appropriate governance, and the next steps agreed.
Outbound Ready Times (PDSA) Workstream	On Track	• PDSA data to date has been reviewed: some clinics identified as not meeting the standards but overall, efficiencies have been gained • It has been identified that clinic ready times are being amended monthly. It will not be feasible to continue to amend this once 350 clinics are onboard. This is being discussed internally.	• c250 Clinics to be onboarded in January 2023.
NET Centre, Planning and Day Control Workstream	On Track	• Issues with performance and recruitment within the NET Centre which have delayed the project. • New starters are informed of pending roster review. • Project on track to deliver by end of Q4.	• Demand and UHP data to be gathered. • Optima to undertake Erlang C modelling to support creation of new roster keys.
T1 Walkers Demand Reduction Workstream	Off Track	• Position paper being created and will be shared with NCCU and WG.	• Dependent on response from NCCU and WG.
NEPTS Operational Improvement Project			
Discharge Lounge Trial Workstream	Off Track	• Trial remains paused, at the request of BCUHB. However, a contact for BCUHB has been provided from NCCU and meeting scheduled for beginning of December to discuss recommencing the trial.	• To have a meeting within BCUHB and restart the trial.
Standardised Guidance and Risk Assessments Workstream	Off Track	• Remains paused whilst supporting the training of Health Boards with online booking in line with the December deadline.	• Work to continue once online booking training is complete; SOPs without risk assessments to be risk assessed.
Oncology Workstream	On Track	• The PDSA is ongoing and data on this will be shared at the next ACT programme board.	• PDSA to be reviewed on a monthly basis.

Risks and Issues

Title	Description	Score	Mitigation / Actions
Impact of service changes by Health Boards on the Programme	If Health Boards change their service models without timely communication with WAST this may result in changes which are detriment to the aims of the Programme. An example is the fast tracking of the Swansea Bay transfer and discharge model.	16	• Health Boards, Commissioners and Planning and Performance are represented in ACTPB • Regular communication with NEPTS DAG • Planning and Business Partners engaged with Health Boards and monitored through ISPG and reported to STB • Allocated slot on ACT agenda for service changes

Programme Highlight Report – Ambulance Care

Navigation Panel

Description	Status	Current Position	Forward View
Transfer and Discharge Project			
Performance, HI and Demand Modelling Sub Group	On Track	• Meeting taken place with modelling supplier and ToRs in development. • Script developed to pull data from EMS and NEPTS systems into one report. This has been quality assured and the data has been reviewed for a 12 month period. This will be provided to modelling supplier when required.	• Work with supplier to progress the modelling. • Review of BCU data and plan. • Detailed review of GUH data.
Model Development Sub Group	On Track	• Workshop took place on 28 October to discuss the P2 back up option and other alternatives for inter hospital transfers and HCP requests. A process mapping session will be required to work through the options suggested.	• Arrange the process mapping session and feedback outcome to T&D. • Review of work undertaken on single system options to inform concept. • Produce a comms plan.
Implementation of the Vascular Network in SE Wales	Complete	• This workstream is complete. Operational meetings are taking place as business as usual.	
NEPTS Operational Improvement Project			
Discharge Lounge Trial Workstream	Off Track	• Trial remains paused, at the request of BCUHB. However, a contact for BCUHB has been provided from NCCU and meeting scheduled for beginning of December to discuss recommencing the trial.	• To have a meeting within BCUHB and restart the trial.
Standardised Guidance and Risk Assessments Workstream	Off Track	• Remains paused whilst supporting the training of Health Boards with online booking in line with the December deadline.	• Work to continue once online booking training is complete; SOPs without risk assessments to be risk assessed.
Oncology Workstream	On Track	• The PDSA is ongoing and data on this will be shared at the next ACT programme board.	• PDSA to be reviewed on a monthly basis.
Transport Solutions			
Implementation of Eligibility Criteria	Off Track	• Position paper being created and will be shared with NCCU and WG.	• Dependent on response from NCCU and WG.
SOP for online bookings	On Track	• There have been issues surrounding training team capacity however this has been addressed and project is on track to complete training on the new process by December deadline.	• To complete online booking training by December.
Plurality Model			
Procurement Process	On Track	• Majority of lots have been awarded, with a few exceptions; contracts due to commence on 01/12/22 and 16/01/23.	• Award the contracts not already awarded. • Complete call off order for DPS
Quality Management Framework	Complete	• Demonstrations are underway for the newly created BI Dashboard.	• Continue demonstration to SMT
Ambulance Car Services	Complete	• A paper reviewing and proposing further applications of ambulance car services (LRV review) was presented to the Operations Senior Leadership Team w/c 7th November.	• Senior Operations Team will explore the opportunities of replicating the ambulance car services across all operational services.
NEPTS CAD			
Upgrade of existing CAD	On Track	• Majority of testing complete; training in progress with no identified issues • Recovery and go live plans are complete	• 2nd penetration (PEN) test scheduled for 28/11 with subsequent go live scheduled for 07/12. • Go live Plan to be shared key personnel within the recovery plan.

Programme Highlight Report – Gateway to Care

Navigation Panel

Report Month:	Current RAG	Previous RAG	STB Action Required
Quarter 3–22/23			SALUS delivery delays for noting; however beyond WAST control. Escalation in place with request for Capita to submit a final delivery plan in early Dec-22 for scrutiny and identification of next steps by the National 111 programme team.

SRO:	Rachel Marsh
Business Partner:	James Houston / Kelsey Rees-Dykes
Project Manager:	Lydia Hutton

Description	Status	Current Position	Forward View
Promote and expand the use of 111	On Track	**111 Comms:** Phase 1 of the National 111 Comms campaign, Digital & Stakeholders assets, went live Nov 14th. **111 Strategy:** 111 Strategy workshop postponed, replaced with Commissioning and IMTP Planning meeting on 12th Dec. **111 Recruitment:** 12 x FTEs due to be operational in mid-Dec and new base established in Cardiff MRD. Further recruitment cycles underway for Jan & Feb (see risk slides)	**111 Comms:** Phase 2 Paid for media go-live 26th Dec 2022. **111 Strategy:** 111 Strategy workshop to take place - 12th December. **111 Recruitment:** November clinicians cohort to start in roles wk. 9th Jan 2023. January cohort to start training. February cohort short listing and interview starting.
Increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team	On Track	**CCC Recommendations:** Reframing of the CCC recommendations needed for consolidation. SBAR to be presented to G2C Board 2nd Dec for decision on consolidating CCC recommendations **CSD Stabilisation**: Action plan developed, including: ▪ Review of CSD clinician rota and rostering model ▪ Define CSD Ops Manager role, including training and practice ▪ Further enhance CSD dashboard and reporting metrics ▪ Define and develop clinical structure within CSD ▪ Make other WAST estate available to CSD staff ▪ Develop possibility for a full home working offer for Clinicians ▪ Implement video into CSD – complete ▪ Develop a standard for the use of Taxi's ▪ Move to CISCO Finesse platform ▪ Implement incoming telephony queue **RCDM:** Joint presentation to the HEIW strategic planning phase 2 board to confirm the position of progressing to a full HEIW led 'once for Wales' educational provision for RCDM	**CCC Recc:** CSD stabilisation plan to be approved by G2C Board in Jan, working continuing to refine and deliver plan. **CSD Stabilisation:** Continue to scope and develop current work packages and 2023 IMTP deliverables **RCDM:** Awaiting outcome of HEIW Board decision on RCDM.
Work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations	Delayed	**SALUS:** Capita submitted a further draft plan ahead of a Joint CEO meeting on 14/11/22. The outcome of the CEO meeting was for Capita to review and submit one final Delivery Plan to the Authority by early Dec 2022.	The final Capita Delivery Plan, due early Dec 22, will be subject to final scrutiny and assessment via the National 111 Programme, WG and WAST governance processes with a final recommendation to be established. Continued development of the core operating solution along with delivery of supporting Programme Workstreams.

Programme Highlight Report – Gateway to Care

Navigation Panel

Report Month:	Current RAG	Previous RAG	STB Action Required
Quarter 3–22/23			To note the 111 Clinicians and Dental Recruitment risks.

SRO:	Rachel Marsh
Business Partner:	James Houston / Kelsey Rees-Dykes
Project Manager:	Lydia Hutton

Description	Status	Current Position	Forward View
Take steps to continuously improve the safety and quality of the service and provide an improved patient experience	Complete	Actions under this workstream closed and merged with 'Promote and expand the use of 111'.	N/A
Increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice	On Track	**111.Wales**: £238k of additional funding has been secured from 6 Goals to assure delivery beyond September '22 until March '23. Website iterations continued. **DOS: :** Proposal to be developed by 6 Goals programme for the DOS for Wales, which WAST will be involved with. **111 data:** 111 reports standardised with 6 Goals programme team reporting functions.	**111.Wales**: Continued iterations to 111.Wales including symptom checker. **DOS:** Proposal to be developed by 6 Goals programme for the DOS for Wales, which WAST will be involved with. **111 data:** Continue to enhance the existing 111 reports with newly appointed principle analyst as BAU.

Risks and Issues

Title	Description	Score	Mitigation / Actions
111 Clinicians recruitment	There is a risk to the 111 service / WAST service provision due to the current Clinician staffing numbers. Challenges with recruitment and current level of attrition is impacting the ability to increase the staffing numbers in post to the required baseline position.	**16**	- ***Recruitment Activity:*** Nov Cohort nearing completion - 12 in training and due to be operational by Mid-Dec. Interviews taking place for Jan cohort – expecting similar FTE numbers as Nov cohort. February cohort adverts live. - ***Enhanced offer:*** Hybrid mix of office / wfh being offered for training and contractual hours. Fully remote working and training to be finalised (pending preceptorship functionality).
111 Dental recruitment	There is a risk WAST will not be able to deliver the 111 Dental service due to insufficient staffing levels. Caused by attrition and the difficulty of recruiting to the vacant posts over the last few months.	**16**	

111 recruitment

Risk Score: 16	RED

Risk ID 07: Clinician W/F Numbers
There is a risk to the 111 service / WAST service provision due to the current Clinician staffing numbers. Challenges with recruitment and current level of attrition is impacting the ability to increase the staffing numbers in post to the required baseline position.
ADDITIONAL INFO:
Current staffing levels: 95 FTE
Establishment: 140 FTE (120 FTE agreed not to exceed for 2022/23)
MITIGATING ACTIONS:
- ***Recruitment Activity:*** Nov Cohort nearing completion - 12 in training and due to be operational by Mid-Dec. Interviews taking place for Jan cohort – expecting similar FTE numbers as Nov cohort. February cohort adverts live.
- ***Enhanced offer:*** Hybrid mix of office / wfh being offered for training and contractual hours. Fully remote working and training to be finalised (pending preceptorship functionality).

Risk Score: 16	RED

Risk ID 08: 111 Dental workforce
There is a risk WAST will not be able to deliver the 111 Dental service due to insufficient staffing levels. Caused by attrition and the difficulty of recruiting to the vacant posts over the last few months.
ADDITIONAL INFO:
Current staffing levels:
Establishment:
Number of vacancies:
MITIGATING ACTIONS:
Recruitment activity: Inability to recruit additional workforce over the last recruitment cycles.

Programme Highlight Report – Clinical Transformation

Navigation Panel

Report Month:	Workstream	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Quarter 3–22/23	CC2H			For noting only.	Business Partner:	James Houston
	CIAG				Project Manager:	Sarah Parry

Description	Status	Current Position	Forward View
Care Closer to Home			
APP Workstream • Workforce • Independent Prescribing • APP Navigator Pilots	On Track	• **APP Workforce:** Education funding received for 18 people on MSc, 10 commenced in Sep-22 (North) • **APP Navigator Pilots:** Live in SBUHB and HDUHB • **Independent Prescribing:** Funding received for 10 FTEs, 5 commenced in Sep-22	• APP Workforce: Remaining 8 to commence MSc in Mar-23 • APP Navigator Pilots: Complete SBUHB APP Navigator Pilot Evaluation • Independent Prescribing: Remaining 5 to commence in Mar-23. Benefits Realisation Paper to be developed
Optimising Conveyance / ED avoidance referral pathways	On Track	• **UPCC:** National criteria and pathway not yet agreed • **SDEC:** Ongoing benchmarking against the National Criteria	• **COPD Pathway:** due to go live in SBUHB • **SDEC:** Undertake opportunities missed audit in YGG. SBUHB due to go live (Dec-22) • **Optimising Conveyance Document:** Write initial draft • Ministerial Summit 28/11/22 to specifically address this problem
Embed preferred technical platform to access senior clinical support	On Track	• Tender Process complete	• Awarded Provider to commence contract in Apr-23
Opportunities of eReferral mechanisms for frontline (Non-Injury Falls / Resolved Hypoglycaemia / Resolved Epilepsy)	Off Track	• **Off Track:** Due date Q3 – anticipate Non-Injury Falls will be complete however delays with the Resolved Hypoglycaemia and Resolved Epilepsy due to needing to build RPA Process • **Non-Injury Falls:** Testing underway of new eReferral process and use of RPA	• **Non-Injury Falls:** Implement new process across Wales mid Dec-22 • **Resolved Hypoglycaemia / Resolved Epilepsy:** RPA Process to be built
Clinical Intelligence Assurance Group			
Di-commissioning of DigiPen	On Track	• **Return of Digipen:** Closure Report submitted to TerraPACE Project Board (26/10/22) • **Validation:** Estimated PCR Backlog to be complete by end Q3	• **Assurance:** To commence following completion of validation • **Storage & Accessibility:** Discuss with ICT
Clinical Indicator Plan	On Track	• #NOF, Stroke, STEMI and Hypoglycaemia ePCR CI data audits approved at CIAG • Published as ASIs by EASC	• Design specifications: 1. Call to Door timings for Stroke and STEMI 2. Outcome by Response Type (Commissioning Intention)

Risks and Issues

Title	Description	Score	Mitigation / Actions
Failure to secure appropriate APP Placements due to other AHPs/Nurses that come with placement funding	Within the whole healthcare system there are many AHP groups/nursing colleagues on a similar training journey, some of these come with remuneration in respect of placement (e.g. Pharmacists providing circa £5k of funding). APPs however don't have this funding.	16	Exploring options again with HEIW and the national AHP group as to the potential of some help towards this, but previous efforts have yielded no monies.

Programme Highlight Report – Clinical Transformation

Navigation Panel

Report Month:	Workstream	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Quarter 3–22/23	Mental Health & Dementia			For noting only.	Business Partner:	Deb Kingsbury
	Older Persons & Falls				Project Manager:	Sarah Parry

Description	Status	Current Position	Forward View
Mental Health & Dementia			
Faculty of Emergency Mental Health Practice	Off Track	• **Off Track:** Progress has been delayed due to funding decision. Anticipate that funding will not be receive therefore progress will commence on a smaller scale • **Faculty:** Decision of funding not confirmed. Unlikely to be secured • **Mental Health Response Vehicles:** Programme Initiation Document developed	• **Mental Health Response Vehicles:** Project Initiation Document to be discussed with HEIW and commence project planning
Mental Health & Dementia Plan	On Track	• **Dementia Reminiscence Therapy:** Pilot underway • **Suicide First Aid:** Training commenced • **Service User Engagement:** Patient story presented to QUEST, positive feedback	• **Dementia Reminiscence Therapy:** Evaluate data • **Dementia Learning:** Reports to be provided from Qlik
Mental Health Practitioners	On Track	• Evaluation approach being scoped • Mental Health Dashboard developed	• Undertake Service Evaluation
Older Persons & Falls			
Falls & Frailty Response Model	Off Track	• **Off Track:** Progress has been made however there have been challenges to secure funding for the Level 2 Falls Response, therefore will not be available across all of Wales by winter • **Level 2 Response:** Available in BCU East with funding secured for 5 years and BCU Central to go live 19/12/22 • **Level 1 Response:** Falls Assistant by Night extended until Mar-23	• **National SOP:** Initial draft to be reviewed by respective groups • Full Service Evaluation: Service Evaluation to be presented to EMT (Q4) • **Modelling:** Work with Optima to understand the impact, value of Falls Resources and missed opportunities • **Electric Vehicles:** Continue discussions re: Procurement and Infrastructure
Older Persons Framework	On Track	• **Powys Care Home:** VBHC bid approved, 1 x B6 Paramedic appointed to provide iStumble Tool training 1 day/week for 6 months, starting 29/11/22 • **Falls Code-sets:** Additional codes sets have been identified for Falls Assistants have been approved by CPAS (6 in total) Go Live: 08/11/22	• **Powys Care Home:** Monitoring the improvement of VBHC Bid

Risks and Issues

Title	Description	Score	Mitigation / Actions
Lack of availability of vehicles to support the Response Teams	Falls Teams do not have dedicated vehicles and the build time of new vehicles can take up to 12 months	16	Discussions commenced with the Head of Capital Development and Finance.

Programme Highlight Report – Clinical Transformation

Navigation Panel

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Quarter 3–22/23			For noting only.	Business Partner:	N/A
				Project Manager:	N/A

Description	Status	Current Position	Forward View
		TerraPACE & ePCR	
TerraPACE Project Phase 1 Activities Continued	On Track	• **Deployments to English Hospitals:** 8/10 Hospitals live • **Corpuls Device Interface (Ortus):** Work has been commissioned • **DHCW WGPR Patient Summary Interface:** APP Go live Nov-22	• **Deployments to English Hospitals:** Completion of DPIA from remainder hospitals • **Corpuls Device Interface (Ortus):** Development work to commence in Jan-23
TerraPACE Project Phase 2 Activities	Off Track	• **Clinical Information and Reporting:** Development work complete • **CFR Deployment:** FAT testing complete • **Mass Casualty Information System (MCIS) Software:** Awaiting feedback from Demo. Likely that the Trust are not ready to take on new software or financial consequences for this purpose at this stage - expect work stream to be closed in next period	• **Clinical Information and Reporting:** Target date to deploy end Nov / early Dec • **CFR Deployment:** SAT testing to commence once ARP interface is live • **Mass Casualty Information System (MCIS) Software:** TBC
ePCR Programme Activities Year 2	On Track	• **In-life Team Recruitment:** 4 posts remain outstanding in ICT. • **Clinical Audit OCP:** Job Descriptions are going through Consistency Checking • **Exploring HAS Screen alternatives:** Potential Solution report in development	• **In-life Team Recruitment:** Shortlisting in progress for Digital Systems Product Specialist • **Clinical Audit OCP:** Work to progress on completion of Job Evaluation Process
Formal Closure Activities	On Track	• **ePCR Programme Closure Activities:** Lessons Learnt collected. Transfer to BAU. TerraPACE Project deliverables remain.	• **ePCR Programme Closure Activities:** Undertake Benefits Realisation
Additional Approved Activities	On Track	• **Clinical Risk Management:** Procurement complete. Contract awarded. • ePCR Internal Audit: Work on the actions is in progress.	• **ePCR Internal Audit:** Continue to work on the actions

Risks and Issues

None for noting

Programme Highlight Report – Strategy Development

Navigation Panel

Report Month:	Current RAG	Previous RAG	STB Action Required
Quarter 3–22/23			For noting only.

SRO:	Rachel Marsh
Business Partner:	James Houston
Project Manager:	Sarah Parry

Description	Status	Current Position	Forward View
Organisational Reputation Audit	On Track	• Draft Reputation Audit presented to EMT in November. • Organisational Reputation Audit live w/c 21/11.	• Reputation Audit closes w/c 19/12. • Thematic analysis of feedback and responses.
Purpose Statement	On Track	• Engagement period undertaken to capture initial ideas and feedback (Jun-22). • Proposed Purpose Statement shared at CEO Roadshows (Oct-22). • Feedback from Our People reviewed (Nov-22).	• Amendments to the Purpose Statement and associated video. • Re-circulate to Our People for further consideration and feedback.
Long Term Strategy	Paused	• LTS Strategy endorsed by EASC in May-20. • Agreement to review LTS in Mar-23.	• Not Applicable

Risks and Issues

None for noting

Programme Highlight Report – Inverting the Triangle

Navigation Panel

Report Month:	Current RAG	Previous RAG	STB Action Required
Quarter 3–22/23			For noting only.

SRO:	Rachel Marsh
Business Partner:	James Houston
Project Manager:	Sarah Parry

Description	Status	Current Position	Forward View
Setting Aims & Vision	On Track	• **Literature Review:** Procurement discussions underway – 3 universities contacted for costings (to be incorporated into wider evidence base work stream being formulated) • **Programme Purpose, Objectives and Guiding Principles:** 3 x 2 hour to scope initial draft with members of the TDN • **Health Economics & Data Analytics:** Initial discussions with EMT/ADLT to develop more robust population and health economic data. Draft specification in development.	• **Case for Change Document:** review document aligned to wider discussions linked to Health Economic & Data Analytics work stream • **Literature Review:** Continue procurement process • **Programme Purpose, Objectives and Guiding Principles:** Draft to be submitted to TSAG in Dec-23 • **Health Economics & Data Analytics:** Draft specification in development.
Preparation for Change	On Track	• **Establish Programme Team:** Head of Strategy appointed, start date Dec-22 / Clinical Development Lead appointed, start date in Dec-22 • **Change Management Capabilities:** Initial discussion to explore opportunity to deliver external training to enhance 'Change Management' capabilities (Nov-22)	• **Establish Programme Team:** Complete Job Evaluation process for the Strategy Development Manager and Engagement Manager posts • **Transformation Change Framework:** Draft to be submitted to TSAG in Dec-22 • **Change Management:** identify funding & training provider • **EQIA:** develop draft EQIA
Stakeholder Engagement	On Track	• **Formal Public Engagement:** Paper submitted to the Board of CHC Service Planning Committee (Oct-22). Feedback suggesting for public engagement period of approx. 12 weeks, however formal consultation may not be required • **Consultation Institute:** Initial discussions with CI to explore professional support and expertise	• **Engagement Delivery Plan:** Draft to be submitted to TSAG in Dec-23 • **Stakeholders:** Commissioner support prior to public engagement (EASC/HBs) • **Consultation Institute:** Follow up discussions to map out next steps
Test Change	On Track	• **APP Tasking:** Initial meeting held 21/11/22 to scope project • **APP Navigator:** Reviewing delivery arrangements. Initial 3 month evaluation of the SB pilot (80%) complete by end of Nov-22 • **CSD:** Agreement to initially focus on 'service consolidation actions'. Detailed plan to be presented to G2C Board in November outlining all improvement actions + consolidation of CCC Clinical Review recommendations • **SBRI:** Opportunity presented to work with SBRI and funding allocation of £1.02 mil from WG	• **APP Tasking:** Workshop to be scheduled to identify APP Codesets • **APP Navigator:** Complete initial 3 month evaluation of the SB pilot by end of Nov-22 Undertake PDSAs for SB Phase 2 (CSD / Co-location) and HD (Phase 1) • **SBRI:** SBAR to EMT for consideration

Risks and Issues

None for noting

Programme Highlight Report – Financial Sustainability

Navigation Panel

Month	Current RAG	Previous RAG	FY23/24 Target	STB Action Required
Quarter 3-22/23	£1,189,000/24% (09/11)	-	£5M	Programme plan presented to EMT 09/11/22, and resulting action was transfer of SRO to WOD. Programme restructure will take place before next STB (16/01/23). Ongoing discussions with commissioners may also alter savings target.

SRO:	Angela Lewis (TBC Formally)
Business Partners:	Jessica Price, Gemma Mainwaring, Nathan Jones, Daniel Purnell
Project Manager:	Gareth Taylor

Description	Status	Current Position	Forward View
Achieving Efficiencies To explore and pursue opportunities for cost avoidance, or efficiency savings across WAST	Off Track	1. Nine schemes currently being actively pursued with identified (potential) savings of approx. £400,000 heading into FY23/24 across five of the nine schemes. 2. Unidentified savings can be attributed to four of the nine schemes which are Robotics, De-Carbonisation, Associated Accident Costs, and the Merthyr Workshop. 3. Scoping around proposed ideas / schemes that come via WiiN or other avenues.	1. Benefits Realisation to be undertaken for associated Robotics Programme in early 2023 as pilot funding ends. 2. Working Group to be established on associated accident costs. 3. FSW representation on WiiN Business Group will enable capture of potential schemes. 4. Findings from financial data to be presented in paper format with recommendations in Jan-23.
Income Generation To explore opportunities for income generation across WAST	Off Track	1. Six schemes being actively pursued with identified income of around £880,000 heading into FY23/24 across two of the six schemes. 2. Potential income in a further two schemes amount to approximately £500,000. 3. The final two schemes have unknown estimates attached to them. Actions to identify potential income. 4. 5 schemes in reserve with no identified income. Reserve status due inability to deliver scheme by start of FY 23/24.	1. Alignment of FSW with ongoing programmes of work continues, with Fleet representation providing updates on the Merthyr Workshop Programme, and data from the Intelligent Routing Platform being fed into the Income Generation meetings on a regular basis. 2. Attach approximate estimates for unidentified income generation schemes. 3. Continue to scope income generation schemes as proposed via various avenues.
Benchmarking To explore key lines of enquiry presented via benchmarked data from other Blue Light / Public Sector organisations, and to undertake Investment Evaluations of all ongoing Business Case Investments	Attention Required	1. Benchmarking Group currently undertaking evaluative role, both of recent EASC investments / Business Case investments, and of data recently contributed to the Carter and Blue Light Reports. 2. Value Based Healthcare Working Group currently developing consistent evaluation methodology / framework which will be used by Benchmarking Group to consistently evaluate recent investments. Decision to be made around continuing with investments in light of current financial pressures. 3. Benchmarking Group to also set internal benchmarks from a performance perspective. Key Indicators across all areas of the Organisation will create key lines of enquiry that can be explored against other organisations.	1. Ahead of the next reporting period Benchmarking Group to collate data from organisations that submitted to both the Carter and Blue Light Joint Working Reviews. 2. The group will also determine key benchmarks and begin the development of a dashboard. The end purpose is to provide an annual Benchmark Report. 3. Investment evaluations of ongoing Business Cases will commence on receipt of an evaluation framework, and a detailed list of Business Cases with attached costings has been requested.
Transformation Alignment To collate, align, and report on all associated efficiency savings, spend avoidance, and income generated via wider projects and programmes	Not Started	1. Piece of collaborative work to commence to capture ongoing savings across WAST's Transformation Portfolio. Discussions to commence with Head of Transformation and Finance Leads regarding method of capture.	1. Transformation portfolio document to contain costings once determined, and any income generated, spend avoidance, or efficiency savings to be captured and monitored on ongoing basis - and if appropriate - to be recorded in this Highlight Report.

Risks and Issues

None for noting – *risk review to be undertaken as part of programme restructure*

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

AUDIT REPORT

MEETING	Finance & Performance Committee
DATE	16th January 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update in relation to recommendations resulting from Internal Audit reviews pertinent to the Committee.

2. In addition, the paper sets out the Internal Audit plan activity for 2022/23.

3. No recommendations are showing as complete during this cycle due to the timing of reporting arrangements following the December 2022 Audit Committee. Each recommendation is currently under review, and it is expected that a good proportion of these will be completed during this quarter.

4. Recommendations that were due for completion in November and December 2022 have not been updated on the tracker, as is usual in previous reports, due to current operational pressures. It is not to say that the recommendations have not been completed, rather that the update is not available. The Assistant Directors Leadership Team are undertaking full reviews, finalising the tracker and all updates will be available for Executive review at the end of January 2023.

RECOMMENDATION:

5. **The Committee is asked to:**
   a. **Note and consider the contents of the report.**
   b. **Consider the Internal Audit Plan activity.**
   c. **Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically those relevant to Committee, and**
   d. **Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee**

KEY ISSUES/IMPLICATIONS
6. The internal audit recommendations continue to be reviewed by the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) to ensure that any new completion dates are assigned with realistic timescales and a strong narrative and rationale to support any extension.
REPORT APPROVAL ROUTE
7. The report has been submitted to: • ADLT – 16th October 2022 • ADLT – 31st October 2022 • EMT – 9th November 2022 • Audit Committee – 1st December 2022

REPORT APPENDICIES
8. The Audit Tracker has been circulated as a separate document - Appendix 1. 9. Hazardous Area Response Team (HART) Audit Review – Appendix 2 10. Electronic Patient Clinical Record Audit Review – Appendix 3

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

WELSH AMBULANCE SERVICES NHS TRUST
FINANCE & PERFORMANCE COMMITTEE
INTERNAL AUDIT TRACKER

SITUATION

1. The purpose of this paper is to provide the Committee with an update in respect of recommendations resulting from internal audit reviews that are presented to the Committee for oversight.

2. In addition, the paper sets out the Internal Audit plan activity.

BACKGROUND

3. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned and in a timely manner.

4. This tracker provides Senior Managers with a workable tool that allows for closer scrutiny of audit recommendations and is designed to provide a more detailed focus as to the reasons why recommendations are overdue or have not progressed within the agreed timeframes. This will highlight areas that may require additional support and ensures there are clear mechanisms in place to escalate any issues.

5. The Internal Audit plans have been developed in partnership with the Executive Management Team to identify current and emerging areas of risk, as well as specific assurance needs within the Trust.

ASSESSMENT

Internal Audit Plan 2022/23

6. There are 4 completed internal audit reports relevant to the Committee which form part of the 2022/23 Internal Audit Plan as described in the table below. The Hazardous Area Response Team (HART) and Electronic Patient Clinical Record reports are attached to this paper; both of which were received by the Audit Committee in December 2022.

Internal Audit Report	Assurance Rating	Date received/or due at Audit Committee
Fleet Maintenance	Reasonable	September 2022
Major Incidents	Reasonable	September 2022
Hazardous Area Response Team (HART)	Reasonable	December 2022
Electronic Patient Clinical Record	Reasonable	December 2022

7. There are a further 10 internal audit reviews relevant to the Committee which are included in the 2022/23 Internal Audit Plan as follows:

Internal Audit Report	Estimated Date of Audit	Date due at Audit Committee
Estates Assurance - Decarbonisation	Q1	March 2023
Immediate Release Request	Q2	March 2023
Savings and Efficiencies	Q3	March 2023
IMTP Delivery	Q3	March 2023
Cyber Security	Q3	March 2023
Risk Management and Assurance	Q4	June 2023
Health & Safety (deferred from 2021/22)	Q4	June 2023
Strategy Development	Q4	June 2023
IM&T Infrastructure	Q4	June 2023
Follow Up Action Tracker	Q4	June 2023

Internal Audit Highlights

8. At the time of issuing the paper, there were a total of 97 current internal audit recommendations on the tracker. 30 recommendations were marked as complete at the December 2022 Audit Committee and removed from the tracker.

9. 29 recommendations were added to the tracker resulting from 3 Internal Audit Reports which were presented to the Audit Committee in December 2022. 21 of these recommendations were assigned to FPC and were from Reasonable and rated reports as follows:

- Hazardous Area Response Team (HART) – Reasonable Assurance
- Electronic Patient Clinical Record – Reasonable Assurance

10. The status of each of the current internal audit recommendations is described in the table below.

Status	Total Number of Recommendations on the tracker	Those directly relevant to FPC	High Priority FPC	Medium Priority FPC	Low Priority FPC
Overdue	60	36	11	22	3
Not yet due*	37	30	2	28	0
Complete	0	0	0	0	0
Total	97	66	13	50	3

* accepting extensions have been applied in line with the agreed pandemic arrangements.

11. Of the 11 high priority recommendations showing as overdue these relate to the following reports:

- 2020/21 Clinical Contact Centres Performance Management - Reasonable Assurance review - proposed completion date extended to January 2024.
- 2021/22 Waste Management – Limited Assurance Review - proposed completion date extended from September to December 2022.
- 2021/22 NEPTS Transfer of Operations – Limited Assurance Review – proposed completion date extended from September to December 2022.
- 2022/23 Fleet Maintenance – Reasonable Assurance Review – proposed completion date extended from September to November 2022.

- 2022/23 Major Incidents – Reasonable Assurance Review.

12. The total number of recommendations, separated by financial year, and status this period is described below.

Financial Year	Total Number of Recommendations on the tracker	Those directly relevant to FPC	Complete FPC	Overdue FPC	Not Yet Due FPC
2019/20	3	2	0	2	0
2020/21	5	5	0	4	1
2021/22	40	20	0	16	4
2022/23	49	39	0	15	24
Total	97	66	0	37	29

13. It should be noted that there are no recommendations showing as complete during this cycle due to the timing of reporting arrangements following the December 2022 Audit Committee. Each recommendation is currently under review, and it is expected that a good proportion of these will be completed during this quarter.

14. The number of recommendations by assurance rating and level of priority are detailed below.

Assurance Ratings	Total No. of Recommendations on the tracker	Those directly relevant to FPC	High Priority FPC	Medium Priority FPC	Low Priority FPC
Limited	7	7	5	2	0
Reasonable	89	59	8	48	3
Substantial	0	0	0	0	0
Not Rated	1	0	0	0	0
Total	97	66	13	50	3

15. The Governance team continue to seek assurance from Senior Management relating specifically to each report that:

- Recommendations have been considered and completed within agreed timeframes and;
- All is being done to ensure that the follow up of recommendations will not result in further *Limited* or *No Assurance* rated reports.

RECOMMENDED:

16. The Committee is asked to:

a) Note and consider the contents of the report,
b) Consider the Internal Audit plan activity.
c) Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to Committee.
d) Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.

Hazardous Area Response Team (HART)

Final Internal Audit Report

November 2022

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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Auditors:	Osian Lloyd, Head of Internal Audit Jonathan Jones, Audit Manager
Executive sign-off:	Lee Brooks, Executive Director of Operations
Distribution:	Judith Bryce, Assistant Director of Operations, National Operations & Support Clare Langshaw, Head of EPRR and Specialist Operations Kate Blackmore, Head of Service, EMS Co-ordination Jason Fenard, Service Manager EPRR and Specialist Operations Gavin Davies, HART Locality Manager Giles Hodges, HART Training Manager
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 Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & 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

To review how the Trust ensures the team is appropriately trained and equipped to respond to high-risk and complex emergency situations.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Training records and materials do not fully capture detail of sub-competencies.
- Debriefs take place but no mechanisms to capture or monitor associated actions and learning.
- SOPs require updating to reflect current methods.
- Activity not currently captured in full and lack of reporting to oversight committee.
- SLA with Welsh Government in need of updating with opportunities to achieve further alignment with NARU guidance.

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

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/a

Assurance summary[1]

Assurance objectives		Assurance
1	HART Interoperability	Reasonable
2	Deployment processes and procedures	Reasonable
3	Training compliance	Limited
4	External agency cooperative working	Reasonable
5	Performance reporting and lessons learnt	Limited

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Service Level Agreement content review	1	Design	Medium
2	NARU self-assessment	1	Design	Medium
3	HART asset register	1	Design	Medium
4	HART Standard Operating Procedures	2	Operation	Medium
5	CAD data review	2	Operation	Medium
6	HART Activity Monitoring	2	Design	Medium
7	Training competencies and reporting	3	Design	High
8	Fire and rescue MOU	4	Design	Medium
9	Debriefing and lessons learnt	5	Design	Medium
10	Committee oversight	5	Design	Medium

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

1. Introduction

1.1 The Hazardous Area Response Team (HART) is made up of specially recruited personnel, who are trained and equipped to provide the Welsh Ambulance Services NHS Trust ('the Trust') with the ability to respond to high-risk and complex emergency situations. Established in 2012 and based within a dedicated facility in Bridgend, HART personnel receive specialist training to save lives and improve clinical outcomes across a number of high-risk environments, including situations involving hazardous materials, CBRN(e) events (Chemical, Biological, Radiological, Nuclear and Explosives), response to marauding terrorist attacks, working at height, in water or within confined spaces, or providing healthcare support to security operations.

1.2 HART teams work alongside police and fire and rescue services, and there is the expectation that in line with national standards of interoperability, they can be deployed nationally to support HART teams at other UK Ambulance Services on large scale or high-profile incidents.

1.3 The risks considered during the review were as follows:

i. Failure to meet national interoperability standards would impact Trust deployment and response to high-risk emergency situations.

ii. Reputational damage to the Trust where it cannot provide equipment and training to meet national standards.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	5	0	6
Operating Effectiveness	0	3	0	3
Total	1	7	0	9

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

Audit objective 1: The Trust Hazardous Area Response Team (HART) operates in line with UK standards of interoperability and is equipped accordingly.

2.3 The National Ambulance Resilience Unit (NARU) set out the specialist capabilities for Hazardous Area Response Teams through a set of National Standards. The Standards were last issued in 2018 and are linked to the NHS Emergency Preparedness Resilience and Response Framework, which is a contractual requirement in England.

2.4 The Standards include a requirement for specialist capabilities to be interoperable, i.e. '*they must be maintained according to strict national standards to ensure they can be combined safely to provide an effective national response to certain types of incidents*.' Whilst the Standards state that they do not apply to Ambulance Services in devolved nations, they are accepted as best practice and the Trust's HART unit seeks to ensure alignment.

2.5 The HART capability is provided and funded through a service level agreement (SLA) between the Trust and Welsh Government, which was signed in 2011. The SLA contains an outline of service summary, staffing requirements/training, funding arrangements and equipment.

2.6 The Standards sets out the tactical capabilities required of a HART service across a range of high-risk environments, including hazardous materials; chemical, biological radiological, nuclear, explosives (CBRNe); marauding terrorist firearms attack; safe working at height, in water, on unstable terrain or within confined spaces; and providing healthcare support to security operations. Review of the NARU Standards identifies that there is opportunity to refresh the SLA against its contents, in particular to capture and reflect the services and required capabilities. **See MA1**

2.7 The Standards also define nationally specified 'Safe System of Work', supplemented by guidance on components such as standard operating procedures, rescue plans, risk assessments, training and equipment. We requested and were provided with a sample of risk assessments for three capabilities (Water Operations, Unstable Terrain and ATV (All Terrain Vehicle)), and for any associated training facilities as NARU expectations are that these will be held locally by the Trust.

2.8 We obtained Job Descriptions for HART operatives and operational managers and reviewed against NARU templates and confirmed consistency subject to minor differences NARU Standards also require HART operatives be qualified paramedics. Whilst the Trust has not made this mandatory, there is a desire to move all HART staff to registrants and it has supported staff members who wish to qualify. At present there are two Technician's within the HART unit, and the makeup of the workforce is reported to Welsh Government.

2.9 NARU has also established an annual review process for NHS England Ambulance Trusts, to assess adherence to the EPRR Core Standards and interoperable capabilities. Prior to the Covid-19 pandemic, the previous Head of EPRR had held

discussions with the NARU assessment lead to explore the Trust undergoing a 'critical friend' peer review. The Trust may want to consider undertaking a self-assessment prior to any formal review being commissioned. **See MA2**

Equipment

2.10 The EPRR Core Standards includes a requirement that '*Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets*.' There is also reference to use of national buying frameworks co-ordinated by NARU.

2.11 We were advised by the HART Team that the Trust retains awareness of NARU specifications, but that there have been instances where it has been deemed necessary to diverge from specifications. Examples given include the makeup of the HART vehicle fleet to take into account the geography and urban/rural mix covered by the unit, and incident ground technology (IGT) which we understand has been decommissioned by the Trust as it was operating beyond its original expected lifespan. Funding is currently being sought to allow the procurement of the next generation of IGT, should this not be obtained this would impact the unit's interoperability. We were also informed that there can be variation in standard clinical equipment, depending on sourcing from procurement. However, there is more alignment where equipment is required for the HART capabilities.

2.12 We sampled five items of equipment to identify if those held by the Trust matched the NARU Equipment Data Sheets (EDS). Exceptions were noted for two items related to safe working at height. Discussion with the lead for that equipment noted that the Trust is intending to match the equipment specified by NARU, but this is through iterative replacement as needed.

2.13 Equipment should also be subject to regular inspections by a competent assessor to ensure they are fit for purpose. Noting safe working at height equipment is subject to LOLER requirements, we were provided with a monitoring spreadsheet which records inspections undertaken by HART operatives. We identified whilst all equipment kits have had a service within the past 6 months as required, monitoring spreadsheet did not include the previous date of inspection for all kits to demonstrate regular maintenance has been undertaken. **See MA3**

2.14 Additionally, we note that the NARU annual review process includes a requirement for HART units to maintain an equipment asset register. Currently HART has a split between assets registered on NARU's PROCLUS website and local records. For some entries provided, the PROCLUS register did not include use of all fields available. See **MA3**

Conclusion:

2.15 The Trust provides a HART capability in line with the Service Level Agreement in place with Welsh Government. It also recognises and seeks to align with NARU Standards which is recognised as best practice. We have identified areas where alignment could be improved and highlight an opportunity for the Trust to

undertake a formal self-assessment against the Standards. We assign this objective **reasonable** assurance.

Audit objective 2: There are clear processes and procedures to activate and deploy HART in line with Trust needs and operational demands.

2.16 NARU guidance does not extend to provide specific criteria for incidents which prompt the deployment of HART, although there would be natural links to the capabilities the team are trained for.

2.17 Our review of the Trust's Major Incident Plan earlier this year confirmed that HART deployment is included within the pre-determined response matrix. The matrix assigns set resource levels, determined by number of casualties and anticipated incident duration.

2.18 The HART unit has a suite of Standard Operating Procedures (SOPs) to support the day-to-day operation of the service. The majority were issued in 2016, and would have been due for review in April 2020. Our review has concentrated on a small number which we reference directly below.

2.19 *Deployment Criteria* (SOP-8) outlines the assets required for certain incidents, although it allows for HART Operational Managers and Second in Command (2ic) flexibility to consider resource requirements based upon information available. The incident types outlined include chemical/tanker incidents, rail, aircraft, fire, suspect packages, public order events, amongst others. Each holds a listing of vehicle assets, minimum staffing and deployment reasoning to support these. There is also a column to link to Computer Aided Dispatch (CAD) codes, however this is not populated.

2.20 We were informed that the SOP is in need of updating, including to reflect a Vehicle Deployment Plan to support ongoing interoperability with the majority of Ambulance Trust's across the UK who have adopted this methodology. This allows for the allocation of one 'pod' to support HART specific incidents, allowing the other to provide operational support to the wider Trust, or to operate in tandem where required. The operational support also has a criteria that they should '*only be responded to calls with an achievable response time from the HART base and there should be a clear patient or staff benefit from the attendance of that POD*.' **See MA4**

2.21 There is also a SOP for *HART Dispatch* (SOP-9) which sets out how resources will be mobilised by the Clinical Contact Centres (CCC). A flow chart contained within identifies the process by which a CCC can activate HART and references the deployment criteria above. However, it requires updating to reflect available methods of activation, we were informed that HART vehicles were previously assigned to geographical areas. We were informed these can include HART self-tasking or requesting assignment through monitoring of CCC calls, or requests for support received directly from Duty Operational Managers and Senior Paramedics. **See MA4**

2.22 We were informed that the previous Head of EPRR had undertaken a review of dispatch codes within the CAD system when the HART unit had been established in 2012. This review resulted in codes being assigned a prompt '*consider specialist response*', although we note this is not HART specific and may suggest use of EMERTS or others.

2.23 Review of an extract from the CAD system indicates that 465 out of 2,460 codes contain the specialist response prompt. A review of codes has not been undertaken since, although the Trust does have a mechanism for ongoing oversight through its Clinical Prioritisation Assessment Software group, which has membership from across the Trust, but no representation from HART. **See MA5**

2.24 We were also advised that the HART base in Bridgend was selected in line with the Home Office guidance at the time, but that this has been superseded by methodology based upon population centres. North Wales remains within HART's remit, and we note there is the ability to request mutual aid from North West Ambulance Service NHS Trust if required. We note direct support would be provided by HART team from South Wales if the incident extends beyond four hours.

2.25 HART SOPs have been developed for *Joint responses within Welsh regions* (SOP-29) and arrangements to support requests for *Mutual Aid Requests* (SOP-11). We were informed that requests relating to North Wales are infrequent, but there are no mechanisms for monitoring activity levels which could prompt HART dispatch on an ongoing basis. **See MA6**

2.26 In line with NARU requirements, calls assigned to HART are logged onto the PROCLUS system by HART Operational Managers. Information being recorded includes the type of incident and number of casualties, but not the location. We understand that there are limitations on how this information can be exported and discussions with the HART team also highlighted concerns around the completeness of activity details being captured. The HART Locality Manager is currently considering approaches to address this, including comparison of entries by team.

2.27 We were able to undertake some limited analysis which suggests that activity is underreported. Analysis of data captured within the Trust's CAD system indicated incidents were attended by HART vehicles which were not included within the PROCLUS report for the period. **See MA6**

Conclusion:

2.28 There are HART SOPs which outline deployment criteria and despatch mechanisms. However these have not been updated to reflect current procedures. Improvements can also be made to accurately capture and report HART activity. We assign this objective **reasonable** assurance.

Audit objective 3: Members of the team maintain compliance with required training competencies, and that records are maintained.

2.29 The Trust's 42 HART Operatives are organised across seven teams (known as 'colour watches'). Each team is led by an Operational Manager, who is supported by a 2ic. Each watch operates to a seven-week rota, with one week dedicated for training.

2.30 NARU has issued Training Information Sheet (TIS) for each of the interoperable capabilities, which includes set frequency for re-certification (training frequency per year) and re-qualification (periodic internal or external assessment of capability) period. Review of the Trust's training programme for its HART operatives confirmed alignment with NARU.

2.31 Following each training cycle, Operatives are expected to complete a form to capture the subject of training undertaken, as well as the overall aim of the session, whether the aim was achieved and confidence level. The latter is to recognise that there can be scope for additional training even where session aims are achieved.

2.32 Each competency is broken down further to sub-competencies, the achievement of which would be demonstrated through lesson plans. We requested lesson plans relating to three capabilities and whilst they included reference to sub-competency headings, outline of lesson activities did not necessarily provide sufficient level of detail to support this. We understand that the Trust is planning to migrate to a training record facility within PROCLUS, which includes prompts for Operatives to address each sub-competency. **See MA7**

2.33 The HART Training Manager highlighted non-compliance against three training areas which related to equipment and exercising availability; '*HAZMAT Personal Protective Equipment*', '*Support to Security Operations*' and '*Polaris and Winch*'.

2.34 Review of training records from a sample of ten HART operatives across four capabilities; '*Marauding Terrorist Attack (MTA)*', '*Water Operations'*, '*Fitness Testing'* and Clinical (*Continuous Professional Development - CPD*) identified that outside of CPD, training frequencies were not achieved for these capabilities in 2021. **See MA7**

2.35 We recognise that the above reflects the impact of the pandemic and operational pressures which saw the Trust operate at REAP Level 4 (its highest level of escalation), during which training is typically cancelled due to the need to focus on operational pressures. Recognising that extended periods of REAP Level 4 could impact operatives' ability to meet re-qualification deadlines, the Executive Management Team (EMT) approved an SBAR in April 2022 which allows Trust Strategic Commanders to apply discretion and consider immediate needs, including to support completion of HART training.

2.36 The HART management team meet formally on a regular basis and receive a standing report from the HART Training Manager. The reports mainly provide narrative updates, including on general performance and issues, however there is

opportunity to develop further and enhance to improve compliance monitoring of re-certification or re-qualification. **See MA7**

Conclusion:

2.37 Due to the unprecedented pressures brought by the pandemic, compliance with NARU training frequency requirements has not been achieved. We have also identified opportunities to improve the recording and reporting of training competencies. We recognise actions are underway to address these areas, however currently would assign a **limited** assurance rating.

Audit objective 4: Documented arrangements are in place which outline HART's cooperative working with external agencies.

2.38 The HART Capability references primary functions of the team include '*to provide NHS coordination of casualty management activities by other agencies working inside the high-risk area*' and, *'to provide medical cover for other agencies operating in high-risk areas in response to an emergency.'* There will also be multi agency working where incidents or deployments could involve safe working from height, confined space rescue or inland water rescue.

2.39 The HART Management team has co-developed a briefing document with the Joint Firearms Unit (JFU). The JFU is a specialised team which operates across the three police services of Gwent, South Wales and Dyfed Powys.

2.40 The briefing sets out factors to consider to determine the involvement required by HART in an incident, such as risk assessing the need for immediate clinical care and the risk to officer safety. The document includes that if there is an immediate risk to life, or that the risk assessment does not suggest that the specialist capabilities of HART operatives is required, then the request should be directed through the Trust's normal channels.

2.41 The document includes guidance for scene management, key priorities for HART Operatives under deployment, and overview of incident and activation arrangements. The briefing should support that HART would not necessarily be engaged for all calls received requesting support. We were also informed that the JFU are encouraged to direct calls to the HART Operational Managers rather than the CCC as the managers are better placed to confirm and challenge requests.

2.42 We were informed where activated as above the HART operatives would receive briefings, either ahead of time through co-location, or ad hoc through IIMARCH (Information, intent, method, administration, risk assessment, communication, humanitarian) methodology reflecting the JESIP (Joint Emergency Service Interoperability Principles) which support multi-agency working.

2.43 Support provided to other agencies is captured through the categorisation of incidents logged on PROCLUS. Review of that data highlighted that almost half of the '*Support to Security Services*' incidents responded to in quarter one of 2022 resulted in the HART team being stood down or not required following acceptance of the call. The briefing document and use of Operational Managers to receive

requests, demonstrates the measures the Trust is taking to ensure the appropriate use of this resource.

2.44 We were also provided with a copy of a memorandum of understanding (MOU) which has been signed by representatives of all three Fire and Rescue services (FRS) across Wales. The MOU was signed in 2012 and discussion with the Service Manager, EPRR & Specialist Operations, outlined that the document contained detailed appendices linked to operational deployment arrangements, reflecting that HART was a newly commissioned service at that point.

2.45 With HART now firmly established, and good working and exercising arrangements in place with FRS, discussions had been held prior to the onset of the Covid-19 pandemic to revise the MOU to recognise and better reflect HART capabilities. A draft copy has been shared with FRS colleagues with the intention to revisit this further. **See MA8**

2.46 We also briefly discussed arrangements in place to work with Mountain and Cave rescue services. These are more informal, reflecting that activation of those services would be through external parties rather than directly by HART. Training exercises have been planned for this year with Mountain rescue teams.

Conclusion:

2.47 There is evidence of ongoing co-operative working between HART and other agencies, although this varies in formality. The Trust is taking measures to ensure the appropriate use of resource noting half of incidents responded to did not require HART resources. There is opportunity to revisit the MOU in place with the Fire and Rescue Services, a process started prior to the pandemic. Noting this we assign the objective **reasonable** assurance.

Audit objective 5: Team deployment and performance is monitored, which includes both activity and quality indicators, and lessons learnt are identified and acted upon.

2.48 Our review of Major Incidents undertaken earlier this year reflected positively on the Trust's development of an Organisational Learning SOP ('the SOP') and the processes in place to support actions from both internal and external lessons learnt. The SOP set out the process from the point a debrief request is made from an incident Commander or Senior Manager, through to the support provided by the EPRR team and the resulting report and recommendations which are monitored by the Directorate's Senior Operational Team (SOT).

2.49 There is confidence within the team that the debrief meetings held by HART operatives are to a good standard. However, we were informed that there is no formal structure supporting the process and there are no set triggers or prompts to indicate when a debrief should take place.

2.50 We were provided with a HART Debrief tool which prompts the inclusion of good points, learning points, and what could be done differently. This is consistent with the format in use by the EPRR team within the SOP process above.

2.51 We requested examples of debriefs undertaken in 2022 and were provided with six – although one related to a review of medicine (Ketamine) use rather than a wider incident. Debriefs provided related to three of the seven teams / watches in operation within HART. Their content was generally consistent, although we noted slight variation in their format. However, there was a lack of further actions or recommendations. **See MA9**

2.52 We were also informed that, prior to the Covid-19 pandemic, there had been periodic sharing of lessons learnt by individual HART teams / watches through a regular Continuous Professional Development day. Alongside the sharing of good practice this, provided a platform for discussion on areas for development and training opportunities. **See MA9**

2.53 Our recent review of Major Incidents also included an overview of the arrangements in place for national learning between category one and two responders. NARU also oversees a national safety alerts system which includes focus on the interoperable service and capabilities associated with HART.

2.54 We were provided with a listing of National Safety Notices issued between May and September 2022. 10 notices had been issued during that period, two of these being submissions from the Trust.

2.55 We sampled three of the remaining eight notices, and were provided with evidence to support action being taken relating to one of these. However, we were informed that information for the two remaining notices would have been shared through structured handovers, but that this had not been formally recorded. **See MA9**

2.56 Key Performance Indicators (KPI) for the HART unit are outlined within the SLA with Welsh Government and reported on a quarterly basis. These are also reported internally through the Operations Directorate structure to the SOT and Senior Leadership Team. We were not able to identify reporting arrangements for other HART units to allow us to compare the KPI content against that provided elsewhere, but this might be a useful exercise for the Trust to consider.

2.57 Review of the Q1 2022/23 KPI report confirmed alignment with the SLA requirements, noting there has been some minor amendments and terminology changes also no longer including a small number of workforce indicators. This included a recent change in relation to number of staff a shift has been below a certain level, with the change from six operatives which remains the NARU target. Welsh Government requested the indicator be amended to four operatives, which impacts HART's ability to deploy 'Safe System of Work' for some capabilities and would require the team to stand down from these. We were informed discussion on KPI content regularly takes place with the Welsh Government lead to ensure content is appropriate.

2.58 We have highlighted within earlier objectives recognition by the HART team that all activity is not currently being captured, and there is action underway to address this.

2.59 HART KPI and activity has previously been shared with the Finance and Performance Committee. It received the 2020/21 end of year summary report in May 2021. We have not identified further reporting of KPI or summary information. **See MA10**

Conclusion:

2.60 There is a lack of formal arrangements to capture and confirm implementation of lessons learnt, and this could be supported by a more formalised debrief process. Whilst performance reporting is evident, there is awareness and action to address gaps in capturing the full activity of the HART unit. Reporting within the Directorate is regularly occurring, however there has been a lack of recent reporting to the Trust Committee structure. We assign this objective **limited** assurance.

Appendix A: Management Action Plan

Matter arising 1: Service Level Agreement content review (Design)	Impact
The Trust is commissioned to provide a Hazardous Area Response Team through a Service Level Agreement (SLA) with Welsh Government which was agreed in September 2011. We were informed the document has not received any amendment of content since initial agreement. Review of the SLA identifies that Schedule 1 - Services includes reference to the team being trained and equipped to enter and provide clinical treatment in hazardous environments, an incident response unit capability, and an urban search and rescue capability. The Trust HART unit trains to meet the full range of capabilities outlined within the NARU Standards. Whilst the Standards state that they do not apply to Ambulance Services in devolved nations, they are accepted as best practice and the Trust's HART unit seeks to ensure alignment. Review of the NARU Standards identifies that there is opportunity to refresh the SLA against its contents, in particular to capture and reflect the services and required capabilities.	Potential risk of: • Arrangements and requirements related to HART service not fully documented.

Recommendations	Priority
1.1 The Trust should engage with Welsh Government to update the content within the SLA to recognise the HART capabilities and include reference, where appropriate, to National Standards.	Medium

Management response	Target Date	Responsible Officer
1.1 The Trust accepts this recommendation, recognising that the SLA is provided to WAST by Welsh Government who procure the services from WAST. We will therefore seek to agree the content of the SLA with Welsh Government on next annual refresh of the SLA.	March 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 2: NARU self-assessment (Design)	Impact
NARU has also established an annual review process for NHS England Ambulance Trusts, to assess adherence to the EPRR Core Standards and interoperable capabilities under the heading of Key Lines of Enquiry (KLOE). This assessment combines review of evidence and site visits to assess their adherence to the EPRR Core Standards and interoperable capabilities. Prior to the Covid-19 pandemic, the previous Head of EPRR had held discussions with the NARU assessment lead to explore the Trust undergoing a 'critical friend' peer review. The Trust may want to consider undertaking a formal self-assessment prior to any formal review being commissioned.	Potential risk of: • Potential to ensure fuller alignment with interoperability requirements.

Recommendations	Priority
2.1 The Trust should undertake a self-assessment against the NARU Key Lines of Enquiry review document. This could support any future 'critical friend' review undertaken.	Medium

Management response	Target Date	Responsible Officer
2.1 The Trust accepts this recommendation and is committed to undertaking a self-assessment against the NARU review document.	May 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 3: Asset Register (Design)	Impact
We note that the NARU annual review process includes a requirement for HART units to maintain an equipment asset register. Currently HART has a split between assets registered on NARU's PROCLUS website and local records. PROCLUS entries provided included use of serial numbers and end of life dates, but not all fields are actively used, such as date of issue. Equipment should also be subject to regular inspections by a competent assessor to ensure they are fit for purpose. Noting safe working at height equipment is subject to LOLER requirements, we were provided with a monitoring spreadsheet which records inspections undertaken by HART operatives. We identified whilst all equipment kits have had a service within the past 6 months as required, monitoring spreadsheet did not include the previous date of inspection for all kits to demonstrate regular maintenance has been undertaken.	Potential risk of: • Gaps in completeness of equipment register.

Recommendations	Priority
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.	Medium

Management response	Target Date	Responsible Officer
3.1 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.	April 2023	Clare Langshaw, Head of Service EPRR

Matter arising 4: HART Standard Operating Procedures (Operation)	Impact
There are a range of HART SOPs that are in place to support the day to day operation of the service. A number reviewed date to 2016 and require updating. Of those relating to deployment and dispatch: • *Deployment Criteria* (SOP-08) – to reflect the adoption of a POD Vehicle Deployment methodology and plan. • *HART Dispatch* (SOP-09) – to reflect the above and to capture all processes for the activation of HART, such as HART self-tasking, or requests for support received from Duty Operational Managers and Senior Paramedics. A broader review of all SOPs may be appropriate noting the document control sheet included an April 2020 review date.	Potential risk of: • Guidance and procedure documents do not reflect current processes.

Recommendations	Priority
4.1 HART SOPs should be reviewed to ensure they reflect current practice.	Medium

Management response	Target Date	Responsible Officer
4.1 The Trust accepts this recommendation and will ensure that current SOPS are updated to reflect current practice. Further, we will create a mechanism to monitor the review period of SOPs to ensure currency.	April 2023	Clare Langshaw, Head of Service EPRR

Matter arising 5:CAD Code Review (Operation)	Impact
CAD codes used to identify HART related calls were established following the formation of the HART unit in 2012. Review of an extract from the CAD system indicates that 465 out of 2,460 codes contain the specialist response prompt. A review of codes has not been undertaken since. There is a mechanism to support the oversight of the appropriateness of codes through a Clinical Prioritisation Assessment Software group. The group has membership from across the Trust, but not representation from HART.	Potential risk of: • Appropriateness of codes could impact on effectiveness of dispatch and deployment of service.

Recommendations	Priority
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.	Medium

Management response	Target Date	Responsible Officer
5.1 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.	June 2023	Clare Langshaw, Head of Service EPRR Kate Blackmore, Head of Service, EMS Co-ordination

Matter arising 6: HART Activity monitoring (Operation)	Impact
In line with NARU requirements, calls assigned to HART are logged onto the PROCLUS system by HART Operational Managers. Information being recorded includes the type of incident and number of casualties, but not the location. We understand that there are limitations on how this information can be exported and discussions with the HART team also highlighted concerns around the completeness of activity details being captured. The HART Locality Manager is currently considering approaches to address this, including comparison of entries by team. We were able to undertake some limited analysis which suggests that activity is underreported. Analysis of data captured within the Trust's CAD system indicated incidents were attended by HART vehicles which were not included within the PROCLUS report for the period. HART SOPs have been developed for *Joint responses within Welsh regions* (SOP-29) and *Mutual Aid Requests* (SOP-11). We were informed that requests relating to North Wales are infrequent, but there are no mechanisms for monitoring activity levels which could prompt HART dispatch on an ongoing basis.	Potential risk of: • Underreporting of HART activity. • Gap in monitoring of potential activity.

Recommendations	Priority
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 6.2 The Trust should consider mechanisms to capture activity including through review of location which could generate HART deployment for assessing against any future service needs.	Medium

Management response	Target Date	Responsible Officer
6.1 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 2023	Clare Langshaw, Head of Service, EPRR Kate Blackmore, Head of Service, EMS Co-ordination
6.2 The Trust accepts this recommendation and will finalise the work on capturing location of deployments in order to assess any future service needs.	May 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 7: Training competencies and reporting (Design)	Impact
NARU has issued Training Information Sheet (TIS) for each of the interoperable capabilities, which includes set frequency for re-certification (training frequency per year) and re-qualification (periodic internal or external assessment of capability) period. Each competency is broken down further to sub-competencies, the achievement of which would be demonstrated through lesson plans. We requested lesson plans relating to three capabilities and whilst they included reference to sub-competency headings, outline of lesson activities did not necessarily provide sufficient level of detail to support this. We understand that the Trust is planning to migrate to a training record facility within PROCLUS, which includes prompts for Operatives to address each sub-competency. The HART management team meet formally on a regular basis and receive a standing report from the HART Training Manager. The reports mainly provide narrative updates, including on general performance and issues, however there is opportunity to develop further and enhance to improve compliance monitoring of re-certification or re-qualification. Our review of training records, and discussion with the HART Training Manager, outlined that as a result of pandemic and operational pressures training frequencies were not attained for '*Marauding Terrorist Attack'*, '*Water Operations'*, '*Support to Security Operations'*, and '*Fitness Assessments'* (bi-annual requirement not met). Training was also not undertaken for '*HAZMAT Personal Protective Equipment*' due to a changeover in the generation of PPE which was not available until 2022, and '*Polaris and Winch*' where the vehicle was unavailable.	Potential risk of: • Gap in capture, monitoring and escalation of training activity.

Recommendations	Priority
7.1 We would support the action taken to trial recording operative training on PROCLUS, and the Trust should review opportunities to incorporate any data extracts to support training performance and compliance monitoring which could be included in Training Manager update reports.	**High**

Management response	Target Date	Responsible Officer
7.1 The Trust accepts this recommendation and will ensure there is a robust system in place to capture the training compliance for teams. Where there is potential for compliance to be compromised, an early escalation system will be activated to ensure remedial action and reporting.	March 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 8: Fire and Rescue MOU (Design)	Impact
We were provided with a copy of a memorandum of understanding (MOU) which has been signed by representatives of all three Fire and Rescue services (FRS) across Wales. The MOU was signed in 2012 and discussion with the Service Manager, EPRR & Specialist Operations, outlined that the document contained detailed appendices linked to operational deployment arrangements, reflecting that HART was a newly commissioned service at that point. With HART now firmly established, and good working and exercising arrangements in place with FRS, discussions had been held prior to the onset of the Covid-19 pandemic to revise the MOU to recognise and better reflect HART capabilities. A draft copy has been shared with FRS colleagues with the intention to revisit this further but is yet to be finalised.	Potential risk of: • Roles and responsibilities not aligned to current practices.

Recommendations	Priority
8.1 The Trust should make arrangements to update and finalise the MOU with Fire and Rescue services.	Medium

Management response	Target Date	Responsible Officer
8.1 The Trust accepts this recommendation and will ensure that the MOU with Fire and Rescue Services is updated appropriately.	May 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 9: Debriefing process and lessons learnt (Design)	Impact
We were provided with a HART Debrief tool which prompts the inclusion of good points, learning points, and what could be done differently. This is consistent with the format in use by the EPRR team within the Trust Organisational Learning SOP. Example debriefs were provided and related to three of the seven teams / watches in operation within HART. Their content was generally consistent, although we noted slight variation in their format. However, there was a lack of further actions or recommendations. We were informed that there had been periodic sharing of lessons learnt by individual HART teams / watches through a regular Continuous Professional Development day. Alongside the sharing of good practice this, provided a platform for discussion on areas for development and training opportunities. NARU oversees a national safety alerts system which includes focus on the interoperable service and capabilities associated with HART. We sampled three notices, and were provided with evidence to support action being taken relating to one of these. We were informed that information for the two remaining notices would have been shared through structured handovers, but that this had not been formally recorded.	Potential risk of: • Gap in mechanisms for capture and implementing of lessons learnt.

Recommendations	Priority
9.1 A formal mechanism should be developed for the recording, monitoring and completion of actions related to debriefs and lessons learnt. Periodic reporting within the Directorate should be undertaken to provide assurance that these mechanisms, and the debrief process are operating as expected. 9.2 In progressing the above there could be consideration to aligning the recording of actions and responses to NARU National Safety Notices.	Medium

Management response	Target Date	Responsible Officer
9.1 The Trust accepts this recommendation and will develop a formal mechanism to record, monitor and complete actions from debriefs and lessons learnt. This mechanism will include a reporting process to Senior Operations Team (SOT) with relevant assurance to Senior Leadership Team (SLT) where appropriate.	May 2023	Clare Langshaw, Head of Service EPRR

9.2	The recording of actions and responses to NARU National Safety Notices will be incorporated into the formal reporting mechanism in 9.1	May 2023	Clare Langshaw, Head of Service EPRR

Matter arising 10: KPI Reporting & committee oversight (Design)	Impact
The Finance and Performance Committee terms of reference include '*review performance against targets and standards set by Commissioners and/or Welsh Government for the Trust and, where appropriate, against national ambulance quality indicators.*' It received the 2020/21 end of year summary report in May 2021. We have not identified further reporting of KPI or summary information.	Potential risk of: • Responsible committee not sighted on commissioned service activity.

Recommendations	Priority
10.1 HART KPI should be provided to the Finance and Performance Committee on an annual basis.	Medium

Management response	Target Date	Responsible Officer
10.1 The Trust accepts this recommendation and will provide the HART KPIs to the Finance and Performance Committee on an annual basis.	April 2023	Judith Bryce, Assistant Director of Operations

Appendix B: 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.
 **No 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.

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Electronic Patient Clinical Records - ePCR

Final Internal Audit Report

November 2022

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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Final report issued:	21st November 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Brendan Lloyd, Senior Responsible Owner for the Electronic Patient Clinical Records (ePCR) Programme, Executive Medical Director
Distribution:	Leanne Smith, Interim Director of Digital
	Chris Turley, Director of Finance
	Duncan Robertson, Project Executive, Interim Assistant Director of Research, Audit & Service Improvement
	Alexander Crawford, Assistant Director of Planning & Transformation
	Aled Williams, Head of ICT
	Wyn Morris ICT Programme Manager
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 Institute of Internal Auditors

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 audit was undertaken to review the delivery and management arrangements in place to progress the implementation of the electronic patient clinical record system (ePCR). The solutions will provide access to appropriate medical information to inform on-scene decisions. A key objective was to enable appropriate and timely replacement of the Trust's Digital Pen.

Overall Audit Opinion and Overview

The programme was progressing within budget and target delivery for a highly complex implementation involving multiple health bodies across Wales.

Cost

The Full Business Case was endorsed by Welsh Government in December 2020 in the sum of £2.541m with targeted delivery for 31st March 2023. The approved budget was revised to £2.445m in July 2022 to align with revised national priorities of the Digital Priorities Investment Fund and expenditure to date.

The programme is currently anticipated to be delivered within the agreed budget allocation.

Time

A target deadline of 31st March 2022 was agreed with Welsh Government to coincide with the end of contractual support for the Digital Pen.

The programme suffered a significant lag in recruiting resources, in part due to the impact of Covid. However, the core elements of the programme were delivered by their target date of 31st March 2022. The efforts of a smaller team to deliver the programme in this context have therefore been significant. Further elements, such as the Welsh GP Records System interface (which are currently being developed) are targeted for delivery by 31st March 2023 (in accordance with the approved business case).

The significant matters arising at the programme include:

- The need to consider the timing and method of engagement of health bodies within lessons learnt; and
- The need for early development plans with DHCW.

The audit did not find any high priority issues arising at the programme, and many instances of good practice.

Considering the above, a **reasonable** assurance has been determined at this interim stage of the management and implementation of ePCR programme.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary [1]

	Assurance objectives	Assurance
1	Governance arrangements	Reasonable
2	Monitoring and reporting	Reasonable
3	Contractual arrangements	Substantial
4	Approvals	Reasonable
5	Programme management	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Management should update governance arrangements to reflect current operational arrangements.	*1*	Design	Medium
2	Management should consider the timing and method of engagement of health bodies within lessons learnt.	1,4	Design	Medium
3	Management should ensure that quantified, measurable and achievable targets are set for benefits realisation.	*2*	Operation	Medium
4	There is a need to learn lessons, notably relating to early engagement with DHCW and associated co-ordination with the contractor, and sufficient lead time to engage a programme team.	*4*	Operation	Medium
5	The time and cost implications of variations should be reported against remaining contingency	*5*	Design	Medium
6	The approval roles of the Programme and Project Boards should be specified.	*5*	Design	Medium
7	Time implications of change control, designating client or contractor liability should be included at both change authorisations and the change control register.	*5*	Design	Medium

1. Introduction

1.1 The Electronic Patient Clinical Records (ePCR) Programme is intended to deliver a digital patient records solution for the Welsh Ambulance Services NHS Trust. This will also include new access to appropriate medical information to inform on-scene decisions. A focussed version will be provided to Community First Responders, and the system will facilitate data interrogation and audit.

1.2 The Full Business Case was endorsed by Welsh Government on 15th December 2020 in the sum of £2.541m (incl. VAT). The solution involves both an external procurement, and tailored interfaces with other systems.

1.3 The business case envisaged implementation of core scope by March 2022, and full implementation by March 2023.

1.4 A core system has been procured from a third party supplier with interface to NHS Wales systems, as facilitated by the Trust, working with the supplier and Digital Health and Care Wales (DHCW).

1.5 Further product development aims to add further enhancements (not included within the business case) as part ongoing system operation. These are not considered here, being outside the scope of the current audit.

1.6 The audit has not included an assessment of the proposed technical solution.

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

- the programme may not be delivered as approved;
- the Trust may breach Welsh Government Funding stipulations, Standing Orders or Standing Financial Instructions; and
- Best Value may not be achieved.

2. Detailed Audit Findings

Programme Performance: Summary of the achievement of the programme's key delivery objectives (time, cost and quality) to date.

2.1 The Programme Definition Document notes that the Programme Board has the mandate of driving the wider programme, outputs and benefits (e.g. considering workforce or clinical implications), while the Project Board is concerned solely with implementing the technical solution. This audit includes consideration of how terms of reference delineate responsibilities between the two boards.

2.2 The chosen ePCR system is one already operated commercially by the supplier. However, this has required tailoring of the application software and interfaces with Welsh NHS information systems. Accordingly, Digital Health and Care Wales have been actively involved with the supply contractor to ensure effective specification and implementation of these interfaces. There has been an associated need to ensure appropriate workforce training to ensure that health staff are informed as to system access and capabilities.

2.3 At this interim audit, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.4 The Full Business Case (FBC) aimed to deliver core elements of the system by 31st March 2022, and remaining elements by 31st March 2023. While there remain some operational issues, Trust management have confirmed to Welsh Government that core elements were delivered by the target date of 31st March 2022 (the date the solution for the Emergency Medical Service was required to replace the contractual expiry of the prior Digital Pen). The Programme Manager has also confirmed that operational issues currently reported do not relate to core elements.

2.5 Remaining elements include tailoring of the application for Community First Responders use, and interface with the Welsh GP Records System (an interface to bring in summary information from the Welsh GP Records system).

2.6 The most recent contractor plan now shows full delivery by 22nd February 2023 (over a month ahead of the agreed delivery date specified at the Welsh Government funding approval), with remaining contingency for unplanned over-run to the end of the funding approval period (end of March 2023).

Cost

2.7 It was confirmed that overall funding has been reduced from the original £2.541m to £2.445m (as above). This was badged by Welsh Government as a reduction driven by assessment of all-Wales funding priorities (of the Digital Priorities Investment Fund - DPIF). However, no reduction in scope or quality is envisaged, with this sum being accommodated within remaining contingency allowance.

2.8 Cost reporting confirmed that final expenditure was anticipated to be within the revised allocation of £2.445m.

Quality

2.9 Delivery of the core elements by the required date has been confirmed to Welsh Government. However, some workforce familiarisation remains ongoing.

2.10 The full range of remaining elements within the FBC remained on target for delivery prior to 31st March 2023.

2.11 Some post-implementation issues were experienced in "core" delivery, largely relating to Health Board user familiarity with the system operation and capabilities. However, the Programme Manager confirmed that all such issues relating to core delivery have now been resolved.

Governance arrangements: assurance that appropriate programme governance arrangements and resource are maintained for the current programme stage.

2.12 The programme governance was defined via a Programme Definition Document which included the programme objectives, structures, roles and responsibilities, supported by terms of reference of associated programme groups.

2.13 The Programme Board was chaired by the Executive Medical Director (the Senior Responsible Officer), and addressed wider issues impacting the programme e.g. clinical, workforce, and stakeholder issues. This was also attended by the Project Executive officer (the single point of project accountability – product delivery), and the Programme Manager. It was supported by a Project Board (chaired by the Project Executive Officer), to oversee technical implementation with the supply contractors and Digital Health and Care Wales (DHCW).

2.14 These members of the senior management team provided strong corporate linkage to the Executive and enabled effective decision making.

2.15 A programme team (established to implement the programme) was specified and funded via the Full Business Case (FBC). Following approval, it was initially supported to April 2021 by Medical Directorate staff within their current roles. Recruitment difficulties during the Covid period, and subsequent lead times substantially impacted the establishment of the full team. This meant that the key roles of Project Team Manager, and Project Support Officer were not engaged until August 2021. Associated risks and issues were appropriately reported and escalated.

2.16 Both the Programme Board and Project Board meetings were held regularly and were well attended.

2.17 Key issues were escalated to the Clinical Transformation Programme Board. However, noting the commencement of this group subsequent to the Programme Definition Document, it has been recommended that the defined governance arrangements should be updated to reflect current arrangements (**MA 1**), including escalation arrangements with key parties (**MA 2**).

2.18 While recognising these matters, **reasonable** assurance has been determined in relation to the governance arrangements applied at the programme to date.

Monitoring and reporting: an assessment of appropriate monitoring and reporting arrangements.

2.19 A range of reporting was provided with coverage including elements such as risks, finance, and issues arising.

2.20 These contained some best practice examples of monitoring and reporting e.g. time-phased dashboard of tasks – visually combining a traffic light rating of issues with delivery deadlines.

2.21 Many of these were included within a comprehensive report to Welsh Government (the Digital Priorities Investment Fund).

2.22 Regular updates of the overall cost position were reported to the Programme Board, and progress summaries were provided for the CEO Trust Board report and relevant committees.

2.23 At the time of audit, while general benefits had been specified, many still lacked quantification (advised by management to have been impacted by resource issues). However, in recognition of this outstanding task, management have

convened a review of Programme benefits with Welsh Government in August 2022 (**MA 3**).

2.24 Accordingly, while recognising the need to more fully address benefit targets, additionally noting some exemplar reporting, and comprehensive reporting to both Welsh Government and the Trust Executive, a **reasonable** assurance has been determined in relation to monitoring and reporting.

Contractual arrangements: assurance that processes to appoint the developer and any advisers provide value for money in accordance with local and national requirements.

2.25 The procurement strategy was informed prior to the agreement of the Full Business Case (FBC) by a consultancy review commissioned by WAST, as requested by Welsh Government (to examine the in-house potential of DHCW to deliver a bespoke system). This advised that an in-house option was not feasible. Accordingly, an NHS ePCR framework was utilised to progress a mini-competitive exercise to identify a preferred provider. Full details of the procurement were provided within the approved FBC.

2.26 Subsequent to the FBC approval, a contract was signed by the supplier on 1st February 2021, and the Trust on 4th February 2021 i.e. prior to contract commencement (of 8th February 2021).

2.27 Contracts were also placed for two agency staff engaged to assist in year 2 delivery (i.e. an external Project Manager, and Implementation Manager).

2.28 Noting timely and authorised contractual arrangements, a **substantial** assurance has been determined.

Approvals: evidence that appropriate approvals have been obtained at key junctures, including stakeholder agreement, and design sign-off and that the programme progresses within these approvals.

2.29 Funding was approved by Welsh Government on 15th December 2020 in the sum of £2.541m (incl. VAT).

2.30 As previously noted, this was reduced to £2.445m in July 2022. However, there have been no other changes to the agreed time / cost position with Welsh Government. The programme remains forecast to deliver within the revised funding envelope, with no reduction in delivered outcome (reduced funding being accommodated within programme contingency).

2.31 As previously noted, there was a need to engage two external agency staff to assist with the second year of the implementation programme (selected from a staffing supply framework to assure best value). It was confirmed that these were authorised in accordance with Standing Financial Instructions.

2.32 Additional revenue costs of £0.501m over the first three years of operation were identified at the FBC, to be financed via the IMTP process. These include additional post-implementation staffing.

2.33 To facilitate implementation, numerous presentations and notifications were made to health bodies and leads, preceding the implementation phase. A number of post implementation issues have shown that there may be benefit in particularly reviewing any lessons around engagement (**MA 2**)(It is recognised that engagement and Health Board priorities were complicated by the pandemic response to Covid-19 and significant pressures within Emergency departments).

2.34 Similarly, there was a need for early engagement with DHCW to ensure effective and timely delivery (**MA 4**). While recognising the above issues, no changes have been required to the approved Welsh Government funding, and the programme remains within approved time and cost parameters. A **reasonable** assurance has therefore been determined in relation to approvals.

Programme management: to determine application of an appropriate range of programme and project controls including performance management, risk management and change control.

Time and Cost management

2.35 A target deadline of 31st March 2022 was agreed with Welsh Government to coincide with the end of contractual support for the prior Digital Pen system.

2.36 The programme suffered a significant lag in recruiting resource, in part due to the impact of Covid. However, the core elements of the programme were delivered by their target date of 31st March 2022. The efforts of a significantly smaller team to deliver the programme in this context have therefore been significant.

Risk management

2.37 Risks and issues were assessed at both a programme and project level (as applicable). These registers were found to be regularly updated and reported. However, they could usefully be supplemented by reporting of total time and cost implications as compared to remaining contingency (**MA 5**).

Performance management

2.38 Regular meetings with the contractor and DHCW were utilised to manage progress against milestones, which has facilitated delivery to Welsh Government targets.

2.39 However, it is recognised that several complex and some bespoke interfaces remain.

Change management

2.40 Change registers were found to be regularly updated and supported by appropriately completed change authorisation forms. These were reported to both Programme and Project Board.

2.41 While individual roles in scrutinising and approving changes were defined, neither the Programme Board nor the Project Board (as the responsible bodies) had defined responsibilities for approving programme changes (**MA 6**).

2.42 Increases in the supply contractor costs have been minimal to date (£38,793, of which £19,535 was due to the extension of the contractor programme due to

additional time required by Health Board partners to prepare for "Go live"). These have been accommodated within the approved budget. However, the time implications of contract changes were not included within either the change schedule or change authorisation forms. This should also identify responsible parties for delay, to inform any contractual liabilities or claims (**MA 7**).

2.43 While noting the above matters, noting delivery performance to time and cost, together with controls operated, a **reasonable** assurance is determined in relation to project management.

Appendix A: Management Action Plan

Matter Arising 1: Governance arrangements (Design)		**Impact**
Welsh Health Circular 2018 (043) - NHS Wales Infrastructure Investment Guidance requires specification of the programme delivery and governance arrangements within the Business Case. These were variously defined in both the Full Business Case (FBC) and Programme Definition Document, showing escalation arrangements to the Quality, Patient Experience & Safety Committee, as well as interface between the Programme Board, the Executive Management Team, and the Strategic Transformation Board. The Clinical Transformation Board was attended by both the Executive Medical Director, and the Project Executive officer. However, this Board was newly introduced subsequent to compilation of the Programme Definition Document. The defined structures therefore required update to reflect those operating.		Potential risk that: • The programme is not effectively governed.
Recommendations		**Priority**
1.1 Management should update governance arrangements to reflect current operational arrangements.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Agreed. Update Programme Definition Document to include reference Clinical Transformation Programme Board – to come to ePCR Programme Board for approval and sign-off.	End of December 2022	ICT Project Manager

Matter Arising 2: Stakeholder agreements / engagement (Design)	**Impact**
Noting the wide range of stakeholders identified at the Programme Definition Document, best practice would require the development and implementation of a stakeholder engagement plan and associated stakeholder forums through the development and implementation of the programme. This would typically be provided in the first instance by formal letters of support for the Business Case by Chief Executive Officers (containing the proposed programme). Additionally, it is normally evident that users / stakeholders finalise and sign off their requirements in order to reduce the potential for programme changes (DHCW engagement is considered further at **MA 4**). Letters of support from third parties form part of the Welsh Government inclusion checklist for business cases submissions. However, in this case the Trust advised that they were not applicable for inclusion (being an electronic replacement of a paper information to third parties). In the case of ePCR, the key requirements were for user sign off of the agreed implementation time-tables and training. External stakeholders were informed by letter that ePCR forms part of a "Welsh Government sponsored" implementation. As such, management advised that this was the reason that formal stakeholder agreements were not obtained. A programme stakeholder and communication approach document was maintained, detailing engagement with all parties at each programme stage – the majority of which confirmed "significant" involvement. However, involvement of Emergency Departments was stated to be "minimal" at both the business case, and early development stages. While there were a range of communications, and presentations to relevant Health Board leads and key staff, it was evident that some issues were resolved at live implementation as recorded in issue logs. Such issues have therefore included workforce implications, and post-implementation training. However, these have not delayed implementation or resulted in additional programme costs. For context, some key dates were:	Potential risk that: • Lessons are not learnt

FBC Endorsement by Welsh Government	15th December 2020
Supplier contract commencement	8th February 2021
Welsh Government required core deployment (in September 2021 at SRO appointment)	30th November 2021
Go Live deadline (core elements) & Digipen withdrawal	31st March 2022

Management have commented that there was a "*lack of responses to formal letters to the Health Boards from the Trust.*" Via escalation and provision of a dedicated Implementation Manager supplied by WAST, "Go live" for the final Health Board area was achieved on 29th March 2022.

However, issues such as those noted above, show that there may be benefit in particularly reviewing any lessons around engagement.

While Health Board leads were informally nominated as programme links, it would be beneficial for such a collaborative programme if governance arrangements also specified third party leads, to facilitate jointly planning and programme management. This should include agreed monitoring and escalation arrangements for any issues arising.

Recommendations	Priority
Future assurance 2.1 Management should consider the timing and method of engagement of health bodies within lessons learnt e.g. formal letters of support for Full Business Case plans from CEO's.	**Medium**
Future assurance 2.2 Terms of reference, roles and responsibilities should be agreed with third parties to facilitate effective planning, management, and escalation arrangements.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
2.1 Agreed. WAST to run an ePCR lessons learned workshop in Q4 2022/23	By end of Q4 2022/23	Interim Assistant Director for Research, Audit and Service Improvement & Assistant Director of Planning & Transformation
2.2 Agreed. WAST to run an ePCR lessons learned workshop in Q4 2022/23	By end of Q4 2022/23	Interim Assistant Director for Research, Audit and Service Improvement & Assistant Director of Planning & Transformation

Matter Arising 3: Benefits realisation (Operation)		**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) outlines the "*requirement*" for the service delivery model to be supported. The funding approval letter from Welsh Government (of 15th December 2020), additionally stated the need to specify agreed benefits. While a benefits register has been produced, quantified targets for all benefits have yet to be specified e.g. the ability to divert from A&E to clinic referral.		Potential risk that: • Service efficiencies are not optimised.
Recommendations		**Priority**
3.1 Management should ensure that quantified, measurable and achievable targets are set for benefits realisation.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Agreed. Benefits realisation to be completed by the end of the funded programme. IMTP has the benefits realisation to be completed by the end of Q4 2022/23 ongoing piece of work that has been delayed, but will be completed by end of Q4.	End of Q4 2022/23	Assistant Director of Planning & Transformation

Matter Arising 4: Lessons learnt (Operation)	**Impact**
Welsh Health Circular (WHC) 043 (2018) – NHS Wales Infrastructure Investment Guidance, requires Health Boards to undertake a post programme evaluation delivered schemes. While the core elements of the programme have been reported as successfully delivered to date, there have been pressures and issues along the way. These have included the need to engage agency staff and priced extensions to the supply contract. Potential issues (as noted in this audit) have included effective engagement with DCHW. The Stakeholder & Communication Approach detailed "significant" involvement of DHCW at project phase 1 (Feb – Nov 2021). There was engagement with DHCW both at the business case stage, and during the tender in June 2020. The Trust confirmed that the full technical specification was subsequently agreed with the supplier and DHCW during the 4 month period post signing of the contract. The Trust also engaged with DHCW prior to procurement, regarding interfacing into NHS Wales Systems. However, some issues relating to effectiveness of engagement with DCHW were evident. The audit also found escalation of issues relating to Digital Health and Care Wales engagement during 2021 and into 2022, during a time frame in which contractual delivery had commenced. The supply contract agreed a contract commencement of 8th February 2021, and delivery date for all elements by 18th November 2021. This date was based on their tender response (in July 2020) - supplying an existing system already operational elsewhere. However, required interfaces were only specified and agreed subsequent to contract commencement. Accordingly, contractual plans were initially extended from 18th November 2021 to 31st March 2022, at no additional charge from the supplier (to co-ordinate with both health bodies and DHCW). They were subsequently extended to 24th August at a charge of £19,535, and at the time of audit a revised plan had been agreed for 24th February 2023 (for which associated charges by the contractor await confirmation). These dates remain within the agreed Welsh Government targets of delivery by 31st March 2023. Management have confirmed that these latter extensions to the supply contract were planned in as contingency, as the details of functional design were not available until after the design stage.	Potential risk that: • Lessons are not applied to future projects or programme stages.

It would therefore be useful to consider the extent to which broad DHCW resource and time could be reserved at an earlier stage, or perhaps a time window built into the contract to permit better co-ordination with both DHCW, the contractor, and engagement of a programme team. Recruitment of the programme team also presented a timing issue. This could not commence until post FBC funding approval. Following a 3 – 4 month job evaluation of the new roles, initial advert during the Covid period met with no qualified applicants. Following further lead times for advert, and notice periods, this meant that the key roles of Project Team Manager, and Project Support Officer were not engaged until August 2021. In the interim, to April 2021, key programme and project lead roles were fulfilled by the Business Manager within the Medical Directorate (appointed in April 2021 as the Programme Manager). The most recent Project Manager was the third in post, with interim infill by the Programme Manager. This meant that the programme / project support officers averaged 2.5 staff over the first year compared to a target team of 8. This also impacted upon the early establishment of project structures. While a Project Board was created in 2018 an executive Programme Board was not created until May 2021 (in the period of contract performance).	

Recommendations	Priority
4.1 Management should undertake a lessons learnt review, with particular focus on enhancing DHCW and contractor co-ordination, and sufficient lead time for DCHW and mobilisation of a programme team.	**Medium**

Agreed Management Action	Target Date	le Officer
4.1 Agreed. WAST will undertake an ePCR lessons learned workshop in Q4 2022/23 This will additionally need to recognise the context of Covid-19.	End of Q4 2022/23	Interim Assistant Director for Research, Audit and Service Improvement & Assistant Director of Planning & Transformation

In 2020 during the height of the pandemic, the Trust were not allowed to send programme delivery staff into Emergency Departments to scope business change to the risks that contracting COVID posed. From March 2020 the programme team were not allowed to enter WAST offices and were provided with equipment to work from home. When lock down was lifted there was still a reluctance from Health Boards to allow any programme staff onto their sites for fear of carrying or contracting COVID on sites. Microsoft Teams was not fully rolled out in the Welsh NHS until after COVID 19 lockdown so was not established as a form of communication early in the programme. No access to offices prevented face to face meeting and any access to Video Conferencing facilities was blocked as these were predominantly available in NHS buildings. <u>Recruitment</u> Covid-19 also formed a significant part of the context here. It also took 9 months from having a job description to the start date for the candidate. This was a major problem in recruitment to all the posts. We did not anticipate having to job match posts, having recruited such positions previously, and this interaction will also be something to consider at future projects (which included time involvement by the Programme Manager for the job match panel). Additionally, by that point the UK Government has introduced the national Furlough Scheme which had a direct impact on recruitment.		

There were also potential issues as the ePCR Team roles that would involve being on site in high risk health care facilities at a time when fatalities were high prior to the UK vaccination programme. Evidence of the Trust and hospital rules are documented in the COVID enquiry report.		

Matter Arising 5: Risk register (Design)		**Impact**
The NHS Wales Infrastructure Investment Guidance states: *"Risk registers for each individual project/programme must be completed, shared and monitored, with reference not only to time, cost and quality but also operational/service impacts, functionality and benefits realisation"* As the programme progresses, and requirements become firmer, so the risks in future works and commitments are reduced. The estimated contingency requirement should be periodically updated to reflect this. While top risks were profiled at reporting, associated time and cost implications were not included. Noting the above, the risk register could usefully sum an assessment of mitigated time and cost risks for comparison to remaining contingency. Noting the absence of individual time and cost quantification at the risk register, recognising the maturity of the project (and associated risks), there would remain benefit in confirming an appropriate methodology for assessing the aggregate time and cost implications of remaining risk for comparison to remaining contingency. Note – specific recommendation is not being made here as to the system or mechanism by which the above is achieved.		Potential risks that: • Risks are not appropriately managed • Contingency is not appropriately managed
Recommendations		**Priority**
5.1 Management should confirm an appropriate methodology for assessing the aggregate time and cost implications of remaining risk for comparison to remaining contingency		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**

5.1 – Agreed – we will review the mechanisms utilised for risk management for appropriate functionality as part of a broader lessons learned exercise.	n/a	Not applicable

Matter Arising 6: Change control responsibilities (Design)	**Impact**
Best practice would assign the Programme / Project Board as the accountable body for programme delivery. The Business Case includes a section for change control which refers to the Clinical Reference Group as having responsibility for authorising changes. Responsibilities of key programme / project managers were also defined for scrutinising and managing change. A range of bodies were also involved in approving changes (as applicable), notably: • the ICT Change Advisory Board – providing permission to proceed with new releases; • the Health Informatics Change Advisory Board – providing permission to proceed with database changes; and • the ePCR Clinical Reference Group – providing permission to proceed with new developments to the application. However, terms of reference of the Project Board did not include change control, and those of the Programme Board included only understanding and managing the impacts of change. The change control log listed the authorising "change forums" to have included the ICT Clinical Advisory Forum, and individual officers. While supporting groups may apply expert scrutiny and advice, the Programme and Project Boards approval roles should be clarified.	Potential risk that: • The accountable parties are not appropriately involved in programme authorisations of time and cost changes.
Recommendations	**Priority**
6.1 The approval roles of the Programme and Project Boards should be specified.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
6.1 Update Programme Definition Document to reflect approval roles and bring to ePCR Programme Board for approval.	End of December 2022	ICT Programme Manager

Matter Arising 7: Time - Change control (Design)	**Impact**
The change control register acts as the prime control document summing total programme cost changes. It was supported by change control authorisations. The contract details (at clause 19.3.4) that where delays occur due to the contractor, that they may be liable for "*the extra costs of management time*". A paper submitted to the Programme Board on 11th April 2022 details that the contractor has not been responsible for any such delay. The contract was initially extended free of charge from 18/11/21 to 31/3/22, but the contractor has levied an additional charge of £19,535 due to further client delay to 24th August 2022 (due to additional time required by Health Board partners to prepare for "Go live"). While the additional costs were approved as part of the change control process, there was therefore a need to identify time implications of any changes (and any additional resultant costs), assigning responsibility to the client or the contractor. While both the change control register and authorisation forms included costs, they did not separately identify time implications.	Potential risk that: • Management are not appropriately informed

Recommendations	**Priority**
7.1 Time implications of change control, designating client or contractor liability should be included at both change authorisations and the change control register.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
7.1 Agreed – we will review the mechanisms utilised for risk management for appropriate functionality as part of a broader lessons learned exercise.	End of Q4 2022/3	Interim Assistant Director for Research, Audit and Service Improvement & The Assistant

		Director of Planning & Transformation

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that the project achieves its key delivery objectives and 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.
	**No 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.

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AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

Environment, Decarbonisation and Sustainability Update – December 2022

MEETING	Finance & Performance Committee
DATE	16th January 2023
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Richard Davies – Assistant Director of Capital and Estates Nicola Stephens – Environment and Sustainability Manager Jo Williams – Head of Capital Development
CONTACT	Joanne.williams10@wales.nhs.uk

EXECUTIVE SUMMARY

- To provide an update on progress with delivering the WAST Decarbonisation Action Plan (in response to Welsh Government's NHS Wales decarbonisation strategic delivery plan (*NHSW- DSDP*))
- To provide an update on Welsh Government reporting
- To update the Committee on work to progress with an EV charging network
- To note receipt of a recent draft Internal Audit review and report of Audit Wales
- To note confirmation of capital investment in the Trust and schemes of work

Recommendation – Committee to asked to note this update

KEY ISSUES/IMPLICATIONS

None

REPORT APPROVAL ROUTE

Capital Management Board – 13th December 2022 for noting

EMT – via email – 30th December 2022

Finance & Performance Committee – 16th January 2023– for noting

REPORT APPENDICES
N/A

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

December 2022

SITUATION

1. This paper presents the Finance and Performance Committee with an update on the work being undertaken in support of the Trust's Environment 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 reporting on a regular basis accordingly. This discipline will be further developed over the course of future updates as the performance reporting against the programme develops and programme management arrangements are further enhanced and embedded.

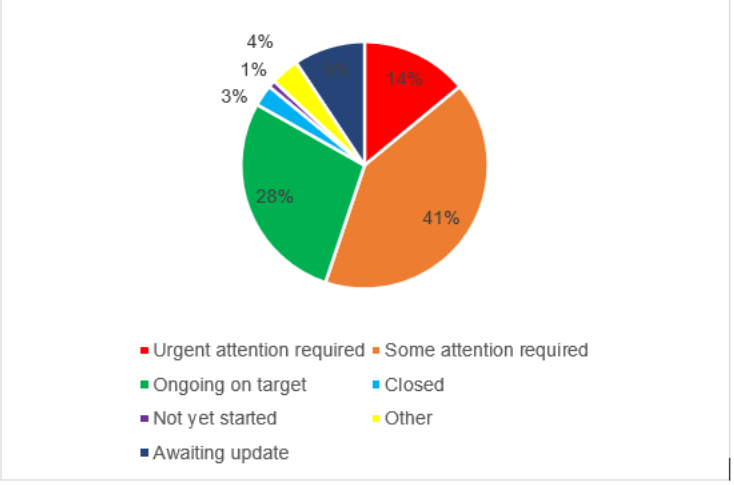
ASSESSMENT

WAST Decarbonisation Action Plan update.

5. At its meeting in September 2022 the Finance and Performance Committee received an initial assessment of delivery against the Trust Decarbonisation Action Plan (DAP). 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 is a work in progress and somewhat subjective but helpful in identifying an overall value. At that time, the assessment was Red/Amber with 27 red (urgent attention required) and 32 amber (some attention required) actions noted alongside 29 green actions (ongoing on target). It should however be noted that given the complexity and range of actions within this plan (106 separate actions in total), it is perhaps too simplistic at this stage to attribute an overall value to the plan.

6. A second assessment update (December 2022) is enclosed below, and an overall indicative rating has now been regraded to **AMBER** to reflect the shift in progress and reduction in the number of red actions during this period.

ALL	**Total actions on report**	**106**
	Urgent attention required	15
	Some attention required	44
	Ongoing on target	30
	Closed	3
	Not yet started	1
	Other	4
	Awaiting update	10
	OVERALL REPORT RATING	**AMBER**



Items of progress

- The Trust has received confirmation of an additional £0.5m All Wales Capital Funding through to the end of the 2022/23 financial year, to further accelerate some decarbonisation schemes (see below).
- Linked to the above, the Trust is investing in Building Management Systems which provide the opportunity to remotely manage and monitor key systems such as heating and cooling within a number of our larger buildings.
- A design guide is being written for the retrofit of existing WAST estate to improve compliance with decarbonisation requirements such as LED lighting and double glazing. Implementation of this will be further supported through the above funding.
- Following a separate successful bid to WG for £60k funding, work continues on the scoping of the WAST estate to determine optimum locations and infrastructure requirements for EV charging as well as opportunities to access other technologies such as installation of solar panels, battery storage and alternative heating systems.
- A project has commenced with Welsh Government Energy Services to scope the requirements for rapid EV charging at Newtown Ambulance Station.
- Establishment of programme management arrangements now that Project Manager support is in place. The first Decarbonisation Programme Board is scheduled for January 2023 (rescheduled from December due to Industrial Action and Operational pressures).

Areas of action

- Focus on areas within the DAP which require attention and further support for example NWSSP support in procurement including encouraging more localised expenditure and realising community benefits, wider infrastructure requirements and directorate ownership and progression of specific actions.
- Some areas have actions which have yet to be started, for example lease/pool cars and clinical impacts – the establishment of project management arrangements and programme board reporting/structures will facilitate some support to increase momentum in these areas.

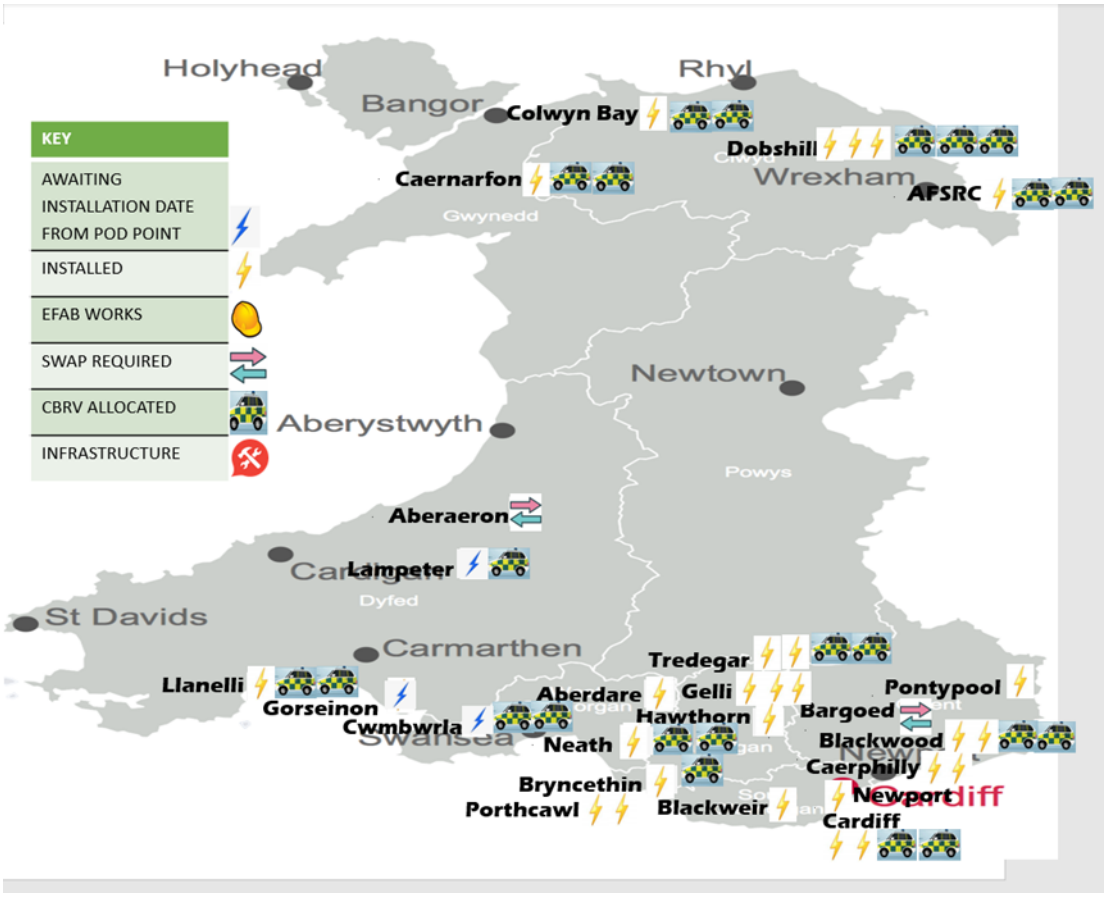
Welsh Government reporting

7. Welsh Government set out a new framework for reporting comprising quantitative and qualitative reporting data sets. The Trust's quantitative report was submitted on 9th September with the qualitative report submitted on 14th September via the *NHS Performance Framework Qualitative Measures - 2022-2023 - Qualitative Reporting* template. At the time of writing, no feedback has yet been received from WG but a workshop was scheduled for 20th December 2022 for all NHS Wales organisations where it is hoped feedback will be provided – an update on this will therefore be provided to the Committee.

8. Following on from a discussion with Welsh Government's Deputy Director – Climate Change and Environmental Public Health, and a further joint meeting between WAST, WG officials and Welsh Government Energy Services to highlight some of the risks around the WAST specific actions in the Decarbonisation Strategy, WAST also attended the NHS Wales Decarbonisation Programme Board in September. Representatives gave an overview of progress being made as well as the challenges currently being faced. In response to this, and input and comments from other NHS Wales organisations, a further Transport Task and Finish Group has been established to consider impacts of EV infrastructure, fleet and investment requirements. WAST will continue to participate in these groups and to raise the profile of WAST owned actions within the strategy.

Roll out of 23 hybrid Car based response vehicles and EV charging network

9. Work continues on the infrastructure and EV charging network which will support the roll out of WAST's EV fleet. An updated map of charging locations and EV placement is provided overleaf.



10. The Executive Management Team considered a detailed paper on proposals for progressing the EV charging network in September 2022. EMT have noted that staff charging is a desirable future opportunity but that currently the Trust is clear that the charging infrastructure is for Trust vehicles only. Further actions have been identified to consider opportunities for trickle charging via external sockets on Trust sites where safe and practical to do so. This is included within the estate scoping work outlined in the previous update and as highlighted in the further update below.

11. As noted at the September Finance and Performance Committee meeting and above, a wider survey of the existing WAST estate to analyse the infrastructure available, capacity at sites, and a programme of works for the roll out of improvement works, including installation of chargers, was identified against £60k funding provided by WG. This work has commenced, with an initial pilot at the Pembroke Dock site, before being extended on a prioritised list (areas of greatest opportunity/return) focussing on packages of 5 sites each within North, Central and West and South East. It should be noted that these surveys are likely to generate a significant capital investment requirement to upgrade current infrastructure.

12. Whilst the initial work has been led by Finance and Corporate Resources (Fleet, Finance, Capital and Estates), it is acknowledged that wider support from across the Trust will be required as the group works through a range of implications such as ICT, counter fraud, health and safety, workforce and operational arrangements. A Transport Project Board is being established and representatives from across the Trust are being sought for this. The first meeting will take place in February 2023 following the rearranged date for the

Programme Board in January 2023. The original group overseeing this work continues to meet in the meantime.

Internal Audit – Decarbonisation

13. An Internal Audit (IA) took place during October, as part of this year's agreed IA plan, and a significant amount of information (comprising c50 pieces of information) was provided to the Internal Audit Team.

14. It is noted that the output of this work is a generic all NHS Wales report, a draft of which has now been received. and further discussions with the Internal Audit team held on 19th December. The management response to the recommendations is now being finalised following these discussions, but it is noted that many of these actions are already being managed by the Trust, given the non-specific nature of the findings and recommendation of the report. The final report will then be presented to Audit Committee on 2nd March 2023.

Audit Wales Report

15. The report "*Public Sector Readiness for Net Zero Carbon by 2030: Report of the Auditor General for Wales*" was published by Audit Wales on 14th July 2022 based on information submitted by public service organisations in 2021 (WAST participated fully in the request for information from Audit Wales and completed a comprehensive submission in December 2021). Within that submission, WAST was clear at that stage that whilst we were developing our response to the WG strategy, the development of our Decarbonisation Action Plan was in its infancy and whilst there was an anticipation of significant investment requirements to support the implementation of the plan, the costs of this were not yet quantified. Detail was provided regarding the barriers and risks to implementation.

16. The recommendations of the report, across the public sector in Wales, were as follows:
    a. *Strengthen your leadership and demonstrate your collective responsibility through effective collaboration*
    b. *Clarify your strategic direction and increase your pace of implementation*
    c. *Get to grips with the finances you need*
    d. *Know your skills gaps and increase your capacity*
    e. *Improve data quality and monitoring to support your decision making*

17. The Trust recognised the themes as a reflection of information provided as well as discussion across NHS Wales organisations. The report and initial reflections from the Trust were discussed at the Audit Committee in September 2022. A formal response to the report was not sought by Audit Wales, but the themes are helpful in guiding the Trust's further development of the Decarbonisation Action Plan and align to work already ongoing. It is acknowledged that improvements have accelerated quickly during the past six months, especially with the appointment of a dedicated Project Manager and Environment and Sustainability Officer. A current reflection on progress against the recommendations is therefore outlined below.

- There is Executive level commitment to the DAP and the establishment of the Decarbonisation Programme Board further strengthens and extends the ownership of actions from the Finance and Corporate Resource Teams (Finance, Fleet, Capital Development and Estates) across the organisation. We continue to work with partners and welcome further opportunities to do so. WAST already participates in Welsh Government, NHS Wales and Joint Emergency Services Committee governed groups, representing WASTs unique position as both an NHS and a blue light response organisation.
- The Decarbonisation Action Plan sets out the strategic direction and this is included within the 2022/25 IMTP which has received WG endorsement. The pace of implementation will vary across different elements of the plan. We are however clear in our response, and in our planning assumptions, that there will be a resource requirement to facilitate this both in terms of project management resource, people resources to implement the work and act as change agents for this major programme of change, and capital and revenue investment to do so.
- The team has started to increase the resources available to dedicate to this work, but it should be noted that to date this work has been an additional element of wide portfolio roles for a small number of individuals. It is recognised that additional people resources will be required to implement the changes required, but this will come with a significant revenue implication in order to do so. It may be necessary to think about joint opportunities across teams, and even across organisations but this will need further work and a prioritisation of resource to do so, even more so given the current financial outlook.
- The Trust is making some significant improvements with regard to data collation and monitoring. We are developing metrics to be reported at Board level, and a suite of metrics to be considered at Programme Board level. The delivery of actions within the DAP is now regularly monitored as outlined within this report.

Capital Investment

18. Following a call for bids against All Wales Capital Funding slippage though to the end of 2022/23, the Trust has been successful in obtaining £0.5m for decarbonisation schemes across the estate. A significant amount of work is currently underway therefore to progress the schemes against this funding (see below) and undertake procurement processes in order to commence the work in line with the 31st March 2023 deadlines.

19. The schemes broadly comprise a range of projects under the following headings:
    i. LED lighting
    ii. Building Management Systems
    iii. Air Source Heat Pumps
    iv. Double glazing
    v. EV charging infrastructure

20. Further WG Estates Funding Advisory Board (EFAB) funding for 2023/24 and 2024/25 has also been confirmed, with a range of schemes proposed by the Trust receiving support. This is a very positive development, with the Trust being awarded a proportionally significant amount of the total funding available,

with a breakdown of the schemes supported outlined below. One difference from when this funding has been made available previously however is that alongside the confirmation of the funding from Welsh Government (70%), WAST will be required to make a contribution (30%) from its discretionary capital funding, in the relevant financial year.

Received 2023-24			
Scheme	Total cost	WG 70%	WAST 30%
Decarbonisation	£568,800.00	£398,160.00	£170,640.00
Infrastructure	£381,600.00	£267,120.00	£90,720.00
Fire Safety	£0.00	£0.00	£0.00
	£950,400.00	**£665,280.00**	**£261,360.00**

Received 2024-25			
Scheme	Total cost	WG 70%	WAST 30%
Decarbonisation	£596,400.00	£417,480.00	£178,920.00
Infrastructure	£302,400.00	£211,680.00	£90,720.00
Fire Safety	£332,400.00	£232,680.00	£99,720.00
	£1,231,200.00	**£861,840.00**	**£369,360.00**

21. The delivery of schemes under the EFAB funding scheme will be project managed by the Capital Development and Estates Teams and will be overseen by the Decarbonisation Programme Board.

RECOMMENDATION

Finance and Performance Committee is asked to:

- **NOTE** this update, specifically in relation to the DAP reporting and establishment of programme management arrangements

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of APPENDIX ATTACHED	**0**

Committee Priorities 2022/23

MEETING	Finance and Performance Committee
DATE	16 January 2023
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 2022/23.

2. Progress is steady across all priorities.

RECOMMENDATION

3. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable

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)	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 FOR 2022/23

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2022/23.

BACKGROUND

5. During the course of the 2021/22 effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year.

6. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2022 and will be tracked quarterly.

ASSESSMENT

7. The Committee priorities, and progress against them is as follows:

Priority	Progress

Focus on assurance to be provided on the additions to the terms of reference i.e. estates and fleet, environmental and sustainability, digital systems and strategy, and emergency preparedness, resilience and response.	• The November 2022 meeting approved the Lease Car Policy
	• The November 2022 meeting in private session will review the fleet replacement business case.
	• The September 2022 meeting received the cycles of business. These set out with more particularity the assurances and reporting that will be forthcoming to the Committee and their timing.
	• The May, July, September and November meetings received decarbonisation and sustainability updates.
	• The July meeting reviewed:
	  • Business continuity assessment
	  • Emergency preparedness, resilience and response and document tracker
	• The May meeting reviewed:
	  • Internal audit on digital governance.
	  • Internal audit on Cardiff MRD
	• Risk 244 'estates accommodation capacity limitations impacting on EMS CCC's ability to provide a safe and effective service'; Risk 245 'failure to have sufficient capacity at an alternative site for EMS CCCs which could cause a breach of statutory business continuity regulations'; and Risk 311 'inability of the estate to cope with the increase in FTEs' are reviewed at each meeting.
	• Risk 260 'a significant and sustained cyber-attack on WAST, NHS Wales and interdependent

	networks resulting in the denial of service and loss of critical systems' is reviewed by the Committee.

RECOMMENDATION

8. The Committee is asked to note the update.